

## **LECTURE NOTES**

For Nursing Students

# *Community Health Nursing*



**Ethiopia Public Health  
Training Initiative**

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**UNIT ONE**  
**CONCEPT OF HEALTH IN COMMUNITY HEALTH**  
**NURSING**

**Learning Objectivities:**

On completion of this of this unit, students will be able to:

- Discuss the basic concepts in community health nursing using various definitions
- Describe the health – illness continuum
- Explain the relation ship between community health perception of the community and related health problems
- Analyze components of community health practices
- Describe characteristics of community health practice

**1.1 Introduction**

Broadly defined, a community is a collection of people who interact with one another and whose common interest or characteristics gives them a sense of unity and belonging.

- A community is a group of people in defined geographical area with common goal and objective

and the potential for interacting with one another (Dryer's den).

The function of any community includes its members' sense of belonging and shared identity, values, norms, communication, and supporting behaviors. Some communities who may share almost everything, while other communities (large, scattered and composed of individuals) who may share only their common interests and involvement in certain goals.

A community is often defined by its geographic boundaries and thus called a geographic community. Example, a city, town or neighborhood is a geographic community. A community demarcated by geographic boundaries becomes a clear target for analysis of health needs to form basis for planning health programs and a geographic community is also easily mobilized for action.

Community can also be identified by a common interest or goal. A collection of people, although they are widely scattered geographically, can have an interest or goal that binds the members-together called common interest community. (e.g., Disabled individual scattered through out a large city may emerge as a community through a common interest in their need for improved wheel chaired access or other handicapped facilities).

## **The Three Features of a Community**

A community has three features, location, population and social system.

**Location:** every physical community carries out its daily existence in a specific geographical location. The health of the community is affected by this location, including the placement of the service, the geographical features...

**Population:** consists of specialized aggregates, but all of the diversified people who live within the boundary of the community.

**Social system:** the various parts of communities' social system that interact and include the health system, family system, economic system and educational system.

### **1.2 Health**

Health is defined as a state of physical, mental and social well being not merely the absence of disease or infirmity (WHO, 1948). Health, in its holistic philosophy differs greatly from that of the acute care settings. Physical health implies a mechanistic functioning of the body. Mental health means the ability to think clearly and coherently and has to do with your thinking and feeling and how you deal with your problem. A mentally healthy person has a capacity to live with other

people, to understand their needs, and to achieve mutually satisfying relationships.

Social health refers to the ability to:

- Make and maintain relationship with others:
- Interact well with people and the environment.

Health designates the ability to adopt to changing environments to growing up and to aging, to healing when damaged, to suffering and to peaceful expectation of death (Illich 1975). The ability of a system (e.g. Cell, organism, family, society) to respond adaptively to a wide variety of environmental challenges (Brody and Sobel, 1981).

Lamberton (1978) sees the opposite of health as being no health and the opposite of illness as being no disease. Furthermore, death is not viewed as the ultimate illness but as a natural part of growth and development. She also considers an individual's interaction with ecology as being an important influence on health and on illness. Health is also conceptualized as a source for every day living. It is a positive idea that emphasizes social and personal resources and physical in abilities.

### **1.3. Health and Wellness**

#### **Health**

Each person has a personal perception of health. Some people describe their state of health as good even though they may actually have one or more diagnosed illness (es). That is because each person perceives health in relation to personal expectations and values

The concept of health must allow for his individual variability. Health is a dynamic state in which the person is constantly adapting to changes in the internal and external environments. For example, a person may see himself/herself as healthy while experiencing a respiratory infection.

#### **Wellness**

Wellness is a life – style aimed at achieving physical, emotional, intellectual, spiritual and environmental well being. The use of wellness measures can increase stamina, energy and self – esteem, then enhance quality of life.

The concept of wellness also allows for individual variability. Wellness can be thought of a balance of the physical, emotional, psychological, social and spiritual aspects of a

person's life. This is a dynamic state. Each person would define wellness in relation to personal expectations.

Wellness behaviors are those that promote healthy functioning and help prevent illness. These include, for example, stress management, nutritional awareness, and physical fitness.

## **Models of Health**

There are various models of the concept of health. Some models are based narrowly on the presence or absence of definable illness. Others are based more conceptually on health beliefs, wellness and holism.

### **A. Clinical Model (Dunn, 1961)**

In this model, health is interpreted as the absence of signs and symptoms of disease or injury; thus the opposite of health is disease. Dunn defined, in this model, "health as a relatively passive state of freedom from illness, and a condition of relative homeostasis." Illness is therefore, something that happens to a person.

Many health care providers focus on the belief of signs and symptoms of disease and conclude that when these are no longer present, the person is healthy.

**N.B.** This model may not take into consideration person's health beliefs or person life- styles.



## B. Host –Agent – Environment Model (Leavell, 1965)

This model helps to identify the cause of an illness. In this model:

**Host:** Refers to the person (or group) who may be at risk for or susceptible to an illness.

**Agent:** is any factor (internal or external) that can lead to illness by its presence.

**Environment:** refers to those factors (physical, social, economic, emotional, spiritual) that may create the likelihood or the predisposition for the person to develop disease.

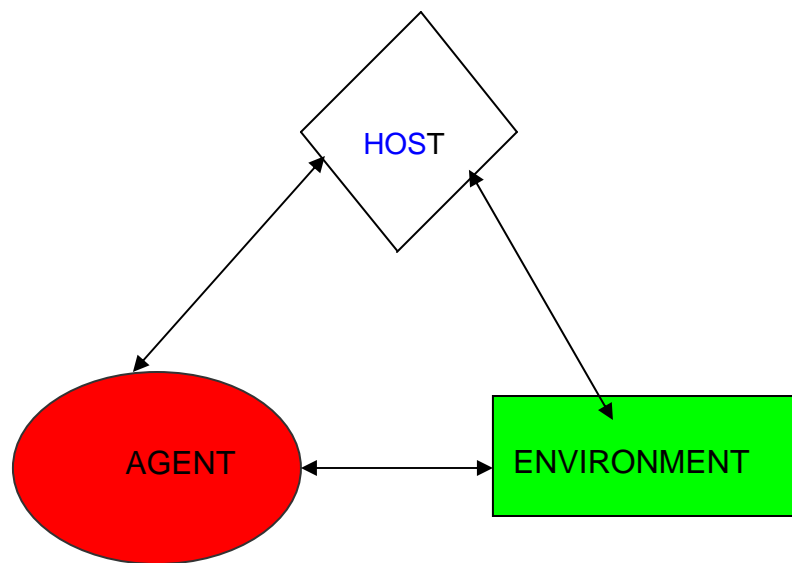


Fig1. Host – agent – environment model.

In this model health and illness depends on the interaction of these three factors.

C. Health Belief Model (HBM) (Rosenstock, 1974, as Modified by Stone 1991).

There is a relationship between a person's belief and actions.

Factors that influence persons belief's:

- Personal expectation in relation to health and illness
- Earlier experience with illness or health
- Age and development state.

Health beliefs are person's ideas, convictions and attitudes about health and illness. They may be based on factual information, misinformation, commonsense or myths, or reality or false expectations.

Health beliefs usually influence health behavior this influence can be positive or negative.

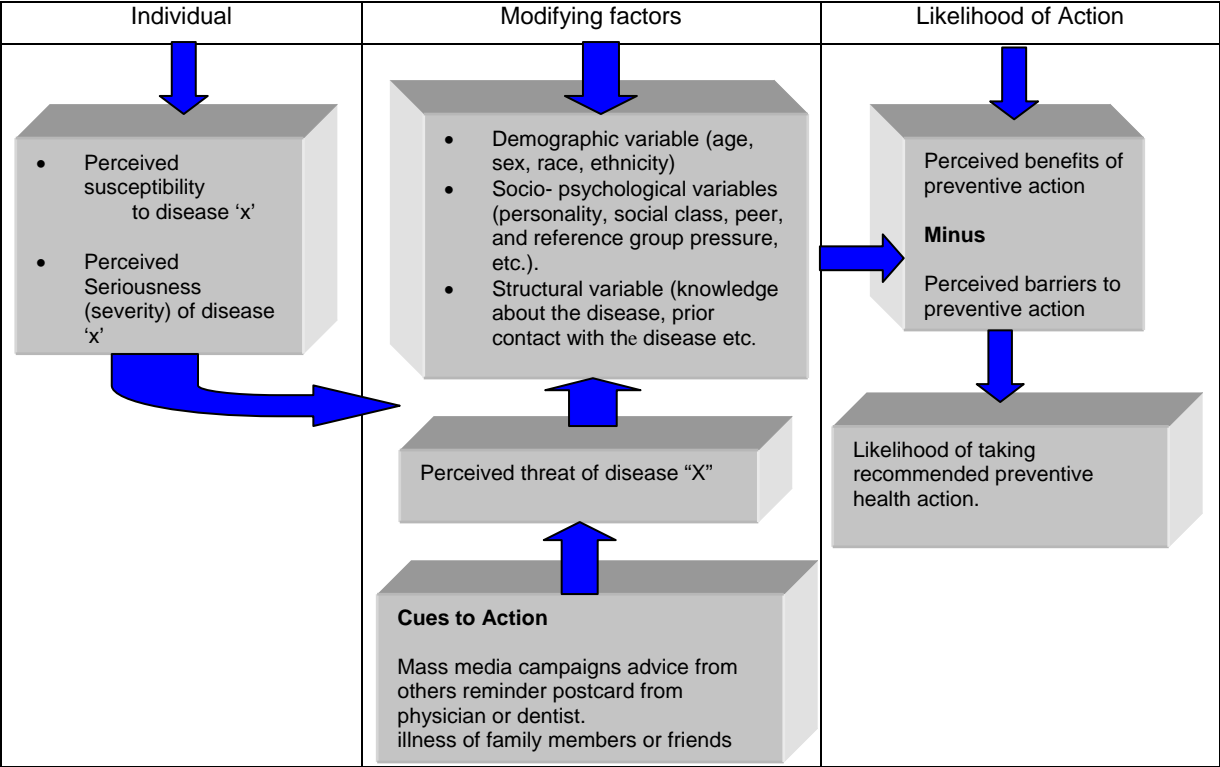


Fig.2 Health- belief model

## Health Belief Model (HBM)

- Addresses relationship between persons belief and behavior
- Provides a way of understanding and predicting how clients will behave in relation to their health and how they will comply with health care therapies.

## Components in HBM

### First component (Individual Perception)

- Individual's perception of susceptibility to illness: e.g. family like with coronary heart disease (CHD), after link is recognized particularly if one parent or both siblings have died in the 4<sup>th</sup> decade from myocardial infarctions (MI).

### Second component (Modifying Factors)

- Individual's perception of the seriousness of the illness. This perception is influenced and modified by demographic and socio-psychological variables, perceived threat of the illness and cues to action.

### **Third component (Likelihood of Action)**

The likelihood that the person will take preventive action results from the person's perception of the benefits of and barriers to taking action. The preventive action may include: Lifestyle modification/change, increased adherence to medical therapies or search for medical advice or treatment.

### **Implication of HBM to Nursing**

Helps nurses to understand factors influencing client's

- Perception
- Beliefs and
- Behaviors
- Plan care that will most effectively assist client in maintaining or restoring health and preventing illness.

### **D. High – Level Wellness Model (Dunn, 1961)**

According to Dunn (1961), health recognized as an ongoing process toward the person's highest potential functioning. This process involves the person, family, and Community.

Dunn described high level wellness as the experience of the person alive with the glow of good health, alive to the tips of their fingers with energy to burn, tingling with vitality – at times like this the world is a glorious place.

### **E. Holistic Health Model**

Holism is seen as a “new” model of health, but actually it is not new at all. Holism has been a major theme in the humanities, western political tradition and major religions throughout history.

Holism is a different approach to health is that acknowledges and respects the interaction of a person’s mind, body and spirit within the environment.

Holism is derived from the Greek holos (whole), was first used by South African philosopher Jan Christian Smuts (1926) in Holism and Evolution.

Smuts viewed holism as antidote to the atomistic approach of contemporary science. An atomistic approach takes things apart, examining the person piece by piece in an attempt to understand the larger picture by examining the smaller molecule or atom.

Holism is based on the belief that people (or even their parts) cannot be fully understood if examined solely in pieces apart from their environment. People are seen as every changing systems of energy.

Below figure illustrates, the organism and the system in which it lives are seen as greater than and different from the sum of their parts.

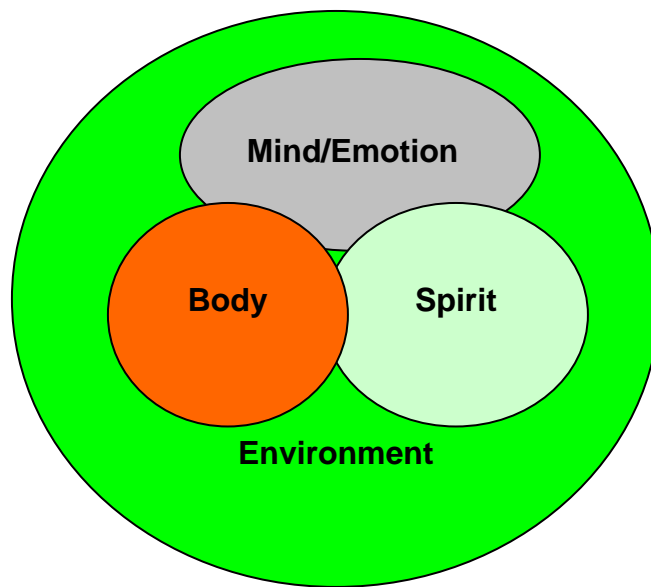


Fig. 3 Schematic representation of holism.

#### **1.4. Health and illness**

Rather than focusing on curing illnesses, community based nursing care focuses on promoting health and preventing illness. This holistic philosophy therefore differs greatly from that of the acute care setting.

Improvement of health is not seen as an outcome of the amount and type of medical services or the size of the hospital. Care provided in acute care setting is usually directed at resolving immediate health problems. In the community, care focuses on maximizing individual potential for

self-care regardless of any injury or illness. The client assumes responsibility for health care decisions and care provision. Where health is the essence of care, the client's ability to function becomes the primary concern.

Educational and community based programs can be designed to address life- style. Health protection strategies relate to environmental or regulatory measures that confer protection on large population groups. Health protection involves a community wide focus. Preventive services include counseling, screening, immunization, or chemoprophylactic interventions for individuals in clinical settings.

The prevention focus is a key concept of community based nursing. Prevention is conceptualized on three levels:

- Primary prevention level
- Secondary prevention level
- Tertiary prevention level

### **1.5. Health – illness continuum**

The wellness- illness continuum (Travis and Ryan 1988) is a visual comparison of high – level wellness and traditional medicine's view of wellness. At the neutral point, there are no signs or symptoms of disease. A person moving toward the left experiences a worsening state of health. Someone with wellness – oriented goals wants to move beyond the neutral



point (more absence of disease) to the right (toward high – level wellness).

This person evaluates the current conduct of his/her life, learns about the available options, and grows toward self – actualization by trying out of these options in the search of high level wellness.

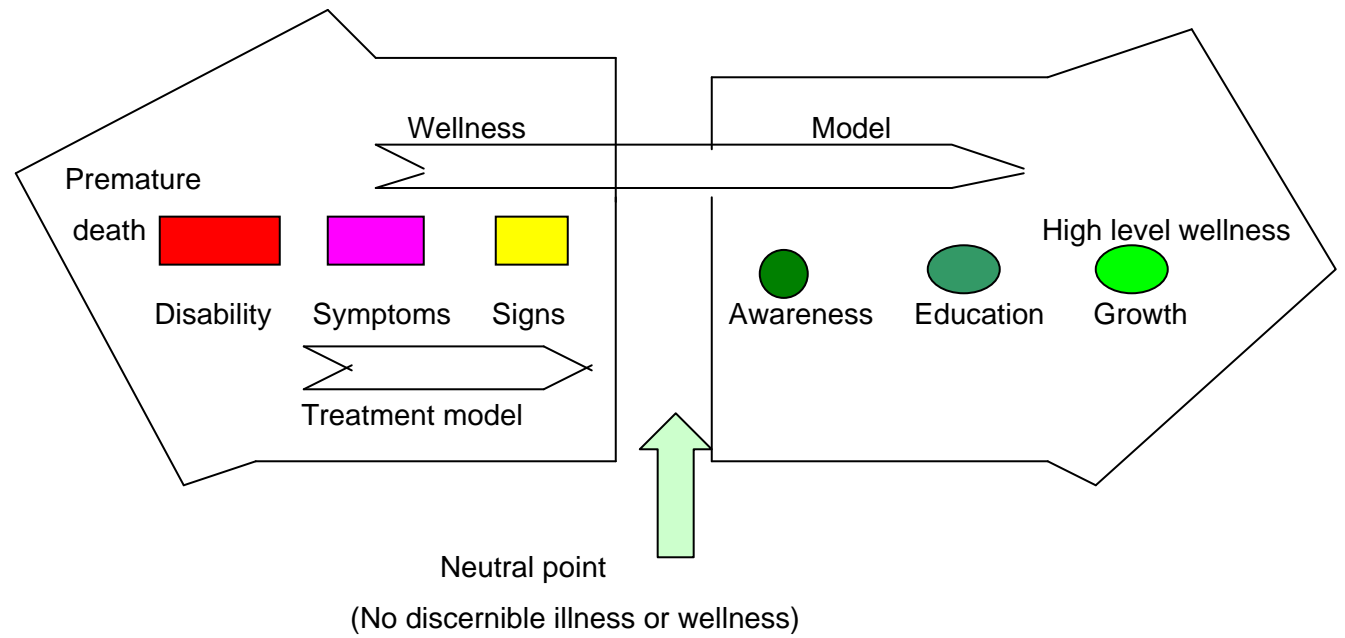


Fig. 4 Illness – wellness continuum model (Travis and Ryan, 1988)

## **1.6. Community health Practice**

It is part of the larger public health effort that is concerned with preserving and promoting the health of specific populations and communities. Community health practice incorporates six basic elements:

### **Promotion of health**

- It includes all efforts that seek to move people closer to optimal well-being or higher level of wellness.
- It is the combination of educational and environmental supports for action and condition of living conducive to health.

### **Prevention of health problems (refer to unit three for the details)**

### **Treatment of disorders**

- It focuses on the illness end of continuum and is the remedial aspects of community health practice. This is practiced by:
  - a. Direct service to people with health problems; E.g. home visit for elderly peoples, chronic illness, etc
  - b. Indirect service; e.g. assisting people with health problem to obtain treatment and referral.
  - c. Development of program to correct unhealthy condition; e.g. alcoholism, drug abuse, etc.

**Rehabilitation**

- It involves efforts which seek to reduce disabilities, as much as possible, and restore functions; e.g. stroke rehabilitation.

**Evaluation**

- It is the process by which the practice is analyzed, judged, and improved according to established goals and standards.
- It helps to solve problems and provides direction for future health care planning.

**Research**

- It is a systematic investigation which helps to discover facts affecting community health and community health practices, solve problems, and explore improved methods of health services.

**1.7. Community health Nursing**

It is defined as the synthesis of nursing and public health practice applied to promoting and protecting the health of population. It is a specialized field of nursing that focuses on the health needs of communities, aggregates, and in particular vulnerable populations. It is a practice that is continuous and comprehensive directed towards all groups of community members. It combines all the basic elements of professional, clinical nursing with public health and community practice. It

synthesizes the body of knowledge from public health science and professional nursing theories to improve the health of communities.

### **1.7.1. Characteristics of Community health Nursing**

Six important characteristics of community health nursing are particularly salient to the practice of this specialty.

- It is a specialty field of nursing
- Its practice combines public health with nursing
- it is population focused.
- it emphasizes on wellness and other than disease or illness
- it involves inter-disciplinary collaboration
- it promotes client's responsibility and self-care

### **1.7.2. Community settings nursing care**

Community health nursing takes place in a wide variety of settings which includes promoting health, preventing illness, maintaining health, restoration, coordination, management and evaluation of care of individuals, families, and aggregates, including communities (Lancaster, S.). In the community settings, care focuses on maximizing individual potential for self-care regardless of any injury or illness. The client assumes responsibility for health care decisions and care provision.

The change in health care services resulted in changes in nursing care as well. Settings are changed to the community and especially to home. The intent of care is not to fix with treatment but to enhance the quality of life and support actions that make the client's life as comfortable as possible.

**Table 1. Comparison of values currently in acute care and community – based settings**

<b>Nursing concepts</b>	<b>Acute care setting</b>	<b>Community based setting</b>
<b>Client</b>	Client or patient separated from family and characterized by disease	Client seen in the content of the family and the community
<b>Environment</b>	Standardized room, ward or specialized unit, family access and client freedom controlled by facility	Natural environment shared with family and community. Client cannot be separated from environment.
<b>Health</b>	Dichotomy with illness, considered its polar opposite, purpose of care is to eliminate illness.	Illness in an aspect of life: purpose of care is to maximize function and quality of life.
<b>Nursing</b>	Activities largely delegated by physician, centered on the treatment of illness, medication, and technology, Short-terms, predictable interventions.	Autonomous practice with interventions mutually decided based on client's values.

### **1.7.3. Acute Care Setting**

This term is used for people who are receiving intensive hospital care.

Care provided in acute care setting is usually directed at resolving immediate health problems.

An acute care setting is part of the hospital setting which also can be used as an ambulatory clinic or day surgical clients or they require highly technical care. Many of these clients have life-threatening conditions and require close monitoring and constant care. Therefore, acute nursing care is different from community based nursing care.

### **1.8. Public Health Nursing**

It is the art and science of prolonging life, promoting health and preventing disease through organization of community efforts.

Public health nursing refers to composition of nursing services and health promotion of the population.

It is aimed to:

- improve sanitation
- control of community epidemics
- prevent the transmission of infection
- provide education about the basic principles of personal hygiene



- organize medical and nursing services for early diagnosis, prevention and treatment of diseases.

**Review question**

- Discuss the basic concepts in community health nursing using various definitions
- Describe the health – illness continuum
- Explain the relation ship between community health perception of the community and related health problems
- Analyze components of community health practices
- Describe characteristics of community health practice

# **UNIT TWO**

## **HISTORICAL DEVELOPMENT OF COMMUNITY HEALTH NURSING**

### **Learning Objectives**

On completion of this of this unit, students will be able to:

- Describe the four stages of community health nursing development
- Describe factors that influenced the growth of community health nursing
- Explain some of the roles of community health nursing
- Summarize the settings of community health nursing

### **2.1. Introduction**

Before one can fully grasp the nature of community health or define its practice, it is helpful to understand the roots and influencing factors that shaped its growth over time.

Community health nursing is the product of centuries of responsiveness and growth. Its practice was adapted to accommodate the needs of a changing society, yet it has always maintained its initial goal of improved community health. Community health nursing development has been

influenced by changes in nursing, public health and society that is traced through several stages.

In tracing the development of public health nursing, now it is clear that leadership role has been evident throughout its history. Nurses in this specialty have provided leadership in:

planning and developing programs;

shaping policy;

administration; and

the application of research to the community health.

Four general stages mark the development of public health or community health nursing.

- The early home care stage
- The district nursing stage
- The public health nursing stage
- The community health nursing stage

### **Early Home Care Stage (Before Mid 1800s)**

For many centuries female family members and friends attended the sick at home. The focus of this care was to reduce suffering and promote healing (Kalish and Kalish, 1986). The early roots of home care nursing began with religious and charitable groups.

In England the Elizabethan poor law written in 1600, provided medical and nursing care to the poor and disabled. In Paris, St. Vincent DePaul started the sisters of charity in 1617, an

organization composed of laywomen dedicated to serving the poor and the needy. In its emphasis on preparing nurses and supervising care as well as determine causes and solutions for clients' problems their work laid a foundation for modern community health nursing (Bullough and Bullough, 1978).

The set back of these services were:

- Social approval following the reformation caused a decline in the number of religious orders with subsequent curtailing of nursing care for the sick and poor.
- High maternal mortality rates prompted efforts to better prepare midwives and medical students.
- Industrial revolution created additional problems; among them were epidemics, high infant mortality, occupational diseases, injuries and increasing mental illness both in Europe and America.

This stage was in the midst of these deplorable conditions and response to them that Florence Nightingale (1820 - 1910) began her work. Much of the foundation for modern community health nursing practice was laid through Florence Nightingale's remarkable accomplishments. Nightingale's concern for population at risk as well as her vision and successful efforts at health reform provided a model for community health nursing today.

### **District Nursing (Mid 1800s to 1900)**

The next stage in the development of community health nursing was the formal organization of visiting nursing (Phoebe, 58AD) or district nursing. Although district nurses primarily care for the sick, they also thought cleanliness and wholesome living to their patients, even in that early period. Nightingale referred to them as “health nurse”. This early emphasis on prevention and health nursing became one of the distinguishing features of district nursing and later of public health nursing as a specialty.

The work of district nurses focused almost exclusively on the care of individuals. District nurses recorded temperatures and pulse rates and gave simple treatments to the sick poor under the immediate direction of a physician. They also instructed family members in personal hygiene, diet and healthful living habits and the care of the sick.

Problems of district nursing:

- Increased number of immigrants
- Increased crowded city slums
- Inadequate sanitation practices
- Unsafe and unhealthy working conditions

Nevertheless, nursing educational programs at that time did not truly prepare district nurses to cope with their patients, multiple health, and social problems.

### **Public Health Nursing Training (1900-1970)**

By the turn of the century, district nursing had broadened its focus to include the health and welfare of the general public, not just the poor. This new emphasis was part of a broader consciousness about public health. Specialized programs such as infant welfare that brought health care and health teaching to the public and gave nurses an opportunity for more independent work, and helped to improve nursing education (Bullough and Bullough 1978, p. 143).

Lillian D. Wald's (1867-1940) contributions to public health nursing were enormous. Her driving commitment was to serve needy populations. Wald's emphasis on illness prevention and health promotion through health teaching and nursing intervention as well as her use of epidemiological methodology established these actions as hallmarks of public health nursing practice. The public health nursing stage was characterized by service to the public with the family targeted as a primary unit of care.

### **Community Health Nursing (1970 to present)**

The emergence of the term community health nursing heralded a new era while public health nurses continued their work in public health by the late 1960s and early 1970s. Many other nurses, not necessarily practicing public health, were based in the community. Their practice settings included

community based clinics, doctor's office, work sites, schools, etc, to provide a label that encompassed all nurses in the community.

The confusion was laid in distinguishing between public health nursing and community health nursing. The terms were being used interchangeably and yet, had different meanings for many in the field in 1984 the division of nursing convened a consensus conference on the essentials of Public Health Nursing practice and education in Washington DC (1985). This group concluded that community health nursing was the broader term referring to all nurses practicing in the community regardless of their educational preparation.

Public health nursing, viewed as a part of community health nursing, was described as generalist practice for nurses prepared with basic public health content at the baccalaureate level and a specialized practice for nurses prepared in the public health at the masters level or beyond.

The debate over these areas of confusion continued through the 1980's with some issues unresolved even today. Public health nursing continues to mean the synthesis of nursing and public health sciences applied to promoting and protecting the health of populations. Community health nursing is used synonymously with public health nursing and refers to specialized population focused nursing practice which applies public health sciences as well as nursing services.

A possible distinction between the two terms might be to view community health nursing as a beginning level of specialization and public health nursing as advanced level. Whichever term is used to describe this specialty, the fundamental issues and defining criteria remain as:

Are the populations and communities the target of practice?

Are the nurses prepared in public health and engaging in public health practice?

**Table 2: The Summary of Development of Community Health Nursing**

Stages	Focus	Nursing Orientation	Service Emphasis	Institutional base (Agencies)
Early home care (Before mid 1800s)	Sick poor	Individuals	Curative	Lay and religious Leaders.
District nursing (1860-1900)	Sick poor	individuals	Curative and beginning of preventive	Voluntary and some governments
Public health nursing (1900-1970)	Needy public	Families	Curative and preventive	Government and some volunteers
Emergence of community health nursing (1970-present)	Total community	Population	Health promotion and illness prevention	Many kinds and some independent practitioners



## **The specialty of Community Health Nursing**

The two characteristics of any specialized nursing practice are:

- Specialized knowledge and skills, and
- Focus on a particular set of people receiving the service.

These two characteristics are also true for community health nursing. As a specialty, community health nursing adds public health knowledge and skills that address the needs and problems of communities and focuses are on communities and vulnerable population. Community health nursing then, as a specialty, combines nursing and public health sciences to formulate a practice that is community based and population focused (Williams, 1992).

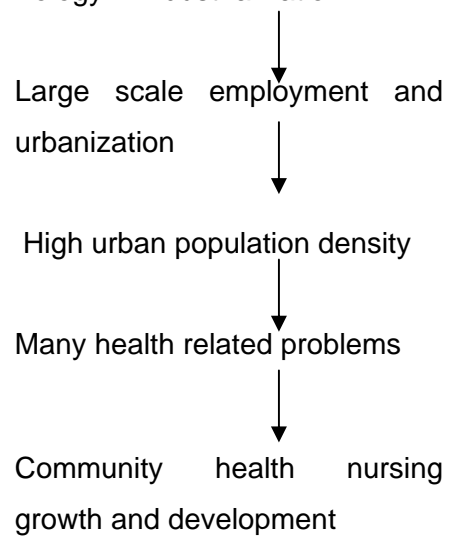
It is a synthesis of the body of knowledge from the public health sciences and professional nursing theories to improve the health of communities and vulnerable populations (American Public Health Association, 1992). Community health nursing is grounded in both public health and nursing sciences, which makes its philosophical orientation and the nature of its practice unique.

## 2.2. Factors Influenced the Growth of Community Health Nursing

Even though many factors influenced the growth of community health nursing, six are particularly significant:

### a. Advanced technology

- As technological innovation increased, health care services and nutrition improved, and life style changed, community health nursing has become grown and developed to meet the needs of the communities.
- Advanced technology → industrialization



### **b. Progress in causal thinking**

Germ theory disease causation (single cause → single effect)



Tripartite view of disease causation (i.e. agent, host, environment)



Multiple disease causation approach (multiple cause → multiple effect)

This progress in the study of causality, particularly in epidemiology, has significantly affected the nature of community health nursing to control health problem by examining all possible causes and then attacking strategic causal point.

### **c. Changes in Education**

When people's understanding of their environment grows, an increased understanding of health is usually involved. As a result, people feel that they have the right to know and question the reason behind the care they receive. Community health nurses have shifted from planning for clients to collaborating with clients.

### **d. Consumer movement**

Consumers demanding quality service seek more comprehensive and co-coordinated care. This movement has stimulated some basic changes in the philosophy of community health nursing.

**e. Changing demography**

Shifting patterns in immigration, number of births and deaths, and rapidly increasing population of elderly persons affect community health nursing planning and programming efforts.

**f. Economic forces.**

Economic forces like unemployment, escalating health care cost, limited access of health services, and changing health care financing patterns affected community nursing practices. In order to respond to these forces community nursing has established new programs and projects.

**2.3. Roles of Community Health Nursing**

Seven major roles are:

- Clinician
- Educator
- Advocate
- Managerial
- Collaborator
- Leader
- Researcher

The most familiar community health nurse role is that of clinician or provider of care. However, giving nursing care takes on new meaning in the context of community health.

#### **A. Clinician role /direct care provider**

The clinician role in the community health means that the nurse ensures that health services are provided, not just to individuals and families but also to groups and population. For community health nurses the clinician role involves certain emphasis different from basic nursing, i.e. – Holism, health promotion, and skill expansion.

**Holism:** In community health, however, a holistic approach means considering the broad range of interacting needs that affect the collective health of the client as a larger system. The client is a composite of people whose relationships and interactions with each other must be considered in totality.

**Health Promotion focus on wellness:** The community health nurse provides service along the entire range of the wellness – illness continuum but especially emphasis on promotion of health and prevention of illness.

**Expanded skills:** the nurse uses many different skills in the community health clinician role skill. In addition to physical care skill, recently skills in observation, listening, communication and counseling became integral to the clinician role with an increased emphasis on environmental

and community wide considerations such as problems with pollution, violence and crime, drug abuse, unemployment and limited funding for health programs.

### **B. Educator role**

It is widely recognized that health teaching is a part of good nursing practice and one of the major functions of a community health nurse (Brown, 1988). The educator role is especially useful in promoting the public's health for at least two reasons. The educator role:

- Has the potential for finding greater receptivity and providing higher yield results.
- Is significant because wider audience can be reached.

The emphases throughout the health teaching process continue to be placed on illness prevention and health promotion.

### **C. Advocate role**

The issue of clients' rights is important in health care today. Every patient or client has the right to receive just equal and humane treatment. However, our present health care system is often characterized by fragmented and depersonalized

services. This approach particularly affected the poor and the disadvantaged.

The community health nurse often must act as advocate for clients pleading the cause or acting on behalf of the client group. There are times when health care clients need someone to explain what services to expect and which services they ought to receive.

#### **D. Managerial role**

As a manager the nurse exercises administrative direction towards the accomplishment of specified goals by assessing clients' needs, planning and organizing to meet those needs, directing and controlling and evaluating the progress to assure that goals are met. Nurses serve as managers when they oversee client care, supervise ancillary staff, do case management, manage caseloads, run clinics or conduct community health needs assessment projects.

#### **E. Case management**

Case management refers to a systematic process by which the nurse assesses clients' needs, plans for and co-ordinates services, refers to other appropriate providers, and monitors and evaluates progress to ensure that clients multiple service needs are met.

**F. Collaborator role**

Community health nurses seldom practice in isolation. They must work with many people including clients, other nurses, physicians, social workers and community leaders, therapists, nutritionists, occupational therapists, psychologists, epidemiologists, biostatisticians, legislators, etc. as a member of the health team (Fairly 1993, Williams, 1986). The community health nurse assumes the role of collaborator, which means to work jointly in a common endeavor, to co-operate as partners.

**G. Leader role**

Community health nurses are becoming increasingly active in the leader role. As a leader, the nurse directs, influences, or persuades others to effect change that will positively affect people's health. The leadership role's primary function is to effect change; thus, the community health nurse becomes an agent of change. They also seek to influence people to think and behave differently about their health and the factors contributing to it.

**H. Research role**

In the researcher role community health nurses engage in systematic investigation, collection and analysis of data for the purpose of solving problems and enhancing community health practice. Research literally means to search and/or to



investigate, discover, and interpret facts. All researches in community health from the simplest inquiry to the most epidemiological study uses the same fundamental process.

The research process involves the following steps:

- Identifying an area of interest
- Specify the research question or statement
- Review of literature
- Identifying the conceptual frame work
- Select research design
- Collect and analyze data
- Interpret the result
- Communicate the findings

The community health nurse identifies a problem or question, investigates by collecting and analyzing data, suggests and evaluates possible solutions and selects and or rejects all solutions and starts the investigative process over again. In one sense, the nurse in gathering data for health planning, investigates health problems in order to design wellness – promoting and disease prevention for the community.

#### **2.4. Settings of community health nursing practice**

The types of places in which community health nurses practice are increasingly varied including a growing number of non-traditional settings and partnership with non-health groups.

These settings can be grouped into five categories:

Homes

Out patient department (ambulatory service settings) in  
the health institutions

Occupational health setting (factories, cottage industries)

Social institutions (schools, Prisons, Orphanages)

The community at large

### **Review Questions**

- Describe the four stages of community health nursing development
- Describe factors that influenced the growth of community health nursing
- Explain some of the roles of community health nursing
- Summarize the settings of community health nursing

# UNIT THREE

## HEALTH CARE DELIVERY SYSTEM

### Learning Objectives:

On completion of this of this unit, students will be able to:

- Define health care delivery system
- Describe factors affecting health care delivery system.
- Discuss Historical development of Medicine in Ethiopia
- Describe the health care delivery system in Ethiopia
- Explain Primary Health Care

### 3.1. Introduction

The term “Health care delivery system” is often used to describe the way in which health care is furnished to the people. Classification of health care delivery system is by acuity of the client’s illnesses and level of specialization of the professionals.

- Primary care level
- Secondary care level
- Tertiary care level

**Primary care level:** is the usual entry point for clients of the health care delivery system. It is oriented towards the promotion and maintenance of health, the prevention of

disease, the management of common episodic disease and the monitoring of stable or chronic conditions. Primary care ordinarily occurs, in ambulatory settings. The client or the family manages treatment with health professionals providing diagnostic expertise and guidance.

**Secondary care level:** It involves the provision of specialized medical services by physician or a hospital on a referral by the primary care provider.

A patient has developed a recognizable sign and symptoms that are either definitively diagnosed or require further diagnosis. It is oriented towards clients with more severe acute illnesses or chronic illnesses that are exacerbated. If hospitalization occurs it is usually in a community (district) hospital. Most individuals who enter this level of care are referred by primary care worker, although some are self-referred. The physicians who provide secondary care are usually specialists and general practitioners.

**Tertiary care level:** It is a level of care that is specialized and highly technical in diagnosing and treating complicated or unusually health problems.

Patients requiring this level often present in extensive and complicated pathological conditions. It is the most complex level of care. The illness may be life-threatening, and the care ordinarily takes place in a major hospital affiliated by a medical school. Clients are referred by workers from primary or

secondary settings. The health professionals, including physicians and nurses tend to be highly specialized, and they focus on their area of specialization in the delivery of care.

The other classification of health care delivery system is:

**Preventive:** is aimed at stopping the disease process before it starts or preventing further deterioration of a condition that already exists.

**Curative:** is aimed at restoring the client's health.

**Rehabilitative:** is aimed at lessening the pain and discomfort of illness and helping clients live with disease and disability. Some nurse theorists have conceptualized the nursing role as being focused on sustaining care and preventing disease. However, the work role of nurse practitioners and home health care nurses would probably span all three of these orientations. The nurse must understand and remember that the preventive services are also popularly categorized as primary, secondary, and tertiary preventive health care.

### **Levels of prevention**

**Primary prevention:** refers to the prevention of an illness before it has a chance to occur.

Aims

- Health promotion
- Protection against illness

Primary preventive measures apply before a disease manifests with sign and symptoms.

Examples:

- Eating well balanced diet
- Regular exercise program
- Maintaining weight
- No smoking
- Moderation of alcohol
- Information on  
alcohol  
substance
- Nutritional counseling
- Environmental control
- Safe water Supply
- Good food hygiene
- Safe waste management
- Vector and animal reservoir control
- Good living and working condition
- Stress management
- etc

**Secondary prevention:** includes the early detection of actual or potential health hazards. This allows for prompt intervention and possibly a cure of a disease or condition. It is directed

forwards health maintenance for patients experiencing health problems.

**Secondary prevention has two sub-levels**

- a. early detection (diagnosis) of disease
- b. prompt treatment

e.g. hypertension screen and acute care.

Secondary prevention increases awareness of:

breast self – examination

testicular self-examination

mammography

pap smear

BP screening

Blood glucose screening

Teaching breast self - examination

Antibiotic treatment of streptococcal pharyngitis

aimed at preventing rheumatic fever

“Caution” of cancer

**Tertiary Prevention:** is aimed at avoiding further deterioration of an already existing problem. Rehabilitative efforts are sometimes tertiary preventive measures. It deals with rehabilitation and return of client to a status of maximum function within the limit posed by the disease or disability and preventing further decline in health. This level of prevention occurs after a disease caused extensive damage.

Examples     -Rehabilitation after stroke  
                  -Smoking cessation program for clients with emphysema.

### **3.2. Factors affecting the delivery of health care services**

Several factors have contributed to the growth and complexity of health care delivery system.

#### **Health care as a right**

In this country access to health care is the privilege to the rich. The poor either goes without or has to be satisfied with less quality care. In developed countries, today equal access to health care is viewed as every one's fundamental human right, rich or poor and it is run as a national health service (NHS).

#### **Technological advances**

Today advances in technology has so far made an increasingly dramatic changes on health care.

Example

- Better diagnostic tools assist in recognizing conditions while they are treatable
- Organ transplants e.g. Renal transplant, bone marrow transplant are becoming common treatment procedures.



- Life can be maintained mechanically  
e.g. mechanical ventilator.
- Changing technology alters the profile of hospital patients.  
e.g., after insulin was developed (1920s), people with diabetes could manage their disease at home instead of in the hospital.

### **Rising Consumerisms**

Consumerism is the public expectation that it will have a voice in determining the type, quality and cost of health care.

Previously the health – care system operated fully on the assumption that the health professionals physician and nurses knew what was best for the patient and should make decision for them, now there is steady increase on the patient expectation, and demand to be involved in health care decisions and thus new relation is developing between consumers and the health care providers.

### **Changing Health Services**

Today health services have been marked as a holistic approach. Health promotion and disease prevention receive as much emphasis as the diagnosis and treatment of disease. More emphasis is being placed on holistic health:

Holistic care focuses on human integrity and stresses that the body, mind and spirit are inter- dependent and inseparable and holistic health care includes:

- Nutritional awareness
- Environmental sensitivity
- Stress reduction
- Spiritual health and
- Self responsibility

Thus, all aspects of patients need to be considered in planning and delivering care. Health care provider predicts that patients physical condition progress in predictable manner in the absence or presence of co-morbid conditions.

Less clearly understood is the effect of psychosocial issues on the healing process. Inclusion of support system in care family focus, cultural diversity, sensitivity to openness, lifestyle, opinion, values and beliefs. Thus nurses must possess the knowledge about bio-cultural, Psychosocial and Linguistics differences in society to make accurate assessment

### **3.3. Health Care Delivery System in Ethiopia**

#### **3.3.1. Historical development of medicine in Ethiopia**

Long before the advent of modern medicine, Ethiopia had its own methods for combating diseases and injuries. This traditional medicine in Ethiopia, in many cases, was

concerned with both the prevention and cure of disease. For instance, informing people not to travel to the area where epidemic is present, advising ill patients not to sneeze / cough in front of others, isolation or 'destruction' of sick, etc. were some of the preventive aspects in traditional medicine. The curative aspects of traditional medicine including providing certain medications (plants, animal products, minerals... etc.) to the sick people, and performing different operations like bone setting, amputation, intestinal operations etc..., were practiced in the history of traditional medicine in Ethiopia. Even today it is believed to be used by almost 60-80% of Ethiopian rural population.

### **Traditional disease causation theory**

A. **Naturalistic disease causation theory:** according to this theory the causes of disease were believed to be:

- External factors: e.g. -drinking polluted water  
-eating contaminated foods  
-bitten by animals, snakes,  
etc
- Contagium: e.g. through physical contact (sexual, kissing, sharing ...) with ill people.
- Interpersonal conflicts: e.g. fighting each other

- Personal excessive: e.g.
  - eating / drinking
  - prolonged exposure to sun, rain, etc.
  - excessive crying and the like

B. **Magico – religious factor:** here the causes of disease were believed to be:

- god, kole, zar, dache, Atete
- Magic factors: evils eye, sorcery, witch craft, ancestry ghosts, magagna, etc. And people believed that disease which is caused by magical factors is more serious and stayed for prolonged time.

#### **Source of traditional medicine**

Plants ...76 %

Animal source ...14%

Mineral source ...6%

#### **Routes of administrations for traditional medicines**

- Topical: in the form of oil, powder .....
- Oral – mixing with butter, blood....
- Respiratory route – by smoking, fumigations
- Anal – (for Rx of hemorrhoids)

### **Surgical practices in traditional medicine**

Amputation  
Uvelectomy / tonsilectomy  
Hemorriodectomy  
Bone setting  
Circumcision  
Eye-brow cutting

### **Other traditional practices**

- Bathing in thermal water
- Placing magical devices (like iron, amulet, etc.)
- Avoiding members from atresians
- Slaughtering of sacrificed animals.

### **Why the community used traditional medicine?**

Lack of awareness  
Inaccessibility of modern medicine  
Low economy  
Low satisfaction in health personnel

**N. B.** Now a days traditional medicine has become one of the components of primary health care and recognized by the MOH in Ethiopia with the objectives of:

- Co-ordination of national activities that include pharmacopeias
- Clinical evaluation of traditional medicines
- Census of traditional medicine practitioners.

### **3.3.2 Modern Medicine in Ethiopia**

Prior to the 19<sup>th</sup> century, there was no organized modern medicine in Ethiopia. The early history of modern medicine in Ethiopia started with the reign of Emperor Libene Dingel (1508-1540) that has been described by R. Pankhurst. The first foreign practitioner on record is Joas Bermudes, a Barber-Surgeon who was a member of Portuguese diplomatic mission to Libene Dingel. Then a century later a German Lutheran Missionary (GLM) by the name of Peter Heilling was documented to practice medicine at the court of Fasiladas in 1636 in Gondar.

During the reign of Emperor Eyasu (1682-1700) a French physician named Dr. Donecel was practicing medicine in Gondar, at the same time a historian but amateur physician named James Bruce had also practiced in Gondar. The Famous Scottish explorer James Bruce (1768-1773) has recorded his successful medical practice during a smallpox epidemic in northern Ethiopia.

The advent of formal French and British Scientific and diplomatic mission to Ethiopia in the late 1830s and early 1840s was significant in that it brought Ethiopia view to medicine to a sizable section of the population.

As a result of the scramble for Africa, the 19<sup>th</sup> century has witnessed an increased contact between Europe and Africa. Several travelers, missionaries and diplomatic from Britain and

France were also in Ethiopia during this period. Even though these foreigners came for different missions, they were expected to know and practice modern medicine by the local inhabitants. The expectation on part of the natives may have emanated from desperate actions of seeking alternatives during major epidemics and outbreaks, or may be the reflection of the belief in some localities, that the white man's superior and able to remedy all ailments. The latter fact may be reflected in the report in which king Sahle Sellasie (1842) said to ask a member of a French diplomatic mission to prescribe him 'an amulet against death' Thus, modern medicine was introduced in Ethiopia by different categories of people that include.

- Religious missionaries

- Diplomatic

- Travelers

- Traders

- Invaders and Warriors

The interesting fact about these foreign introducers was that most of them were not a medical people by themselves. Some may have been exposed to the practice with friends or relatives while they were in their country. Some may have brought some first aid drugs with instructions to use them. Some of them were forced to prescribe the drugs and

instructions after they have reached in Ethiopia and were obliged to do so.

A few of them were actually medical practitioners. However, even those ones confine their practice to the royally circles. There were also preventive medical activities practiced by westerners. The advice of the British medical mission to king Theodros II, for instance, has helped him in the control of the spread of the cholera epidemic that at time plaud his army. He was also able to introduce modern scientific vaccination for the first time. Yohannes IV actions employing decree to free vaccination against smallpox and his being vaccinated the first time was also significant with regard to his fanatic religiousness.

As most of the developments in social sector, great progress in the introduction of western medicine was also achieved during the region of Menelik II. The first Russian operated hospital was established at the time as a result of the Adowa battle, few Ethiopian were also in the country at that time.

Emperor Menelik II, invited help from Russian Red Cross, because Menelik II had over 3,000 wounded soldiers as a result of Adowa battle. At the first time the first medical team consists of 3 doctors 4 nurses and several health orderlies arrived and treated wounded soldiers in Harrar. After completing the task the team arrived at Addis Ababa and



established a hospital in the tent with 50 beds. Then they built a hut.

Again in that year there were several Christian missionaries operating in the country, and in addition to their religious and sometimes educational activities, they often provided health services. One of the missionaries named Dr. Thomas Capable coasted money, erected a building in the Gulele area, west of Addis Ababa, and established a hospital with 70 beds. This hospital had four medical doctors and five nurses on its staff. The hospital was operational until the Italian occupation. And after the liberation it was converted first into “Medical Research Institute” in 1942, then “Institute Pasture” in 1950 and finally in 1964 in to the “Central Laboratory and Research Institute” as it is called today.

In speaking of the history of medicine in Ethiopia one must mention the first Ethiopian medical doctor. He was Doctor Martin Workneh. As a child of three years he was found on the battlefield after the battle of Magdala in 1868 by the British Indian forces that took the child to Indian and later to Britain, sponsored by two officers, Colonel Charles Chamberlain and Colonel Martin, and he was then named Charles Martin.

After the first abortive Italian invasion of Ethiopian in 1896, Dr. Martin arrived in Addis Ababa where he pitched a tent in the center of the city and operated a clinic, treating patient free of

charge. During that time he learned who are parents were and found his grandmother who told him his name was Workneh. Hakim (Doctor) Workneh, as he was popularly known, served not only as physician but also as a diplomat. He died in 1952 at the age of 80.

The second Ethiopian medical doctor was Dr. Melaku Beyan who early in the 20th century obtained his medical degree from Howard University in the United States. He was chief medical officer of the Ethiopian Army during the Italian occupation of Ethiopia.

The first Ethiopian graduate nurse was princess Tsehai, Emperor Haile Selassie's youngest daughter. She had her training in England at the Great Ormond Street Hospital for Children where she graduated as children's nurse in 1939 and later at Guy's Hospital in London. She was married and lived with her husband in Lekempte where she died of childbirth at the age of 23 years.

Sister Mahret Paulos is probably the second Ethiopian nurse graduate in Jerusalem in 1942. Sister Sambatu Gabru graduated from Beirut in 1949 is the third Ethiopian trained nurse.

A new chapter in the development of health services was opened when the Ethiopian Red Cross Society established the first school of nursing at the Haile Selassie I Hospital (Bethesda Hospital). It was in March 1953 that the first eight

nurses graduated. The Ethiopian Red Cross Society itself was formally established in 1934 and became members of International Council of Red Cross Society (ICRC). The patron was Emperor Haile Selassie and its chairman was Belata Geta Hiruy W/Selassie.

In 1952 the Gondar public health collage and training center was established to train three categories of health personnel called the three man team (Health Officers, Community Nurses and Sanitarians), who were intended to serve in health centers, a new type of health institution. One health center was supposed to serve 50,000 people with the help of satellite health stations.

The first organized training of health personnel can be traced back to 1945 when a six month course was offered to hospital orderlies, who were then upgraded to the status of “dressers.” A training center for laboratory technicians was established in 1963 at the Menelik II Hospital.

A Medical School was established in 1962 and graduated nearly 140 medical doctors in 20 years of its existence, because of which the past regime considered it as a prestigious project for the elite.

One might say that the actual concrete development of health services started after the 1974 revolution. There had been several attempts and successes to mobilize the masses of

Ethiopia to participate actively in the development of health services even to the remote areas of the country. One criticizes the Mangistu regime's health policy for being too centralized. The present regime's decentralized health policy has to be tested in due course.

### **History of establishments of health institutions in Ethiopia**

- 1897 First hospital established by Russians like Mobile hospital or red cross medical centers
- 1898 Menilik II hospital started to give health service- Emperor Menelik introduced smallpox vaccination.
- 1902 Ras-Mekonen Hospital in Harrar was found.
- 1909 Hospital was built and was named the Menelik II hospital, this hospital was staffed and equipped by Russia medical personnel, it was mainly for military patient.
- 1910 –1939 More hospitals, pharmacy and clinic were opened by Russia.
- 1926 – Majesty Haile Selassie I built Beth-saida hospital and was staffed by Swedish medical personnell (160 bed general hospital)
- 1927 The Presbyterian (a church government by elders of all equal rank) mission built a 100 bedded

hospital at Gulele, Addis Ababa named the Teferi Mekonnen Hospital.

- 1927 The Swedish mission built two hospitals one in Harrar and the other in Lekempte each having the name of the Taferi Makonnen hospital, they also established a hospital in Arussi in 1931.
- 1934 Aleprosarium, the work of a scrdan interior mission was opened, with a Canadian doctor and a staff of twelve nurses.
- 1934-A Government dispensary was established in Addis Ababa under the supervision of the French doctor.
- The Italians under the guise of the consulate mission built a hospital which late they presented as a “token of friendship” to Ethiopians. This hospital organized in the early treat as 1930 as a clinic, then changed to hospital which was named Ras-Desta hospital.
- 1937 The Emmanuel hospital was established. It is a General hospital at that time with a small department for mental cases, today it is a mental hospital with 300 beds.
- 1937 – Jimmma hospital was established by the Italians for military patients.
- 1942 A- 70 bedded hospital established in west of Addis Ababa, the hospital was operational until the

Italian occupation, and after the liberation it was converted first in to “Medical Research Institute” In 1942, Then “Institute of Pasteur.” In 1942, then “Institute Pasteur” in 1950, and finally in 1964 in to the “Central Laboratory and Research Institute” as it is called today.

- 1946 -A center for venereal disease treatment was established. By 1961 the center was operating under the support of WHO and UNICEF.
- 1948- St Paul’s hospital was established, until 1952, it was administrated by the ministry of public health and then by the order of the Emperor, then by administrated by its won Board whose president was General Mulugeta.
- 1948- The Dejasmatch Balcha hospital was established by Soviet Red Cross it is a general hospital with 100 beds..
- 1951- The princess Tsehai memorial hospital was opened (Army Hospital today). In 1953- The hospital was changed to Haile Selassie foundation.
- 1956- The Mahatma Gandhi children hospital was a gift from the Indian community of Addis Ababa, “Intended as a maternity hospital and clinic but several hospital in the city for maternity and no hospital for children, so it was decided that Gandhi memorial

hospital should be established as the 1<sup>st</sup> children hospital in Ethiopia.

- 1957 The Ethio- Swedish pediatric clinic was established and attached to the Leul Mekonnen memorial hospital (Black Line hospital).
- 1960 With a help of WHO and Swedish technical assistance the Empress Menen established a new children home.

### **Health and Health Related Indicators (MOH, 2005)**

#### **Health Facilities**

Hospitals	126
Health Centers	519
Health Stations	1797
Health posts	2899
Private Clinics	1229
Pharmacies	275
Drug shops	375
Rural Drug vendors	1783

#### **Health Human Resources**

Physicians	1996
Health Officers	683
Nurses	15,543

Environmental health workers	1169
Laboratory Technicians	2403
Radiographers	300
Pharmacy Technicians	1171
Health Assistants	6628
CHAs, TBAs, and PHWs	15,752

### **Health Service and Population Indicators**

Total Population	71,066,000
<1 Yr (%)	3.4 %
<5Yr (%)	16.9 %
Female aged 15-49 Yr(%)	23.3 %
Potential Health service coverage (%)	64.0
Health service utilization (per capita)	0.36
Life Expectancy M ++	53.4
“ “ F ++	55.4
Crude Birth Rate per 1000	39.9
Crude Death Rate per 1000	12.6

### **3.4. Primary Health Care (PHC)**

#### **3.4.1. Historical Development of Primary health Care (PHC)**

1948 MOH was established with the technical assistance of WHO and USAID (United States Aid for International



Development). The goal of MOH was to provide adequate medical care and health services to all sectors of the Ethiopian population. Ethiopia being a member of world health assembly (WHA) started to implement the “Vertical Health Services”

Vertical Health Service (VHS):

The VHS programs are directed centrally and it includes: malaria eradication and smallpox eradication, and leprosy and tuberculosis control.

After some years WHO evaluated the program and found out that:

- These programs were autonomous with central direction, hence, expensive and ineffective
- Supported exclusively by foreign agencies with little or no national budgetary support hence, reduced their activities.
- Heavy expenses in transport and per diem because the head offices were in Addis Ababa
- These programs were imported and translated in the country.
- Therefore, WHO decided that this strategy was not effective and shifted over to basic health service era.

### **Basic Health Services (BHS)**

Basic health services gave more attention to rural areas through construction of health centers (HCs) and health stations for ambulatory care and tried to emphasize both preventive and curative. The development of BHS goes with the establishment of Gondar Public Health College producing three categories of health workers ("3 man team", Public Health Nurses, Health Officers, and Sanitarians).

### **Development of three five years plan**

**First five years plan (1958 – 1963).** In this plan period emphases were:

- Development of health centers (HCs, for 50,000) health stations (HS, for 5000) people.
- Health human power development
- Malaria eradication

**Second five years plan (1963 – 1967).** This plan tried to establish a strategy for the basic health services with the following objectives.

- ensure promotion of health services to rural population
- Increasing of the number of beds
- construct four new hospitals one of which was Block Lion.

**Third five years plan (1967-1972).** In this plan period there was nothing especial except strengthening the 2<sup>nd</sup> 5 yr plan.

After the implementation of the three 5 yr plan, evaluation of what has been done was undertaken. The findings were (in 1974 – after 20 yrs.)

- 93 HCS
- 400 HS

Problems identified were:

- high cost of establishing health institutions
- Curative health services predominated other health services
- Inadequate health budget
- Prevailing of attitude was for hospitals
- Unclear health policy
- No community participation and intersect oral collaboration

After several years of vertical and basic health services attempts, the health situation observed were:

- Prevalence of most common diseases remained static in some cases it showed an increase, Eg. Schistosomiasis
- Maldistribution of available resources appeared in exaggerated form
  - Health expectations were not improving. Eg. Many mothers and children continued to die).

These were some of the disturbing situation that enhanced the consideration of an appropriate approach to at least move a

little more a head. Obviously an alternative health care delivery approach was needed. Therefore, PHC

**PHC defined as:**

- essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that community and country can afford to maintain at every stage of their development in the spirit of self reliance and self-determination
- it forms an integral part of the country's health system and the over all social and economic development of the country
- 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.

**The New approach of PHC** (Alma-Ata, Kazakiston international conference on PHC, 1978)

It was declared that PHC is the key to the attainment by all people of the world by the year 2000 of a level of health that will permit them to head socially and economically productive life.

## **Certain important terms**

**Essential** health care provided through PHC is basic and indispensable

**Practical** - appropriate and realistic

- Selection of priorities based on resources

**Universally accessible** – the approach is to bring health care as close as possible to where people live and work.

Scientifically sound

- The strategy we use to implement PHC should be scientifically explainable and should be understood.
- PHC should not entertain quack medicine

### **Socially Acceptable Methods and Technology**

- Not every method and technology is acceptable to societies.

In order to implement PHC the method and technology we are using should be accepted by the local community. We need to consider the local value, culture and beliefs etc.

### **Universally Accessible**

- Collective expression of political will in the spirit of social equity.
- Because of the inequitable distribution of the available resources, the services are not

reachable (approachable) by all who need them.

### **Community involvement**

- active involvement of people in the planning implementation and control of PHC
- Individuals and families assume more responsibility for their own health.

It was wrongly conceived that health for communities can be achieved through the efforts of health workers alone.

- Health is not a gift that could be given to communities by health professionals.
- Communities can achieve better health status through their own efforts and the health workers role is to help them identify their problems and to point out methods for dealing with the problems.

### **Cost that the community or country can afford**

- Health services are expensive because of professional costs and the cost of equipment and capital expenses.
- PHC demands the use of methods which are cheap or within the cost the community can afford to pay.

### **Self reliance and self determinations**

- implies individuals, families, and community's initiative in assuring - responsibilities for their own health development
- Adopting measures that are understand by them & accepted by them.
- Knowing when and for what purpose to turn to others for support and co-operations.

### **3.4.2 Philosophy of PHC**

#### **Equity and justice**

- equitable distribution of services , resources, health care
- if all can't be served, priority for these in need individual and community self – reliance
- personal responsibility for their own & their families health

#### **Inter – relationship of health and development**

- Development is a multi-dimensional process involving changes in structure, attitude, and institutions as well as the acceleration of economic growth, reduction of in equity and eradication of absolute poverty.

- Better health among adults means a bigger and better work force leads to increased productivity, on the other hand, a developed nations can provide a better health service for its citizens.

### **3.4.3 Principles of PHC:**

**I. Equity-** Equitable distribution of services, resources and facilities for the entire population.

**II Inter-sectoral approach-** A joint concern and responsibility of sectors responsible for development in identifying problems, programmes and undertaking actions. Education, income supplementation, clean water, improved housing and sanitation, construction of roads and water ways, enhanced role of women have substantial impacts on health.

#### **Key health related sectors**

- public education and information
- agriculture, commerce, industry
- water, sanitation and housing
- related to human behavior and human development.
- related to human population and economic relationships.
- related to human settlements and environmental control.



### **Three major determinants of health**

#### **A. Public Education and Information**

- Teach local health problems in schools
  - Use locally produced learning materials
  - Organize refresher courses for teachers
  - Provide sanitary facilities and water in schools
  - Organize a school health (preventive) programme and interschool health competitions.
- Informal community education
  - Cultural activities, traditional media
  - Meetings or community based (mass) organizations
  - Guidelines for counselors and health committees
  - Adult literacy classes
- Public information for health
  - Publicize experiences of community health activities
  - Provide accurate information on health status and health problems
  - Organize training / orientation seminars for journalists
  - Diffuse health related legislation
  - Organize periodic awareness campaigns.

## **B. Agriculture, Food and Nutrition**

- Promotion of household food security, local food crop production, fishing and animal husbandry
- Training of farmers in new methods
- Promotion of agricultural extension
- Promotion of agricultural extension
- Organize marketing for agricultural products
- Food hygiene measures
- Local weaning foods
- Management and prevention of specific deficiencies
- Organize conservation/ Storage of foodstuffs
- Production of simple efficient agricultural technologies
- Education/Management of pesticide use.

## **C. Public works, water, sanitation and housing**

- **Clean drinking water**
  - Protect and maintain existing supplies
  - Provides new water supplies, digging wells, etc.
  - Water use and conservation (in the house and education of public)

- Check water quality
- **Environmental sanitation**
  - Drainage of surface rain water
  - Ensure adequate disposal of human excreta
  - Ensure adequate disposal of domestic waste
  - Ensure public education
  - Implement, legislative measures.
- **Housing / building**
  - Promote health protective housing improvements.
  - Prepare and promote standard designs of affordable housing
  - Demonstrate hygienic measures in hospital/health centers
  - Ensure especially affordable vector control devices
  - Ensure protection from environmental hazards

### **III. Community Involvement**

- Community involvement is the process by which individuals and families assume responsibility for the community and develop the capacity to contribute to their and the community's development. While the community must be willing to learn, the health system is responsible for explaining and

advising and providing clear information about the favorable and adverse consequences of the interventions being proposed as well as their relative costs.

**Important rules to follow in community involvement:**

- Do not tell them, but inform them
  - Do not force them, but persuade them
  - Do not make them listeners, but decision makers
- Involve them in the :
- In the assessment of the situation
  - Definition of the problems
  - Setting of priorities
  - Planning, implementation, monitoring and evaluation and management programs.

**Benefits**

- Extended service (coverage)
- Programmes are affordable and acceptable
- Promote self – reliance and confidence
- success has a multiplying effect
- Create sense of responsibility
- Consideration of real needs and demands
- Promote local community initiatives and technologies
- Reduce dependency on technical personnel
- Builds the community's capacity to deal with problems.

- Helps to choose correct strategy.

#### **Factors influencing Community Involvement**

- Social: community organization leader, status of women, education
- Cultural: Values, beliefs taboos etc.
- Political – ideology, policy etc.

#### **IV. Appropriate technology**

Methods, procedures, techniques and equipment that are:

- Scientifically valid
- Adopted to local needs, acceptable to those who use them and those for whom they are used
- Maintained and utilized with resources the community or the country can afford.

All technology reality means is a way to carry out a task, using a tool and/or technique, together with the necessary skills and knowledge. Technology is generally understood to mean the knowledge, skill (soft ware) and hard ware that are used to solve a problem. Example, Breast-feeding is a technology although no hard war is involved. Introduction of cereal based oral rehydration therapy (ORT) to improve consequences of diarrhea episodes. If the things do not fit the people and places, then these things are unlikely to be helpful in the long run and may well prove to be a disappointment and a waste of

resources. Example, a health center with a flush toilet Vs pit latrine. The final design of PHC technology must be to the liking of the people because they have to live with it, use it to meet their needs, help to pay for it, maintain it well and if possible, gradually improve it strength and its possibilities.

**Criteria of appropriate technology:**

- Effective- It must work and fulfill its purpose in the circumstances in which it needs to be used. e.g. Fancy incubators for low-birth weight infants Vs warm cloths
- Culturally acceptable and valuable - It must fit into the hands, minds and lives of its users. e.g. TBAS Vs TTBAS
- Affordable- This doesn't mean that an appropriate technology must always be cheap. Cost effectiveness should be carefully considered and the choice must be an informed one
- Locally sustainable- it should not be over dependent on imported skills or supplies for its continuing functioning, maintenance and repair e.g. Lift – pump – water supply.
- Possessive of an evolutionary capacity- A technology is highly appropriate if its introduction and acceptance can lead to further benefits e.g. Community-level

training programs on PRT water supply and sanitation, food hygiene, and nutrition should stimulate communities to develop appropriate methods to handle the above areas of community concern.

- Environmentally accountable- The technology should be environmentally harmless or, at least minimally harmful. E.g. Indiscriminate use of pesticides
- Measurable- The impact and performance of any technology needs proper and continuing evaluation if it is to be widely recommended. Eg. Water lumps, solar energy etc.
- Politically responsible- It may be unwished to alter an existing balance in a way that might be counter productive. Eg. To encourage minimally trained health workers to take too great initiative without first making sure that influential medical leaders in the area favor this delegation of responsibility may be the appropriate.

#### **V. Emphasis on health promotion and prevention**

- Health promotion:- includes all effort that seeks to move people closer to optimal Well-being or higher level of wellness. It is the combination of educational and environmental supports for action and condition of living conducive to health.

- Health prevention:- is aimed at stopping the disease process before it starts or preventing further deterioration of a condition that already exist. These preventive service are popularly categorized as:
  - primary prevention:- prevention of an illness before it has a chance to occur e.g. immunization
  - secondary prevention:- include early detection of actual or potential health problems e.g. Screening hypertension.
  - Tertiary prevention:- a voiding farther deterioration of an already existing problem Ex. Rehabilitation after stroke

#### **VI. Decentralization**

- Away from the national or central level
- Bring decision making closer to the communities served.
- Provide greater efficiency in service providers but, may lead to geographically inequitable resources and technical skill.

#### **3.4.4 PHC strategy**



A. Changes in the health care system

- total coverage
- integrated system
- community involvement
- design planning, and management of health system

B. Individual and collective responsibility for health

- decentralization of decision making
- personal responsibility

C. Intersectoral action for health.

**3.4.5. Components of Elements of PHC**

1. Health education
2. Promotion of food and proper nutrition
3. Adequate supply of safe water and basic sanitation
4. MCH including FP
5. Immunization
6. Prevention and control of locally endemic disease
7. Rx of common diseases and injuries
8. Provision of essential drugs

**Components added after Alma-Ata declaration**

9. Mental health

10. Oral health
11. Control of ARI
12. Control of HIV/AIDS and other STIs
13. Occupational health
14. Use of traditional medicine

### **3.4.6. Approaches of PHC**

#### **A. Comprehensive PHC (CPHC)**

- Health is not merely the absence of disease
- Multi-sectoral approaches and community involvement

#### **B. Selective PHC (SPHC) Announced by UNICEF to cut child mortality in the 3<sup>rd</sup> world. Ex. GOBI FFF**

- Growth monitoring
- ORS
- Breast feeding
- immunization
- Family planning
- Food supplement
- Female education

Advantage - Results achieved faster

- Give more satisfaction

Disadvantage – limited scope of activities

- disease oriented

- doesn't address priority problem
- little / no intersectoral collaboration
- community dependant on physician

**Table 3- PHC as a level of Health Care**

Level	Area	Health facility	Types of care	Level of prevention
Local	Kebele + Woreda	PHCU 5 CHP	Primary (1 <sup>0</sup> )	1 <sup>0</sup> , 2 <sup>0</sup> and 3 <sup>0</sup>
Intermediate	Zonal Regional	Zonal hospital Regional hospital	2 <sup>0</sup>	1 <sup>0</sup> , 2 <sup>0</sup> and 3 <sup>0</sup>
Central	National	Central, referral teaching hospitals	3 <sup>0</sup>	3 <sup>0</sup>

Key – PHCU – Primary health care Unit

-CHP – Community health posts.

### **3.4.7. Status of PHC and Problems encountered in the implementation of PHC in Ethiopia**

PHC implementation in Ethiopia started in 1980. Although the implementation of PHC varies from country to country depending on the political economic and social conditions, contents of PHC activities in Ethiopia include the following:

Education concerning the prevailing health problems and methods of preventing and controlling them.

Locally endemic diseases prevention and control

Expanded programme on immunization

Maternal and child health, including family planning

Essential drugs provision

Nutrition, promotion of food supply

Treatment of common diseases and injuries

Sanitation, and adequate, and safe water supply

**A review of PHC implementation was attempted in Ethiopia in 1985 revealed:**

**General Achievements:**

- Expansion of health services (HS and HPS)
- Expansion of EPI
- MCH/FP
- Increase in No. of health personnel
- Increase in health propaganda to improve the health consciousness of the population
- Established health committees

**Health Policy**

- Emphasis on disease prevention
- priority to rural health services
- Promotion of self-reliance and community involvement

#### **Major Problem Encountered**

- Absence of an infrastructure at the district level to implement PHC
- Difficulty in achieving intersectoral collaboration
- Inadequate health service coverage and misdistribution of available health services
- Inadequate resource allocation
- Absence of clear guidelines or directives to governmental institutions and mass organization on how to implement.
- Presence of culturally dictated harmful traditional practices
- Absence of sound legal rules to support environmental health

#### **What PHC is Not**

- A greater attention to people on defined needs only
- Meant only for the urban poor and the rural population
- Integrated as a service of lower quality care
- Concerns only the developing countries

- An obstacle to the Development and growth of hospital care
- Simple health development process that can only be directed by CHWS
- Reduce academic excellence in health science and technology development
- Academic excellence must be a strategy for change.

### **3.5. Organization of Health Delivery System in Ethiopia**

- Public health sector – controlled by MOH
- Private health sector
- NGOs

Health care system in Ethiopia was dominated by the public centers with small contribution from missionaries and NGOs.

However – due to:

- increasing high population growth,
- people need modern Rx
- slow expansion of public health institutions
- absence of clear governmental regulation and other problems allow the government to design policies and the health policy of Ethiopia issued in 1993 , and has 2 components.
  - participation of NGOs
  - Participation of private sectors.

Regulations were designed by council of ministers in 1994 to control & licensing the private health institutions.

**MOH** has power and authority to license

- hospitals any where of the country
- radiological, diagnostic centers and any form of health institutions to be run by foreigners.

**Regional health department** has the power to license

- health centers
- Clinics
- Clinical diagnostic centers

For this function, standard and guidelines were given by MOH to private sectors, following this development, the private sub-sectors seem to have growth very fast but various problems encountered both by regulatory force and providers in operation of private: sectors, these include:

- difficult for private sectors getting medical equipment and drugs
- Complaints professionals in public sectors for not being allowed to work par-time.
- existence of several unlicensed private institutions
- very high service charge
- poor referral and reporting by private facilities
- too much and unnecessary lab. Investigation
- mal-practice and illegal practices in some private sectors

- Absence of clear and standard measures to be taken in case of mal-practices
- Exodus of health professionals to private sectors
- Shortage of resources and human power at the MOH level for properly enforcing and supervising guidelines.

NGOs are non- profitable organizations whose central purposes are to provide materials, assistance and management as well as technical services at little or no cost to the needy. These organization in general are not sponsored, governed, or funded by the government, yet they work on the policy & guideline established by government.

NGOs usually focus on public health services. The challenged faced by NGOs in health institutions in any country includes:

- Lack of clean water
- Poor sanitation
- Poor waste disposal system
- High level of infectious disease
- In adequate and in equilibrium health services. Before 1980 NGOs focus on PHC, but how a days NGOs focused on advanced health services to provide specialized and advanced health services.
- Currently 82 % Ethiopian population is believed to get basic health services, out of this > 7% is covered by NGOs





## ORGANIZATION OF HEALTH CARE DELIVERY SYSTEM IN ETHIOPIA

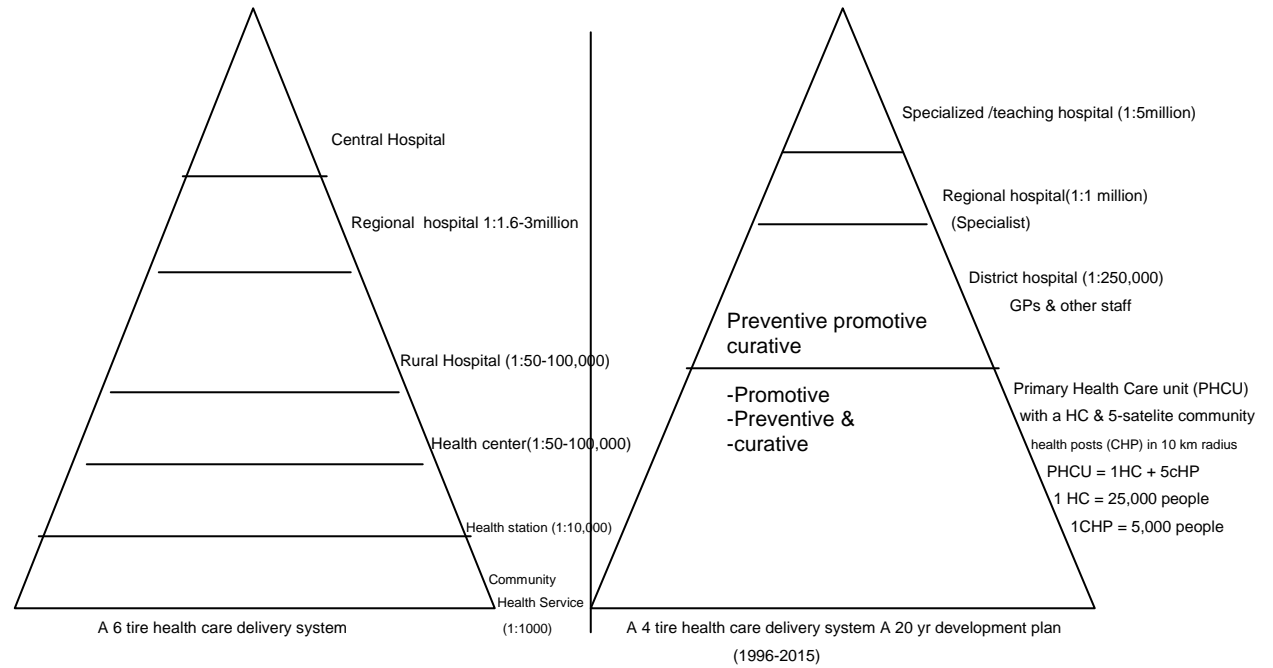


Fig. 5 Organization of Health Care Delivery system in Ethiopia

## Summary Question

- Define health care delivery system
- Describe factors affecting health care delivery system.
- Discuss Historical development of Medicine in Ethiopia
- Describe the health care delivery system in Ethiopia
- Explain Primary Health Care

# UNIT FOUR

## NURSING PROCESS IN THE COMMUNITY

### Learning Objectives

On completion of this of this unit, students will be able to:

- Mention the three dimension community as a client
- Apply the steps of nursing process in a community setting
- List six community variables
- Discuss the eight sub-system of community assessment
- Mention the community cores
- List the three areas of community assessment perspectives

### 4.1 Introduction

The nursing process is a systematic way of determining a client health status, isolating health concern and problems, developing the plans to remediate them, initiating actions to implement the plan, and finally evaluating the adequacy of the plan in promoting wellness and problem resolution.

The nursing process defines interactions and interventions with the client system, whether that system is an individual, a family, an integrate or a community.

The nursing process commonly consists of five phases:

- Community assessment;
- Community diagnosis;
- Planning;
- Implementation and;
- Evaluation.

It is employed to respond and address the health needs of the community when the community is the client.

The community as a client refers to the broader concept of wide community as people for the nursing services in focus.

### **Community as a Client**

For community health nurses, working with communities has two important missions:

The community directly influences the health of the individuals; families, groups, and populations who may be a part of it,

Provision of the most important health services at the community level.

## **Dimensions of the Community as Client**

A community has three features

Location

A population

A social system

It is useful to think of these dimensions of every community as a rough map to follow for assessing needs or planning for service provision.

### **Location**

Every physical community carries out daily existence in a specific geographic location. The health of a community is affected by this location including the placement of health services, the geographic features, plants, animals and animals and the human made environment.

### **Six Location Variables**

- **Community boundaries**

To talk about community in any sense, one must first describe its boundaries. It serves as basis for measuring incidence of wellness and illness and for determining spread of a disease.

- **Location of health services**

When assessing a community, the community health nurse will want to identify the major health centers and know they are located. Use of health services depends on availability and accessibility.

- **Geographic features**

Communities have been constructed in every suitable physical environment and that environment certainly can affect the health of a community. Injury, death, and destruction may be caused by floods, cyclones, earthquakes volcanoes...etc. recreational activities at lakes, seashores, mountains promote health and wellness.

- **Climate**

Climate has a direct effect on health of a community e.g., extreme heat and cold).

- **Flora and Fauna**

Poisonous plants and disease carrying animals can affect community health.

- **Human made environment**

All human influences on environment (housing, dams, farming, types of industry, chemical wastes, air pollution...etc.) can influence levels of community wellness.

## **Population**

Population consists not only of a specialized aggregate, but also of all the diverse people, who live within the boundaries of the community. The health of any community is greatly influenced by the population that lives in it. Different features of the population suggest the health needs and provide bases for health planning.

### **Population variables**

- **Size:** the size of a population influences the number and size of health care institutions. Knowing community size provides important information for planning.
- **Density:** increased population density may increase stress. Similarly when people are spread out health care provision may become difficult.
- **Composition:** composition of the population often determines types of health needs. A health community is one that takes full account of and provides for differences in age, sex, educational level, and occupation of its members, all of which may affect health concerns. Determining a community composition is an important early step in determining its level of health.



- **Rate of growth or decline:** rapidly growing communities may place extensive demands on health services. Marked decline in population may signal of poorly functioning community.
- **Cultural difference:** health needs may vary among sub-cultural and ethnic populations. Cultural difference can create conflicting or competing demands for resources and services or create inter-group hostility.
- **Social class and educational levels:** social class refers to the ranking of groups within society by income, education, occupation, prestige or a combination of these factors. Educational level is a powerful determinant of health related behavior. Health promotion and preventive health services are most needed for people with low income and educational levels.
- **Mobility:** mobility of the population affects continuity of care and availability of services. Mobility has a direct effect on the health of a community.
- **Social system:** in addition to location and population, every community has a third dimension, a social system. The various parts of community social system that interact and influence the system are called social system variables. These variables include the health, family, economic, educational, religious, welfare, legal,

communication, recreational, and the political systems. Although community health nurses must examine all the systems in the community and how they interact, the health system is of particular importance to promote the health of the community.

## **4.2. Phases of Nursing Process in the Community**

### **4.2.1 Assessment**

Assessment is the first step of the nursing process, which means to collect and evaluate data/information about a community's health status to discover existing or potential needs as a basis for planning.

#### **Community Assessment**

This is the process of searching for and validating relevant community based data according to a specified method, to learn about the interaction among the people, resources and environment.

Community assessment includes;

- Collecting pertinent community data

- Analyzing and interpreting the collected data.

Community need assessment:- is the process of determining the real or perceived needs of a defined community of people.

In some situation; an extensive community study becomes first priority. In others, all that is needed is a study of one system (e.g., health system, educational system ...etc.) or organization (e.g., women association ...etc).

## **Major Aspects of Community Assessment (Eight sub-system)**

### **A. Physical Environment**

Just as physical examination is important to individual patients, so is examination of the community physical environment. Five senses are used in physical assessment: inspection, auscultation, vital signs, system review, and laboratory studies.

**Inspection:** inspection uses all sense organs and is done by walking survey in the community, or micro-assessment of housing, open spaces, boundaries, transportation service centers, markets places, meeting street people, signs of decay, ethnicity, religion, health and morbidity, political media.

**Auscultation:** is listening to the community residents about the physical environment.

**Vital signs:** observe the climate, terrain, natural boundaries such as rivers and hills.

**Community resources:** look for signs of life such as notices, posters, new housing and buildings.

**System review:** housing age, architecture, building materials used, signs of disrepair, running water, plumbing, sanitation, windows (glasses)..etc. Also business facilities and churches.

**Laboratory studies:** census data or planning studies for community mapping.

### **B. Health and social system**

Differentiate between facilities located within the community and those located outside. Hospital: number of beds, staffing, budget, health center, clinics, or health posts, public health services, private clinics, pharmacies, dental and other services. Signs of drugs or substance abuse, alcoholism. Social services include counseling and support, clothing, food, shelter and special needs as well as markets and shops.

### **C. Economics**

Financial characteristics median household income, percentage of households living in poverty less than 100 Birr per month. Labor force characteristics, employment status of the general population greater than 18 years of age. Occupational categories and percentage of persons employed by government, farmers, skilled, unskilled, professional, types of business/industry.

### **D. safety and transportation**

police, sanitation (water source, solid waste disposal, sewage and air quality) and fire services. Primary means of transportation; walking, mule, taxi, bus, train, private car, and

air services. Frequency and affordability of public/private transport, and standard of roads.

#### **E. politics and government**

kebele, peasant association, business alliances, religious groups, youth and women's associations, professional associations, ethical associations, political activism...etc. describe the associations' objectives and activities.

#### **F. Communication**

Bulletin boards, posters, oral messages, radio, television, newspapers, postal services, telephone. Look for TV aeries, telephone wires, magazines, and satellite dishes.

#### **G. Education**

Types of schools, colleges and universities. Note languages used, grades, courses offered, percentage of attendants (male, female), adequacy, accessibility, and acceptability of education. Average number of years completed by people at school.

#### **H. Recreation**

Note facilities such as stadium, recreational areas, volley balls court, playground, picnic areas, museum, music/dancing, theatre/cinema. Who is going out about during the evening and in the morning? Teenagers, mothers and children, the homeless?

## **Community Assessment Tool (Questionnaires)**

The following areas are of nursing concerns when making community assessment that helps to reach a community nursing diagnosis. The point under each sub-heading may be modified to meet the need of individual practice. The questions are modified under the following sub-headings.

### **Location perspectives**

- Where is the community located?
- What is the boundary?
- Where is the major health institutions located?
- What major landforms are in or near the community?
- What geographic features offer opportunities for healthful activities?
- What are the average temperature and precipitation?
- What climatic features affect health and fitness (extreme temperatures)?
- What plants and animals pose possible threats to health?
- What are the major industries?
- How have air, land, and water been affected by humans?
- What is the quality of housing?
- Do highways allow access to health institutions?

## **Population perspectives**

- What is the population of the communities (urban, rural)?
- What is the density of the population per square kilometer?
- What is the age and composition of the community?
- What is the marital status of the community?
- What occupations are presented in the community? In what percent?
- How has the population size changed over the past two decades?
- What are the health implications of the changes?
- What are the ethnic compositions of the community?
- What percentage of the population falls into each social class?
- What is the average income per family member?
- Are there any specific population such as migrant workers that are highly mobile ?
- Is the community organized to meet the health needs of the mobile group?

### **Social system perspectives**

- What are the functions of each major system?
- What are the major organizations in each sub-system?
- Is there adequate communications among the major systems?
- Does the education system offer equal educational opportunities to all children in the community?
- What is the level of health promotion in the community?
- Are there mechanisms for resolving conflicts?
- Does any part of the total system dominate the others?
- What community needs is not being met?
- What recreational facilities are available?
- What types of health services are available?
- What health services and resources are available?

### **Community core**

The definition of core is “that which is essential, basic, and enduring.” The core of a community is its people- their history, characteristics, values and beliefs. The first stage of assessing a community, then, is to about its people.

#### **Major components of community core**

History- history of that society

Demography- age, sex, ethnicity, marital status

Vital statistics- birth, death



Values beliefs, and religious practice of the people

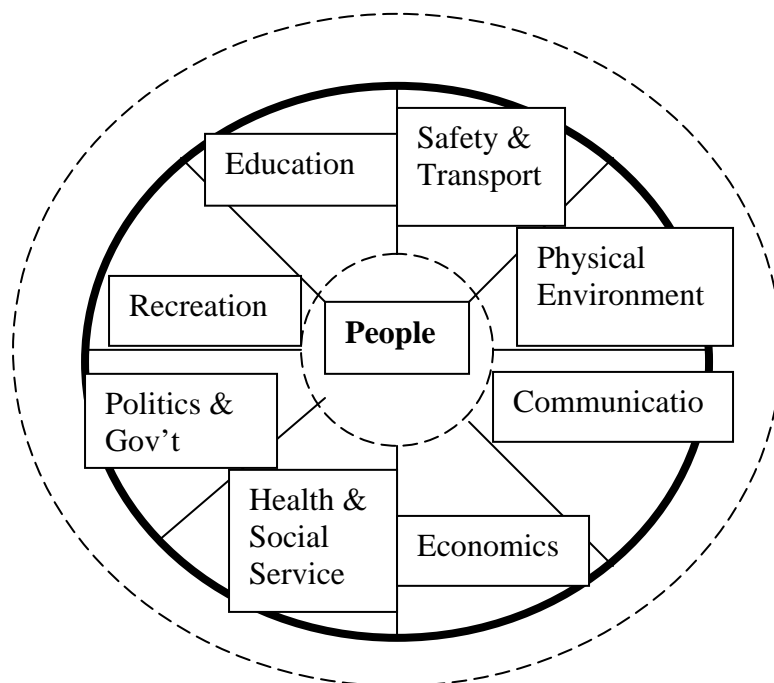


Fig. 6 Community assessment wheel, the assessment segment of the community –as- partner model (source, Anderson, 1996)

#### 4.2.2. Community Analysis and Nursing diagnosis

##### Community Analysis

Analysis is the study and examination of data. Analysis is necessary to determine community health needs and strength as well as to identify patterns of health responses and trends in health care use.

Community analysis, like so many procedures we carry out, may be viewed as a process with multiple steps. The phases of analysis include:

- Data categorization (demographic, geographic, socio-economic, health resource and services...etc)
- Data summarization (rates, charts graphs...etc.)
- Comparing data (with similar data, identification of data gaps, incongruence...etc)
- Draw inferences (draw logical conclusions from the evidence) that lead to community diagnosis.

### **Community nursing diagnosis**

This is a statement that defines the health strength, health problems or health risks of the community. Nursing diagnosis is a real clinical judgment or conclusions about human response to actual or potential problems (ANA). A community diagnosis forms the basis for community based intervention.

A nursing diagnosis has three parts

- Description of the problem (specific target or groups)
- Identification of factors/etiology related to (r/t) the problem
- The sign and symptoms (the manifestations) that characteristics of the problem.

Examples;

**Inadequate ANC** r/t inadequate health information or service accessibility as evidenced by 70% of female delivering at hospital with no antenatal care.

**Poor nutritional status of under five children in the community** r/t knowledge deficit regarding weaning diet as evidenced by growth monitoring chart.

**High infant mortality** r/t inadequate ANC, maternal nutrition, and unhygienic delivery practice as evidenced by IMR 75 /1000 live births.

#### **4.2.3. Planning**

It is a logical, decision making process of design an orderly, detailed programs of action to accomplish specific goals an objectives base d on assessment of the community and the nursing diagnosis formulated.

#### **Activities in planning:**

- **Setting priorities involves:**

Assigning rank/importance to client's needs

Determining the order in which the goal should be addressed. The goal can be immediate, intermediate or long range goal.

- **Establishing goal and objectives**

Goal is a broad statement of desired end results.

Objectives are specific statement of the desired outcomes.

Characteristics of good objectives

**Specific-** target specific population

**Measurable-** when the results are stated

**Achievable-** within the capacity of the available resources.

**Relevant-** fits with the general police

**Time bound-** that is achieved within specified time frame.

- **Planed actions**

are specific activities or methods of accomplishing the objectives or expected outcomes.

- **Outcome measurements**

Is judging of the effectiveness of goal attainment. How and when was each objective met, why not?

- **Recording the plan**

#### **4.2.4. Implementation**

Implementation is putting the plan into actions and actually carrying out the activities delineated in the plan, either by nurse or other professionals. It is the action phase of the nursing process. Community interventions are the therapeutic actions designed to promote and protect the community

health, treat and remediate community health problems and support the community as it changes over time.

**Key areas of nursing intervention in the community are:**

- link the community members with the available resources
- pulls together information and resources to assist community in addressing its health concern and problems
- maintaining its strength through facilitation, education, organization, consultation and direct care.

**4.2.5. Evaluation**

It is systematic, continuous process of comparing the community's response with the outcome as defined by the plan of care. The ultimate purpose of evaluating interventions in community health nursing is to determine whether planned actions met client needs, if so how well they were met, and if not why not.

Evaluation requires a stated purpose, specific standards and criteria by which to judge and judgment skills.

## **Summary questions**

1. What are the three dimensions of the community
2. Discuss the steps of nursing process in the community
3. Explain the six community variables
4. Describe the eight sub-systems of community assessment
5. What is a community core
6. Explain the community assessment perspectives.

# UNIT FIVE

## MATERNAL AND CHILD HEALTH (MCH)

### **Learning Objectives:**

On completion of this of this unit, students will be able to:

- Describe the status of women and children in developing countries, particularly in Ethiopia.
- Identify the socio-economic factors that affect the health of women and children
- Discuss the historical development of MCH services in relation to the advancement of modern medicine
- Explain the role of PHC in improving MCH services
- List reasons for giving priority to MCH services.
- List the major targets and components of MCH services

### **5.1. Introduction**

#### **Status of women and Children in Developing Countries:**

Throughout the world, women and children are the most vulnerable and the least serviced In the less technically developed areas of the world, disease and death take the highest toll among mothers and children who make up over

two-thirds of the population. Prenatal mortality may be as much as ten times higher than that of infants born in industrialized countries: the infant mortality rate may be six to twenty times greater than that of the industrialized regions of Europe and North America; the death rate among pre-school children is also up to ten times as high.

Furthermore, in technically underdeveloped countries half of the total mortality may occur in children under 5 years of age compared to only 5% in countries such as United Kingdom and Sweden. This pattern of death and ill health extends to women not only in the form of maternal mortality, but also in the form of morbidity. Maternal mortality reaches as high as 1,000 per 100,000 live births in developing countries compared to 5 to 30 per 100,000 in industrialized countries.

Women who do not die in childbirth suffer from a number of debilitating conditions including:

- maternal depletion related to pregnancy at an early age;
- continuous cycles of pregnancy;
- inadequate diet leading to anemia or malnutrition and;
- heavy work-load .

All these factors result in premature aging, disease, and early death. Apart from the effect of depletion on the mother, the



fetus and her dependent children, the economic consequences may also be considerable.

## **5.2. Historical Development of MCH Services:**

The term maternal and child health refers to promotive, preventive, curative and rehabilitative health care for mothers and children. It includes the sub-areas of maternal health, child health, family planning, school health and adolescent health.

The specific objectives of MCH are:

- (a) Reduction of maternal, prenatal, infant and child mortality;
- (b) Promotion of reproductive health and;
- (c) Promotion of the physical and psychological development of the child and adolescent within the family.

There have been great improvements in health and medical care in this century and it is in the field of mother and child health that progress has been most noticeable. In most ancient societies less than 50% of the babies born alive survived to maturity. Modern medicine has learned not only how to cure many disease, it has also discovered that the vast majority of children's disorders are preventable. In technically advanced countries, the survival rate is over 97% while in less

developed countries over 50% of total deaths are of children under the age of 5, and the average life span is about 35 years. In scientifically advanced countries, only 5% of the total mortality occurs among the under 5, and the average life span is over 70 years. Before the advent of scientific medicine, it was taken for granted that a large proportion of children born alive would die in childhood, and the parents felt it necessary to have many children in the hope that some would survive.

In Ethiopia, mothers and children under the age of 15 are estimated to constitute 70% of the whole population. Not only they constitute a large proportion, they are also particularly exposed to ill health and even death. The rates of maternal and child mortality in Ethiopia are still among the highest in the world. Poverty, malnutrition, poor environmental sanitation and personal hygiene, incomplete coverage of immunization and inadequate health care facilities are major factors responsible for the high mortality and morbidity of mothers and children.

Inadequate facilities and resources for antenatal and delivery care underlie the poor coverage of maternal health care. Reflection of this is the high maternal mortality, estimated to be between 600 and 1000 per 100,000 deliveries, 100 fold that of developed countries. Unwanted and unplanned pregnancies are important determinants of ill health. The lack of family planning underlies many unplanned and unwanted

pregnancies, and contributes to the high maternal mortality. As a result, MCH is found to be a high priority area in Ethiopia.

### **Important events**

#### **Worldwide**

When the WHO was established in 1948 its for priorities were proclaimed to be malaria, TBc, MCH and veneral disease.

- 1976 - UN started advocacy about women equity social & economic development.
- 1978 - WHO – UNICEF international conference on PHC at Alama-Ata, a comprehensive strategy to achieve “Health for All” by the year 2000, was identified, MCH care was seen as one of the essential components of PHC.
- 1976-1980 – WHO advocacy for women policy development
- 1980 – 85 – Who created mechanisms in members countries for health promotion, planning & co-ordination action
- 1985 – 1990 effort is made to transfer concepts of women health & development in to practical activities and the program focus on.

- Promotion of women health

- Women as a beneficiaries of health care
  - Women as a health care providers
  - Women education for health socioeconomic development.
- The 1987 - Nairobi conference was the 1<sup>st</sup> real universal mobilization in favors of safe mother hood initiative (SM1), since then maternal health issues become crucial agenda in many international conferences including the 1994 Cairo ICPD.
  - 1996 – Mother baby package (MBP) was introduced to promote the immediate action to achieve the goal of SM1 by the year 2000.

## **Ethiopia**

- 1962 – Ethio – Swedish pediatric Hospital was establishes which provided services to children
- 1962 – March 1<sup>st</sup> MCH/FP conference held at Gondar public health
- college and establish a held-day programme per week for MCH clinic started
- 1963 – 1<sup>st</sup> National health policy
- 1966 – Family Guidance Association Ethiopia (FGAE) establish

- 1979 – MCH Co-ordination office was established under MOH.
- 1983 – FH department was established under MOH

N.B. The significance of MCH was re-stated at Alma-Ata (1978), MCH was as seen one of the essential components of PHC.

### **5.3. Main Reasons for prioritizing MCH service:**

- Children are the future of the nation or community. This is a sentimental or a nationalistic statement but a simple fact, a community survival value rests with its children.
- Women and children form the majority of the population. This is particularly true in less developed areas where the life span is short, the population is mainly made up of the younger age groups.
- The health of mothers and infants is inter-related. The majority of conditions women suffer during pregnancy, and deliveries that increase the risk of death, severe morbidity to them have also an adverse effect on the fetuses or the newborn.
- Mothers and children are particularly vulnerable to disease. Less developed countries may have up to 20% of their total deaths in children under 5 years of age, and there are even higher percentages of

maternal mortality, which inevitably have an adverse effect on the health of children.

- Most of the disease that cause mortality and morbidity in children and those associated with pregnancy are preventable. In countries with low levels of maternal and child mortality and morbidity, these disease are prevented with appropriate environmental sanitation, improved nutrition and appropriate antenatal care etc.
- MCH services provide an appealing and appreciated introduction to appropriate aspects of western medicine. Both health staff and the public must learn how to correlate disease with factors producing them. A well-organized and consistent MCH program can provide an acceptable and appealing introduction to health and well being even if this means change in behavior.
- The incidence of lives damaged by physical, mental and social burdens can be reduced. Through preventive measures. MCH services can reduce the incidence of mental and physical disability and provide special services for disabled children so that their lives can be normalized and they are as independent as possible.

- Women and children represent the least powerful members of society without special consideration; their needs are neither considered nor understood. But women must receive the necessary consideration in hospital, health centers and at home.
- Certain mental, physical, and economic characteristics are found to be typical of areas where there are high child mortality rates.

#### **5.4. Major Targets of MCH Services**

- Women of reproductive age group (15-49 yr)
- Pregnant women
- Children < 15yr
- Children <5yr
- Children <1yr

#### **5.5. Major component of MCH services**

- Provision of quality ANC, delivery care, PNC, and FP services
- Prevention of STIs/HIV/AIDS
- Immunization
- Growth monitoring
- Well baby clinic
- Sick baby clinic
- Nutrition Rehabilitation Clinic (NRC)

- Nutrition counseling and health education
- School health education
- Adolescent health services

### **5.6. Child Health**

Children make up one half of the population and usually more than half of the patient needing medical care. As many of their diseases are preventable, most countries in the world have special clinics to help children stay healthy. These clinics have different names that are used inter-changeably such as:

Under five clinics

Well – baby clinics

Children welfare clinics...

They should be part of every program that is taking care of people's health.

The usual services provided for children at these clinics are:

Vaccinations

Nutrition evaluation and advice

Treatment of minor illness

Referral for more difficult problem

The main aim of these clinics is to keep children healthy. As the child health is very much influenced by his/her mother & her child practices, these clinics have also concerned with mother's health as well as how she takes care of her children.



Some of the services offered to the mother include; ANC, FP, general health and nutrition education etc. When a clinic promotes the health of both mother & children together, we call it MCH clinic.

An integrated MCH clinic should include

- Vaccination for children
- ANC
- FP service
- Nutrition advice
- Health education about–  
sanitation of house environment  
etc.....

For a mother to bring her children to a clinic as this type regularly, requires considerable motivation and understanding. To be successful the health workers must make these clinics as easy as possible for women & children to attend & reserve these services. To after this kinds of comprehensive care requires careful organizations at the health staff & activities that need to be carried out the MCH clinic.

### **5.7. Common Indicators of MCH Services (refer to epidemiology texts for details)**

**a. Perinatal mortality rate:** the total number of still-births plus the number of deaths under one week old, per 1000 birth or

the sum of late fetal and early neonatal deaths. The causes of prenatal mortality are generally attributed to trauma and stress of labor, toxemia ante partum hemorrhage, maternal disease (particularly malaria and malnutrition), congenital anomalies, infection and induced abortions. Rates and causes of perinatal mortality are less well documented in developing countries.

**b. Neonatal mortality rate:** The number of deaths under 28 days of age per 1000 live births. The neonatal death reflects not only the quality of care available to women during pregnancy and childbirth but also the quality of care available to the newborn during the first months of life. Immaturity of the infant is the chief cause of these early deaths. Approximately 80% of infants who die within 48 hours of birth weigh less than 2500g.

**c. post-natal mortality rate:** The number of deaths over 28 days but under one year of age per 1000 live births.

**d. Infant mortality rate:** The number of infant under one year of age dying per 1000 live births. It is the sum of neonatal and postnatal deaths. The primary cause is immaturity and the second leading cause is gastroenteritis, which can be prevented by putting the newborn immediately with the mother and advocating breast-feeding.

**e. Child mortality rate:** The number of deaths between 1 and 4 years in a year per 1000 children. This rate reflects the main environmental factors affecting the child health, such as

nutrition, sanitation, communicable diseases and accidents around the home. It is a sensitive indicator of socioeconomic development in a community and may be 25 times higher in developing countries compared to developed countries.

**f. Contraceptive Prevalence Rate (CPR)**

**g. ANC percentage**

**h. Percentage of institutional deliveries**

**i. Percentage of LBW**

**j. Total fertility rate (TFR)**

**k. Percentage of EPI coverage**

**l. Maternal mortality rate (MMR)**

Maternal death is the death of women during pregnancy child birth or up to 42 days after delivery or abortion, regard less of the site of pregnancy and from any cause related to pregnancy or aggravated by pregnancy or its management but not from accidental cause (WHO, 1997)

- Every minute of every day a woman dies
- Every minute 8 babies die because of poorly managed pregnancy and delivery
- According to WHO, reported 585,000 maternal deaths occurred each year.

- 99% of these deaths are in developing countries
- In Ethiopia there are estimated 871/100,000 LB maternal death (2005)/

**The major cause of MM includes**

- Direct cause – are these disease or complications occur only during pregnancy and child birth e.g.,
  - Hemorrhage – 25%
  - Sepsis – 15%
  - Unsafe abortion – 13%
  - Hypertensive disorder – 12%
  - Obstructed labor – 8%
  - Other – 8%
- Indirect cause – are these which are pre-existing disease but aggravated by pregnancy.
  - Ex- Anemia
    - Heart disease
    - Essential HTN / 20% MM
    - DM
    - Kidney disease
  - Coincidental causes – are not related to pregnancy
    - Ex – Death from traffic accident

## **Review questions**

- Identify the socio-economic factors that affect the health of women and children
- Explain the role of PHC in improving MCH services
- List reasons for giving priority to MCH services.
- List the major targets and components of MCH services

# UNIT SIX

## ADOLESCENT REPRODUCTIVE HEALTH (ARH):

### **Learning Objectives:**

On completion of this of this unit, students will be able to:

- Define adolescence
- Outline the aim of ARH
- Discuss why ARH is given attention
- List the components of ARH
- Describe the direct and indirect targets of ARH
- Discuss the consequences of adolescent sexuality and pregnancy.
- Describe the strategies of ARH

### **6.1. Introduction**

Adolescence is a period between 10-19 years where sexual maturity develops but comes in with social demands (WHO,).

Adolescent is a time of:

- Experimentation and curiosity.
- Increasing confidence and self-esteem.
- Increased sexual feeling and impulse

- Beginning to reproduce
- Transition from childhood to adulthood
- Enjoy life before responsibilities of adulthood begins in a way which doesn't affect their life. Skills and knowledge are needed for positive relationships with others (communication, decision making, overcoming peer pressure, assertiveness. etc). It is one of the most crucial periods in an individual life.
- A time when many key socioeconomic, biological and demographic events occur that set for adult life.
- A period rapid psychological changes and vulnerability to physical, psychological and environmental influences.

### **WHO Classify**

- Adolescent – 10-19 years old
- Youth – 15-24 years old
- Therefore the aim of ARH service is
  - To enable them to undergo such changes, safely, with confidence and best prospects, health and productive life.

## **6.2. The Rational why concern, to ARH**

- Comprise large proportion of the total population (20% of the world's population is young (10-24 years)
- An increasing adolescent sexuality, surrounded by so much secrecy, has become one of the major rise factor implicated in the current pandemic of HIV/AIDS and its socioeconomic and health consequences.
- Adolescents are the productive forces Nations of tomorrow: future economic development– depends on having proportion of the population that are reasonably well educated, healthy and economically productive.
- The high prevalence of drug abuse among adolescents leads to risk behaviors i. e.-
  - Unsafe sex, unwanted pregnancy:
  - STIs/HIV, criminal offences
  - Unemployment, poverty, crime
  - Poor socioeconomic development.

## **6.3. Components of ARH**

- Adolescents FP, IEC, service, counseling
- STIS/HIV
- Unwanted pregnancy and unsafe abortion
- Harmful traditional practices
  - FGM
  - Abduction and rape



- Early marriage
- Sexual violence (Gender-violence)

#### **6.4. Problem of Adolescent Fertility**

Adolescent health problem have been generally neglected because:

- Reported mortality and morbidity rate are low
- Health problems are less obvious

Adolescent sexual and reproductive health refers to the physical and emotional well being of adolescents and includes their ability to remain free from unwanted pregnancy, unsafe abortion, STIS including HIV/AIDS and all forms of sexual violence and coercion. The major causes of adolescent reproductive health problems are early unprotected sexual intercourse and unwanted pregnancy which may occur due to:

- Lack of knowledge on physiology of the reproductive system and human sexuality
- Declining age of menarche
- Early marriage
- Sexual violence and coercion
- Peer influence
- Lack of knowledge of family planning
- Unavailability and inaccessibility of service

- Attitude of the society towards use of family planning services by adolescents

**The consequences of adolescent sexuality and pregnancy:**

**Psychological impact**

- Poor psychological development
- lack of confidence
- isolation
- stigmatization.

**Health impact**

- Early child bearing (CPD, LBW, MM), each year about 15 million adolescents aged 15-19 yrs give birth, as many as 4 million obtain abortion and
- STIs / HIV, globally up to 100 million adolescents become infected with STIs and 40% of new HIV infections occur among 15-24 years olds.

**Socio-economic impact**

- School dropouts
- Dwarfs futurity
- Curtails life options
- Juvenile deliquesces
- Dangerous vanagrancy
- commercial sex workers

## **6.5. Strategies of ARH**

### **A. Making clinical service available,**

#### **Meeting their Reproductive health needs include;**

- Confidentiality
- Convenient location and time
- Youth friendly environment
- Range of choices
- Strong counseling component
- Specially trained professionals
- Comprehensive clinical services

### **B. Provision of information**

- Appropriate and relevant information about RH
- Clinic based education and counseling
- For practical skills use role plays, community visits, exercises
- Curriculum should address gender inequalities, that affect health and promotes shared female-male responsibility for health.

### **C. Ensuring community support**

### **D. School based clinics**

### **E. Community based adolescent RH centers**

### **F. Peer group education**

### **G. ARH clubs at schools**

### **H. Youth center**

## **I. Participants**

- Involve youngsters in ARH program and design its evaluation
- Parents should improve interaction with their children, guide them in the right way.
- Support process of maturation of their children in the area of sexual and RH
- Providers should not be judgmental not to make things worse (trust, confidentiality, privacy, helpful)

### **Targets**

#### **Direct :**

- in school adolescents
- out of school adolescent
- street adolescent

#### **Indirect:**

- Parents
- School teachers
- Policy makers
- Community leaders
- Religious leaders.

### **International and National initiatives on adolescent RH**

- The 1994 ICPD and 1995, Beijing conferences highly acknowledged the ARH.

- International organizations (Marie – stops. IPPF, pathfinder have been supporting ARH.
- Nationally, ARH sector under MOH
- FGAE, is the 1<sup>st</sup> to launch FLE and establish ARH center since 1989.
- There are also other National partner NGOs supporting ARH activities.
- FGAE is addressing multipurpose activities for adolescents under
  - The youth counseling & FP education project
  - IEC
  - Counseling service
  - FP services, STIs management and other RH services
  - Recreational services
  - Library services
  - Mass Media
  - School services
  - Community based project centers.
- The Government of Ethiopia gives an emphasis to ARH, and this is reflected in the 1993, population policy.
- The National workshop was held in 1994 by the MOH and the need for youth projects to incorporate adolescent sexual and reproductive Health was emphasized.

### **Conclusions and Recommendations:**

For years, ARH has been neglected: However, recently it is recognized as one of the major concern and determinants of development thus, Government policy makers should concern for ARH and allocate budget to:

- Parents should improve interaction with their children, guide them the right way, enable them to comply with educational duties.
- support the process of maturation of their children in the area of sexual behavior and RH
- Create more supportive Environment for youths efforts should be made to overcome deep-seated adult discomfort with adolescent sexuality in many developing countries.
- Young people should be given information on negotiating skills to resist peer pressure that often leads them to be sexually active.
- Studies show that sex education doesn't increase sexual activity, in fact it may delay or lead to responsible sexual behavior for those who are sexually active, where as keeping teenagers in the dark helps them to discover sex on their won often with tragic consequences.
- Efforts should be made to overcome deep seated adult discomfort with adolescent sexuality.

- Involve youngsters in ARH program design its evaluation.
- Health care providers should not be judgmental, help Adolescents keep privacy and build trust.
- Educate young men to respect girls self determination and share responsibility in matters of sexuality and RH.
- Promote responsible sexual behavior including country abstinence.
- Provide appropriate RH services appropriate to age group.
- Train adolescents on Gender equality, equity, assertiveness and gender violence.

**Develop the following values in adolescents**

A respect of self and others

Non-exploitation in sexual relationships

Mutuality, honesty, and maturity

Non exploration of rights, duties, responsibilities involved in sexual relationships.

Compassion, forgiveness and compromise when people do not agree on their way of life.

Acknowledge diversity (religion, culture etc).

Self discipline in own sexuality.

## **Review questions**

1. List some of the rationale of concern of ARH
2. State major component of ARH
3. Discuss problems and consequence of Adolescent sexuality
4. what is the aim of ARH?



# UNIT SEVEN

## STREET “ON AND OFF” CHILDREN

### Learning Objectives:

On completion of this of this unit, students will be able to:

- Define street on and off children
- Describe factors contributing for being street
- Discuss the major problems of street children
- List some of the strategies to be taken to solve the problem.

### 7.1. Introduction

Homeless persons represent an aggregate that is particularly at risk for disability, injury, or premature death. They suffer from lack of food, clothing, medical services, and social support.

#### ***Children “On” the street***

These are children who depends on the street for their subsistence, but usually return home at night

#### ***Children “off” the street***

These are children who work and sleep on the street, where by street is their principal home.

## **Prevalence**

World wide, an estimated number of street children is 60-80 million. National wide the estimated number of street children is 100,000-150,000, among these 67% are in Addis Ababa.

### **7.2. Reason (contributing factor) for being street**

Even though several and different types of reason is given for being street. The most common reason contributing factor includes.

- Economic reason – (i.e. searching for better life)
- Physical violence by their parents
- Loose family ties
- School failure
- Bribed by an adult
- Orphaned by an adult
- Drought, war, ethnic conflict
- Mental illness

### **7.3. Problems of street children**

Since street children are homeless, living in overcrowding shelters, unsuitable sleeping, unsanitary living condition and they have poor hygienic, and poor nutritional status. They are exposed to different disease causing organisms, they exposed for trauma, even for substance abuse and crime. Therefore,

they are highly exposed to many health and health related problem, the mains health problems include:

- Acute or chronic alcoholism
- Respiratory tract infection
- Drug abuse
- Trauma (assault, accident, burns)
- STIs
- Diarrhea disease
- Leg and ear problems
- Mental illness

Sexual violence like coerced sex through threats, intimidations, or physical forces, rape, attempted rape, unwelcome kiss... are also other problems of female street children the consequences of problems include

- physical injury –loss of vision, hearing, disfiguring
- unwanted pregnancy
- unsafe abortion
- STIs/ HIV
- Psychological problem – fear and anxiety
- Sexual dysfunctions
- Low self – esteem

- Post traumatic stress disorders (PTSD)
- Depression

**7.4. Some of the strategies to alleviate their problem include**

- Making health care facilities available
- Street based health education which focus on FP, personal hygiene, STIs/ HIV etc
- Looking for possibilities to reunite with their families

### **Review question**

1. Define street on and off children?
2. Discuss major health problem of street children
3. Describe factors contributing for being street
4. List some of the strategies to be taken to solve the problem.

# **UNIT EIGHT**

## **SCHOOL HEALTH SERVICE (SHS)**

### **Learning Objectives:**

On completion of this of this unit, students will be able to:

- Mention goal and objectives of SHS
- Describe major component of SHS
- Analyzes the programs of SHS
- List common health problems in school

### **8.1. Introduction**

School health is that phase of community health service that promotes the well-being of the child and his education for healthful living. A school health program refers to all activities that contribute to the initiation, maintenance and improvement of the health school children and personnel. This program includes health learning, health practice during school hours and health services. The school health program is a continuation of the infant and pre-school health program.

### **8.2. Goal:**

To support the educational process by helping to keep children healthy, by teaching students & teachers preventive health measures.

## **Objectives of SHS**

- Promote health and develop concern of their own health.
- Detect disease and deviation from normal health at an early stage and arrange for prompt, treatment and follow up.
- Prevent communicable disease and non - communicable disease.
- Provide a healthy and safe environment in all-round for development of child physical, mental, social, emotional and moral well-being.
- Help children to make the best use of educational facilities
- Help children, their parents and teachers to be health conscious and develop right attitude towards health and illness
- Increase the basic knowledge and skills of children and those concerned in their welfare in all levels of prevention.

### **8.3. Major components of SHS**

#### **8.3.1. Health service**

- Health screening
- Treatment of minor ailments
- Surveillance of immunization status
- Case finding for early detection of health problems
- Case managements
- Counseling
- Care of pupils with special health needs
- Health promotion
- Minimum routine examination  
e.g., of common eye problems and intestinal parasitosis and their Rx
- Simple first Aid facilities
- Accident control – like –fall injury
  - burn injury
  - cut injury
  - traffic accident
  - drowning
  - snake bite



### **8.3.2. Environmental protection and control**

Includes;

- Construction of toilets and waste disposal
- Use of toilet
- Water supply
- Proper waste disposal
- Cleanliness of the compound

### **8.3.3 Health education: Include**

- Teaching about first aids
- Teaching about personal hygiene
- Teaching about environmental sanitation
- Sex education
- Nutrition education

### **8.3.4. Extra –ordinary activities e.g., club**

## **8.4. School health program**

A planned and organized school health program includes:

- Administrative regulations that provide human resource and facilities to participate in school program

- Policies acceptable to the school & health service
- Co-operative study to all factors affecting the health of school children.
- Co-operative planning at all levels.
- Health education, especially health as a part of every day school lesson
- Measures for the promotion of positive health
- Environmental sanitation
- Nutrition
- Provision of health service
- Evaluation of the program
- 

#### **8.5. Common health problems among school children**

- Accident and injuries
- Communicable diseases
- Behavioral problems

#### **8.6. Role of community nurse in school Health program**

- As a member of school health team and participate in planning and coordinating health program.
- The nurse is the school health consultant

- Control the development and maintenance of a safe and healthful environment.
- Demonstrate technique for teacher's health inspection and procedures.
- Assist in screening physical, mental and other special examination of children in school.
- Assist in communicable disease control.
- Help to set up facilities and demonstrate first aid procedures.
- Conduct health program
- Assist In school medical examination and follow up

### **Summary questions**

1. List the objectives of SHS
2. Explain the major components of SHS
3. Discuss on the common health problems in school

# **UNIT NINE**

## **PRISON HEALTH SERVICES (PHS)**

### **Learning Objectives:**

On completion of this of this unit, students will be able to:

- List the main purposes of PHS
- Explain the common health problems among prisoners
- List the responsibilities of community health nurse in PHS
- Identify contributing factors to the spread of disease among prisoners.

### **9.1. Introduction**

Prison is a place where individuals are kept in custody for a certain period of time for any wrong deeds they commit knowingly or unknowingly having political, social and economic nature.

### **9.2. Main Purpose of Prison Health Service (PHS)**

- To solve the immediate health problems of the prisoner both physical and mental.
- Prisoners do have a right to get health service
- To prevent transmission of diseases

- To teach prisoners the basics of health and change their behavior so that when they are released from the prison to join the community once again, they can transmit whatever health messages, they get in the prison. Thus act as a community health educator.
- To prevent the spread of infections and especially chronic ones like TB, Leprosy from the prisoner to the community
- To train the prisoners as first aiders.

### **9.3. Common Health Problems in the Prison**

- Psychological health problem
- Problem of food poisoning (dysentery)
- Febrile illness like relapsing fever, typhoid, typhus
- Intestinal parasites
- Chronic diseased like TB
- Skin infections
- Malnutrition
- Gastroenteritis
- Urinary tract infection
- Arthralgia, rheumatism
- Homosexuality
- Sexually transmissible diseases (STD's)

**Major stressors specific to the condition are:**

Loss such as loss of job, freedom, family contacts, dignity, food choices

privacy and sexual activities. Threats such as the threats of homosexual, physical discomfort, sleeping, eating and other personal functions. Drugs or alcoholic withdrawal, feelings of infidelity (lack of religion, belief)

### **Sources of Diseases**

- Prisoners who join the prison with diseases
- The prison itself

### **Factors responsible for the origin and spread of diseases in prisons**

- Poor housing
- Inadequate ventilation
- Overcrowding
- Malnutrition
- Poor personal hygiene
- Poor environmental hygiene
- Idleness
- Poor waste disposal
- Prolonged stay in prison
- Lack of knowledge
- Others

Effective PHS goes with change in politics; economics and society while making a survey use a well-structured check list which includes the following points.

- Identification of the prison (name, location)
- Construction of the building and their bed rooms
- Waste disposal system
- Latrine
- Water supply
- Health facilities

#### **9.4. Responsibilities of the PHN during PHS**

1. Work with prison administrators and the prisoners
2. Organize prisoners and form health committee in the prison
3. Identify health and health related problems of the prisoners using a developed checklist.
4. Make a plan and encourage them to solve the identified problem
5. Identify the resources of the prison.
6. Work with other health professionals
7. Work to solve the identified problems
  - Screening of the prisoners
  - Treating the sick
  - Health education
  - Delousing of the prisoners
  - Waste disposal system
8. Make a follow up

### **Review question**

1. Explain common health problems among prisoners
2. What are the factors that contribute to the Spread of disease among prisoners
3. Discuss the nursing responsibilities in PHS

## **UNIT TEN SUBSTANCE ABUSE**



**Learning Objectives:**

On completion of this of this unit, students will be able to:

- Define substance abuse and dependence
- Describing the magnitude, distribution and risk factors of substance Abuse
- Identify common substance of abuse and dependence
- Understand the danger of substance abuse & dependence
- Manage substance abusers and dependants
- List and implement the prevention and control strategies of substance abuse.

**10.1. Introduction**

Substance abuse is a mal – adaptive pattern of substance use resulting in repeated problems and adverse consequences.

***Epidemiology of substance abuse***

Substance abuse occurs in all segments of all societies, which result in decreased work and school performance, accidents, intoxication while drinking, absenteeism, violent crime, theft, Adolescents are the most vulnerable age groups for developing substance abuse problems.

Men are more at risk than women.

**Some Important Terms related to Substance Abuse**

**Abuse:** Mis-use, mal-treatment or excessive use  
Addiction: before 1964 the term used but now replaced by the term dependence (by WHO) because it is no longer scientific term. However, it is a physiologic or psychologic dependence on some agent with a tendency to increase its use.

**Dependence:** The psychophysical state of a substance users in which the usual or increasing dose of the substances are required to prevent the onset of withdrawal symptoms.

- It is a compulsion to take subs. To prevent onset of withdrawal symptoms or discomfort
- A strong desire to obtain and take the substance.
- It is a persistent seeking behavior of substance.

**Psychological dependence:**

- is a compulsion that requires periodic or continuous exposure to a substance to produce pleasure and/or avoid discomfort.
- Is a continuous or intermittent craving of a substance (e.g., coffee, chat...)

**Physical (physiological) dependence:**

- It is a body's biological need evidenced by tolerance or withdrawal symptom

**Tolerance:**

- is the requirement for an increased amount of the substance to achieve a desired effect or there is markedly diminished effect regular use of the same dose

**With-drawl:**

- Specific organic brain syndrome that resulting from cessation or reduction in intake of substance.

**10.2. Factors Associated with Substance Abuse and Dependence**

Many variables operate simultaneously to influence the likelihood of any given person becoming a substance abuser or dependent.

These variables can be organized in to 3 categories.

**10.2.1. Agent / Drug Variables.**

The abuse liability of a substance is enhanced by its:

**Availability:** easily available, substances are likely to be abused.

**Cost:** low cost of substance, a likelihood of increase abuse / dependent

**Mode of administration:** The possible modes of dministration of sub. Include chewing, PO, intra-asal, SC, IM, IV, & inhalations.

The easily modes of administration (like chewing, PO, inhalation ....etc.) the increased tendency of abused.

**Speed of onset:** effect that occur soon after administrative more likely to initiate the chain of events that leads to loss of control subs. Taking.

**Termination effect:** Substance that has longer duration of action is more likely to be abused.

### **10.2. 2. Host / Users variables.**

In general, the effect and the likelihood of an individuals becoming substance abused depend on:

- Genetic predisposition and vulnerability Psychiatric disorder
- Psychiatric disorder
- Prior experience or expectations
- Propensity for risk taking behavior

### **10.2.3. Environmental Variables**

Include: Social setting and community attitudes

- peer influence
- Paucity of other option for pleasure or diversion

- Low employment or educational opportunities.

**Table 4. Some of the substances that are commonly abused by individual**

Type	Examples	Effect
Depressant	Alcohol, barbiturate Hypnotic	Drowsiness, pleasant relaxation, disinheriting
Opiate	Morphine, methadone pethidine	Relief pain, pleasant dreamy, euphoria
Stimulant	Cocaine, khat amphetamines	Exhilaration, reduced fatigue and hunger
Hallucinogens	Mescaline peyote	Other world illness.
Cannabis	Hashish Marijuana	Relaxation and hallucinogenic effect
Nicotine	Tobacco	Sedation and stimulation
Volatile Inhalants	Benzene, glues gasoline, lacquer	Relaxation, drowsiness perceptual disturbance.

Substances that are commonly abused in Ethiopia

- Alcohol

- Khat
- Tobacco/shisha
- Hashish
- Benzene
- Pethidine
- Benzodiazepines

### **10.3. Diagnostic criteria for substance abuse**

Clinical guideline (ICD-10) for a definite diagnosis of dependence drawn up by WHO require that three or more of the following six characteristic features have been experienced / exhibited

- a. A strong desire or sense of compulsion to take the substance
- b. Difficulties in controlling substance taking behavior in terms of its onset, termination, or level of use.
- c. A physiological withdrawal state when substance users have ceased or been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance or use of the same (or a closely related) substance with the intention of relieving or avoiding withdrawal symptoms.

- d. Evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower dose.
- e. Progressive neglect of alternative pleasures or interest because of psychoactive substance use increased the amount of time necessary to obtain or take the substance or to recover from its effect.
- f. Persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to liver through excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug related impairment of cognitive functioning, efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm.

The fourth Diagnostic and Statistical Manual (DSM-IV) of the American Psychiatric Association uses the following criteria for substance abuse. If any individual has experienced one or more of the following at any time for at least in one-month period:

- Recurrent drug use resulting in failure to fulfill major responsibilities.
- Recurrent drug use in physically hazardous situation
- Recurrent drug – related legal problems
- Continued use despite drug related social / inter personal problem

**10.4. Problems associated with substance abuse and dependence**

- The dependence producing properties of substance that reinforce the users for continuation of the substance taking behavior are responsible for ill effects of a substance on the abuser & the society virtually, all substance that producer dependence can cause varying degree of health, social & economic problems.
- The degree of harm produced in general depends on
  - o The quantity of a substance consumed per occasion
  - o The frequency with which it is consumed
  - o The duration of consumption

**10.4. 1. Health related problems**

a. Acute – toxicities – can cause death and / or ill health



- b. chronic toxicities – e.g., liver damage
  - coronary heart disease
  - psychiatric problems
  - lung cancer

#### **10.4.2. Economic consequence (problems)**

- a. Un employment resulting in decrease national productivity
- b. Economic crisis–because increase expenditure for buying substance
- c. Decrease school performance
- d. Increase school drop out
- e. increase absenteeism leads decreased performance at school, work ...etc
- f. Decrease productivity occupies vast area of the land that other wise be used for cultivation of useful crop and food.

#### **10.4. 3. Social consequence**

- i. Divorce → broken families → prostitution
- ii. Crime (theft, hijacking, rape...)
- iii. Violence
- iv. Accident
- v. Dangerous vagrancy

## **10.5. Management of problems related to substance abuse and dependence**

Many substance abusing patients are known by their dependent personalities, denial and ambivalence.

The purpose and goal of Rx is to prevent and / reduce the incidence & severity of problems associated with the use of substance.

The Rx include

- a) Early detection of cases and early intervention before complicate occurs.
  - Gradual withdrawal
  - Substitution of less addictive
  - Symptomatic treatment
  - Pharmacotherapy (to prevent relapse once on initial remission)
- c. Psychotherapy and counseling
  - Rx designed to produce a response by mental rather than by physical effects
- d. Long term Rx and rehabilitation include
  - education
  - family / friend support
  - self – help group
  - vocation rehabilitation

### **10.5.1. Prevention and control**

#### **Primary prevention**

- identifying and avoiding drugs alcohols that the community used
- information and education about alcohol, drug, miss- use to the community to avoid the appearance of the new cases of drug or other substance users

#### **Secondary prevention**

- early detection and management be fore complication occur

#### **Tertiary prevention**

- To avoid further disabilities & to reintegrate in to society

### **10.5.2. Control methods**

#### **Control of production, supply and availability**

Include:

- stopping the supply process as its source
- crop eradication
- crop substitution
- control of distribution & access

### **Demand reduction**

- reducing consumption
- increase price
- control of advertisement and promotion

### **Rational prescribing, dispensing and uses of narcotic and psychotropic drugs**

- Proper diagnosis and decide on the use of drugs
- Keep records
- Take as prescribed
- Not use for non – medical purpose etc...
- Increasing individual resistance from social pressure by health education.

**Review question**

1. Discuss major problems and health consequences related to substance abuse
2. Describe the types of managements and controlling measures of substance abuse
3. States the most important variables to influence the individuals becoming substance abused or dependent.

# UNIT ELEVEN

## ADDRESSING THE NEEDS OF THE FAMILY

### **Learning objectives:**

On completion of this of this unit, students will be able to:

- Define a family
- Discuss characteristics all families in common
- Describe the function of a family
- Identifying main areas of family health assessment
- Recognize the application of nursing process on promoting family health.

### **11.1. Introduction**

Many different definitions exist, but most family theorists agree that a family consists of one or more individuals who share a residence or live near one another, possess some common emotional bond and engage in inter-related social positions, roles and tasks.

## **11.2. Universal Characteristics of Families**

Every family shares some universal characteristics with every other family. These universal characteristics provide an important key to understanding each family's uniqueness.

Five universal family characteristics are:

### **11.2.1. Every family is a small – social system**

- a) Families are interdependent; each member's actions affect other members
- b) Families maintain boundaries;
  - family closeness
  - links family members together in bond
  - greater concentration within the family
- c) Family exchange energy:
  - exchange materials, information
  - need, take, health care, education, employment.....
  - Contribute to the community by working, consuming goods services....
- d). Families are adaptive behavior:
  - equilibrium seeking behavior
  - shift and change in response to internal and external forces.

Some times, if the internal /external forces (stress) beyond its limit, the family members

leave and become dysfunctional, at this time the family need help / interventions to restore equilibrium.

- e). Families are goal directed:
- exist for purpose, for example to
  - establish and promote the development of their members, to provide love security, assistance etc... to their family members.

### **11.2.2. Every family has its own cultural values and rules.**

- o Shared values and effects
- o Certain roles are presented and defined for family members

### **11.2. 3. Every family has structures**

#### **Traditional family:**

- Nuclear family (husband, wife, and children  
Live in common house)
- Nuclear –dyad (husband, wife, with no children  
or grow children out side home)
- single parent (one adult male/female living alone)
- multigenerational (several age group live  
together. E.g., widowed women live with  
divorced daughter with grand  
children's)



## **Non traditional family structure**

ex-Un married single parent (single women live with children

- co-habituating couple (two adults, just friends
- group marriage (several adults who share common household and consider that all are married, share every thing including sex, child rearing etc.)

### **11.2. 4. Every family has certain basic function**

#### **a) affection**

- give love and emotional support to the members
- sharing of gifts during holiday
- -love for sick family members

#### **b) provide security and acceptance**

- meet there members physical need (food, shelter, clothing
- acceptance of individual members

#### **c) affiliation & companion companionship**

- development of communication pattern
- Establishment of durable bond not broken by distance, time... ex.

gathering during holiday, weeding  
...even when scattered.

**d) socialization**

- Internalization of value
- Guidance for internal and external relationship

**e) control** – maintenance of social control (ex. appropriate dressing

- division of labor
- allocate various tasks, responsibilities .....

**11.2. 5. Every family moves through stages in its life cycle two broad stages**

- period of expanding →when the family add new member/roles
- period of contracting →when members leave or dead.

**11.3. Characteristics of healthy families**

**Healthy interaction among members**

- Discuss problems
- Confront each other
- Share ideas and concern ....etc

**Enhancement of individual development**

- Promote each members growth

**Effective structuring of relation ship**

- Structure their role relationship to meet changing family needs over time. (flexibility of role)

**Active coping effort**

- Actively attempt to over come life's problems and issues

**Healthy environment and life-style**

-create safe and hygienic living conditions for their members.

**Regular links with the broader community**

- Maintain dynamic ties the broader community
- Participate regularly in external groups and activities

**11.4. Application of nursing process on promoting FH**

**Family health Assessment-** provides information's on the measuring a current health situation of family member and emotional support that can be expected to be offered to an individual from the family.

Main areas of assessment includes:

- Family demography (age, sex, education, occupation, etc....)
- Physical environment (housing space, climate, dietary pattern...)

- Psychological and spiritual environment (mutual respect, support,
- Family structure and role (division of labor, socialization process allocation and use of power...)
- Family function (ability to carry out appropriate developmental tasks....
- .Family value and belief
- .Family communication pattern (frequency and quality of communication with in the family, b/n the family and its environment)
- Family decision making pattern (how, by whom, when decision is made)
- Family problem solving pattern (how a family handles its problem
- Family coping pattern (how a family handles conflicts and life change, family perception and response to stressors)
- Family health behavior (family health history, current health status, health belief, use of health resource...)

**Family Nursing Diagnosis-** example:

- Potential for enhanced parenting
- Potential for role conflict related to prolonged separation

- Altered family process related to emergency hospital admission of child
- Altered family process related to unplanned pregnancy.

**Planning** – depend on the type of diagnosis established and the goal to be achieved

-must be appropriate and desired by family members.

**Implementation-** A plan can be easily implemented if a family members have agreed on it and support one another.

**Evaluation** - include not only the goals was achieved, but also that the family feels more cohesive after working together toward the goal.

**Review question**

1. Discuss the universal characteristics of every family
2. Describe the characteristics of healthy family
3. What is the application of nursing process on promoting family health

# UNIT TWELVE

## PROMOTING AND PROTECTING THE HEALTH OF THE OLDER ADULT POPULATION

### **Learning objectives:**

On completion of this of this unit, students will be able to:

- Describe the general health status of older adult
- List some of the major misconception held about the older population
- Describe the major health problems of the older population
- Describe various health maintenance programs for older adults populations.

### **12.1. Introduction**

Peoples are living longer as a result of improved health care, eradication and control of communicable disease, use of antibiotic and other medicines and accessibility to a better quality of life for residents.

The older population does, however, have higher percentage (80%) of chronic conditions, some of which may limit activities.

These chronic illnesses include arthritis, heart diseases, high BP, DM, visual and hearing impairments.

Good health in elderly means maintaining the maximum degree possible of physical, mental, and social rigor. It means being able to adapt, to continue to handle stress, and to be active and involved in life and living. In short, healthy aging means being able to function, even when disabled, with a minimum of ordinary help from others.

Wellness among the older population varies considerably. It is influenced by many factors including personality traits, life experiences, current physical health and current societal support some elderly people demonstrate maximum adaptability, resourcefulness, optimism, and activity, however, misconception often arises from negative personal experience, myths shared through out the ages, and a general lack of information on older people. Some of these misconception and stereotypes of older people includes

- Most older adults can't live independently
- Chronological age determines oldness
- Most old people have diminished intellectual capacity/are senile
- All older people content and serene
- Older adults can't be productive or active
- All older adults are resistant to change.



## **12.2. Health problems of elderly people**

### **12.2.1. Problems associated with aging process**

- Cataract
- Glaucoma
- Deafness
- Reduced vision
- Immobility (due to changes in joints and bones)

### **12.2.2. Chronic disease**

- Arthritides
- heart disease
- Peripheral vascular disease
- Hypertension
- Cancer
- Diabetes mellitus
- Emphysema, Chronic Obstructive Pulmonary Diseases (COPD)

### **12.2.3. Psychological problem**

- Dementia
- Depression
- Rigidity of out look
- Social and emotional withdrawal
- Suicide

**12.2.4. Sexual problems** diminished sexual activity, this leads to physical and emotional disturbance

**12.3. Health maintenance program for older people**

- communication service ( phones, emergency access to health care)
- dental care service
- dietary guidance and food services
- escort and protective services
- exercise and fitness program
- financial aid and companions
- health education
- hearing aid and hearing-aid assistance
- home health service
- legal aid and counseling
- library service
- medical supplies /equipment
- medication supervision
- recreational and educational program
- safe, affordable, and ability appropriate housing
- social assistance service offered in conjunction with the health maintenance

**Review question**

1. Describe the major health problems of elderly population
2. Discuss some of the health maintenance programs for the older population

# UNIT THIRTEEN

## HIV/AIDS

### Learning Objectives:

On completion of this of this unit, students will be able to:

- Define HIV/AIDS
- List the routes of HIV transmission
- Explain the different stages of HIV infection
- List some of the drugs used in the treatment of HIV/AIDS
- Discuss the aims of nutritional therapy in HIV/AIDS
- Explain the needs for support services for PLWHA

### 13.1. Introduction

#### HIV and AIDS

Human Immunodeficiency Virus

Acquired Immune Deficiency Syndrome

The HIV infection continues to spread around the world. In a number of countries AIDS is the leading cause of death in young people. Today there are over 42 millions people living with HIV around the world. New HIV infections occur at a rate of about 16000 people a day, of whom approximately 700 are children. At present HIV/AIDS is among the top ten causes of death worldwide.

## **HIV/AIDS –The beginning**

1981 CDC in the US reported unusual clusters of PCP and KS in gay men

1983 HIV first isolated in France

1984 test for detecting antibodies developed

1985 industrialised countries screen blood/ tissue donations

1985/6 Development of antiretroviral therapy (AZT)

1996 Combination Anti- retroviral therapy results in 67% fall in AIDS mortality (those with access)

## **HIV/ AIDS- Global Epidemiology**

In 1981 CDC reports unusual clusters of PCP and KS

Twenty Years later HIV/AIDS has killed estimated 21.8 million people and 42 million are living with HIV infection

Over 90% of people living with HIV Infection do not know they are infected Sexual transmission is the most common mode of transmission

## **HIV is found**

Blood

Vaginal and Cervical Secretions

Most body organs

Semen

Skin  
Cerebral and Spinal Fluid  
Saliva  
Breast Milk  
Tears

### **Spread of HIV infection**

HIV transmission involves complex cultural, behavioural and economic forces.

Poverty, illiteracy and violence often force people to engage in unsafe sexual practices. As well, the “invisible” nature of HIV infection fuels the epidemic in that the carriers infect others without realising that themselves are infected.

### **Routes of HIV transmission**

Unprotected sex between homosexual men

Unprotected heterosexual

Intravenous drug use and sharing of needles

Blood transfusion

Mother –to-child

In rare circumstances, HIV infection can spread in health care settings to patients/clients or health care providers, through needle stick or injury with other sharps (ICN, 1996).

## **The different stages of HIV Infection**

Primary Infection  
Clinically Asymptomatic Stage  
Symptomatic HIV Infection  
Progression from HIV to AIDS

## **Markers of Disease Progression**

CD4 Cell Counts  
Viral Load

## **WHO Case Definition for AIDS Surveillance**

### **Adults and Adolescents**

WHO has recommended AIDS case definitions for use in adults and adolescents in countries with limited clinical and laboratory diagnostic facilities. The recommended case definition depends on whether HIV testing is available.

### **WHO case definition for AIDS surveillance where HIV testing is not available.**

The case definition for AIDS is fulfilled in the presence of at least 2 major signs and least 1 minor sign.

### **Major signs**

- Weight loss > 10% of body weight
- Chronic diarrhea for more than 1 month

- Prolonged fever for more than 1 month

### **Minor signs**

- Persistent cough for more than 1 month
- Generalized pruritic dermatitis
- History of herpes zoster
- Oropharyngeal candidiasis
- Chronic progressive or disseminated herpes simplex infection
- Generalized lymphadenopathy
- For patients with tuberculosis, persistent cough for more than 1 month should not be considered as a minor sign.

## **13.2. Opportunistic Infections**

**13.2.1 Diarrhoea** is a common symptom in patients with HIV occurring about 27% of symptomatic HIV infected patients

40- 90% of patients with AIDS

Acute- Patients present almost immediately

Chronic- Symptoms present for at least a month and continue

### **Causes:**

HIV affecting small bowel

Bacterial Infection- Salmonella/ campylobacter

Protozoal Infection- cryptosporidium

Fungal Infection- candida



**Investigations:**

Stool specimens

Sigmoidoscopy/ Colonoscopy

Biopsy

**Treatment:**

Depends on severity and duration of treatment

Ensure hydration and adequate nutrition

Modify Diet

Treat underlying cause of diarrhoea

Antidiarrhoeal treatment may be administered in some cases

**13.2.2. Pneumocystis Carinii Pneumonia (PCP)**

Commonest opportunistic infection occurring in 80% of all HIV positive patients.

Remains a primary presentation in the undiagnosed patient

**Clinical Presentation**

Severe Shortness of Breath

Dry cough

Unexplained Fever

Potentially very unwell

**Diagnosis**

Exercise Tolerance

Chest X- ray

Induced Sputum

Broncheolar Lavage

**Treatment:**

Depending on the severity of infection

Intravenous Co-trimoxazole (high toxicity- rash, nausea, bone marrow suppression)

Intravenous Pentamidine (toxicity, renal failure, low blood pressure, low blood sugar)

Dapsone/ Atovaquone

**13.2.3. Candida**

Oral candida (thrush) is a common opportunistic infection occurring in more than 95% of HIV positive patients.

**13.2.4. Oesophageal candidiasis is an AIDS defining condition****Clinical Presentation**

Creamy/ Whit plaques on the tongue, back of throat

Oral discomfort and pain

Taste perversion

Discomfort on Swallowing

Nausea

Sensation of food sticking to gullet when swallowing

**13.3. Antiretroviral Therapy****Goal of Antiretroviral Therapy**

To increase the length and quality of life by improving immune function

## **How?**

By reducing the amount of replicating virus to as low a level as possible, for as long as possible, in all sites where HIV infected cells are present

## **Antiretroviral Drugs**

### **1. Nucleoside Reverse Transcriptase Inhibitors (NRTIs)**

Abacavir

Didanosine (ddI)

Lamivudine (3TC)

Stavudine (d4T)

Zalcitabine (ddC)

Zidovudine (AZT)

### **2. Non-nucleoside Reverse Transcriptase Inhibitors (NNRTIs)**

Efavirenz

Nevirapine

### **3. Protease Inhibitors (PIs)**

Amprenavir

Indinavir

Lopinavir + Ritonavir

Nelfinavir

Ritonavir

Saquinavir

#### **4. Nucleotide Reverse Transcriptase Inhibitors (NtRTI)**

Tenofovir

#### **History of Antiretrovirals**

- 1987 zidovudine (NRTI)
- 1993 Didanosine & zalcitabine (NRTI)
- 1996 Protease inhibitors
- 1998 Nevirapine (NNRTI)
- 2002 Tenofovir (NtRTI)

#### **HAART - Highly Active Antiretroviral Therapy**

- a. 2 NRTIs + 1 NNRTI
- b. 3 NRTIs
- c. 2 NRTIs + 1 PI
- d. 2 NRTIs + 2 PIs

#### **When to start therapy**

- a. HIV status
- b. CD4 count
- c. viral load
- d. assessment of compliance & risk of drug toxicities

#### **Adverse Effects**

Immediate / short term

- nausea, vomiting
- diarrhoea
- malaise, lethargy

- headache

Long term / emerging

- mitochondrial toxicity

- pancreatitis, peripheral neuropathy, lactic acidosis **(NRTIs)**

- lipodystrophy **(PIs)**

- lipoatrophy **(NRTIs)**

Drug Specific

- Nevirapine - liver toxicity

- Efavirenz - vivid dreams, hallucinations

- Indinavir - renal stones

- Abacavir - hypersensitivity reaction

#### **13.4. Adherence**

Adherence of 70 - 80% only 25% of patients maintained viral load suppression

Adherence of 95% then 81% maintained viral load suppression

#### **Practical measures to aid adherence**

- a. Health care professional consultation
- b. Medication record cards
- c. Alarm watches, mobile phones, pagers
- d. Daily/weekly pill boxes
- e. Information phone lines
- f. Information available in other languages

### **Antiretroviral Failure**

- Main causes:
  - lack of adherence
  - intolerance
  - resistance

### **Post Exposure Prophylaxis**

- Risk of infection has been estimated at 0.3% (3 in 1000)
- Combination of three drugs is recommended for at least four weeks
- Drug choice depends on antiretroviral history of source patient, adverse effects, contraindications, drug interactions

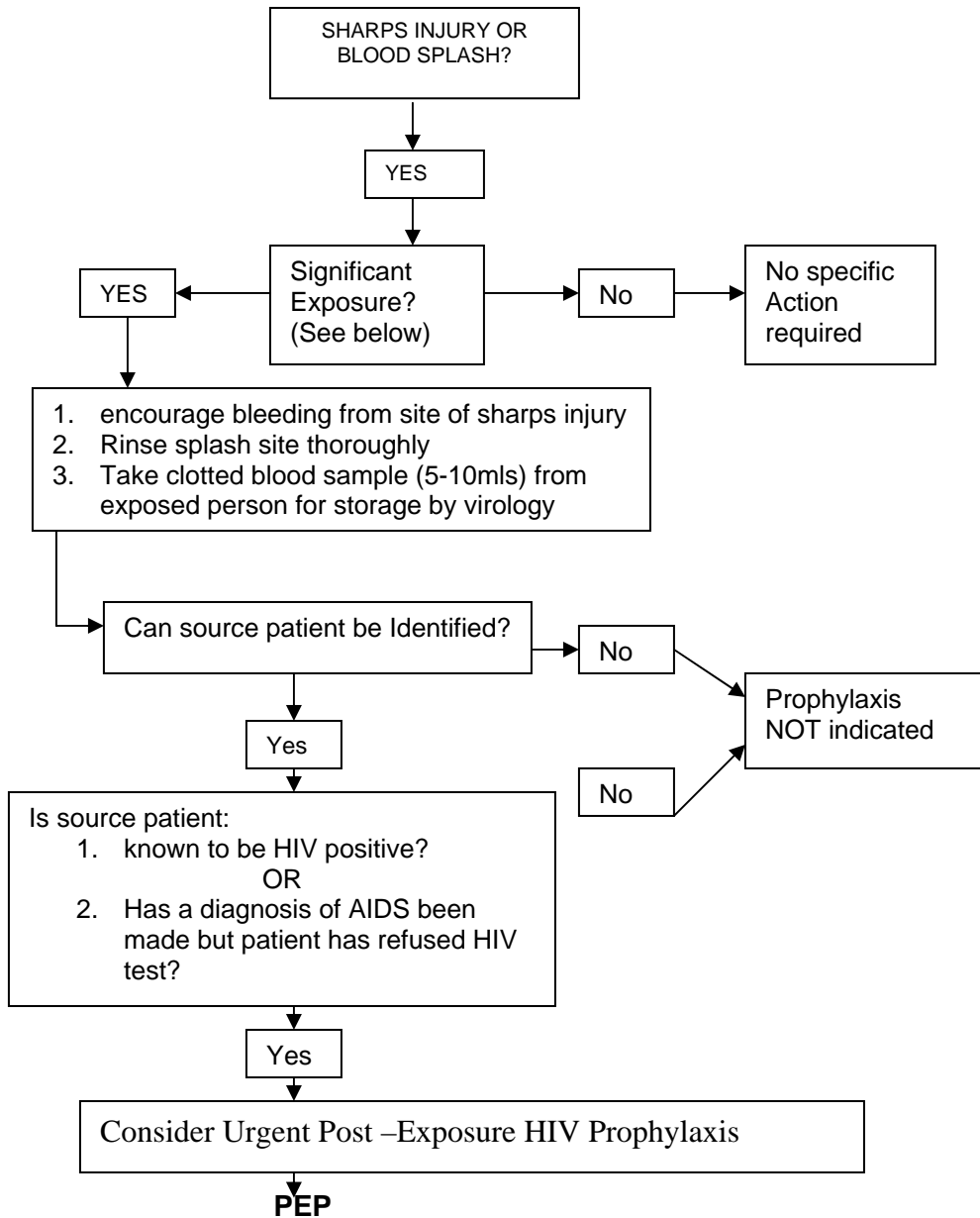


Fig. 7 Post exposure prophylaxis of HIV infection

### **Primary prevention**

- Voluntary counseling and testing (VCT)
- Preventing mother-to-child transmission
- STIs prevention and management
- Blood safety
- Sexual Behavioral changes
- Youth- based prevention
- Public-private partnerships
- Prevention among injecting drug users (IDU)
- Faith-based interventions

### **Care support and treatment**

- Expanding and strengthening TB prevention and care
- Prevention and treatment of HIV related opportunistic infections
- Enhancing palliative care
- Promoting appropriate and effective use of anti – retrovirals

### **Prevention of mother-to-child transmission of HIV**

- Implementation of voluntary counseling in ANCs
- Implementation of zidovudine and nevirapine preventive therapy
- Interventions to prevent postnatal transmission:



- Exclusive breastfeeding associated with early weaning
- Replacement feeding
- Linking HIV prevention to care activities

### 13.5. NUTRITION AND HIV/AIDS

The aim of Nutrition therapy, and type of nutritional advice will differ according to the stages of disease:

**Table 5.** Nutrition in relation to stages of HIV/AIDS

	<b>Nutrition Aims</b>	<b>Nutrition Intervention</b>
STAGE 1: As symptomatic - Patient is HIV positive, but generally well	AIMS: 1. Advise health eating 2. Maintain a healthy weight 3. Provide accurate information on alternative therapies and megadosing. 4. Advise on food safety	Advice on Healthy Eating, Food Safety, Alternative therapies, Healthy Eating on a budget. Weight monitoring.
STAGE 2; Brief periods of illness	Aims: 2. Maintain optimal nutritional status	Meal fortification or enrichment. Advice on coping with the side effects of drug therapies. Weight

	3. Improve and alleviate symptoms as a result of drug therapies or infection.	monitoring. Possible supplementation.
STAGE 3: Symptomatic patient-patient showing symptoms of diseases progression to AIDS	Aims: 1. Same as for 2, however the method of achieving goals may differ and be more aggressive.	Nutrition support- Nasogastric or PEG feeds, Parenteral nutrition. Advice on coping with side effects of drug therapies. Weight monitoring.

Table 6. Nutrition advice:

<p><b><u>FOOD SAFETY</u></b> (CD4&lt;200-boil drinking water)</p>	<ol style="list-style-type: none"> <li>1. Avoid raw meats</li> <li>2. Avoid unpasteurised dairy products</li> <li>3. Ensure foods are thoroughly reheated</li> <li>4. never eat foods past their sell-by date, or foods that are mouldy.</li> <li>5. Wash all fruit and vegetables</li> <li>6. Keep cooked and uncooked foods separate</li> <li>7. Keep pets out of the kitch and away from food</li> <li>8. Follow good hygiene practices such as washing hands before cooking etc.</li> </ol>
<p><b><u>HEALTHY EATING</u></b></p>	<p>Balance food from the five food groups, ensuring a variety of foods-meet the requirements of Energy, protein, fats, vitamins and minerals. Advise other healthy habits.</p> <ol style="list-style-type: none"> <li>4. Stop smoking</li> <li>5. Moderate alcohol intake (social drinking can help reduce stress &amp; anxiety). Heavy drinking suppresses the immune system, decrease recovery from infections, cause hepatitis or liver damage, vomiting within 1hr of taking medication may require re-dosing. The liver is important for metabolizing drugs, therefore important to take care of it's function.</li> <li>6. Exercise – decrease stress, decrease fats in blood, improve muscle mass and strength, decrease fat on tummy and bottom</li> </ol>
<p><b><u>ALTERNATIVE THERAPIES</u></b></p>	<ol style="list-style-type: none"> <li>1. Often very expensive with little benefit. B12 –improve nerve damage</li> </ol>

	<p>2. Controversial</p> <p>3. Risks –interfere with drug treatments, toxicity.</p> <p>Garlic –(good for the heart) inhibits Saquinavir and possibly Protease Inhibitors</p> <p>St John’s Wart –(depression) not suitable with Protease inhibitors or NNRTI’s. Decrease the levels of indinavir.</p> <p>Vit E-megadoses have known adverse effects, ?</p> <p>Amprenavir</p> <p>Vit A- Liver &amp; bone damage, vomiting, headaches</p> <p>Vit C Kidney stones, diarrhea, hardening of the arteries, careful wit indinavir</p> <p>Vit B6-Nerve damage, periferal neuropathy</p> <p>Zinc-copper deficiency, neutropenia, may increase HIV related symptoms</p> <p>Selenium – immune suppression</p> <p>Calcium-hypercalcaemia</p>
<p><b><u>DRUG SIDE EFFECTS</u></b></p>	<p>Loss of Appetite – Weight loss</p> <p>Nausea and vomiting- Weight loss</p> <p>Diarrhoea- Weight loss</p> <p>Taste alterations – Weight loss</p> <p>Lippodystrophy – fat wasting and redistribution (decrease saturated fats, increase fruit and vegetables, exercise).</p>

### **13.6. Other Support Services**

People who have AIDS or people who are in contact with someone with AIDS are often afraid that the negative feelings towards PLWHAs will be too strong to bear. Those feelings cannot and should not be avoided. They are normal reactions to crisis. Family, friends, neighbors, community based health workers- anyone who cares-can help another person cope with these feelings by listening and talking to the person about these feelings.

Support services are those given to PLWHAs to help meet social, spiritual, emotional, economic and medical needs.

Support service help to:

- Assure quality of care
- Reduce anxiety
- Provide sense of belonging
- Improve relationships between PLWHAs and care givers
- Meet material needs

#### **Linking PLWHAs to Support Services**

To ensure that PLWHAs have access to needed support services, community health workers should:

- Assist PLWHAs and their families to identify the support that is needed

- Identify groups/agencies/individuals that can provide the support
- Inform the PLWHA about the existence of the agencies/individuals and the services they provide
- Introduce the identified groups/individuals to the PLWHAs and their homes
- Help the PLWHAs to evaluate the groups/individuals who provide the support
- Allow PLWHAs to choose the agency/individual to meet their own needs
- Help plan for transportation if needed, or help set up home visit
- Follow up to assure coordination of services

### **Community Mobilization**

It is the process of gearing the community into action.

This is important for several reasons:

- It helps to counter the stigma on AIDS patients and their families face, so that they can live without fear or discrimination.
- It involves the PLWHAs themselves and helps them to “live positively.”
- It can increase community awareness and thus help prevent the further spread of HIV.

- It brings the community together in the care of PLWHAs, AIDS orphans and others.

Community – based health care occurs when community members take on the responsibility of initiating and sustaining their own health care. It implies the use of locally available resources and the community's full participation and involvement in decision making for the planning, organizing, implementing, monitoring and evaluating of those services.

### **13.7. Actions by National Nurses Associations (NNAs) and others**

It is important that nurses and others are up to date with the HIV/AIDS situation in their country, the mode of spread, access to care and treatment. Nurses need to use facts and figures to lobby for increased access to prevention, treatment and a continuum of care to people living with HIV/AIDS.

#### **Nurses can:**

1. **Dispel myths and misinformation.** Network with the media and other health professionals to provide information, education and communication to combat ignorance, fear and stigma associated with HIV/AIDS
2. **Lobby policy makers.** Advocate for access to prevention, counseling, care and treatment, and

political commitment to mobilize resources, including access to ART.

3. **Safeguard human rights.** Stimulate dialogue on respect to human rights, support voluntary testing and treat people with HIV/AIDS like other people with a chronic disease.
4. **Reduce transmission.** Provide education on safe sex, abstinence, and condom accessibility and empowerment of women through education, economic rights and access to condoms. Disseminate information materials.
5. **Increase capacity for care.** Provide training and supervision of family members in home care; strengthen health systems capacity to prevent and care, mobilize community resources and donor agencies.
6. **Target vulnerable populations.** Focus preventive efforts on those that are at high risk of HIV infection including commercial sex workers, homosexual men, intravenous drug users, street children and homeless people.
7. **Promote a continuum of care.** Advocate for compassionate nursing care, prevention, access to drug and referral services to hospital and community facilities.



## **Summary questions**

1. define HIV/AIDS
2. explain the main routes of HIV transmission
3. explain the different stages of HIV infection
4. list antiretroviral drugs
5. discuss the aims of nutritional therapy in HIV/AIDS
6. explain the needs for support services for PLWHA

# UNIT FOURTEEN

## HOME VISITING AND HOME HEALTH SERVICES

### **Learning objective:**

On completion of this of this unit, students will be able to:

- Define home visiting and home service
- Explain purposes of home visiting and home health service
- Describe phases and activities of home visiting
- List main areas to be assessed during home visiting

### **14.1. Introduction**

Home visiting or home health service is one of the oldest type of health services in history. Phoebe was the 1<sup>st</sup> visiting nurse recorded in history

(58 AD)

Modern home visiting began in 1880s by the visiting Nurse Associations with the objective of giving skilled nursing care at home or place of residence. Home environment is the most effective ways of increasing family's understanding and involvement in health problems. At times, home visiting is the

only way to obtain a comprehensive picture of the family health status.

**Definition**

Home visiting / home health service is that components of a continuum of a comprehensive health care in which health services are provided to individuals, and families in their place of residence for the purpose of promoting maintaining or restoring health or of maximizing the level of independence while minimizing the effect of disability and illness, including terminal illness.

Home health service refers to all the services and products provided to clients in their home, to maintain, restore, or promote their physical, mental, & emotional health.

**14.2. Purposes of home health services**

- To prevent institutionalization (primary goal)
- To maximize clients level of independence
- To maximize the effects of existing disabilities through non-institutional services.

### **14.3 Factor influencing the growing of home health services**

1. Increasing elderly population: because chronic illness is more common in elderly & need help & assistance
2. Growing of HIV/AIDS populations: for better understanding of client need at home.
3. Advanced technology: technology allows all the services at home level.
4. raising the cost of health care
5. Demands for consumer satisfaction.

#### **Home visiting**

##### **Purpose:**

- Afford the opportunity to gain more accurate assessment of the family structure and behavior in the natural environment.
- Provide opportunity to make observations of the home environment and to identify both barriers and supports for reaching family health promotion work
- Meeting the family on their home ground may also contribute to family's sense of control and active participation in meeting their health needs.

### **Advantage**

1. the family is seen in a familiar atmosphere which is were relaxed and makes communication easier than at hospital or clinic
2. All family members can be seen & assessed by one person at one visit
3. The health workers, who know the neighborhood, are aware of local problems, priorities, customs, difficulties, & resources.]
4. High risk families can be identified & visited as a priority
5. The health workers, can observe, assess, & act up on obvious and latent health problems. Health workers can follow these problems, Health workers can follow these problems at subsequent visit.'
6. Much can be assessed at one time. Ex personal hygiene, water supply, sanitation, waste disposed, food storage .....
7. More accurate assessment is done
8. Better understanding & good relation ship is established with the family members.
9. Advice will be practical and suited to the family's needs.

### **Limitations**

1. time consuming
2. limited equipment can only be carried to home
3. appointment might be not kept
4. destruction in the home makes construction difficult
5. certain homes may be geographical not reachable

### **Objectives of Home Visiting**

- To create close relation ship with communities and families
- To discover the condition in which the family lives & to identify how these conditions affect their health.
- To promote family health by providing family members with health education adapted to their levels of growth and development
- To monitor the use of skill learned in health education
- To demonstrate to the family how to administer health care needed by others family members.
- To refer to appropriate specialized services.

#### **14.4. Kinds of Home Care**

**Home for the aged.** This is a kind of home health care provided for the elder greater than 65 years of age, who need a minimum care which is often characterized as “supervised living or residential care.”

**Basic home.** It is a home for those individuals who need assistance in activity of daily living (ADL), such as eating, breathing or routine nursing care including administration of medication.

**Skilled home.** It is a home for those individuals with serious health problems who need 24 hours nursing care or supervision.

#### **14.5. Principles of home visiting**

1. Family members should be included in all phases of the care process
2. The health workers (teams) are guests in the clients home there fore only make these interventions that the clients agrees with
3. Mutual health team – client goal and intervention may require long periods to achieve, therefore, patience is necessary
4. Home visiting can be done by health professionals employed in various ways.

5. The health team function autonomously in the family health care provision. The family and the team develop a positively interpersonal relationship as they work to achieve the goal
6. The health team is a visitor at a client therefore; the team must not wait to be motivated.

#### **14.6. Phases and activities of home visiting**

Phase 1. Initiation phase – clarify purpose of home visiting

- share information to family member

Phase 2. Pre-visit phase – initiate contact with family

- determine family willingness
- schedule home visiting
- review records

Phase 3. On home phase – introduction him/her self

- warm greeting
- social interaction (to develop trusting r/s)
- implement nursing process.

Phase 4. Termination phase – review visit with family

- plan for future visit

Phase 5. Post – visit phase – Record visit

- plan for next visit



#### **14.7. Areas (points) to be assessed during Home visiting**

1. General cleanliness
2. Solid waste disposal
3. latrine
4. personal hygiene
5. vaccination of <1yr infants
6. vaccination of women
7. ANC
8. Feeding of children <2 yrs
9. FP
10. Presense of insects / rodents in the house
11. Presence of sick person in the house and action taken.

#### **14.8. Community Health Nursing Bag**

**Definition:** A specially prepared bag for carrying supplies to the field a clean and orderly way.

**Purpose**

- Helps the nurse to give service effectively in homes
- Reduces the danger of spreading infections
- Provides the necessary items needed in the field
- Identifies the nurse in the field because a home visiting bag is a part of the uniform

## **Contents of the Bags**

A. General supplies

B. Equipment

C. Others

### **A General supplies**

Soap and soap dish

Plastic apron

Plastic square to put the bag on

Aluminum cup for water

One or two small towels to dry the hand

### **Instrument**

- Thermometer
- Fetoscope
- Scissors
- Artery forceps
- Tape measure
- Plaster
- Cotton
- Gauze
- Applicator
- Bandage
- Antiseptic solution
- Syringe and needle
- GV. Tetracycline eye ointment
- Kidney dish

- Vaseline
- Tongue depressor,
- Disposable gloves
- Cord tie
- Anti pain
- Ergometrine tablets
- Ferrous sulphate
- Vitamin, A
- Test tube
- Baby scale
- Chloroquine
- Mebendazole
- BBL
- Pocket
- Small towel
- Soap and soap dish
- Plastic square
- News paper for placement of the gag
- Match

**Care of the bag**

Change inner lining as needed.

Label bottles

Refill supplies as needed

Do not put bag on the beds

Do not put your properties on the bag

Do not put on the floor

**Basic principles of using the bag**

- Select safe area to place it
- Place on the plastic square
- Wash your hands before you do anything
- All wastes should be covered in newspaper and burned

**14.9. Responsibilities of nurses**

Use the bag correctly

Keep the bag clean and orderly

Pay attention for broken equipment

Report all broken equipment

Do not miss equipment

Go through nursing process and form family focused nursing

## **Review question**

1. What is the difference between home visiting and home health service
2. What is the purpose of home visiting and home health service
3. Discuss the main areas to be assessed during home visiting
4. Explain the responsibilities of community health nurses during home visiting.

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