COURSE GUIDE

COURSE CODE: **PHS 801**

COURSE TITLE: **INTRODUCTION TO PUBLIC HEALTH AND PRIMARY HEALTH CARE.**

COURSE DEVELOPER: **DR. MRS. MARTINA .C. EZEAMA**
DEPARTMENT OF NURSING SCIENCE. FACULTY OF HEALTH SCIENCES. IMO STATE UNIVERSITY OWERRI

NATIONAL OPEN UNIVERSITY OF NIGERIA

TABLE OF CONTENT

CONTENTS PAGE

INTRODUCTION:

The terms in Public Health are used differently in different countries and are interpreted differently depending upon their ideological perspectives. There is a multitude of terms, including health education, health improvement, health protection, disease prevention and health development. It is important to reflect upon the historical context, the professional interests and ideologies that underpin these different concepts. The origin of these terms and their application will be explored by reviewing the history of development of health promotion. In 1920, the most influential thinker and writer on Public Health, C.E.A. Winshow described Public Health as: ”The science and art of providing health, preventing disease and prolonging life through the organized efforts of society (Winshow 1923). In his writing of the modern Public Health he provided a scholarly analysis of the origins of Public Health. Most important, he emphasized the beginnings of new phase in Public where “education is the key note of modern campaign for Public Health”. He identified new machinery through which such education could be accomplished as health instituton among others.

This course covers the evolution of the concept of Public Health (PH), Primary Health Care (PHC) and current Primary Health Care (PHC) practices in the developing countries. It analysis and reviews the principles and eight essential elements of PHC, as defined by the 1978 Alma Ata conference under the joint sponsorship of the World Health Organization (WHO) and the United Children’s Education Fund (UNICEF). Management and logistical aspects of PHC profiles child survival, a global initiative began by UNICEF and embraced by the United States Agency for Internal Development (AID) and many voluntary organizations dedicated to the health and development is reviewed in the content of PHC. This course provides the students with an introduction to the Public Health and PHC delivery system.

WHAT YOU WILL LEARN IN THIS COURSE

The Course consists of units and a course Guide. This course guide tells you briefly what the course is about, what course materials you will be using and how you can work with these materials. In addition, it advocates some general guide lines for the amount of time you are likely to spend on each unit of the course in order to complete it successfully. The course highlights the issues of Public Health and Primary Health Care in broad perspectives; ranging from historical perspectives, development and growth to the various actors in the course of their development and the various roles played by them.

It gives you guidance in respect of your Tutor Marked Assignment which will be made available in the Assignment file. There will be regular tutorial classes that are related to the course. It is advisable for you to attend these tutorial sessions.

The course will prepare you for the challenges you will meet in the field and practice of Public health.

GOAL:

This course is designed to advance Public Health knowledge, promote health and well being, and prevent diseases, disability and premature mortality. This will be accomplished through academic excellence in education of Public Health professionals, rigorous scientific research of Public Health problems, creative partnerships to advance the practice of public Health innovative service to the local, national and international Public Health community.

COURSE OBJECTIVES:

On the completion of this course the students will:

- Define Public Health.
- Trace the Historical perspective of Public Health.

- Describe the development and growth of Public Health with various approaches and concepts
- Describe recent developments in Public Health and its future directions;
- Define the Problems and the magnitude of the problems
- Describe the problem-solving methodology applied in Public Health
- Developing Conceptual Framework for understanding the key determinants.
- Identify and develop strategies(Policies and interventions)
- Set priorities and recommend interventions or policies
- Implement intervention and evaluation plan.
- Develop a communication strategy
- Define Primary Health Care (PHC) as defined by 1978 Alma Ata declaration conference
- Enumerate eight essential elements
- Describe the evolution of the concept of Primary Health Care
- Current PHC practices in the developing countries
- Reduction of the gap existing between the Health Status of developing and developed countries

WORKING THROUGH THIS COURSE

To complete this course, you are required to read each study unit, read the text book and read other materials which may be provided by the National Open University of Nigeria.

Each unit contains self assessment exercises and at certain points in the course you would be required to submit assignments for assessment purposes. At the end of the course, there is a final examination. The course should take you about a total of 15 weeks to complete. Below, you will find all the listed components of the course, what you have to do and how you should allocate your time to each unit in order to complete the course on time and successfully.

This course entails that you spend a lot of time to read. I would advise that you avail yourself the opportunity of attending the tutorial sessions where you have the opportunity of comparing your knowledge with that of other people.

COURSE MATERIALS

The main components of the course are:

1. The Course Guide
2. Study Units
3. References/Further Readings
4. Assignments
5. Presentation Schedule

STUDY UNITS:

This course comprises of five modules broken into 18 units. They are as listed below:

Module 1	**Introduction to Public Health**
Unit 1:	Definition and Concept of Public Health
Unit 2:	Concept of Social Justice of Public Health
Unit 3:	Unique Functions of Public Health
Unit 4:	Developing Conceptual Framework for Understanding the Key Determinants
Module 2	**Recent Developments in Public Health and Its Future Direction**
Unit 1:	Defining the Problem and Measurement of the Magnitude of the Problem
Unit 2:	Identifying and Developing Strategies
Unit 3:	Implementing Intervention and Evaluation Plan
Unit 4:	Developing Communication Strategies
Module 3	**Introduction to Health for All in the Year 2000 AD**
Unit 1:	Definition & Concept of Health for All
Unit 2:	Historical Perspective
Unit 3:	Target for Health for all
Module 4	**Introduction to Primary Health Care Concept and National Health Policy**
Unit 1:	Concept of Primary Health Care
Unit 2:	Principles of Primary Health Care
Unit 3:	Organization of Primary Health Care
Unit 4:	Referral Services in Primary Health Care
Unit 5:	Introduction to National Health Policy

Module 5	**Reduction of Gaps Existing Between the Developed and Developing Countries**
Unit 1:	Identification of Gaps
Unit 2:	Way Forward in Identifying the Gaps

Module 1

Unit one, introduces you to the Concept and Definition of Public Health. Unit two concept of social justice in public health. Unit three will take you to the unique functions of public health and Unit four deals with the development of conceptual framework for its determinant.

Module 2

Unit one deals with Defining the Problem and Measurement of the Magnitude of the Problem. Unit two deals with Identifying and Developing Strategies. Unit three deals with Implementing Intervention and Evaluation Plan. Unit four deals with developing Communication Strategies.

Module 3

In Unit one, you will be taking through the definition and concept of Health for all in the year 2000 AD. Unit two you will be introduced to the Historical perspective. Unit three, you will learn about the UNICEF/WHO Health for Health for Policy to provide Health Services to all. Unit four, you will learn about the Targets for Health for all and launching movement.

Module 4

Unit one, you will be taken through the Concept of Primary Health Care. Unit two, you will learn the Principles of Primary Health Care. Unit three, you will be introduced to the

Organization of Primary Health Care while Unit four deals with the referral services in Primary Health Care.

Module 5

Unit one, you will be taken through the Identification of Gaps. Unit two, you will learn the Way forward in filling the identified Gaps.

PRESENTATION SCHEDULE

Your course materials have important dates for the early and timely completion and submission of your TMAs and attending tutorials. You should remember that you are required to submit all your assignments by the stipulated time and date. You should guard against falling behind in your work.

ASSESSMENT

There are three aspects of the Assessment of the course. First is made up of self-assessment exercise, second consists of the tutor marked Assignment (continuous assessment) and third is the final examination at the end of the course. You are advised to do the exercises. In tackling the assignments, you are expected to apply information, knowledge and techniques you gathered during the course. The assignments must be submitted to your facilitator for formal assessment in accordance with the assignment file. The work you submit to your tutor for assessment will count for 30% of your total course work. At the end of the course, you will need to sit for a final or end of course examination of about three hour duration. The examination will count for 70% of your total course mark.

TUTOR MARKED ASSIGNMENT

The TMA is a continuous assessment component of your course. It accounts for 30% of the total score. You will be given four (4) TMAs to answer. Three of them must be answered before you are allowed to sit for the end of course examination. The TMAs would be given to you by your facilitator and returned after you have done the assignment. Assignment questions for the units in this course are contained in the assignment file. You will be able to complete assignment from the information and the material contained in your reading, references and study units. However, it is desirable in all degree level of Education to demonstrate that you have read and researched more into your references, which will give you a wider view point and may provide you with a deeper understanding of the subject.

Make sure that each assignment reaches your facilitator on or before the dead line given in the presentation schedule and assignment file. If for any reason, you cannot complete your work on time, contact your facilitator before the assignment is due to discuss the possibility of an extension. Extension will not be granted after the due date unless there are exceptional circumstances.

FINAL EXAMINATION AND GRADING

The end of course, examination for introduction to the concept of Public Health and Primary Health Care will be for about 3 hours and or has a value of **70%** of the total course work.

The examination will consist of questions, which will reflect the type of self testing, practice exercise and tutor marked assignment problems you have previously encountered. All areas of the course will be assessed.

Use the time between finishing the last unit and sitting for the examination to revise the whole course. You might find it useful to review yourself test, TMAs and comments on

them before the examination. The end of course examination covers information from all parts of the course.

Table 1

COURSE MARKING SCHEME

Assignment	**Marks**
Tutor Marked Assignment – 4	Four Tutor Marked Assignments, best three marks of the four count at 10% each 30% of the course marks
End of course Examination	70% of overall course marks
Total	100% of course materials

FACILITATORS / TUTORS AND TUTORIALS

These are 16 hours of tutorials provided in support of this course you will be notified of the dates, times and location of these tutorials as well as the name and phone number of your facilitator, as soon as you are allocated a tutorial group. Your facilitator will Mark and comment on your assignments, keep a close watch on your progress and any difficulties you might face and provide assistance to you during the course. You are expected to mail your Tut or Marked Assignment to your facilitator before the schedule date (at least two marking days are required). They will be marked by your tutor and returned to you as soon as possible. Do not delay to contact your facilitator by telephone or e-mail if you need assistance.

The following might be circumstances in which you would find assistance necessary, hence you would have to contact your facilitator if:

- You do not understand any part of the study or the assigned readings.
- You have difficulty with the self –tests.
- You have a question or problem with an assignment or with the grading of an assignment.

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

SUMMARY

Introduction to Public Health (PH) and Primary Health Care(PHC)system are courses that intend to provide information on Evolution of Health care delivery system in Nigeria. Is concerned with all process and the entire system of definition of concepts of PH and PHC, development and growth with various approaches and concepts, recent development and its direction, Primary Health Care ,National Health Policy, Defining and measuring the magnitude of the problems, Setting Priorities and recommending interventions or Policies ,drawing evaluation Plans ,developing communication strategies and recommending way forward in the reduction of the gaps between the developed and developing countries, ensuring availability, affordability and accessibility health care services to members of the community. Upon completing this course, you will be equipped with the basic knowledge of the above concepts at all levels of Government. In addition, you will be able to answer the following types of questions:

- Define Public Health.
- Define Primary Health Care.
- Describe the historical perspective of PH and PHC
- Describe recent development and its direction
- Defining Problems
- Describing measurement of the magnitude of the problems
- Describing a conceptual framework for understanding key determinants of the problems.

- Identify and develop strategies (Policies and interventions).
- Set Priorities in recommending interventions
- Implement intervention and evaluation plans
- Identify strategy for reduction of the gap existing between the developed and undeveloping Countries..

Of course, the list questions, that you can answer is not limited to the above list.

To gain the most from this course you should endeavour to apply the principles you have learnt to your understanding of Public Health and Primary Health Care concepts. I wish you success in the course and I hope that you will find it both interesting and useful.

PHS 801 MODULE 1: INTRODUCTION TO PUBLIC HEALTH

STUDY UNIT 1: DEFINITION AND CONCEPT OF PUBLIC HEALTH

TABLE OF CONTENTS

1.0 INTRODUCTION

The passing of one century and the first decade of another afford a rare opportunity to look back at where Public Health has been and forwarded to the challenges that lies ahead. As far back as from 1950-2000, life expectancy at birth was poor 12.6%, life expectancy at age 65 (1950-2000) was 26.6%. Some improvement were recorded from 1900-2000 where life expectancy at birth was 60.3% and infant mortality rate was 93.7%.

These results did not occur by themselves. They came about through decisions and actions that represent the essence of what is Public Health. This text will discuss the story of Public Health and its immense value and importance in our lives. Also is an introduction to Public Health that links basic concepts to practice. The topic

in the text provides a foundation for understanding what Public Health is and why it is important. The conceptual framework that approaches from a system perspective is introduced to identify the dimensions of Public Health system and facilitate an understanding of the various images of Public Health that coexists in Nigeria.

2.0 Unit Objectives

At the end of this Unit, you will:

- Define the concept of Public Health
- Describe the history and development of Public Health in Nigeria
- State the objectives of Public Health
- Describe structure and organization of health services in Nigeria

3.0 Main Content

3.1 Definition and Concept of Public Health

Winshow, one of the leading figures in the history of Public Health in 1920 defined Public Health as "The Science and Art of preventing diseases, prolonging life and promoting health and efficiency through organized community effort" for the sanitation of the environment, the control of communicable infections, the education of the individual in personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and for the development of the social machinery to insure everyone a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize his birthright of health and longevity. This definition summarizes the philosophy of Public Health, which remains largely true even today.

3.2 History of Public Health in Nigeria

History does not only remind us of the past, it also helps us to understand the present and plan for the future. Thus we need to understand this aspect for us to

appreciate the enormous task of organizing a health service in a large country, like Nigeria. There is paucity of information on the evolution of public health in Nigeria. The following accounts were given by Bashua and Akinbola.

The history of Public Health in Nigeria can be traced back to the 19th century when the white settlers arrived in Nigeria. Although the primary aims of these white settlers were threefold: to colonize, trade and act as missionaries but no sooner they came than they drew attention to the poor health condition of the natives and their poor hygienic practices.

Like other West African countries, medical services in Nigeria emerged from a military background intermingled with commerce and missionary efforts. The first medical doctor to come to Nigeria was Dr. Jones Mcwilliam. He came during an expedition between 1841 and 1854. His coming to Nigeria was significant because he made available the first written account about health problems in Nigeria, especially as regards the death among the crews due to malaria.

The first hospital in Nigeria was built in Lagos around 1863. This hospital started primarily as a centre for sick seaman of the Royal Navy. All the medical activities in Nigeria at that time were confined to Lagos.

During the time of Lugard as the commander of the West African frontier force, he set up his headquarter in Lokoja. This being a “river town” and a poor rural area posed a lot of health problems for Lugard and his men. These problems which resulted to many deaths among the crew was rightly associated with bad housing, poor food and exertion by lord lugard and his crew. Lugard therefore made provision for good housing for his men and warned them against exposure to sun. In 1898, Ross discovered that malaria was due to the bite of mosquitoes and not due to decayed vegetable matter as previously believed. Lugard became aware of this discovery and that prompted him to inform his men to protect themselves with mosquito net, take 5 grains of quinine daily and boil their water and milk; he also

stressed the importance of physical exercise. Although history had it that he nearly poisoned himself of overdosage of quinine, nevertheless his measures gradually improved the health of his crew. As a follow up all these preventive measures, between 1900 and 1910, Lugard established small military hospitals in Lokoja, Jeba, Zungeru and Zaria.

It should be recalled that in all the towns where the Europeans settled in Nigeria, they lived in reservations, mainly for health reasons. In the towns, the streets were dirty; houses had no water supply, bath or even kitchen; and no access roads. Because of the gravity of the problems, the few medical men could not make an impact.

Gradually, sanitary reforms were commencing and by 1877, the appointment of the first inspector of Nuisances was gazette. By 1897, Lagos had a Medical and Sanitary Directorate which was headed by DR. H. Strachan as the Chief Medical Officer. He was assisted by Mr. W.M. Mackinson (the sanitary engineer) and Mr. F. Lumpkin (The inspector of Nuisances). These three men were also assisted by thirteen colonial surgeons, three of whom were Nigerians- Dr. C.J. Lumpkin, Dr. S.A. Leigh-Sodipo and Dr. O. Sapara who later founded Massey Street Maternity Center, Lagos. This team of 16 government officials worked relentlessly to reform Lagos. They drew up ordinances and rules for housing and sanitation, meat houses and markets, hospital, erection of new houses, etc. The ordinances stipulated that building plans and sites should be approved by the medical officer.

One major problem which the teak faced was the problem of sewage disposal. Several factors were responsible for this, such as the swampy nature of Lagos, poor habits, bad impassable roads, etc. By 1897, £5 penalty was stipulated on anyone who contravened the regulation that “bucket content should be thrown into Lagoon from 9:00pm till mid night only”. This led to the introduction of “night soil conservancy”.

By 1899, Sir William MacGregor, a doctor by profession, was appointed the governor of Lagos. He became keenly interested in sanitation and because of his activities; his period was referred to by Nigerians as a "Golden age". With the support from Sir Ronald Ross, anti-malaria measures were vigorously pursued in form of drainage and treatment of stagnant water with spades, shovels and mineral oil which Ross himself actively did. Apart from this, a government chemist was appointed to test all the 203 wells in Lagos. All the wells except one were polluted. This led to the provision of new wells which were cemented for the prevention of malaria, quinine was regularly supplied to the officials and also "Lagos mothers and children". In 1901, Lagos was divided into districts and a voluntary women's group was formed which served as the first group of health visitors, under the chairperson of Mrs. Sapara William whose husband aided the development of llesa hospital. This group did not only visit patients but also donated food to them and cared for the sick.

In 1909, the secretary of state for the colonies sent Professor W.J.R. Simpson to West Africa to achieve the following objectives:

i. To control the outbreak of plague in Ghana and revise quarantine laws and procedure and

ii. To report on sanitary matter in all the West African colonies. In what was later known as the Simpson's. report, Simpson recommended that

a. A uniform system of quarantine should be adopted for the West African colonies

b. People travelling from one West African port to another should be put under quarantine except if they possessed valid certificate of inoculation and certificate of disinfection of clothing and

c. Notification of mortality amongst rats or passengers

On Simpson's visit to Lagos he was impressed by the efforts of Macgregor and Ross, especially the canal and reclamation of swamps. He therefore recommended Iju river should supply Lagos, an infectious disease hospital should be built to supplement the existing nursing home in Lagos, and that a general hospital should be built in Calabar.

In 1911 Dr. J.A. Pickles was appointed a senior sanitary officer in Lagos after working in Ogbomoso district. During his tenure, he visited Brazil to observe methods of yellow fever treatment and later recruited three white sanitary inspectors to assist him in Lagos. His team development an anti-malaria campaign measure consisting of oiling of stagnant water, spraying of pools and building: and the use of mosquito proofing. As a result of the team's efforts to destroy all the rats in homes and surroundings, the plague epidemic in Ghana never reached Nigeria.

Except for the withdrawal of some of the health officers for military operation in 1914, Dr. Pickles wanted to introduce the training of sanitary inspectors. The school for public health inspectors was later established by Dr. Oluwole in 1952 when he was the Assistant Medical Officer of Health.

In 1916, keeping of vital statistics (i.e. record of marriage, birth and death) was introduced after arranging for numbering of streets a move which initially received with opposition by members of the public.

In 1918, Nigeria suffered from an epidemic of influenza, small pox and meningitis while in 1924; Lagos was hit by an epidemic of bubonic plague. During these periods of disaster, every conceivable measure was put into operation, including evacuation of people from worst hit area; disinfection where necessary; demolition of houses; burying of corpses; destruction of rats with poison; and house to house inspection to remove the sick to the Infectious Diseases Hospital.

In 1925, Dr. L.C. Olumole, who today is regarded as the father of Public Health in Nigeria, was appointed the Assistant Medical Officer of Health, Lagos. Having been inspired by the efforts of Ross, he believed that doctors could not solve the problems alone. He therefore established the first school of Hygiene in Lagos in 1925 where sanitary inspectors were trained for the whole of Nigeria. With the graduates from this school, sanitary efforts were started in Lagos in earnest. Dr. Oluwole later became the first African Chief Medical Officers and through his efforts, the Royal Society of Health West African Examination Board was established.

The examples laid by Dr. Oluwole were later followed to lay a good pattern for public health in other provinces outside Lagos. In 1946, Nigeria was divided into three regions politically and administratively with Ibadan, Enugu and Kaduna as regional headquarters. Each province had a Deputy Director of Medical Services who was still responsible to the Chief Medical Director in Lagos. Each region had a Medical Department Headquarter which had two arms; curative and preventive. The curative service was under the Chief Medical Officer while the preventive side was under the Chief Health Officer. Apart from being medically qualified, the Chief Health Officer must also have a Diploma in Public Health.

The creation of the regions gave room for the establishment of more schools of hygiene at Ibadan, Aba and Kano and thus the training of more sanitary inspectors to enforce sanitary laws. Between 1956 and 1959 when self-government was granted to the three regions, each region established a Ministry of Health and Social Welfare to replace the Department of Health. The ministries were headed by a Director of Medical Services. Furthermore, local government authorities were created to share the responsibility with the ministry of Health. Apart from Lagos and Ibadan, this arrangement was not successful in other regions.

Finally, it is worthy of note that apart from the activities of those described above, the history of public health in Nigeria cannot be complete without mentioning the important roles played by missionary organizations, such as the Catholic Church, the Methodist, Baptist Church, Seventh Day Adventist Church, etc

3.3.1 Aims and Objectives of Public Health

- To protect the general public from the spread of communicable diseases
- Promote physical and mental health prevent diseases, injury and disability
- Improve health outcomes and health status that can be achieved by work of all as individually and collectively

3.4 Structure, Organization and functions of Health Services in Nigeria

In Nigeria today, there are three tiers of government. These are Federal, State and Local governments. Each one has a very important role to play in the organization of health services in Nigeria. Nevertheless, it is note worthy that today, unlike in the past, local governments have very important role to play in the provision of health services at grass root level and they are now directly responsible to the Federal government – Federal Ministry of Health.

Federal Government Level-Federal Ministry of Health

The role and functions of the Federal Ministry of Health in the organization of health services in Nigeria are as follows:

1. Formulation of national health policies
2. Provision of funds for manpower training and establishment of specialized training and establishment of specialized training and research institutions, such as colleges of Medicine, Teaching hospitals and research units

3. Provision of funds for the ministries of health or health departments at state and local government levels respectively, either for capital projects, training or research
4. Monitoring and supervision of projects and programs at state and local government levels
5. Setting of standard of state and local government health department departments
6. Organizing tertiary care institutions etc

State Level-Ministry of Health

The state ministry of health is responsible for the organization and management of training institutions in the state, such as the schools of Nursing and the schools of Health Technology respectively. Other important functions of the state ministry of health include:

1. Formulation of state health policies
2. Translation and execution of federal health policies
3. Recruitment and discipline of staff
4. Setting of standard for private and mission hospitals and clinics
5. International liaison, i.e. liaison with international agencies , such as UNICEF
6. Research activities

Local Government Level (Department Of Health)

The functions of the local governments as health care providers can be listed as follows:

1. Formulation of policies at local government level
2. Recruitment, training promotion and discipline of staff
3. Planning and organizing of P.H.C. services
4. Liaising with state and federal governments on primary health care matters

5. Enforcement of environmental health laws
6. Referral services e.t.c.

4.0 Conclusion

In this unit you have learnt the definition and concept of Public Health, history and development of Public Health in Nigeria and the goals and importance of Public Health. You should now be able to briefly describe the history of Public Health in Nigeria, define the concept and the importance of Public Health in the National Health Care Delivery System.

5.0 Summary

This unit focused on the definition of Public Health, historical perspective, the goal and its importance in improving the Health Care Delivery Services in Nigeria. The next Unit will take to the social justice of Public Health.

6.0 Tutor Marked Assignment

1. Define the term Public Health?
2. State five importance of Public Health in Health Care Delivery System in Nigeria.

7.0 References / Further Readings

Akinsola (1993) A to 2 of Community Health and Social medicine in Medical and Nursing Practice Ibadan, Nigeria: 3 AM COMMUNICATION.

Bandura .A. (1995) Self – efficacy in changing Societies. New York; Cambridge University press Nutbean D., Harris .T. (2004) Theory in Nutshell practical guide for health promotion theories Syidney, NSW: Mcgraw Hill.

Chinweuba A.U. (2016) principles and Precepts of Health Services Management: Publisher Eminota Nigeria limited, Enugu, Nigeria

FMOH (1988) National Health Policy and Strategies to achieve Health for all Nigeria, Lagos.

Kirby. D (2000) School-based prevention programme design, evaluation and effectiveness in Diclemene, RJ (ed) Adolescent and AIDS: A generation in jeopardy, sage thousand Oaks, (CAPP 159-180.

Maggi, D. and Wendy Macdowell (2010), Health Promotion: Theory: New York Open University Press

Park. K. (2007) Park''s text book of preventive and social medicine, 19 ed. M/S Banarsidas BHANOT Publishers.

WHO (1981). Health for All Sr. No 5

WHO (1987)

STUDY UNIT 2: CONCEPT OF SOCIAL JUSTICE OF PUBLIC HEALTH.

TABLE OF CONTENTS

1.0 Introduction

This unit introduces you to the concept of social justice. It is necessary to recognize the social justice orientation of public health and its inherent expanded roles and benefits to both individuals and the public. Social justice of public health provides you with a good understanding of equitable distribution of resources in any health care setting

2.0 Unit Objectives

At the end of this Unit, you will:

- Describe social justice
- Describe marked justice.

3.0 Main Content

3.1 Social Justice Concept

Social concept is the foundation of public health. The concept first emerged around 1848, a time that might be considered as the birth of modern public health.

Social justice is of the opinion that public health is properly a public matter and that results in terms of death disease good health reflects the decisions and actions that the society makes for good or for ill (15). Justice is an abstract concept that determines how each member of a society is allocated his or her own share of collective burden or benefits social justice demands fairness in distribution of benefits and burdens. Injustices occur when person are denied some benefits to which they are entitled or when some burden is imposed unduly. Social justice and market justice (personal responsibility) represents two forms of modern justices expected to operate. Social justice enable people to claim their human rights meet their weeds and have greater control over the decision-making processes that affect their lives.

3.2 Personal Responsibility (Market Justice)

Market justice emphasizes personal responsibility as the basis for distributing burdens and benefits. Other than respecting the basic rights of others, individuals and primarily responsible for their own actions Individual's rights are highly valued. In terms of health, individuals assume responsibility for their own health. There is little expectation that society should act to protect or promote the health of its members beyond addressing risks that cannot be controlled through individual action. In case of public health the goal of extending the potential benefits of physical and behavioral sciences to all groups in the society, especially when the burden of disease and ill health within that society is unequally distributed is largely based on principles of social justice

4.0 Conclusion

In this unit you have learnt of social justice, personal responsibility (market justice) you should by now be able to apply these concept in resource mobilization

5.0 Summary

The unit focused on social justice in distribution of resources and market justice which he described as the personal responsibility. The next unit will take you to unique functions of public health

6.0 Tutor Marked Assignment

1) Describe the term social justice
2) How will you apply the concept of social justice in resource allocation in your work place?

7.0 References / Further Readings

Akinsola (1993) A to 2 of Community Health and Social medicine in Medical and Nursing Practice Ibadan, Nigeria: 3 AM COMMUNICATION.

Bandura .A. (1995) Self – efficacy in changing Societies. New York; Cambridge University press Nutbean D., Harris .T. (2004) Theory in Nutshell practical guide for health promotion theories Syidney, NSW: Mcgraw Hill.

Chinweuba A.U. (2016) principles and Precepts of Health Services Management: Publisher Eminota Nigeria limited, Enugu, Nigeria

FMOH (1988) National Health Policy and Strategies to achieve Health for all Nigeria, Lagos.

Maggi, D. and Wendy Macdowell (2010), Health Promotion: Theory: New York Open University Press

Park. K. (2007) Park''s text book of preventive and social medicine, 19 ed. M/S Banarsidas BHANOT Publishers.

Sofoluwe, S.O, & Chran, R and Ogummekan, D.A (1988) Principles and practice of Public Health in Africa Ibadan: University press plc.

Tope-Ajayi, F (2004) A guide to primary Health Care Practice in developing countries. Akure. Rotime Excels production

UNDP,: (1988) Primary Health care retrieved at www.nof.org/2012/06/19

UNDP, Human Development Report 1999, Oxford University press

Vincent. C.C (2012) Community Health Care Practice in developing countries Nigeria: Springfield publisher Ltd.

WHO (1981). Health for All Sr. No 5

WHO (1987)

STUDY UNIT 3: UNIQUE FUNCTIONS OF PUBLIC HEALTH

TABLE OF CONTENTS

1.0 Introduction

Public health role is one of servicing us all as our village, whether in African or in the United States. This assertion that improving the health status of others provides benefits to all is a fare value of public health. Having been acquainted with these concepts you will be guided in the practice of PH and also will help you face challenges ahead.

2.0 Unit Objectives

At the end of this Unit, you will:

- Describe Unique Functions of Public Health
- Enumerate the Essential Public services

3.0 Main Content

3.1 Unique Functions of Public health

Public health functions includes: assessment, policy development and assurance

- Assessment is done to identify or diagnose community health problems and needs
- Policy development is an intermediate role of collectively deciding which remedies or interventions are most appropriate for the problems identified. (formulation of treatment plan)
- Assurance is similar treatment and implies that the necessary remedies or interventions are put in place to remove the burden of disease. These core functions broadly describe what public health does as opposed to what it is. They PH functions are based on social justice and focus on preventive strategies
- Public health prevents epidemics and spread of disease
- Protects against environmental hazards
- Prevents injuries
- Promotes and encourages healthy behaviors
- Responds to disasters and assists communities in recovery
- Assures the quality and accessibility of health services

3.2 Essential Public Health Services

- Monitor health status to identify community health problems
- Diagnose and investigate health problems and health hazards in the community
- Inform, educate and empower people about health issues
- Mobilize community partnerships to identify and solve health problems
- Develop policies and plans that support individual and community health effort
- Enforce laws and regulations that protect health and ensure safety

- Link people with needed personal health services and ensure the provision of health care when otherwise unavailable
- Assure a competent public health and personal health care workforce
- Evaluate effectiveness, accessibility and quality of personal and population-based health services
- Research for new insights and innovative solutions to health problems

4.0 Conclusion

In this unit you have learned about the unique functions of public health and essential services. You should by now be able to enumerate these functions on your own

5.0 Summary

The unit focused mainly on the three unique functions of public health and the essential public health services. This unit has provided good information on what public health does

6.0 Tutor Marked Assignment

1) Enumerate three (3) main functions of public health
2) List at least five public health services provided to the public

7.0 References / Further Readings

Akinsola (1993) A to 2 of Community Health and Social medicine in Medical and Nursing Practice Ibadan, Nigeria: 3 AM COMMUNICATION.

Bandura .A. (1995) Self – efficacy in changing Societies. New York; Cambridge University press Nutbean D., Harris .T. (2004) Theory in Nutshell practical guide for health promotion theories Syidney, NSW: Mcgraw Hill.

Chinweuba A.U. (2016) principles and Precepts of Health Services Management: Publisher Eminota Nigeria limited, Enugu, Nigeria

FMOH (1988) National Health Policy and Strategies to achieve Health for all Nigeria, Lagos.

Maggi, D. and Wendy Macdowell (2010), Health Promotion: Theory: New York Open University Press

Park. K. (2007) Park''s text book of preventive and social medicine, 19 ed. M/S Banarsidas BHANOT Publishers.

Sofoluwe, S.O, & Chran, R and Ogummekan, D.A (1988) Principles and practice of Public Health in Africa Ibadan: University press plc.

Tope-Ajayi, F (2004) A guide to primary Health Care Practice in developing countries. Akure. Rotime Excels production

UNDP,: (1988) Primary Health care retrieved at www.nof.org/2012/06/19

UNDP, Human Development Report 1999, Oxford University press

Vincent. C.C (2012) Community Health Care Practice in developing countries Nigeria: Springfield publisher Ltd.

WHO (1981). Health for All Sr. No 5

WHO (1987)

STUDY UNIT 4: DEVELOPING A CONCEPTUAL FRAMEWORK FOR UNDERSTANDING THE KEY DETERMINATS

TABLE OF CONTENTS

1.0 Introduction

Unit 4 takes you to theoretical models which aid in the description of health related behavior as well as in planning to change behavior. Having a theoretical framework to guide programme design and evaluation is considered essential for successful progranmme (Kirby 2000). The Unit will help you understand clearly in your choice of intervention and evaluation of your programme.

2.0 Unit Objectives

At the end of this Unit, you will:

- Describe theoretical framework for understanding key determinants
- Enumerate different theories that can
- Apply one of the theories in changing health behavior

3.0 Main Content

3.1 Description of Theoretical/Conceptual Framework

Theories help in understanding the methods you can use as the focus of your intervention specifically by improving understanding of the process by which changes occur in the targeted people, organization or polices and by clarifying the means of achieving change in these targets. These theories that explain and predict individual, groups health behavior and organizational practice are worthy of close consideration in the planning phase of the programme. Some theories also inform decisions on the timing and sequencing of your interventions in order to achieve maximum effects

3.2 Types of Theories or Models That Explains Health Behavior and Health Behavior Change by Focusing on the Individual or Organization

- Health belief model (HBM)
- Social learning theory
- Transtheoritical model (stages of change)
- Theory of reasoned action

3.3 Application of One of the Theories In Changing Health Behavior

The Social Learning theory was developed by Albert Bandura in 1977. Its evolution was originally from behaviours but it has now embraced some of the ideas of cognitivists and this is the reason the theory is also referred to as social cognitive theory (University South Alabama 2011). Social Learning Theory (SLT) focuses on the learning that takes place within the social context and asserts that people serve as models of human behaviour and some people (significant others) are capable of eliciting behavioural change to certain individuals based on his value and interpretation system. It emphasized the importance of observing and modeling behaviours, attitudes and emotional reactions of others. Cherry (2008) in an overview of Bandura's social learning

theory noted that the theory is likely the most influential theory of learning and development. Cherry further explained that SLT is rooted in many of the basic concept of traditional learning theory but however Bandura believed that direct reinforcement could not accounts for all types of learning. The theory therefore added a social component arguing that people can learn new information and behaviours by watching other people and this is referred to as observational learning or modeling. It is also known as vicarious or imitation learning which can be used to explain a wide variety of behaviours in the study observation learning occurred as the student interact with peers in the schools and communities.

SLT is also known as social cognitive theory and was developed by Bandural (1977). It explains the relationship between an individual, her environment and her behavioural patterns. Bandural is of the opinion that behaviour does not occur in isolation but is a response to the environment. Thus, interaction among the person, the environment and the behaviour is termed "reciprocal determinism". Thus a change in one of these factors impacts on the other two. The theory is behavoiural prediction theory that represents a clinical approach to health behavioural change (Fishbein et al 1991). SLT has been widely applied to health behaviour with respect to prevention, health promotion and modification of unhealthy life styles for many different risk behaviours.

The factors have been identified as supporting the learning or unlearning and final adoption or rejection of a particular behaviour in an environment.

- Observational learning
- Self – efficacy or self confidence perceptions.
- Outcome and value expectancies.

Observational learning with the environment embodies modeling by either peer or elders whose performance of an experience with behaviour influences the adoption

or extinction of a particular behaviour. Though the perceived susceptible and severity component of health belief model buttress these by stressing that people will only take preventive measures or action if the perceive that problem and its consequences serious enough to deserve attention and they are convinced that recommended treatment or preventive activities are beneficial and at the same time will pose no overwhelming costs.

In these issues of HIV/AIDS adolescents may observe the behaviours of their brothers, sisters and friends and hear stories and even seeing those who are already infected and affected. These experiences can influence the adoption or extinction of those preceding risk factors.

Self – efficacy expectations are personal perceptions to capacity to perform certain behaviour. Outcome expectancies are the perceived results of carrying out a particular behaviour, and value expectancies are the positive and negative assessment of the impact of these results. If a child may assess the negative outcome and value his/her behaviour as unproductive, and destructive, he/she may perceive it as risk and then withdraw or extinguish the behaviour, depending on the value she places on a given outcome. However, the risky sexual behaviours are usually the interaction between the individual, environment and behaviour. The environmental factors like family structure and family size could influence the adolescents' sexual bahaviour positively or negatively.

Theoretical Background: It has been argued the theory will enhance understanding of both the success and failure of interventions. However, there has been criticism that some theories focus excessively on explanation and prediction, and they have little application as far as the design, implementation and evaluation of actual intervention is concerned (Leviton 1989, Hochbaum et al 1992 McCammish et al 1993). Furthermore, they noted that some theoretical based information have influenced antecedent to bahaviours (Hughes and Mccauley 1998)

See my Project Diagram

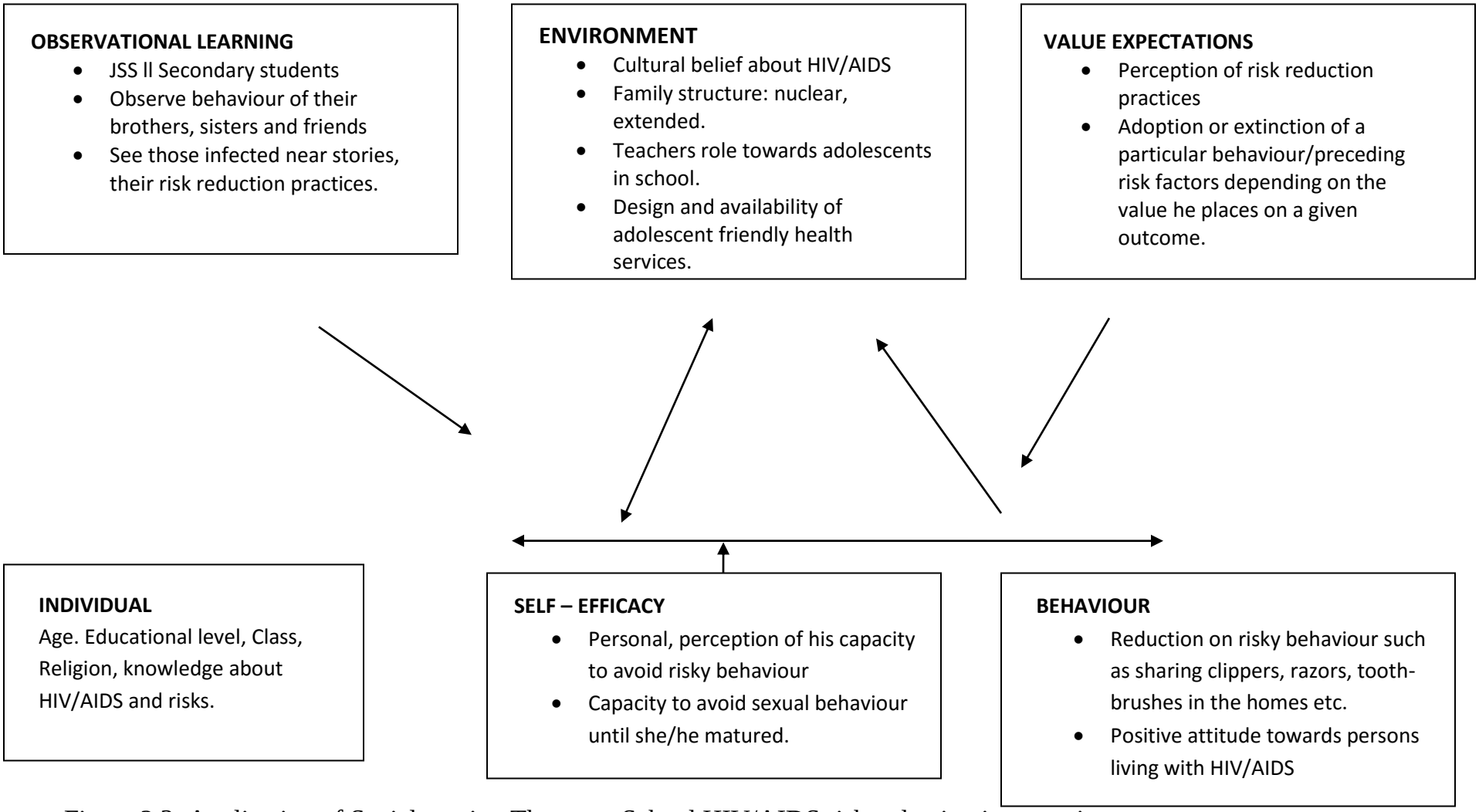

Figure 2.3: Application of Social earning Theory to School HIV/AIDS risk reduction intervention

4.0 Conclusion

In this you have learnt about the theoretical/conceptual framework that explained health behavior and health behavior change. The unit also provides the important guidance in major elements of health programs and application of the theoretical framework in planning, designing and evaluation of programme.

5.0 Summary

This unit introduces you to some important theories to guide individual behavior change. Theory also provides guidance on how and when change might be achieved in the target population, organization or policy. Taken together the theories and models described emphasize the importance of knowledge and belief about health, the importance of self-efficacy, perceived social norms and social influences related to the value individual places on social approval or acceptance by different social groups and the importance of recognizing that individuals in a population may be at different stages of change at any one time.

6.0 Tutor Marked Assignment

1. Define the concept of theoretical/conceptual framework
2. List types of theories that can be used in planning a change in behavior

7.0 References / Further Readings

Akinsola (1993) A to 2 of Community Health and Social medicine in Medical and Nursing Practice Ibadan, Nigeria: 3 AM COMMUNICATION.

Bandura .A. (1995) Self – efficacy in changing Societies. New York; Cambridge University press Nutbean D., Harris .T. (2004) Theory in Nutshell practical guide for health promotion theories Syidney, NSW: Mcgraw Hill.

Chinweuba A.U. (2016) principles and Precepts of Health Services Management: Publisher Eminota Nigeria limited, Enugu, Nigeria

FMOH (1988) National Health Policy and Strategies to achieve Health for all Nigeria, Lagos.

Maggi, D. and Wendy Macdowell (2010), Health Promotion: Theory: New York Open University Press

Park. K. (2007) Park''s text book of preventive and social medicine, 19 ed. M/S Banarsidas BHANOT Publishers.

Sofoluwe, S.O, & Chran, R and Ogummekan, D.A (1988) Principles and practice of Public Health in Africa Ibadan: University press plc.

Tope-Ajayi, F (2004) A guide to primary Health Care Practice in developing countries. Akure. Rotime Excels production

UNDP,: (1988) Primary Health care retrieved at www.nof.org/2012/06/19

UNDP, Human Development Report 1999, Oxford University press

Vincent. C.C (2012) Community Health Care Practice in developing countries Nigeria: Springfield publisher Ltd.

WHO (1981). Health for All Sr. No 5

WHO (1987)

PHS 801 MODULE 2: RECENT DEVELOPMENTS IN PUBLIC HEALTH AND ITS FUTURE DIRECTION

STUDY UNIT 1: DEFINING THE PROBLEM AND MEASUREMENT OF THE MAGNITUDE OF THE PROBLEM

TABLE OF CONTENTS

1.0 Introduction

This unit covers not only problem definition but also disease definition which is essential for any kind of epidemiological activities. It also covers measurement of the magnitude of the identified problems. For example epidemic diseases such as measles, chicken pox and cholera as well as non-communicable diseases.

2.0 Unit Objectives

At the end of this Unit, you will:

- Describe problem definition
- Define disease definition
- Enumerate some problems identified

- Outline sources of this diseases
- Describe measurement of the magnitude of the problem.

3.0 Main Content

3.1 Problem Definition

Identification of the parameters of the health problem to be addressed may involve drawing on a wide range of epidemiological and demographic information as well as information from the behavioral and social sciences and knowledge of community needs and priorities. Here certain theories can help to identify what should be the focus for an intervention. This might be individual characteristics, beliefs and values that are associated with different health behaviors and that may be amenable to change (model of behavior change HBM, SLT etc). Alternatively if it is associated with organizational characteristics that may need to be changed too

3.2 Definition of Disease

Definitions are essential for any kind of epidemiological activity e.g. disease reporting, measurement of mortality and morbidity etc. clear cut definition of these in term of “infection” “epidemic’” and surveillance are needed in the study of infectious diseases. Adequate knowledge of these gives direction to new line of actions towards prevention and control. It is also a guide in setting priorities and determining prompt interventions. The definition covers not only the usual epidemic diseases such as measles, chicken pox and cholera which are compressed in time but also the modern “show” epidemic of non-communicable diseases e.g. lung cancer, chronic heart disease in which the time scale of the epidemic is shifted from days or weeks to years WHO 1983. The slow growth of this epidemic conceals their size.

Identification of Health Problem that can cause hill-health to others and there sources

Human Biology:

The element of human biology which include and individual's genetic inheritance and the process of maturation and aging e.g.

- Congenital problems resulting from genetic factor.
- Genetic disorders in the child which could be chromosomal anomalies like down syndrome (Mongolism)
- Diabetes, Haemophilia, Sinkle cell anaemic etc

Environmental

The environmental includes health problems emanating from internal and external environment. The internal pertains to each and every components parts, every tissue, organ and their harmonious functioning within the body system. The external environment consist those things to which an individual are exposed to after birth.

- **Physical Environment**: Housing, food, air, light, noise, excreta disposal which man is in constant interaction.
- **Biological Environment**: includes all living things which surround man e.g animals, rodents micro-organism and plants. Some harmful, some are not harmful.
- **Psychological Environment:** This refers to macro – environment or personal which includes individual lifestyle, at school, home and work place and neighborhood.
- **Emotional**

  Emotional problems result from the Psycho social stresses on individual through child hood to old age.

Any defect on the above stated lead to health problems. Other environmental problems recently emerged result from industrialization and increasing urbanization. The contamination of water ways by industrial pollutants is currently a matter of major concern; Air pollutions is a potential threat to people living in urban areas

3.3 Measurement of the Magnitude of the Problems

It is mandatory to have a clear picture of the amount of disease (disease load) in the population. The information should be available in form of mortality, morbidity, disability and so on; and should preferably be available for different subgroups of the population. Measurement of mortality has two aspects:

Incidence and prevalence Incidence can be obtained from "longitudinal studies" and prevalence from "cross-sectional". Descriptive epidemiology may use cross-sectional or longitudinal design to estimate the magnitude of the health and disease problems. In human population for example in cross sectional study of Hypertension, we can collect data about the age, sex, physical exercise, body weight, salt intake and other variable of interest. The percentage ascribed to each determines your prevalence. This information about disease prevalence providing a guide for possible ways of preventing the disease.

4.0 Conclusion

You have been introduced to problem identification, disease definition and measurement of the identified problem. This will help in determining intervention in evaluations of the disease identified.

5.0 Summary

The unit introduces you to problem definition, disease identification. This will help in differentiating between the infections, epidemics and surveillance. The unit

also takes you the measurement of the magnitude of identified problems and ways of preventing and controlling disease spread.

6.0 Tutor Marked Assignment

1. Describe problem identification
2. Explain measurement of the magnitude of the problem
3. List five environmental sources of health problems

7.0 References / Further Readings

Akinsola (1993) A to 2 of Community Health and Social medicine in Medical and Nursing Practice Ibadan, Nigeria: 3 AM COMMUNICATION.

Bandura .A. (1995) Self – efficacy in changing Societies. New York; Cambridge University press Nutbean D., Harris .T. (2004) Theory in Nutshell practical guide for health promotion theories Syidney, NSW: Mcgraw Hill.

Chinweuba A.U. (2016) principles and Precepts of Health Services Management: Publisher Eminota Nigeria limited, Enugu, Nigeria

FMOH (1988) National Health Policy and Strategies to achieve Health for all Nigeria, Lagos.

Maggi, D. and Wendy Macdowell (2010), Health Promotion: Theory: New York Open University Press

Park. K. (2007) Park''s text book of preventive and social medicine, 19 ed. M/S Banarsidas BHANOT Publishers.

Sofoluwe, S.O, & Chran, R and Ogummekan, D.A (1988) Principles and practice of Public Health in Africa Ibadan: University press plc.

Tope-Ajayi, F (2004) A guide to primary Health Care Practice in developing countries. Akure. Rotime Excels production

UNDP,: (1988) Primary Health care retrieved at www.nof.org/2012/06/19

UNDP, Human Development Report 1999, Oxford University press

Vincent. C.C (2012) Community Health Care Practice in developing countries Nigeria: Springfield publisher Ltd.

WHO (1981). Health for All Sr. No 5

WHO (1987)

STUDY UNIT 2: IDENTIFYING AND DEVELOPING STRATEGIES

TABLE OF CONTENTS

1.0 Introduction

It is necessary to analyze the defined problems, finding possible causes and measures to reduce or solve the problems using appropriate strategies. This unit introduces you to the concept of identifying and developing strategies for solving the defined problem.

2.0 Unit Objectives

At the end of this Unit, you will:

- Identify problem through need assessment, listening to people, survey among others
- State objectives for carrying out need assessment
- Develop strategies for solving the problem

3.0 Main Content

3.1 Need Assessment/ Tentative Diagnosis through listening to the people, observing, survey and investigation; Examination of service date etc

Need assessment is a process of identification of problems that are responsible for the ill health of a community. It is also a scientific and epidemiological approach for identification of community problem/needs step by step. It requires team work and assistance from other sectors.

3.2 Rationale/Objective

Objectives for need assessment or community diagnosis

- ✓ To determine the major health problems and needs of the community and identify resources to deal with these problems
- ✓ To ensure community participation

3.3 Problems that can be identified in any targeted community

Problems that can be identified in any community include:

- ✓ Direct health problems such as malaria, diarrhea, hypertension, polio, guinea worm infestation etc
- ✓ Indirect health problems such as lack of portable water supply, environmental insanitation, unhygienic housing conditions, unhealthy habits, uncontrolled vector breeding and practices etc
- ✓ Health related problems such as poverty, illiteracy, ignorance, unemployment, uncontrolled production etc
- ✓ Service-related problems such as poor health care facilities, untrained staff, inadequate drug supply, inadequate monitoring and supervision

3.4 Developing Strategies

Having identified the problems, then prioritize the problems to enable you identify your strategies and choose your intervention strategies. For example, if healths

care coverage is low as 30%. It means that the community has no access to health care facilities; you identify appropriate strategies for solving this problem such as:

1. Improving access: That is facilities should be closer to the community.
2. Improving referral system (transportation, communication) should be strengthened

Other strategies are:

- ✓ Improving health workers skills: accelerating pre-service and in-service licensing support and supervision
- ✓ Improving health system and ensuring constant availability of essential medicines, potent vaccines in health facilities sustained supervision and referral
- ✓ Improvements in the case management skills of health staff through provision of locally adapted guidelines for the most common causes of death
- ✓ Improvements in health system required for effective management of epidemic disease
- ✓ Improvement in family and community practices

4.0 Conclusion

You have learnt how to conduct needs assessment/community diagnosis to identify people's problem and needs, identified strategies for solving the problem causing ill-health in the community. This knowledge will guide you know when facing similar situation in your field experience

5.0 Summary

This unit introduces you to the identification and development of strategies for solving your identified problem. It also taught you on how to carryout need assessment and community diagnosis

6.0 Tutor Marked Assignment

1) Define need assessment
2) State five strategies which can be used to solve identified health problems
3) Enumerate, direct and indirect health problems which can lead to ill-health in the community

7.0 References / Further Readings

Akinsola (1993) A to 2 of Community Health and Social medicine in Medical and Nursing Practice Ibadan, Nigeria: 3 AM COMMUNICATION.

Bandura .A. (1995) Self – efficacy in changing Societies. New York; Cambridge University press Nutbean D., Harris .T. (2004) Theory in Nutshell practical guide for health promotion theories Syidney, NSW: Mcgraw Hill.

Chinweuba A.U. (2016) principles and Precepts of Health Services Management: Publisher Eminota Nigeria limited, Enugu, Nigeria

FMOH (1988) National Health Policy and Strategies to achieve Health for all Nigeria, Lagos.

Maggi, D. and Wendy Macdowell (2010), Health Promotion: Theory: New York Open University Press

Park. K. (2007) Park''s text book of preventive and social medicine, 19 ed. M/S Banarsidas BHANOT Publishers.

Sofoluwe, S.O, & Chran, R and Ogummekan, D.A (1988) Principles and practice of Public Health in Africa Ibadan: University press plc.

Tope-Ajayi, F (2004) A guide to primary Health Care Practice in developing countries. Akure. Rotime Excels production

UNDP,: (1988) Primary Health care retrieved at www.nof.org/2012/06/19

UNDP, Human Development Report 1999, Oxford University press

Vincent. C.C (2012) Community Health Care Practice in developing countries Nigeria: Springfield publisher Ltd.

WHO (1981). Health for All Sr. No 5

WHO (1987)

STUDY UNIT 3: IMPLEMENTING INTERVENTION AND EVALUATION PLAN

TABLE OF CONTENTS

1.0 Introduction

In this unit you will identified health problems causing ill-health in the community and identified strategies for tackling the identified problems working with your target community members. This unit will take you to prioritizing the problems, recommending interventions, implementing and evaluating the intervention

2.0 Unit Objectives

At the end of this Unit, you will:

- Identify problems and strategies for solving problems
- Set priorities in choosing appropriate interventions
- Mobilize resources
- Implement the intervention
- Evaluate the intervention

3.0 Main Content

3.1 Identification of Problem

Problems that can be identified in any targeted community

Problems that can be identified in any community include:

- ✓ Direct health problems such as malaria, diarrhea, hypertension, polio, guinea worm infestation etc
- ✓ Indirect health problems such as lack of portable water supply, environmental insanitation, unhygienic housing conditions, unhealthy habits, uncontrolled vector breeding and practices etc
- ✓ Health related problems such as poverty, illiteracy, ignorance, unemployment, uncontrolled production etc
- ✓ Service-related problems such as poor health care facilities, untrained staff, inadequate drug supply, inadequate monitoring and supervision

Strategies: Here in the community intervention, community mobilization and education are the best strategies to improve related services, identify and utilize available local resources e.g. Human resources, material and financial resources before seeking for external input. Therefore community has to be actively involved in the assessment and defining of the problems, planning, prioritizing, implementing activities, monitoring and evaluating the programmes. It is not possible that the individual families and communities can be made healthy against their will. They need to be sensitized and mobilized to participate actively in their own health development. The most valuable resource for the health of people are people themselves. They are the biggest resource for health and development.

3.2 Setting priorities in choosing appropriate Intervention

In planning stage the mobilizers should officially enter the community and pay courtesy call to the community leaders or decision makers and arrange meeting with him and his cabinet members. The purpose of the meeting is to exchange

ideas acquaint them to the major problems in the community that are amendable to health care and how to get rid of them. Making them to see the community problems as real and their solution as of paramount importance. Similar discussion should be held with the leaders of the different organization and innovations in the community. At the end of this awareness campaign the mobilizers can now request for a health committee to work with. The committee will compose of youth representatives, age grade, different organizations and other health related groups. Several meetings of the committee will be held in other to reach a consensus as to the problems of the community. These problems are thus prioritized on how to solve them bearing in mind the life threatening ones and those that will contribute to the achievement of others which are to be handled first. The committee should come up suggestions on how the problems will be solved, each alternative is evaluated on its merit and the best alternatives are selected.

3.3 Resource Mobilization

The health workers should inform them of the resources required to tackle the problems. The resources can come from government, community, non-governmental organization etc. The committee members should participate in all health promotional activities, including raising fund to ensure achievement of the goals.

3.4 Implementation of Intervention and Evaluation

This is the stage of implementing/carrying out and evaluating all the plans for the programme. It is the action itself. The community members are used to implement the plan. Some of the actions that can be undertaken to promote health and prevent diseases include:

- ✓ Mobilizing women to bring their children in a healthy manner and ensure that they are immunize against infectious diseases which are prevalent in the community while the country can afford to provide immunization

- ✓ Cooperate farming to ensure that community has sufficient food of right kind to prevent malnutrition.

Evaluation should be carried out intermittedly while all these are on to ensure that the set goals are being met. In general evaluation ensure that activities are having intended effects (effectiveness) determine whether activities are cost effective (efficacy) and establish whether activities are acceptable to the target population (humanity)

4.0 Conclusion

In this unit you have learnt the identification of problems, strategies to tackle problems, setting priorities in choosing appropriate interventions, implementing interventions and evaluating the intervention programme. You should by now be able to itemize all in your own words and be able to apply them when need arises in designing any programme

5.0 Summary

This unit focused mainly on defining problems that can cause ill-health to the people, identified strategies for tackling the problem, setting priorities in choosing appropriate intervention, implementing intervention and evaluate the intervention as regards to the objectives discussed in this unit.

6.0 Tutor-Marked Assignment

1) Describe the strategies for implementing community interventions
2) List five problems that can cause ill-health with examples

7.0 REFERENCES

Akinsola (1993) A to 2 of Community Health and Social medicine in Medical and Nursing Practice Ibadan, Nigeria: 3 AM COMMUNICATION.

Bandura .A. (1995) Self – efficacy in changing Societies. New York; Cambridge University press Nutbean D., Harris .T. (2004) Theory in Nutshell practical guide for health promotion theories Syidney, NSW: Mcgraw Hill.

Chinweuba A.U. (2016) principles and Precepts of Health Services Management: Publisher Eminota Nigeria limited, Enugu, Nigeria

FMOH (1988) National Health Policy and Strategies to achieve Health for all Nigeria, Lagos.

Maggi, D. and Wendy Macdowell (2010), Health Promotion: Theory: New York Open University Press

Park. K. (2007) Park''s text book of preventive and social medicine, 19 ed. M/S Banarsidas BHANOT Publishers.

Sofoluwe, S.O, & Chran, R and Ogummekan, D.A (1988) Principles and practice of Public Health in Africa Ibadan: University press plc.

Tope-Ajayi, F (2004) A guide to primary Health Care Practice in developing countries. Akure. Rotime Excels production

UNDP,: (1988) Primary Health care retrieved at www.nof.org/2012/06/19

UNDP, Human Development Report 1999, Oxford University press

Vincent. C.C (2012) Community Health Care Practice in developing countries Nigeria: Springfield publisher Ltd.

WHO (1981). Health for All Sr. No 5

WHO (1987).

STUDY UNIT 4: DEVELOPING COMMUNICATION STRATEGIES

TABLE OF CONTENTS

1.0 Introduction

This unit introduces you to communication strategies. Communication has been traditionally defined as transfer of thoughts and feelings from one person to another. It involves the exchange of words, letters, symbols or messages in a way that one-organization member shares meaning and understanding with another. Communication unit across every aspect of human activities and behavior

2.0 Unit Objectives

At the end of this Unit, you will:

- Define communication
- State the purpose of communication

- Enumerate communication strategies
- Skills in communication
- Describe the effect of communication or health

3.0 Main Content

3.1 Communication in Health

Communication refers to the giving and receiving of verbal and non-verbal message or information. It involves the exchange of words letters, symbols or message in a way that one-organization member shares meaning and understanding with another. At all levels and at any moment of the organizations activities, communication process is continuously in action conveying information, ideas, attitudes and feelings among individuals and among group of individuals with communication, the leader provides information to members, seeks information from them , facilitates exchange of information and shows awareness of affairs pertaining to the group

3.2 Purpose of Communication

- To change behavior of people
- To adopt healthy behavior
- To improve and maintain health
- To discourage/ discontinue behavior which harmful to health

3.3 Enumeration of Communication Strategies

- ✓ Interpersonal (individual approach): this is on to one communication which happens during home visits by health workers.
- ✓ Group communication: the members of the group (eg men group or youth) are expected to contribute their views and come to an agreed upon solution to identified health problems. Many strategies can be used here, e.g. discussion, demonstration an audio visual, question and answers etc

- ✓ Mass communication: this covers a wide geographical area and population In short time. It uses radio-television and print media (newspaper). The message is disseminated to large population with clear focus on target groups

3.4 Key Elements in Communication Process

The key elements in communication process. They include:

a. The communicator
b. The message
c. The audience and
d. The channels of communication

There the health worker is the communicator in health promotion and education programme. The message is the information she wishes his audience (consumers of the message) to receive, understand accept and act upon. The channel of the communication is the choice of the medium to relay the information (message) to the audience (receiver). Proper application of communication skills such as listening, speaking scientifically and clearly what to speak, when to speak and whom to speak and reasoning, the most important effects of communication which is change in behavior and practice must be achieved

3.5 Effects of Communication

Three main effects of communication

- ✓ Thinking: the communication may lead to change in thinking and perception of an individual, group or community. It adds to the body of knowledge and build cognitive domain.
- ✓ Feeling/attitude: negative attitudes may change to positive attitudes and often indicates an action that the individual may take
- ✓ Behavior changes: change in action (practice) there are changes In overall behavior such as adopting a contraceptive, quit smoking etc

3.6 Barriers of Communication

- ✓ Physiological Barriers: difficulties in hearing expression
- ✓ Psychological Barriers: emotional disturbances, neurosis
- ✓ Environmental Barriers: noise, invisibility, congestion
- ✓ Cultural barriers: level of knowledge and understanding, customs, belief, religion and attitudes

Conclusion

4.0 You have learned about communication, purpose, communication strategies , effective communication and barrier to effective. You can on your own communicate effectively.

3.0 Summary

4.0 This unit introduces you to the development of communication strategies, purpose of communication, skill in communication and effect s of communication. This provides you with good understanding of communication and will improve your communication skills

5.0 Tutor Marked Assignment

1) Describe elements of good communication
2) Define the term communication

7.0 References / Further Readings

Akinsola (1993) A to 2 of Community Health and Social medicine in Medical and Nursing Practice Ibadan, Nigeria: 3 AM COMMUNICATION.

Bandura .A. (1995) Self – efficacy in changing Societies. New York; Cambridge University press Nutbean D., Harris .T. (2004) Theory in Nutshell

practical guide for health promotion theories Syidney, NSW: Mcgraw Hill.

Chinweuba A.U. (2016) principles and Precepts of Health Services Management: Publisher Eminota Nigeria limited, Enugu, Nigeria

FMOH (1988) National Health Policy and Strategies to achieve Health for all Nigeria, Lagos.

Maggi, D. and Wendy Macdowell (2010), Health Promotion: Theory: New York Open University Press

Park. K. (2007) Park''s text book of preventive and social medicine, 19 ed. M/S Banarsidas BHANOT Publishers.

Sofoluwe, S.O, & Chran, R and Ogummekan, D.A (1988) Principles and practice of Public Health in Africa Ibadan: University press plc.

Tope-Ajayi, F (2004) A guide to primary Health Care Practice in developing countries. Akure. Rotime Excels production

UNDP,: (1988) Primary Health care retrieved at www.nof.org/2012/06/19

UNDP, Human Development Report 1999, Oxford University press

Vincent. C.C (2012) Community Health Care Practice in developing countries Nigeria: Springfield publisher Ltd.

WHO (1981). Health for All Sr. No 5

WHO (1987)

PHS 801 MODULE 3: INTRODUCTION TO HEALTH FOR ALL IN THE YEAR 2000 AD

STUDY UNIT 1: DEFINITION AND CONCEPT OF HEALTH FOR ALL

TABLE OF CONTENTS

1.0 Introduction

In this unit you are introduced to the concept of Health for All (HFA) era was based on the defining principles of social justice and equity, recognition of the crucial role of community participation, changing ideas about the nature of health and development, the importance of political will called for new approaches to make medicine in the service of humanity more effective.

2.0 Unit Objectives

At the end of this unit, you will:

- Describe the concept of Health For All
- State the goal of Health for All
- Identify target for Health for All

3.0 Main Content

3.1 Definition and Concept of Health for All

Health for all was a holistic concept calling for all effort in agriculture, industry, education, housing and communications, just as much as in medicine and public health. The attainment of Health for All by the year 2000 AD was the central issue and official target of WHO and its member countries. It symbolized the determination of the countries of the world to provide an acceptable level of health to all people. Health for All has been described as a revolutionary concept. Discussing these issues at the Joint WHO-UNICEF International Conference in 1978 at Alma Ata (USSR), the Governments of 134 countries and many voluntary agencies called for a "revolutionary approach" to health care. Declaring that "The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable", the Alma Ata conference called for acceptance of the WHO goal and Health for All by 2000 AD and proclaiming primary health care as way to achieving health for all.

3.2 Goal of Health for All

All people in all countries should have at least a level of health that they are capable of working productively and of participating actively in the social life of the community in which they live.

3.3 Target of Health for All

Taking note of the inequality distribution of Health services between the Urban and Rural, the rich and poor, UNICEF and WHO jointly came out with a health policy to provide basic health services to all. In 1977,WHO health assembly resolved to launch a movement called Health for All by 2000 AD and fixed ambitious targets for promotion of health to be achieved in stages:

- ✓ Providing right kind of food for all by year 1985
- ✓ Essential drugs by 1986
- ✓ Basic sanitation, safe water and immunization against 6 killer/infectious diseases by 1990. These were some of the targets fixed beside many others.

4.0 Conclusion

In this unit, you have learnt the goal, concept of Health for All and targets for promotion of health of individuals and society in both developed and developing countries

5.0 Summary

The unit focused on providing Health for All the people. It implies the removal of obstacles to health that is to say the elimination of malnutrition, ignorance, disease, contaminated water supply, unhygienic housing etc. It depends on continued progress in medicine and public health. Knowledge of these will help you in proper health delivery care to the targeted population.

6.0 Tutor-Marked Assignment

1) What do you understand by the concept Health for ALL
2) State the goal of Health for All

7.0 references

Akinsola (1993) A to 2 of Community Health and Social medicine in Medical and Nursing Practice Ibadan, Nigeria: 3 AM COMMUNICATION.

Bandura .A. (1995) Self – efficacy in changing Societies. New York; Cambridge University press Nutbean D., Harris .T. (2004) Theory in Nutshell practical guide for health promotion theories Syidney, NSW: Mcgraw Hill.

Chinweuba A.U. (2016) principles and Precepts of Health Services Management: Publisher Eminota Nigeria limited, Enugu, Nigeria

FMOH (1988) National Health Policy and Strategies to achieve Health for all Nigeria, Lagos.

Maggi, D. and Wendy Macdowell (2010), Health Promotion: Theory: New York Open University Press

Park. K. (2007) Park''s text book of preventive and social medicine, 19 ed. M/S Banarsidas BHANOT Publishers.

Sofoluwe, S.O, & Chran, R and Ogummekan, D.A (1988) Principles and practice of Public Health in Africa Ibadan: University press plc.

Tope-Ajayi, F (2004) A guide to primary Health Care Practice in developing countries. Akure. Rotime Excels production

UNDP,: (1988) Primary Health care retrieved at www.nof.org/2012/06/19

UNDP, Human Development Report 1999, Oxford University press

Vincent. C.C (2012) Community Health Care Practice in developing countries Nigeria: Springfield publisher Ltd.

WHO (1981). Health for All Sr. No 5

WHO (1987)

STUDY UNIT 2: HISTORICAL PERSPECTIVE

TABLE OF CONTENTS

1.0 Introduction

This unit introduces you to the history of health for all 2000 AD. This is a major landmark in health care delivery system. The next unit will take you to target. It is expected that you gain from this history

2.0 Unit Objectives

At the end of this Unit, you will:

- Describe the history of the concept of health for all 2000 AD
- Describe the launching of health for all movement

3.0 Main Content

3.1 Historical Perspective

After three decades of trial and error and dissatisfaction in meeting people's basic health needs, the World Health Assembly, in May 1977, decided that the main social goal of governments and WHO in the coming years should be the "attainment by all the people of the world by the year 2000 AD of a level of health

that will permit them to lead a socially and economically productive life". This goal has come to be popularly known as "Health for all by the year 2000" (HFA). The background to this "new" philosophy was the growing concern about the unacceptably low levels of health status of the majority of the world's population especially the rural poor and the gross disparities in health between the rich and poor, urban and rural population, both between and within countries. The essential principle of HFA is the concept of "equity in health", that is, all people should have an opportunity to enjoy good health.

3.2 Launching of Health for All movement

Taking note of the inequitable distribution of health services between the urban and rural, the rich and the poor, UNICEF And WHO jointly came out with a health policy to provide basic health services to all. In 1977, WHO health assembly resolved to launch a movement called HEALTH FOR ALL by 2000 AD and fixed ambitious targets for promotion of health to be achieved in stages. Providing right kind of food for all by 1985, essential drugs by 1986 and basic sanitation, safe water and immunization against 6 infectious diseases by 1990 were some of the targets fixed besides many others.

4.0 Conclusion

This unit has taken you through the historical aspect of Health for All in the year 2000 AD and the launching of health for all movement in the year 1977. The next unit will take you to targets for health for all 2000.

5.0 Summary

This unit focused mainly on the history of health for all 2000 AD and reason for not achieving the goal despite all efforts and huge resources (financial and human). The knowledge acquired will help in your clearer understanding of health care delivery system in Nigeria.

6.0 Tutor Marked Assignment

1) Briefly describe the concept of health for all in 2000 AD.
2) In what year was the goal health for all launched?
3) State the three ambitious targets with dates.

7.0 References

Akinsola (1993) A to 2 of Community Health and Social medicine in Medical and Nursing Practice Ibadan, Nigeria: 3 AM COMMUNICATION.

Bandura .A. (1995) Self – efficacy in changing Societies. New York; Cambridge University press Nutbean D., Harris .T. (2004) Theory in Nutshell practical guide for health promotion theories Syidney, NSW: Mcgraw Hill.

Chinweuba A.U. (2016) principles and Precepts of Health Services Management: Publisher Eminota Nigeria limited, Enugu, Nigeria.

FMOH (1988) National Health Policy and Strategies to achieve Health for all Nigeria, Lagos.

Maggi, D. and Wendy Macdowell (2010), Health Promotion: Theory: New York Open University Press

Park. K. (2007) Park''s text book of preventive and social medicine, 19 ed. M/S Banarsidas BHANOT Publishers.

Sofoluwe, S.O, & Chran, R and Ogummekan, D.A (1988) Principles and practice of Public Health in Africa Ibadan: University press plc.

Tope-Ajayi, F (2004) A guide to primary Health Care Practice in developing countries. Akure. Rotime Excels production

UNDP,: (1988) Primary Health care retrieved at www.nof.org/2012/06/19

UNDP, Human Development Report 1999, Oxford University press

Vincent. C.C (2012) Community Health Care Practice in developing countries Nigeria: Springfield publisher Ltd.

WHO (1981). Health for All Sr. No 5

WHO (1987)

STUDY UNIT 3: TARGET FOR HEALTH FOR ALL 2000 AD

TABLE OF CONTENTS

1.0 Introduction

This unit will help you acquire basic understanding of the targets set for implementing health for all strategy. The objectives set below will show you what you expected to learn.

2.0 Unit Objectives

At the end of this Unit, you will:

- Identify targets for the health for all year 2000
- Enumerate four themes of the target

3.0 Main Content

3.1 Target for improving the health status that reflect in the health for all strategy

WHO promoted a common approach to health policy in Europe by designing a series of targets and for improved health status that reflect the health for all

strategy-target for health for all 2000 (WHO, 1986). The report provided a clear statement of the scope for improving health status within member countries and called for a fundamental reorientation of the health system in individual countries towards the achievement of the target.

3.2 Grouping of the target into four main themes

This target was grouped into four main themes

- ✓ Lifestyles and health
- ✓ Risk factors affecting health and the environment
- ✓ Reorientation of the health care system.
- ✓ The infrastructure support necessary to bring about the desired changes in the above three areas

The document recognized the importance of structural prerequisites for health for all by setting targets for resource allocation, public policy and workforce training. The report also emphasized the need to engage and reorient health systems towards the provision of appropriate care, in particular stressing the primary health care as the basis for the health system. On the whole 38 targets were specified, together with 65 essential regional indicators that could be used to measure progress. These can be seen in the WHO targets for health for all published in 1985. There were thirty-eight targets grouped as follows:

- ✓ Targets 1-12: Health for All; covering equity, increasing life expectancy and reducing disease
- ✓ Targets 13-17: Lifestyles conductive to health for all; including target 13 ‘developing healthy public policies’, which you will look at in more detail below.
- ✓ Targets 18-25: Producing healthy environments; including environment, housing and work related risks.
- ✓ Targets 26-31: Providing appropriate care; with focus on primary care and the importance of improving the quality of services.

- ✓ Targets 32-38: Support for health development; covering research, information, education and training, and health technology assessment.

  These progress reports are submitted to the WHO every three years by the individual member states.

3.4 Goal of the Target

The main social goal of the target of government, international organization and world community in the coming decades should be the attainment by all people of the world by the year 2000 of a level of health that will permit then to lead a social and economic productive life.

4.0 Conclusion

In this unit you have learnt the targets set for implementing and monitoring the progress of the health for all 2000 AD and the unit also specify four major themes which the health status of the people will be improved. You should at this point be able to enumerate in your own words these targets and explain the scope.

5.0 Summary

The unit taught you about the targets of health for all 2000, and the three major groups specify to improve the health status of the people. You are therefore expected to learn and observed them in other to improve your individual health by adopting positive lifestyle.

6.0 Tutor Marked Assignment

1) State five reasons for formulating the targets.
2) Enumerate three major targets.
3) State the goal of the target.

7.0 References/Further Readings

Akinsola (1993) A to 2 of Community Health and Social medicine in Medical and Nursing Practice Ibadan, Nigeria: 3 AM COMMUNICATION.

Bandura .A. (1995) Self – efficacy in changing Societies. New York; Cambridge University press Nutbean D., Harris .T. (2004) Theory in Nutshell practical guide for health promotion theories Syidney, NSW: Mcgraw Hill.

Chinweuba A.U. (2016) principles and Precepts of Health Services Management: Publisher Eminota Nigeria limited, Enugu, Nigeria

FMOH (1988) National Health Policy and Strategies to achieve Health for all Nigeria, Lagos.

Maggi, D. and Wendy Macdowell (2010), Health Promotion: Theory: New York Open University Press

Park. K. (2007) Park''s text book of preventive and social medicine, 19 ed. M/S Banarsidas BHANOT Publishers.

Sofoluwe, S.O, & Chran, R and Ogummekan, D.A (1988) Principles and practice of Public Health in Africa Ibadan: University press plc.

Tope-Ajayi, F (2004) A guide to primary Health Care Practice in developing countries. Akure. Rotime Excels production

UNDP,: (1988) Primary Health care retrieved at www.nof.org/2012/06/19

UNDP, Human Development Report 1999, Oxford University press

Vincent. C.C (2012) Community Health Care Practice in developing countries Nigeria: Springfield publisher Ltd.

WHO (1981). Health for All Sr. No 5

WHO (1987)

PHS 801 MODULE 4: INTRODUCTION TO PRIMARY HEALTH CARE CONCEPT AND NATIONAL HEALTH POLICY

STUDY UNIT 1: CONCEPT OF PRIMARY HEALTH CARE

TABLE OF CONTENTS

1.0 Introduction

Health is a fundamental human right. Article 25 of the Universal Declaration of Human Rights grants everyone: the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services. This unit introduces you to the primary health care delivery system.

2.0 Unit Objectives

At the end of this Unit, you will:

- Define Primary Health Care Concept
- Enumerate elements of Primary Health Care

- State Aims and Objectives of Primary Health Care
- Describe principles of Primary Health Care
- Enumerate the Characteristics of Primary Health Care

3.0 Main Content

3.1 Concept of Primary Health Care

Primary health care is a means of protecting this right. Primary health care: is essential care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the self-reliance and self-determination: it forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process.(Alma Ata 1978 Primary Health Care Conference, Geneva; WHO, UNICEF)

3.2 Historical Perspective of Primary Health Care

In their annual assessment of the world's health, delegates to the 28th World Health Assembly, meeting in Geneva, judged the current global situation to be both unhealthy and unjust (WHO 1975). Numerous examples from different parts of the world convinced them that the use of an approach called Primary Health Care (PHC) could contribute greatly to freeing all people from available suffering, pain, disability, and death. They predicted that, if sufficient political will and commitment on the part of the global community could be guaranteed, much of the massive burden of unnecessary illness and death borne by million throughout the world could be prevented through the use. These predictions led them in a

spirit of social justice to set in motion a new global revolution in health care. Because of the global nature of the problem, a worldwide mobilization of personnel and resources was considered necessary. Two of the UN specialized agencies, WHO and the United Nations Children's Fund (UNICEF), began immediately to coordinate the world's effort to study and implement PHC on a global scale.

As with all UN conferences, initial preparatory meetings were held in many parts of the world to gather additional experiences and further refine the principles and basic elements of PHC. Although most of these meetings were held in what were then called the "developing" or poorer, nations of Asia, Africa and Latin America, one meeting for the nations of the western or "industrialized" world was held in New York. At this conference, efforts were made to counter the belief that PHC was appropriate only for poor countries and not for the richer, more industrialized ones. A final preparatory meeting was held in Halifax, Nova Scotia, where nongovernmental organizations (NGOs), ranging from large, internationally active humanitarian organizations to small religious groups active in only one country, were able to review the final draft of the actual conference document. After such extensive preparation, delegates from 134 nations of the world, plus preventatives from those NGO's officially accredited by WHO, met during September 1978 in what was then known as Alma Ata, USSR (now Almaty, Kazakhstan). In that historic meeting, the nations of the world committed themselves and their resources to the achievement of health for all the year 2000 through PHC.

Form the very beginning, The Health for All (HFA) era was based on the defining principles of social justice and equity. In Alma Ata, the original WHO definition of health, "a state of complete physical, mental, and social well-being and not merely the absence of disease" (WHO, 1975), was revised on the basis of the newer understanding of health and its many component parts. According to WHO,

health was now to be defined as “a state of enough physical, mental, social well-being to enable people to work productively and participate actively in the social and economic life of the community in which they live” (WHO 1978). A major consequence of this new definition is that every nation is now challenged to provide a basic level of health for all its citizens so they are able to lead socially and economically productive lives.

3.2 Objectives of Primary Health Care

1. To make health services accessible and available to everyone wherever they live or work.
2. To tackle the health problems causing the highest mortality and morbidity at the cost that the community can afford
3. To ensure that whatever technology is used, must be within the ability of the community to use effectively and maintain
4 To ensure that in implementing the health programme, the community must be fully involved in planning the delivery and evaluation of the services in the spirit of self-reliance.

3.4 Elements of Primary Health Care

Eight essential elements of primary health care were identified at the Alma Ata International Conference on primary Health Care; these include:

1) Education concerning prevailing health problems and the methods of preventing and controlling
2) Promoting of food supply and proper nutrition
3) An adequate supply both of safe water and basic sanitation
4) Maternal and child health care, including family planning
5) Immunization against the major infectious diseases
6) Prevention and control of locally endemic diseases
7) Appropriate treatment of common diseases and injuries

   Provision of essential drugs

3.5 Characteristics of Primary Health Care

- Primary Health Care is essential health care made universally accessible to individuals, families in the community. This accessibility refers to continuing and organized supply of care that is geographically, financially, culturally within easy reach of the whole community
- Primary Health Care socially acceptable to all implies that care has to be appropriate and adequate in quality to satisfy the health needs of people and has to be provided by methods acceptable to them within their social-cultural norms.
- Affordable primary health care implies that whatever the methods of payment used, the services should be affordable by community and country
- Primary Health Care is made available to them through their full participation. The participation implies that the process by which individuals, families and communities assume the responsibility in promoting their own health and welfare
- In Primary Health Care we use appropriate technology, which means using appropriate methods and techniques and with locally available supplies and equipment which together with the people using them can contribute significantly to solving a health problem
- Primary Health Care is based on socially accepted methods which the country can afford. Thus, self-reliance and self-determination are emphasized

The focus of Primary Health Care is broad and encompasses all aspects of the community and its health needs. The community as a whole, rather than the individual is considered the patient. The word “Primary” refers to the most important and central concept of the health care system. Primary health care occurs at a transdisciplinary level. The setting for primary health care is within all communities of a country and permeates all aspects of society.

Primary Health Care is a pattern of health care delivery in which the consumers of health care are partners with professionals and participate in achieving the common goal of improved health. The Primary Health Care strategy encourages self-care and self-management in health and social welfare aspects of daily life. People are educated and empowered to use their knowledge, attitudes, and skills in activities that improve health for themselves, their families and their neighbors. The desired outcome from the primary health care strategy is individual, family and community self-reliance and competence.

The key to a primary health care programme is not to the government or local health personnel but the people as the major target of primary health care. It can be said that the strategy of health care delivery is “by the people, of the people and for the people”. Government officials and health personnel supports technologies and facilities that is most beneficial to the population.

Primary health care, thus, requires the development, adaptation and the application of appropriate health technology that the people can use and afford. Such health care includes an adequate supply of low cost, good quality essential drugs, vaccines, biological and other supplies and equipments as well as counseling and advisory services to help people review their health practices and make healthy choices. Primary health care includes functionally efficient supportive health care facilities such as health centers and hospitals.

The primary health care approach to health development is not only a ‘blue print” for action. It also contains a philosophy to guide that action. The seven key principles involved are:

i. The right and duty of individuals and communities to become self-reliant and to participate fully in matters related to their health

ii. Programmes reflect and evolve from the unique socioeconomic and political characteristics of the country.

iii. Programmes address main health problems, integrate preventive, curative and rehabilitative services and are sustained by referral system.

iv. Reliance at all level, in suitable trained health workers who function as a team and respond to the expressed health needs of population.

v. Programmes based on relevant research finding and experiences.

vi. Government and health professionals have the duty and the responsibility to provide the public with relevant information about health.

vii. In addition to the health sector, primary health care relates to other relevant sectors and aspects of national and community development.

The primary health care approaches include dimensions of social and economic development. The services determined by social goals, such as the improvements of the "quality of life" and maximum health benefits for the greatest numbers. Society benefits form healthier people who are more likely to be able to contribute social and economic development; improved quality of life is a goal of primary health care. Quality of life relates to internal phenomena that determines health matters or external phenomena such as social conditions and environmental influences on human life. A high quality of life is evident when community members have the prerequisites for good health and happiness in their daily lives.

4.0 Conclusion

In this Unit, Primary Health Care has been described as the third tier of the Health Care Delivery system. It focuses in providing Health Care to the grass root (people living in the rural area) at the cost they can afford. It acknowledged that Health Care of individuals, family and society at large is a collective responsibility of government and agencies in the provision of social amenities.

5.0 Summary

1) In this Unit we have learnt that Primary Health Care is a third tier of Health Care delivery system and it aims at provision of food supply and nutrition.
2) Education concerning prevailing health problems and the methods of preventing and controlling
3) Promoting of food supply and proper nutrition
4) An adequate supply both of safe water and basic sanitation
5) Maternal and child health care, including family planning
6) Immunization against the major infectious diseases
7) Prevention and control of locally endemic diseases
8) Appropriate treatment of common diseases and injuries
9) Provision of essential drugs
10) Provides basic Health services to all

6.0 Tutor Marked Assignment

1) Enumerate the Elements of Primary Health Care
2) Describe the concepts Socially acceptable and universally accessible

7.0 References / Further Readings

Akinsola (1993) A to 2 of Community Health and Social medicine in Medical and Nursing Practice Ibadan, Nigeria: 3 AM COMMUNICATION.

Bandura .A. (1995) Self – efficacy in changing Societies. New York; Cambridge University press Nutbean D., Harris .T. (2004) Theory in Nutshell practical guide for health promotion theories Syidney, NSW: Mcgraw Hill.

Chinweuba A.U. (2016) principles and Precepts of Health Services Management: Publisher Eminota Nigeria limited, Enugu, Nigeria

FMOH (1988) National Health Policy and Strategies to achieve Health for all Nigeria, Lagos.

Maggi, D. and Wendy Macdowell (2010), Health Promotion: Theory: New York Open University Press

Park. K. (2007) Park''s text book of preventive and social medicine, 19 ed. M/S Banarsidas BHANOT Publishers.

Sofoluwe, S.O, & Chran, R and Ogummekan, D.A (1988) Principles and practice of Public Health in Africa Ibadan: University press plc.

Tope-Ajayi, F (2004) A guide to primary Health Care Practice in developing countries. Akure. Rotime Excels production

UNDP,: (1988) Primary Health care retrieved at www.nof.org/2012/06/19

UNDP, Human Development Report 1999, Oxford University press

Vincent. C.C (2012) Community Health Care Practice in developing countries Nigeria: Springfield publisher Ltd.

WHO (1981). Health for All Sr. No 5

WHO (1987).

STUDY UNIT 2: PRINCIPLES OF PRIMARY HEALTH CARE

TABLE OF CONTENTS

1.0 Introduction

This Unit introduces you to the Evolution of Primary Health Care. Primary Health Concept was evolved based on four principles. These principles are as described below in the main content.

2.0 Unit Objectives

At the end of this Unit, you will:

- Explain the principles of equitable distribution of Health Care facilities
- Describe Community participation
- Describe intersectorial collaboration
- Explain Appropriate technology
- Manpower development

3.0 Main Content

3.1 Equitable distribution of Health Care facilities

It means that health services must be shared equally by all people irrespective of their ability to pay, age, social status, race, gender, tribe, location, educational background etc. and all the people rich or poor, rural or urban must have access to health services. In fact, the health care resources available in a given community should not be in the hand of a few. Also resources should be accessible and affordable to all. Addressing the issue of equity in Nigeria, it is divided in three components:

i. Decentralization of health services into federal, state, local government ward levels.
ii. The essential drug services and the national drug formulae making drugs available at all levels and at low cost
iii. National health insurance scheme where people contribute to the health services of those who don't have or cannot afford.

3.2 Community Participation

This is the whole mark of PHC. Also the most essential and sensitive principle of PHC. Community participation is the process by which individuals, families, and communities assume the responsibilities in promoting their own health and welfare. Community involvement is a process in which partnership is established between government and local communities in planning and implementation of health care activities. The purpose of community involvement is to help in building local self-reliance and gaining social control over PHC infrastructure and technology for example training of village health workers and aids. They are people selected by the local community and are trained locally in the delivery of primary health care and they are involved in planning the care of the community. The individual in the community know their own situation better and they are motivated to solve their common problems.

3.3 Intersectorial Collaboration

This focuses on the concept that the health of an individual, family and community is affected by other sector in addition to the health sector. The sectors include; (a) banking, (b) agricultural, (c) housing (d) communication, (e) mass media (f) education, (g) environmental protection, (h) water purification (i) road and transport, (j)food production, (k) cooperatives, (l) rural development, (m) industries sect. These sectors need to work together in a multisectoral approach to coordinate their goal, plans and activities to ensure that they contribute to the health of the community and to avoid conflicting or duplicating efforts.

3.4 Appropriate Technology

This means the technology that is scientifically or technologically sound, adaptable to local needs, culturally acceptable (to those who apply it and for whom it is used) and financially feasible. The technology must be understood and accepted by the community people and non expert can also apply them. It must be cheap scientifically valid, acceptable, available at all times. For example oral rehydration fluid, weaning food etc

3.5 Manpower Development

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

4.0 Conclusion

In this you have learnt that PHC evolves through five basic principles and each principle explains what is expected in improving the health of the masses in other to facilitate socially acceptable and universally access health care services at the cost the can afford. You can now be able to explain this principles.

5.0 Summary

In this Unit you have been acquainted with five principles of primary health care. You have learnt the essential ingredients of each principle in ensuring that health care delivery services gets to the grass root. The next unit will take you to the organization of primary health care.

6.0 Tutor Marked Assignment

1) Describe two principles of primary health care
2) What do you understand by the term intersectoral collaboration

7.0 References / Further Readings

Akinsola (1993) A to 2 of Community Health and Social medicine in Medical and Nursing Practice Ibadan, Nigeria: 3 AM COMMUNICATION.

Bandura .A. (1995) Self – efficacy in changing Societies. New York; Cambridge University press Nutbean D., Harris .T. (2004) Theory in Nutshell practical guide for health promotion theories Syidney, NSW: Mcgraw Hill.

Chinweuba A.U. (2016) principles and Precepts of Health Services Management: Publisher Eminota Nigeria limited, Enugu, Nigeria

FMOH (1988) National Health Policy and Strategies to achieve Health for all Nigeria, Lagos.

Maggi, D. and Wendy Macdowell (2010), Health Promotion: Theory: New York Open University Press

Park. K. (2007) Park''s text book of preventive and social medicine, 19 ed. M/S Banarsidas BHANOT Publishers.

Sofoluwe, S.O, & Chran, R and Ogummekan, D.A (1988) Principles and practice of Public Health in Africa Ibadan: University press plc.

Tope-Ajayi, F (2004) A guide to primary Health Care Practice in developing countries. Akure. Rotime Excels production

UNDP,: (1988) Primary Health care retrieved at www.nof.org/2012/06/19

UNDP, Human Development Report 1999, Oxford University press

Vincent. C.C (2012) Community Health Care Practice in developing countries Nigeria: Springfield publisher Ltd.

WHO (1981). Health for All Sr. No 5.

WHO (1987).

STUDY UNIT 3: ORGANIZATION OF PRIMARY HEALTH CARE

TABLE OF CONTENTS

1.0 Introduction

This unit takes you to organization of primary health care. The Directorate of Primary Health Care is one of the various divisions/directorates in both the Federal and state ministry of health. At local government level, there is also the department of health which is mainly established to organize primary health care. Each tier of government has an important role to play in the organization of primary health care as follows: This overview gives you an idea of what the organization of primary health care is.

2.0 Unit Objectives

At the end of this Unit, you will:

- Describe the organizational structure of primary health care
- Outline the functions of the federal and state ministry of health and local government

- And also outline the roles of health workers at local government health facility level

3.0 Main Content

3.1 Federal Government

The federal ministry of health plays the following roles in the organization of the primary health are:

1. Formulation of national policies on primary health care
2. Financial support to the state and local government for the implementation of PHC programmes
3. Provide guidelines on how implement the policies at the state and local government levels
4. Supervises and setting of standards for the training of PHC workers and services delivery
5. Promotes research activities
6. Collaborates with international health agencies, such as WHO, UNICEF etc
7. Monitors and evaluate measures for implementation of PHC programmes at states and L.G. levels
8. Provision of vaccines for states and L.Gs.(NPI)

3.2 State Government

1. Formulation of state policies in line with federal government guidelines.
2. Provision of facilities for training PHC workers e.g. establishment of school of health technology
3. Storage and distribution of the vaccine to L.G. areas
4. Provides guidelines for local government regarding implementation of PHC programmes
5. Promote research activities especially as regards the endemic diseases
6. Collaborates with non-governmental and international health agencies

3.3 Local Government

According to the present arrangement, the local government is responsible for/provides the following:

1. Provision of PHC services at the community level
2. Each local government is expected to organize and deliver PHC services within its domain, including environmental sanitation
3. The political head of the PHC unit in a local government is the supervisory councilor for health
4. The medical officer or community health officer is the head of the health team
   The function of the team is to carry out the day to day organization of the various PHC programmes, such as safe motherhood, family planning, immunization, refuse disposal etc.

3.4 Services Rendered at PHC

There are two distinct type of services rendered in any PHC programme. They are:

1. **Professional/technical services:** They include doctors, midwives, nurses, community health extension workers etc. They provide health services
2. **Supportive/administrative services:** They support the professional/technical services. They are the accountants, secretaries, clerical officers etc. It should be noted that the health workers working at these level comprise of:

- The village volunteers health workers and the traditional birth attendants (TBA) (they work in the villages, wards and neighborhoods).
- The community health extension workers (CHEW) and the community health officers (CHO) are working at the health facilities.
- Nurses, midwives and medical officers use their expertise to attend to various levels of health care delivery system at the PHC level.

3.5 The Role of Community Health Workers and the role of a nurse at local government level

At local government level, there are different categories of community health workers. These include: doctors, nurses/community health officers, sanitary inspectors, community health supervisors and aids, village health workers etc. They work as a team to perform the following roles:

1. Management of resources to achieve maximum results.
2. Planning and implementation of programmes.
3. Health education.
4. Record keeping and data collection for monitoring and evaluation of programmes.
5. Liasing with other agencies whose functions are health related (i.e. intersectoral collaboration).
6. Training of traditional birth attendants (T.B.A) to reduce the risks of complications arising from poor management of cases.
7. Evaluation of programme.
8. Referral services.

4.0 Conclusion

In this Unit the organization of Primary Health Care was described and the roles played by various agencies were also outlined. This will help the student to understand clearly what they expect to do at each level of health care facility domicile in each tier of this government.

5.0 Summary

In this Unit, we have learnt:

- The organizational structure of Primary Health Care.
- Functions of federal ministry of health, state ministry of health and local government towards improving the health of the publance.
- Also the roles of the health workers were also outlined.

6.0 Tutor Marked Assignment

1. Outline the function of the federal government in implementing primary health care
2. Roles of health workers in the local government health facilities

7.0 References / Further Readings

Akinsola (1993) A to 2 of Community Health and Social medicine in Medical and Nursing Practice Ibadan, Nigeria: 3 AM COMMUNICATION.

Bandura .A. (1995) Self – efficacy in changing Societies. New York; Cambridge University press Nutbean D., Harris .T. (2004) Theory in Nutshell practical guide for health promotion theories Syidney, NSW: Mcgraw Hill.

Chinweuba A.U. (2016) principles and Precepts of Health Services Management: Publisher Eminota Nigeria limited, Enugu, Nigeria

FMOH (1988) National Health Policy and Strategies to achieve Health for all Nigeria, Lagos.

Maggi, D. and Wendy Macdowell (2010), Health Promotion: Theory: New York Open University Press

Park. K. (2007) Park''s text book of preventive and social medicine, 19 ed. M/S Banarsidas BHANOT Publishers.

Sofoluwe, S.O, & Chran, R and Ogummekan, D.A (1988) Principles and practice of Public Health in Africa Ibadan: University press plc.

Tope-Ajayi, F (2004) A guide to primary Health Care Practice in developing countries. Akure. Rotime Excels production

UNDP,: (1988) Primary Health care retrieved at www.nof.org/2012/06/19

UNDP, Human Development Report 1999, Oxford University press

Vincent. C.C (2012) Community Health Care Practice in developing countries Nigeria: Springfield publisher Ltd.

WHO (1981). Health for All Sr. No 5.

WHO (1987).

STUDY UNIT 4: REFERAL SERVICES IN PRIMARY HEALTH CARE

TABLE OF CONTENTS

1.0 Introduction

This unit introduces you to the referral system in primary health care. The referral system is closely related to the concept of primary health care. This system which explains the relationship between units of medical care is based on the idea that patients should be treated as close to their homes as possible in the smallest, cheapest, most simply equipped and most humble staffed unit that will provide them an adequate service.

2.0 Unit Objectives

At the end of this Unit, you will:

- Define referral services in primary health care
- Describe two way referral system
- Differentiate between normal pathway and emergency pathway
- Outline advantages of referral system

3.0 Main Content

3.1 Definition of Referral Services in Primary Health Care

Referral service is a process by which a health worker shares or transfers responsibilities temporarily or permanently to another health professional e.g. a community health officer working in health clinic may refer or transfer a patient with hernia to a doctor working in a general hospital. On the other hand, a convalescent patient with normally lives near a health post may be referred from a comprehensive health centre to the health post for follow-up.

3.2 Four Levels of Health Care

There are four levels of health care:

i. Promotive

ii. Preventive

iii. Secondary and

iv. Tertiary levels.

These can again be classified into primary, secondary and tertiary levels. In order to facilitate accessibility and adequacy of care at the level medically fit for everybody demanding it, it is essential to establish a referral system. Hence the primary health care programme through a referral pathway links the four or three levels of care mentioned above.

3.3 The Referral System (Two way referral system)

This referral system or pathway is a two-way system which takes into account the capacity at each level, otherwise the quality of care will deteriorate.

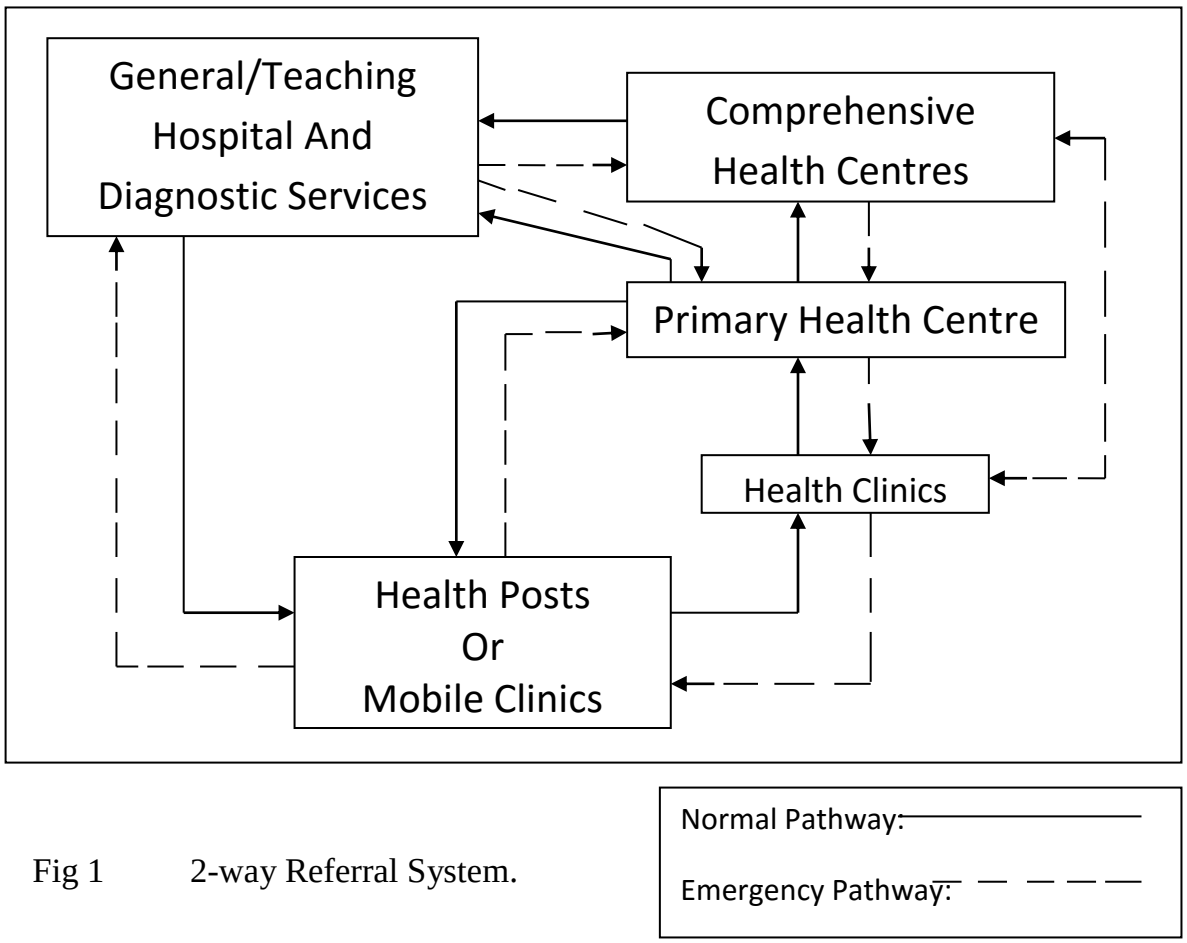

Fig 1 2-way Referral System.

3.4 Advantages of Referral System

The advantages of the referral system are many but the most obvious is that treatment at the periphery of a service is much cheaper than at the centre. So, only when a particular unit cannot care for a patient adequately is he expected to be referred to a higher unit and as soon as the situation is under control to the level that the lower unit can cope with, the patient should be transferred back to the unit. This will safe cost and will also afford the higher units to have enough time and facilities for more serious cases. The 2-way referral system used in primary health care implies communication both ways secondly; it is a learning process for members of the health team, especially the community health workers. For the referral system to be effective, the authority of each centre must provide, organize and maintain a good transport system. Secondly, there should be a good communication network, especially administrative linkage.

4.0 Conclusion

You have learnt about the Referral system in primary health care. Referral system in primary health care is a two-way referral system; the normal pathway and the emergency pathway. These services are required when a patient cannot be treated where he was admitted or patient cannot be treated in his first point of contact in a health facility that patient can be referred to a health facility which has the capacity to deal with his condition. The next unit will take you to national health policy.

5.0 Summary

In this Unit, we have learnt:

- About the referral system in primary health care
- The two-way referral services namely normal pathway and emergency pathway
- And the advantages of referral system

6.0 Tutor Marked Assignment

1. Differentiate between normal pathway and emergency pathway
2. List the four levels of health care

7.0 References / Further Readings

Akinsola (1993) A to 2 of Community Health and Social medicine in Medical and Nursing Practice Ibadan, Nigeria: 3 AM COMMUNICATION.

Bandura .A. (1995) Self – efficacy in changing Societies. New York; Cambridge University press Nutbean D., Harris .T. (2004) Theory in Nutshell practical guide for health promotion theories Syidney, NSW: Mcgraw Hill.

Chinweuba A.U. (2016) principles and Precepts of Health Services Management: Publisher Eminota Nigeria limited, Enugu, Nigeria

FMOH (1988) National Health Policy and Strategies to achieve Health for all Nigeria, Lagos.

Maggi, D. and Wendy Macdowell (2010), Health Promotion: Theory: New York Open University Press

Park. K. (2007) Park''s text book of preventive and social medicine, 19 ed. M/S Banarsidas BHANOT Publishers.

Sofoluwe, S.O, & Chran, R and Ogummekan, D.A (1988) Principles and practice of Public Health in Africa Ibadan: University press plc.

Tope-Ajayi, F (2004) A guide to primary Health Care Practice in developing countries. Akure. Rotime Excels production

UNDP,: (1988) Primary Health care retrieved at www.nof.org/2012/06/19

UNDP, Human Development Report 1999, Oxford University press

Vincent. C.C (2012) Community Health Care Practice in developing countries Nigeria: Springfield publisher Ltd.

WHO (1981). Health for All Sr. No 5

WHO (1987)

STUDY UNIT 5: INTRODUCTION TO NATIONAL HEALTH POLICY

TABLE OF CONTENTS

1.0 Introduction

Policies are general statements based on human aspirations, set of values, commitments, assessment of current situation and an image of a desired future situation {(WHO 1984). A national health policy is an expression of goals for improving the health situation, the priorities among these goals, and the main directions for attaining them (WHO 1981). Health policy is often defined at the national level.

Each country will have to develop a health policy of its own aimed at defined goals, for improving the people's health, in the light of its own problems, particular circumstances, social and economic structures, and political and administrative mechanisms.

2.0 Unit Objectives

At the end of this Unit, you will:

- Define National Health Policy
- State the goal of National Health Policy
- Enumerate reasons for Health Policy Review
- Describe the reviewed policy

3.0 Main Content

3.1 Definition of National Health Policy

A national health policy is an expression of goals for improving health situation, the priorities among these goals and the main direction for attaining them (WHO 1984).

3.2 Goal of Health Policy

The goal is to bring out a comprehensive health care system that based on primary health care that is promotive protective, preventive, restorative and rehabilitative to every citizen of the Country within the available resources so that individuals and communities are assured of productive, social well-being and enjoyment of living.

3.3 Reasons for Health Policy Review

During the second half of 1980s; considerable success was recorded with regard to the state of health system and to some extent the health status of Nigerians. The primary Health Care system was developed and strengthened and this helped to improve some of the health indicators for example routine immunization coverage

increased and led to reduction of infant and child mortality rates. Unfortunately, this success was not sustained. Rather there was a downward trend in health development in 1993.

1. National Health System

   Nigeria overall health is system performance was ranked 187th among 191 member state in Nigeria by who 2000.

2. Health Status

- Preventable disease account for most of Nigeria disease burden and poverty is a major cause of these problems.
- Our maternal mortality rate and some other health indicators such as under-5 mortality rate and adults were than the average in sub Sahara Africa.

3. Health policy, Legislation and health reform agents

- There is a limited capacity/plan/programme formulation, implementation, monitoring.
- There is no act describing the national health system and defining the health function of each of the three tiers of government.

4. Health service delivery/quality of care.

- Disease programmes, such as HIV/AIDS TB malarial and other programmes such as reproductive health where implemented within weak system and made little impact.
- Low immunization coverage.
- Maternal and infant mortality rates higher.
- Primary health care facilities served only 5-10 of patients load.
- Our secondary and tertiary health care facilities equipment was outdate.
- Referral system either nonfunctional or ineffective.

5 Drug

Out of stock syndrome re-emerged

6. Public pirate partnership

Not in existence or inefficient

7. Management and management systems;

Management of Nations limited health resources is ineffective and inefficient.

There is culture of corruption and promotion of self-interest.

8 International Community – poor co-ordination of donors and other development partners.

3.4 The Reviewed Policy

In the reviewed policy, Primary Health Care PHC remain the basic philosophy and strategy for National Health Development. PHC is the key to attaining the goal of health for all people of this country.

PHC focuses mainly on health promotion and prevention and the components of PHC de-emphasize the curative treatment. Well defined health promotions strategies can shape, facilitate, coordinate and evaluate efforts that improve the health status of the masses. In other word PHC is health promotion driven.

3.4.1 KEY POLICY THRUST:

The salient features of the Reviewed policy is to strengthen the national health system such that it would be able to provide effective, efficient, quality accessible and affordable health services that will improve the health status of Nigerians through the achievement of health-related millennium development goals (MDGS)

3.4.2 TARGETS:

The main health policy target are the same as the health targets of the millennium development goals, namely:

- Reduce by two-third between 1990 and 2015 the under under-5 mortality rate.
- Reduce by three-quarters between 1990 and 2015 maternal mortality rate.
- To have halted by 2015 and began to reserve the spread of HIV/AIDS.
- To have halted by 2015 and began to reverse the incidence of malaria and other major disease.

3.4.3 National Health Information System:

The availability of accurate timely reliable and relevant information is the most fundamental step towards informed public health action.

3.4.4 Fostering Partnership for Health Development:

The Federal and State ministries of health and local government health Authorities shall undertake appropriate measures to foster the necessary partnerships.

3.4.5 National Health Research and National Health Acts:

Mechanisms shall be devised to promote support coordinated research activities in the high priorities areas.

4.0 Conclusion

In this unit you have learnt the definition of National Health Policy, the Goal of National Health Policy, reason for its review and reviewed policy. You should at this point be able to define National Health Policy in your own words and you also be able to enumerate the objectives and reasons for National Health Policy review.

5.0 Summary

This unit focuses mainly on the definition of National Health Policy, goal of the National Health Policy, reason for health policy review and reviewed policy. This will help you to understand the reason for National Health Policy in improving the health of the people and guide you in your practices.

6.0 Tutor Marked Assignment

1. Define National Health Policy?
2. Enumerate five Targets of the National Health Policy
3. State the Goals of the National Health Policy

7.0 References / Further Readings

Akinsola (1993) A to 2 of Community Health and Social medicine in Medical and Nursing Practice Ibadan, Nigeria: 3 AM COMMUNICATION.

Bandura .A. (1995) Self – efficacy in changing Societies. New York; Cambridge University press Nutbean D., Harris .T. (2004) Theory in Nutshell practical guide for health promotion theories Syidney, NSW: Mcgraw Hill.

Chinweuba A.U. (2016) principles and Precepts of Health Services Management: Publisher Eminota Nigeria limited, Enugu, Nigeria

FMOH (1988) National Health Policy and Strategies to achieve Health for all Nigeria, Lagos.

Maggi, D. and Wendy Macdowell (2010), Health Promotion: Theory: New York Open University Press

Park. K. (2007) Park''s text book of preventive and social medicine, 19 ed. M/S Banarsidas BHANOT Publishers.

Sofoluwe, S.O, & Chran, R and Ogummekan, D.A (1988) Principles and practice of Public Health in Africa Ibadan: University press plc.

Tope-Ajayi, F (2004) A guide to primary Health Care Practice in developing countries. Akure. Rotime Excels production

UNDP,: (1988) Primary Health care retrieved at www.nof.org/2012/06/19

UNDP, Human Development Report 1999, Oxford University press

Vincent. C.C (2012) Community Health Care Practice in developing countries Nigeria: Springfield publisher Ltd.

WHO (1981). Health for All Sr. No 5

WHO (1987)

PHS 801 MODULE 5: REDUCTION OF GAPS EXISTING BETWEEN THE DEVELOPED AND DEVELOPING COUNTRIES

STUDY UNIT 1: IDENTIFICATION OF GAPS

TABLE OF CONTENTS

1.0 Introduction

This unit introduces you to identification of gaps. The world today is divided into developed and developed countries on the bases of certain feature shared by them. Example of developed countries is USA while developing is India.

The world health situation leaves much to be desired. Over 1000 million people in the developing countries have incomes too low to ensure basic nutrition and have little access to essential health services in a number of industrialized countries, rapid increases in health cost have into question the relationship between health care and health indicators. Social Medicine is concern with disparities that exist among countries. This is because Socio – economic factors and health problems are interlinked.

2.0 Unit Objectives

At the end of this Unit, you will:

- Differentiate the existing gaps between developing and developed countries
- Identify gaps in developing countries
- Identify gaps in developed countries
- Explain the Way Forward

3.0 Main Content

3.1 Identification of the existing gaps;

3.2 Gaps in Developing countries

Socio – Economic Characteristic:

- Most people in developing countries live in rural & urban slums. People depend mainly on agriculture and there is a lack of alternative employment opportunities.
- The GNP per capita ranges from US$ 200 – 6000 in most developing countries (Charles, Sir John 1971).
- Science and Technology are not fully applied
- The level of literacy is low. It is only 49% in the least developed countries and 38% among women.
- The quality of life is poor because of the scarcity of essential goods, facilities and money.
- There is isolation caused by distance, poor communications and transport facilities.
- The environment is unfavourable predisposing to communicable diseases and malnutrition.

Demographic Characteristics :(Developing Countries)

Population in developing countries is a "young" population; the proportion of persons under 15 years of age is about 31.6 per cent compared to 18% in the developed countries.

The proportion of persons over 65 years in developing countries is about 6.5 per cent compared to 12. Percent in the developed countries. The social and economic backlashes of this age distribution are being felt in both developing and developed countries. The developing countries are bearing the heavy burden of providing for a population which is mainly young; and the latter having to deal with the problems of aging

3.3 Gaps in developed Countries

- Most people (8 out of 10) are urban residents. Urban life differs from that in the villages by being impersonal.
- Women are economically employed
- Standard of living and quality of life are high
- GNP per capita ranges from US$ 500 to 40,000 in most developed countries
- The adult Literacy is almost universal.

Demographic Characteristics: The population of the world passed the 6 billion mark on October 12th 1999. About 75 per cent of the world population lives in developing countries. With this world population annual global rate of population growth is estimated to be 1.1 per cent. The advanced countries are failing to reproduce themselves with growth rates less than 0.5 per cent, and some have achieved zero population growth rate (e.g Australia, Belgium, Federal Republic of Germany and UK). Rates over 2.4 per cent have occurred in some African (e.g Nigeria, Zambia, Congo and middle East (e.g UAE, Libya, Saudi, Arabia and Iraq). India current growth rate is about 1.55 per cent. These countries are facing population problem.

3.4 The Way Forward

A search for alternative approaches to reduce and bridge the gaps has led to the birth of (Primary Health Care). Primary Health Care was viewed as the best strategy whereby the health sector, with intersectoral coordination can close the health gap and improve the health status of the population.

4.0 Conclusion

In this unit, you have learned different gaps that have existed between the developed and the developing world. You can also differentiate between developing and developed world and countries that belongs to each. These will guide you in planning health risk reduction programmes, setting priorities and in the choice of intervention.

5.0 Summary

The unit takes you to the identification of the existing gaps between developing and developed countries. It also explains the way forward in bridging the gap between developed and developing countries.

6.0 Tutor Marked Assignment

1. Differentiate between the gaps that have existed between the developing and developed countries
2. Explain the way forward in reduction and bridging the gaps between the two countries.

7.0 References / Further Readings

Akinsola (1993) A to 2 of Community Health and Social medicine in Medical and Nursing Practice Ibadan, Nigeria: 3 AM COMMUNICATION.

Bandura .A. (1995) Self – efficacy in changing Societies. New York; Cambridge University press Nutbean D., Harris .T. (2004) Theory in Nutshell

practical guide for health promotion theories Syidney, NSW: Mcgraw Hill.

Chinweuba A.U. (2016) principles and Precepts of Health Services Management: Publisher Eminota Nigeria limited, Enugu, Nigeria

FMOH (1988) National Health Policy and Strategies to achieve Health for all Nigeria, Lagos.

Maggi, D. and Wendy Macdowell (2010), Health Promotion: Theory: New York Open University Press

Park. K. (2007) Park''s text book of preventive and social medicine, 19 ed. M/S Banarsidas BHANOT Publishers.

Sofoluwe, S.O, & Chran, R and Ogummekan, D.A (1988) Principles and practice of Public Health in Africa Ibadan: University press plc.

Tope-Ajayi, F (2004) A guide to primary Health Care Practice in developing countries. Akure. Rotime Excels production

UNDP,: (1988) Primary Health care retrieved at www.nof.org/2012/06/19

UNDP, Human Development Report 1999, Oxford University press

Vincent. C.C (2012) Community Health Care Practice in developing countries Nigeria: Springfield publisher Ltd.

WHO (1981). Health for All Sr. No 5.

WHO (1987).