LECTURE NOTES

For Nursing Students

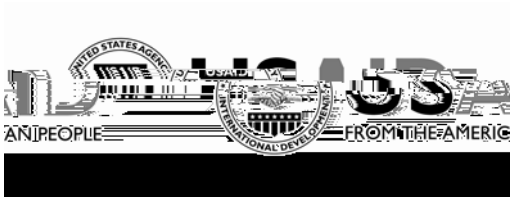
Community Health Nursing

Daniel Mengistu
Equlinet Misganaw

University of Gondar

In collaboration with the Ethiopia Public Health Training Initiative, The Carter Center, the Ethiopia Ministry of Health, and the Ethiopia Ministry of Education

2006



Funded under USAID Cooperative Agreement No. 663-A-00-00-0358-00.

Produced in collaboration with the Ethiopia Public Health Training Initiative, The Carter Center, the Ethiopia Ministry of Health, and the Ethiopia Ministry of Education.

Important Guidelines for Printing and Photocopying

This material is intended for educational use only by practicing health care workers or students and faculty in a health care field.

Health Training Initiative • Ethiopia Public Health Tra
EPHTI

ACKNOWLEDGEMENT

We would like to acknowledge The Carter Center initiative for supporting the preparation of these lecture notes.

We are very grateful to the Nursing and Community Health Department staffs for their valuable comments and ideas in revising the first draft.

We also owe special gratitude to Mr. Mesfin Negussie, and S/r Hanna Alebachew who have produced the first ever lecture note on Public Health Nursing in this country.

We would also like to extend our special regards to Mr. Akililu Mulugeta, Technical Manager, TCC for his support during the entire preparation of this lecture note.

Finally, we wish to extend our thanks to W/ro Serkalem Teshome for writing the draft of these lecture notes.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

ABBREVIATIONS

AIDS	Acquired Immuno -Deficiency Syndrome
Acute	Febrile illness
ANC	Ante Natal Care
BHC	Basic Health Service
CHN	Community Health Nursing
CHP	Community health Post
CHW	Community Health Workers
Dx	Diagnosis
EPI	Expanded Program of Immunization
FGAE	Family Guidance Association Ethiopia
FP	Family Planning
HC	Health Center
HIV	Human Immuno deficiency Virus
HS	Health Stations
ICRS	International Council of Red Cross Society
IEC	Information, Education, Communication
ICPD	International Conference on Population Development
LBW	Low Birth Weight
MCH	Maternal and Child Health
MM	Maternal Mortalities
MOH	Ministry of Health

NGOs	Non – Governmental Organizations
ORS	Oral Rehydration Salt
PCP	Pneumocytic Carni Pneumonia

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

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 diversed people who live with in the boundary of the community.

Social system: the various parts of communities' social system that interact and include the heath 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.

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 – esteecuse l(e)-0.90vironmeneHealth i.0011 Tc0.0981001 Tc-0.0001 Tw[and sar6t)-1

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 ease or in77, in thoy4ns tI0 int i.vswaIn th.vswaIn the Theo person tI0 inIlln[Manyy hol4(y

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.

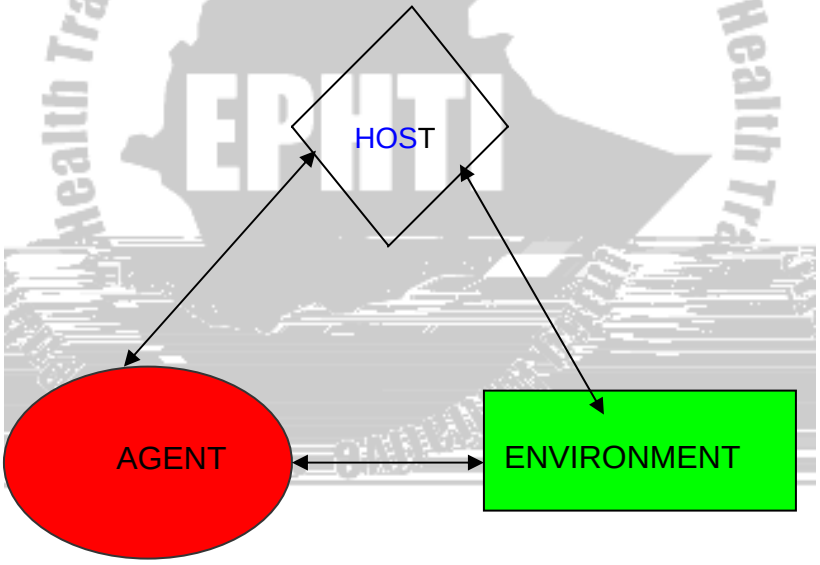


Fig1. Host – agent – environment model.

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.

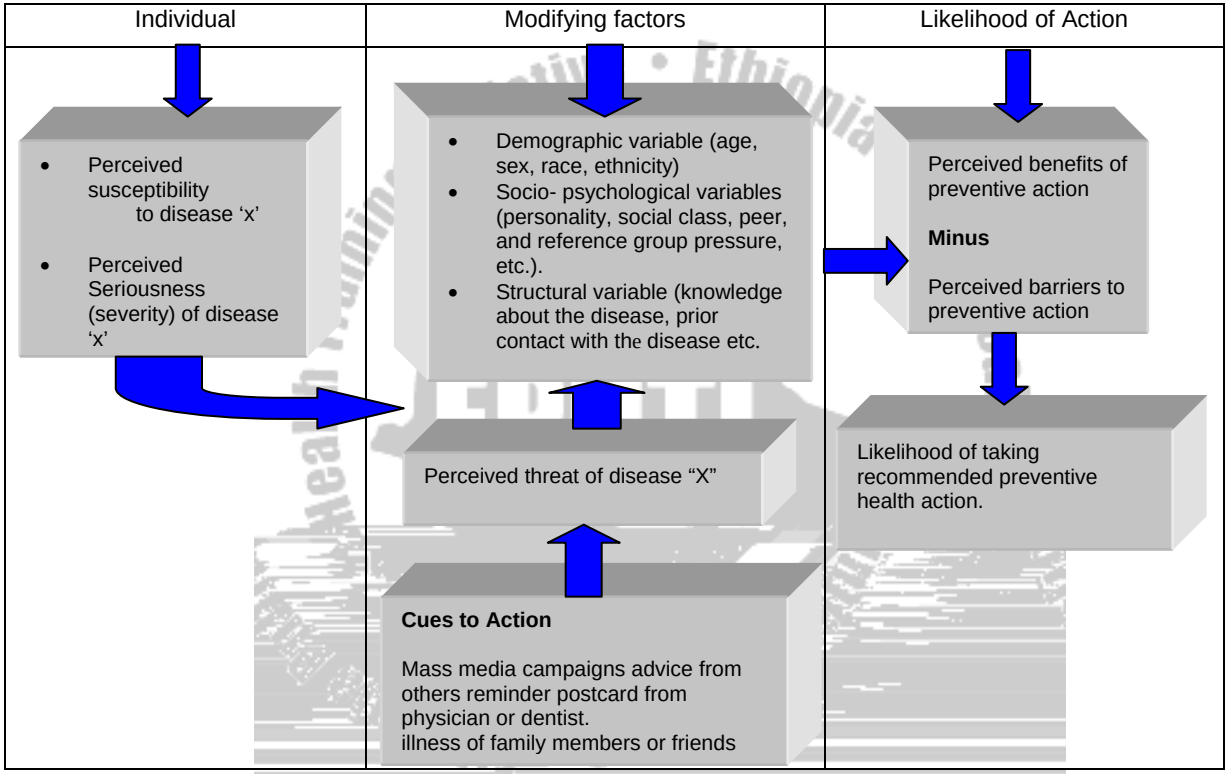


Fig.2 Health- belief model

Health Training Initiative • Ethiopia Public Health Tra
EPHTI

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 automistic approach of contemporary science. An automistic 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

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 more 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 tying out of these options in the search of high level wellness.

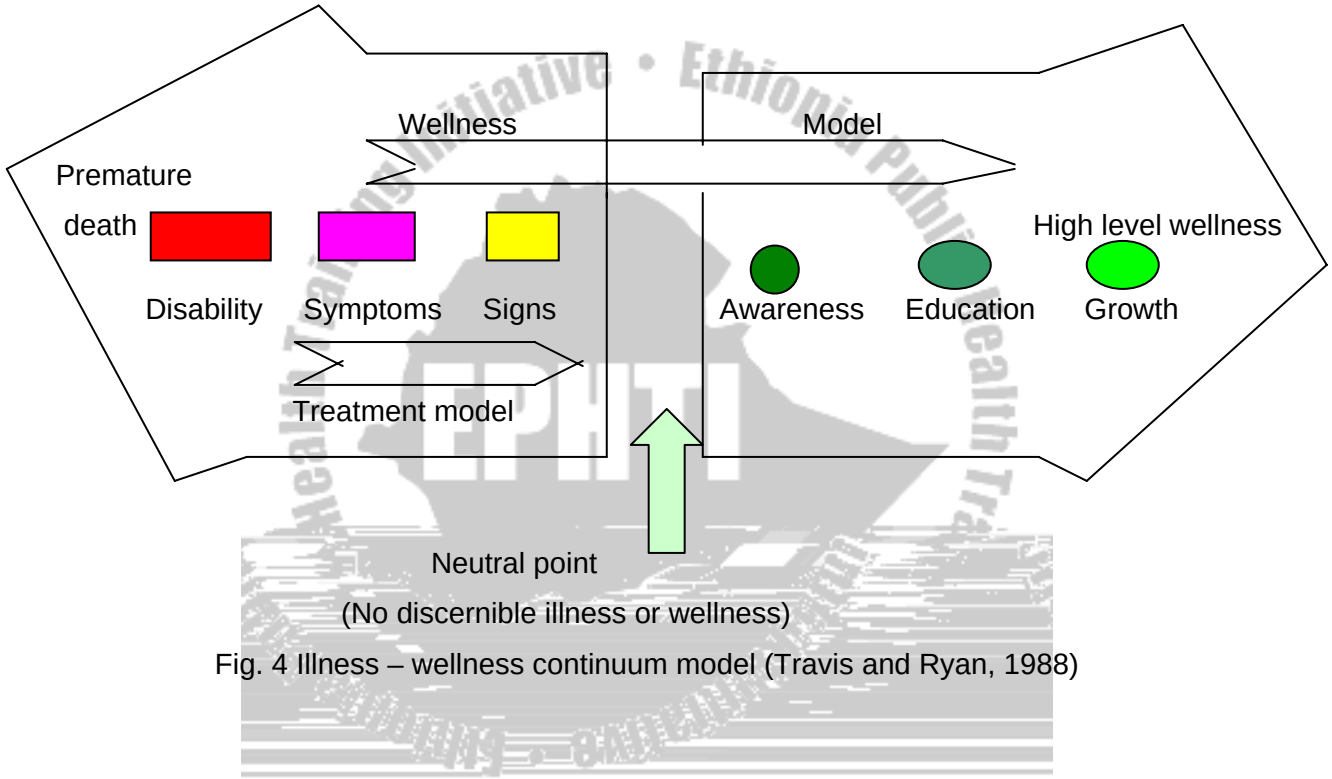


Fig. 4 Illness – wellness continuum model (Travis and Ryan, 1988)

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 divisions 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

Nursing concepts	Acute care setting	Community based setting
Client	Client or patient separated from family and characterized by disease	Client seen in the content of the family and the community
Environment	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.
Health	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.
Nursing	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

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

Review question

- Discuss the basic concepts in community health

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.

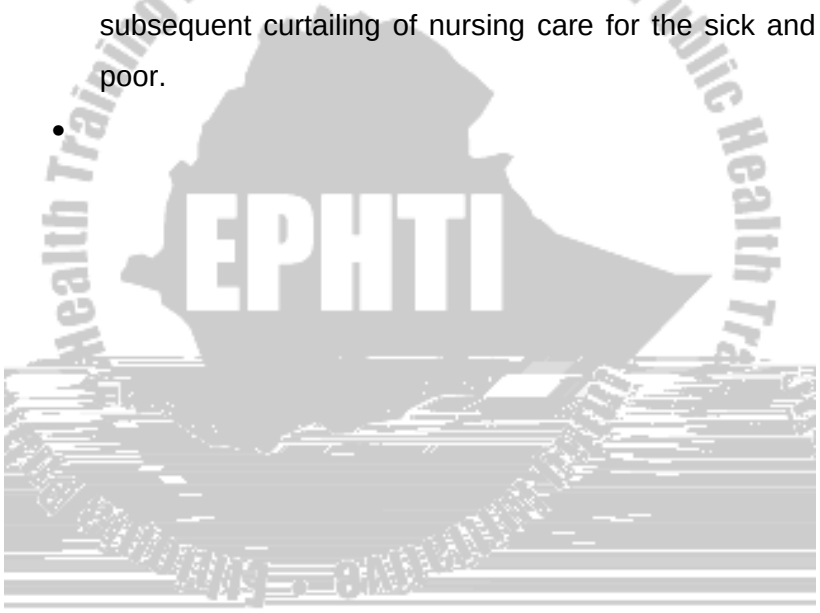
Community health nursing is the product of centuries of responsiveness and growth. Its practice was adapted to accommodate the needs of a changing society, yet it has always maintained its initial goal of improved community health. Community health nursing development has been

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

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.
-



Health Training Initiative • Ethiopia Public Health Tra
EPHTI

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

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?

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).

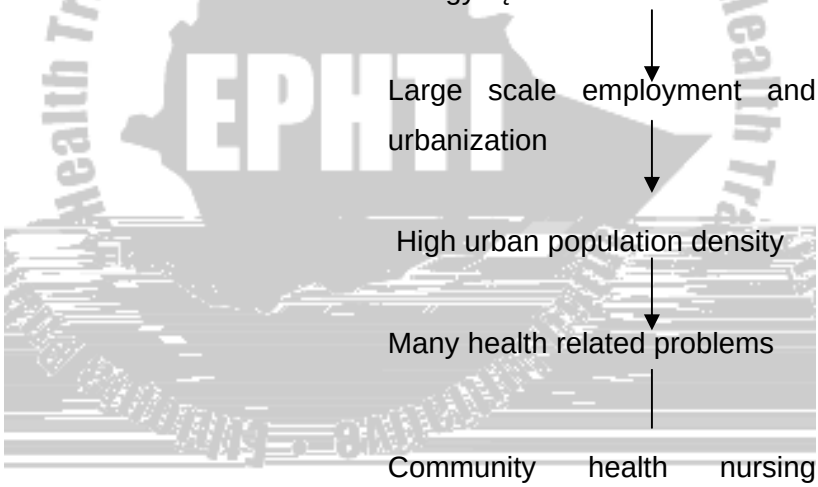
It is a synthesis of the body of knowledge from the public health sciences and professional nursing theories to improve the health of communities and vulnerable populations (American Public Health Association, 1992). Community health nursing is grounded in both public health and nursing sciences, which 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 Ą industrialization



Large scale employment and urbanization

High urban population density

Many health related problems

Community health nursing growth and development

Ethiopia Public Health Training Initiative
EPHTI

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.

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

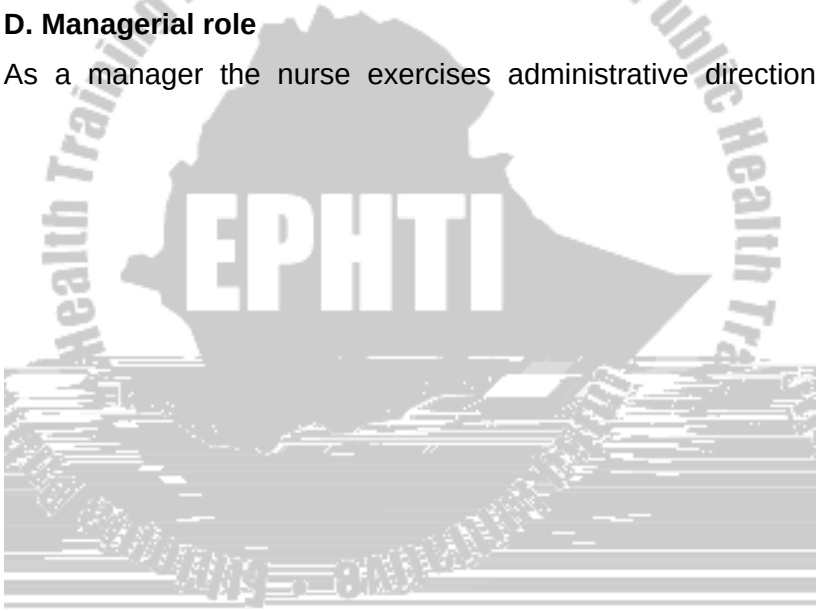
The issue of clients' rights is important in health care today. Every patient or client has the right to receive just equal and humane treatment. However, our present health care system is often characterized by fragmented and depersonalized

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 some one to explain what services to expect and which services they ought to receive.

D. Managerial role

As a manager the nurse exercises administrative direction



F. Collaborator role

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)

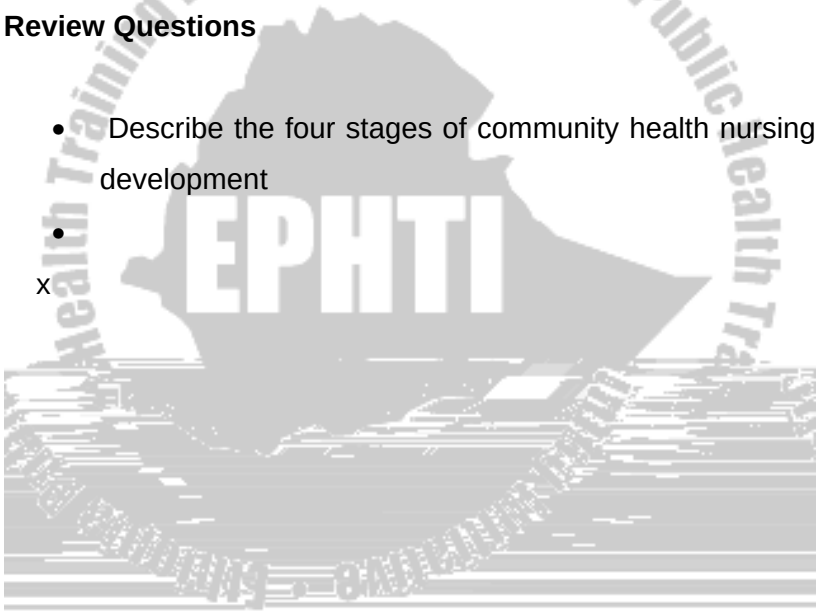
Social institutions (schools, Prisons, Orphanages)

The community at large

Review Questions

- Describe the four stages of community health nursing development
-

x



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:

secondary settings. The health professionals, including physicians and nurses tend to be highly specialized, and they

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 lessen 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:

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.

Surgical practices in traditional medicine

Amputation

3.3.2 Modern Medicine in Ethiopia

Prior to the 19th 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 Germen Lutheran Missionary (GLM) by the name of Peter Heillng 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

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

Health Training Initiative • Ethiopia Public Health Tra
EPHTI

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.

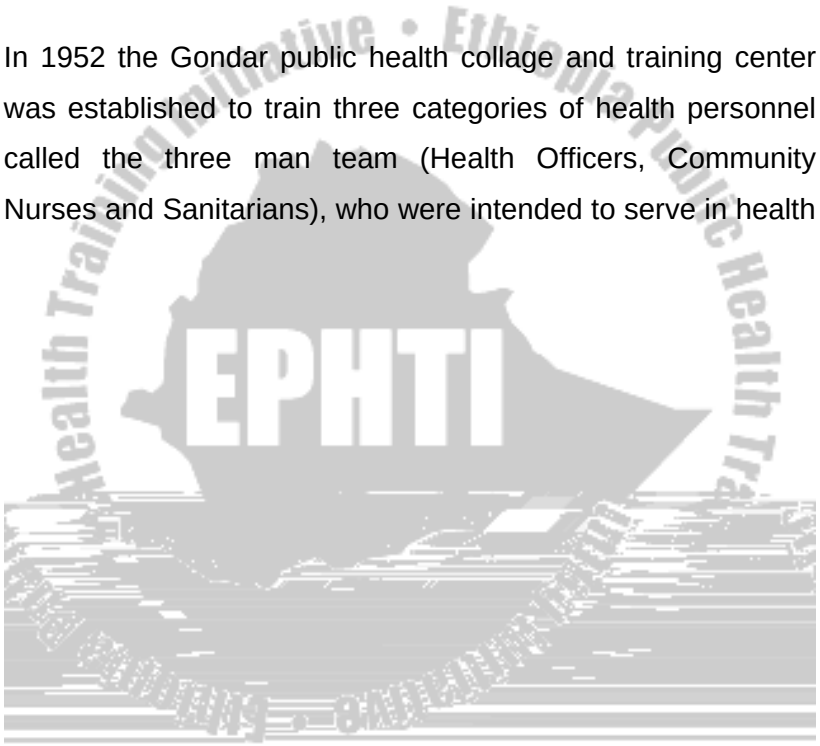
The first Ethiopian graduate nurse was princess Tsehai, Emperor Haile Selassie's youngest daughter. She had her training in England at the Great Ormond Street Hospital for Children where she graduated as children's nurse in 1939 and later at Guy's Hospital in London. She was married and lived with her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



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

Health Training Initiative • Ethiopia Public Health Tra
EPHTI

Environmental heath workers	1169
Laboratory Technicians	2403
Radiographres	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 assistant 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 2nd 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

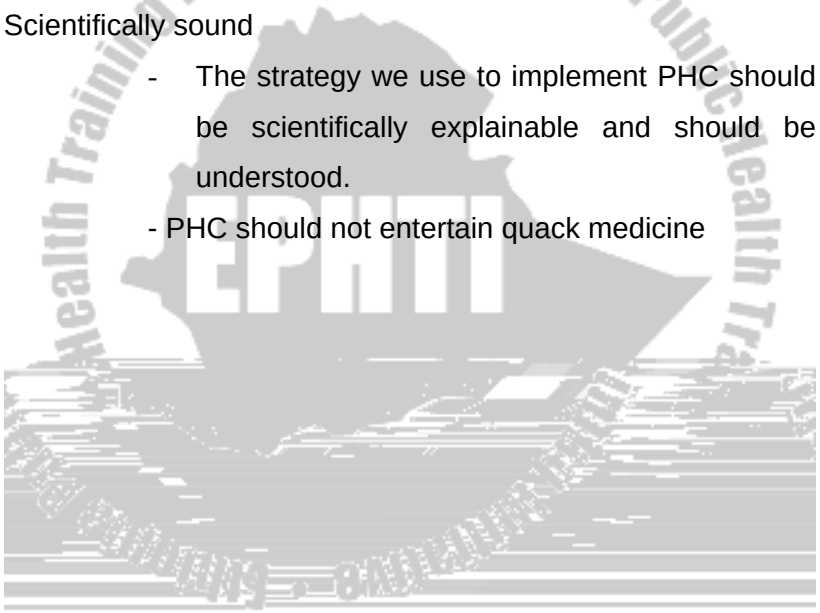
Essential health care provided through PHC is basic and indispensable

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



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.

If was wrongly conceived that health for communities can 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 with in 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

1uia.imi1i /TT2 c0v -1.(2465TT2 n-)T1T6(justice)]TJ/TT4 1 Tf4.574 -1.7322 Tc0

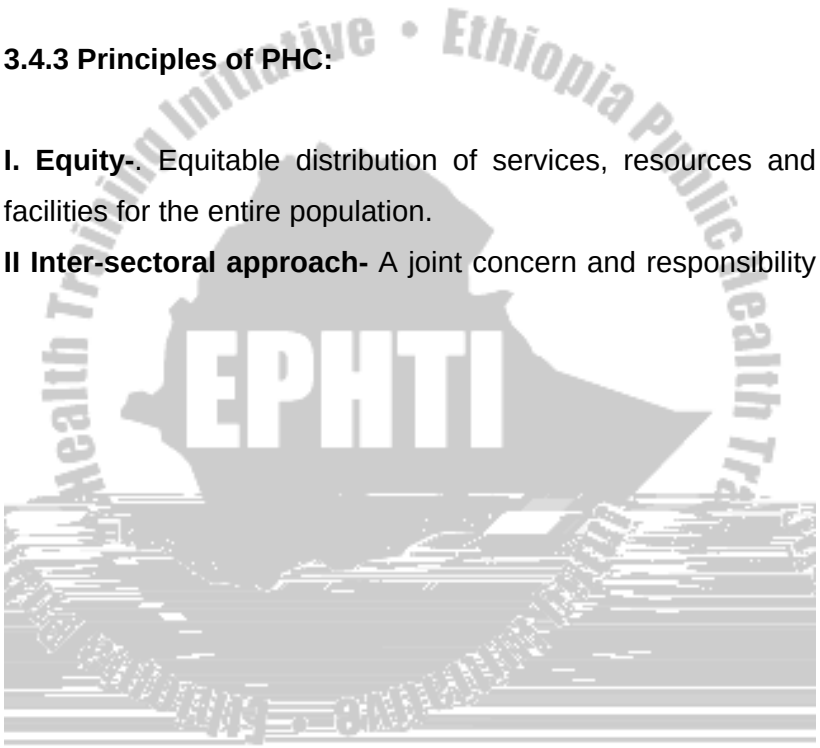
iduals, Tw[d)pmehns.

- 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



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 prpecially 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 circum stances 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

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.
-

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 be fore it has a chance to occur e.g. immunization
  - secondary prevention:- include early detection of actual or potential health problems e.g. Screening hypertension.
  - Territory 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 in equitable 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

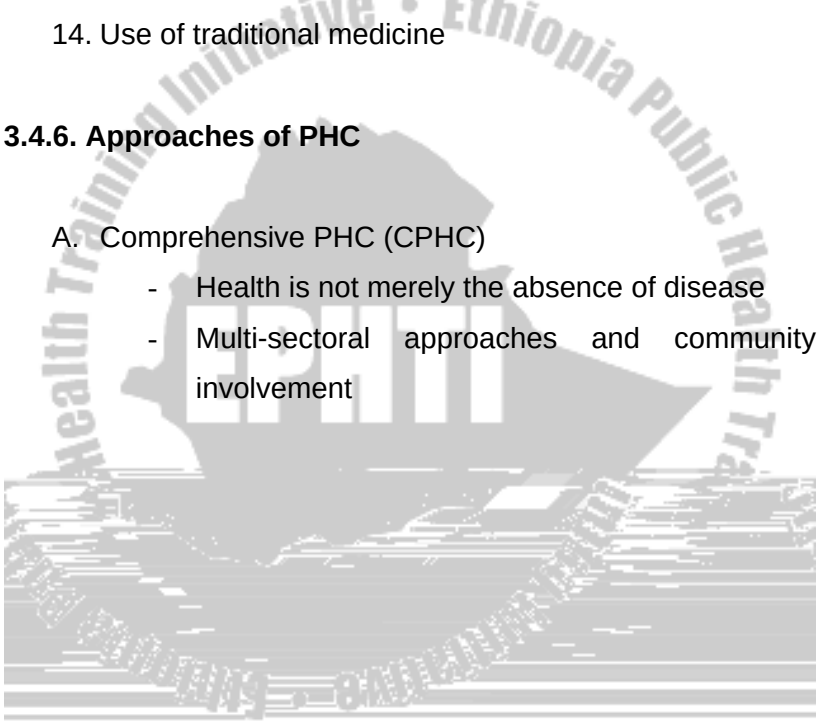
1. Health education
2. Promotion of food and proper nutrition
3. Adequate supply of safe water and basic sanitation
4. MCH including FP
5. Immunization
6. Prevention and control of locally endemic disease
7. Rx of common diseases and injuries
8. Provision of essential drugs

Components added after Alma-Ata declaration

9. Mental health
10. 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



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 (1^0)	1^0, 2^0 and 3^0
Intermediate	Zonal Regional	Zonal hospital Regional hospital	2^0	1^0 , 2^0 and 3^0
Central	National	Central, referral teaching hospitals	3^0	3^0

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 an 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

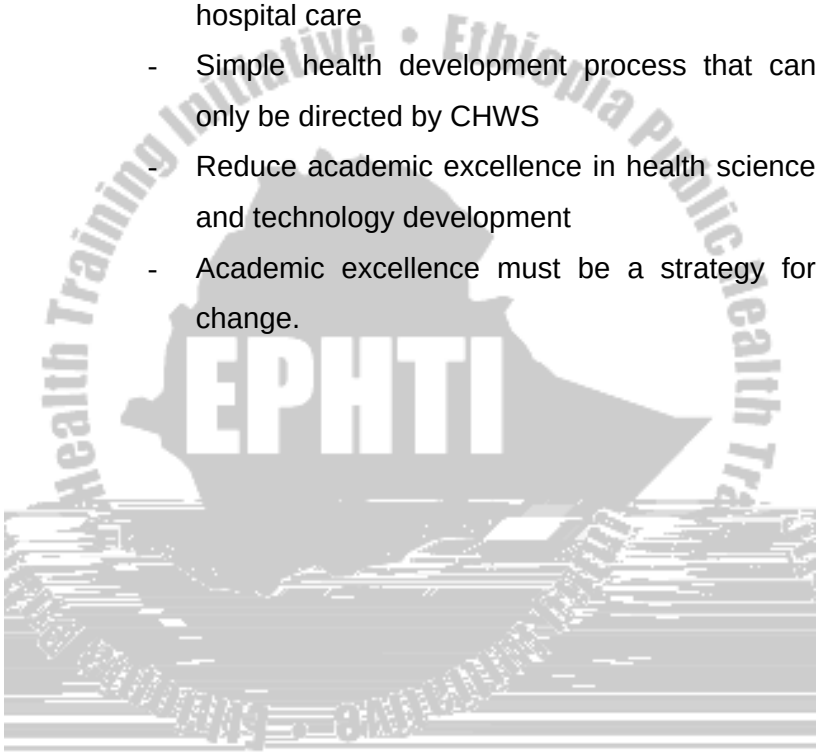
Major Problem Encountered

- Absence of an infrastructure at the district level to implement PHC
- Difficulty in achieving intersectoral collaboration
- In adequate 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.



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 change

Health Training Initiative • Ethiopia Public Health Tra
EPHTI

- Currently 82 % Ethiopian population is believed to get

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

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 JT0.0011 Tccg services in focv

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**

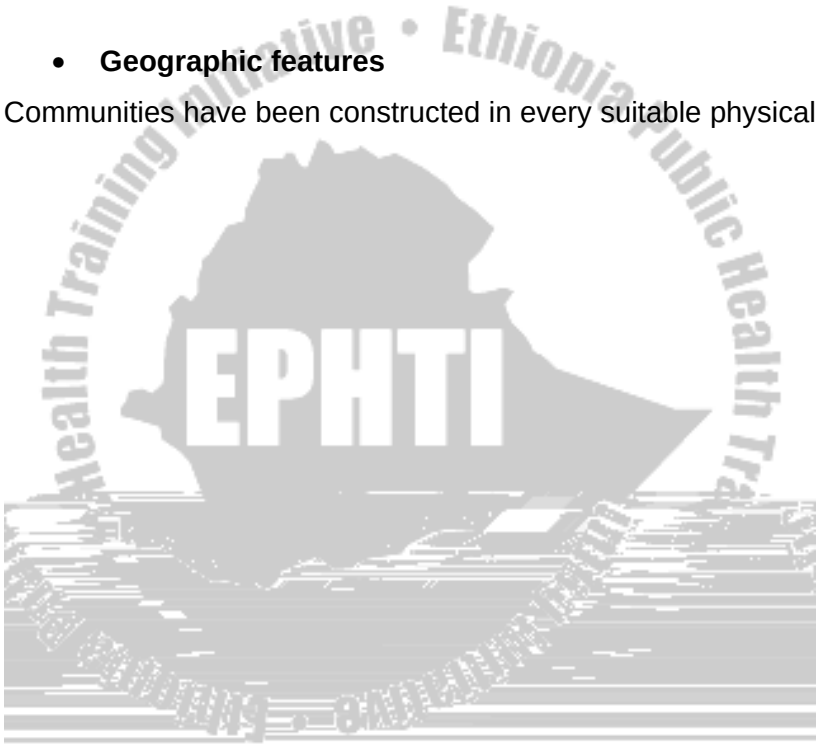
To talk about community in any sense, one must first describe its boundaries. It serves as basis for measuring incidence of wellness and illness and for determining spread of a disease.

- **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



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 a5628 -1.792( )Tjtk(planf one that)6

Health Training Initiative • Ethiopia Public Health Tra
EPHTI

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.

Health Training Initiative • Ethiopia Public Health Tra
EPHTI

System review: hosing 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

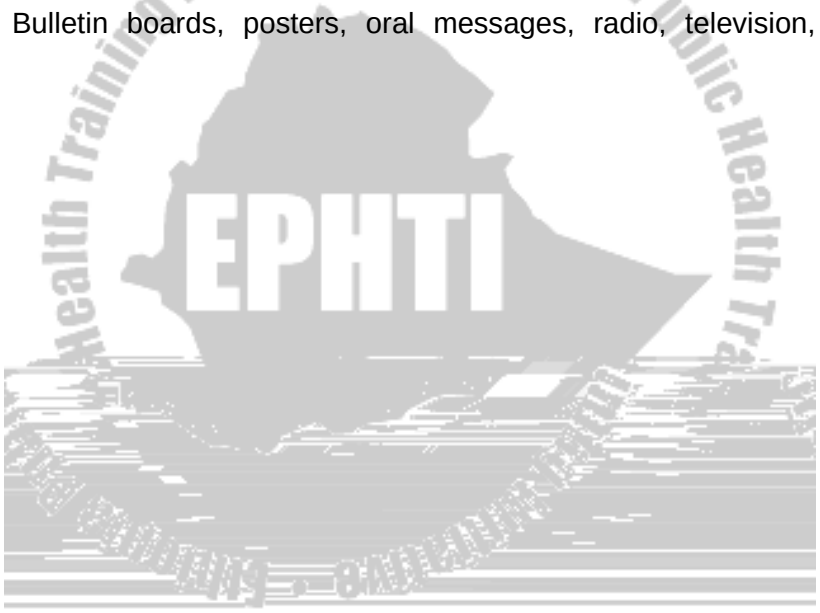
air services. Frequency and affordability of public/private transport, and standard of roads.

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,



Community Assessment Tool (Questionnaires)

Population perspectives

Á

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 eduacational

Values beliefs, and religious practice of the people

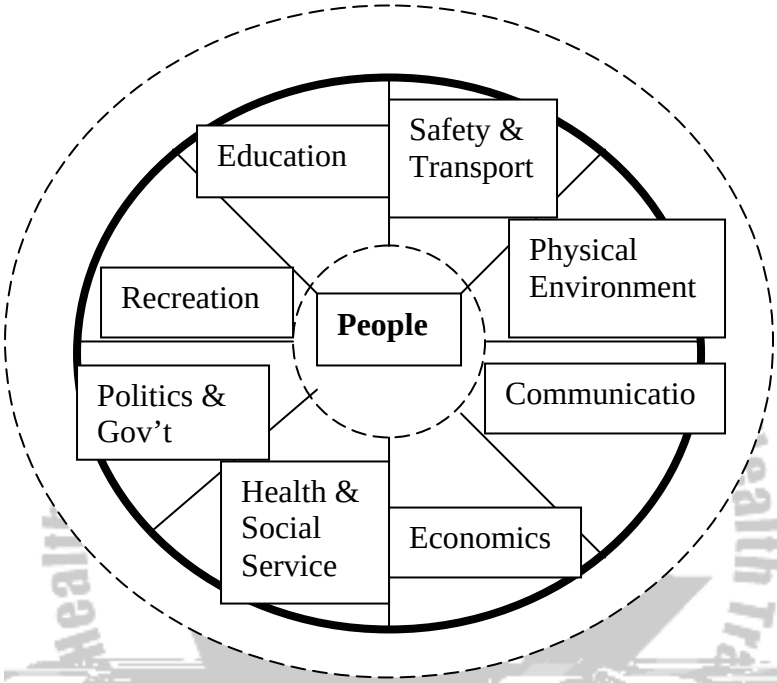


Fig. 6 Community assessment wheel, the assessment segment of the community –as- partner model (source, Anderson, 1996)

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
- marinating its strength through facilitation, education, organization, consultation and direct care.

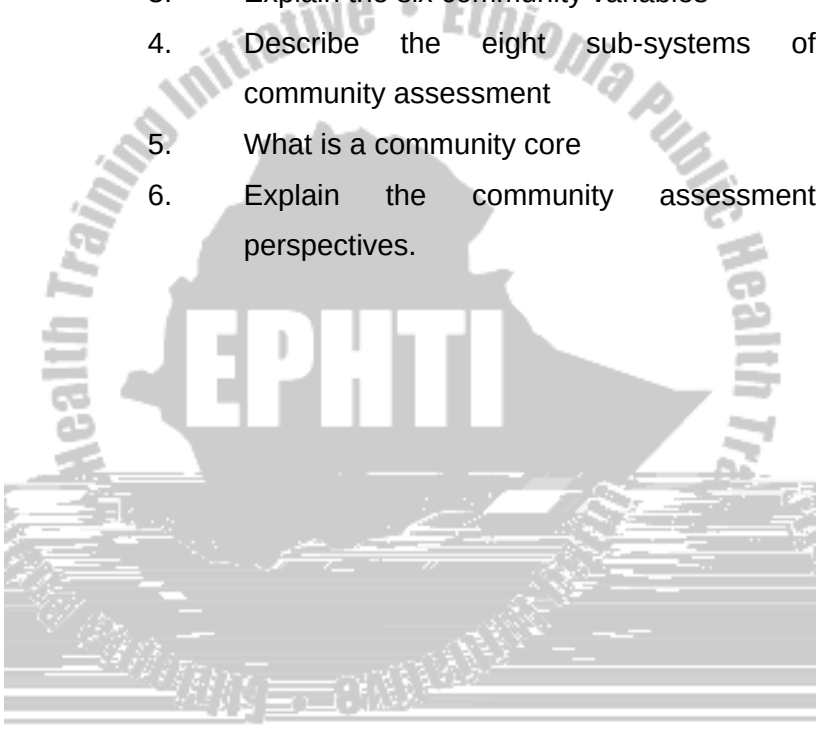
4.2.5. Evaluation

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 weather 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 ExsuHC in imprpono 4s

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:

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 advert 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.

- Á 1976 - UN started advocacy about women equity social & economic development.
- I1978 - 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

Health Training Initiative • Ethiopia Public Health Tra
EPHTI

Health Training Initiative • Ethiopia Public Health Tra
EPHTI

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)

Health Training Initiative • Ethiopia Public Health Tra
EPHTI

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)

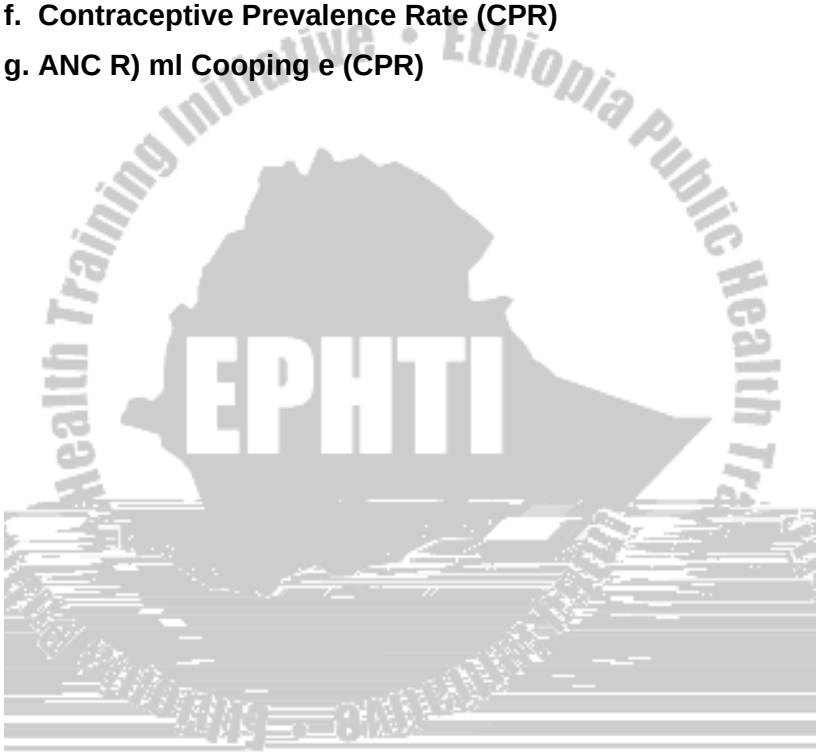
a. Perinatal mortality rate: the total number of still-births plus the number of deaths under one week old, per 1000 birth or

Health Training Initiative • Ethiopia Public Health Tra
EPHTI

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 R) ml Cooping e (CPR)



- 99% of there 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.,
  - Á Hemorrhage – 25%
  - Á Sepsis – 15%
  - Á Unsafe abortion – 13%
  - Á Hypertensive disorder – 12%
  - Á Obstructed labor – 8%
  - Á 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 child hood to adulthood
- Enjoy life before responsibilities of adulthood begins in a way which doesn't affect their life. Skills

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.-
    - Á Unsafe sex, unwanted pregnancy:
    - Á STIs/HIV, criminal offences
    - Á Unemployment, poverty, crime
    - Á Poor socioeconomic development.

6.3. Components of ARH

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

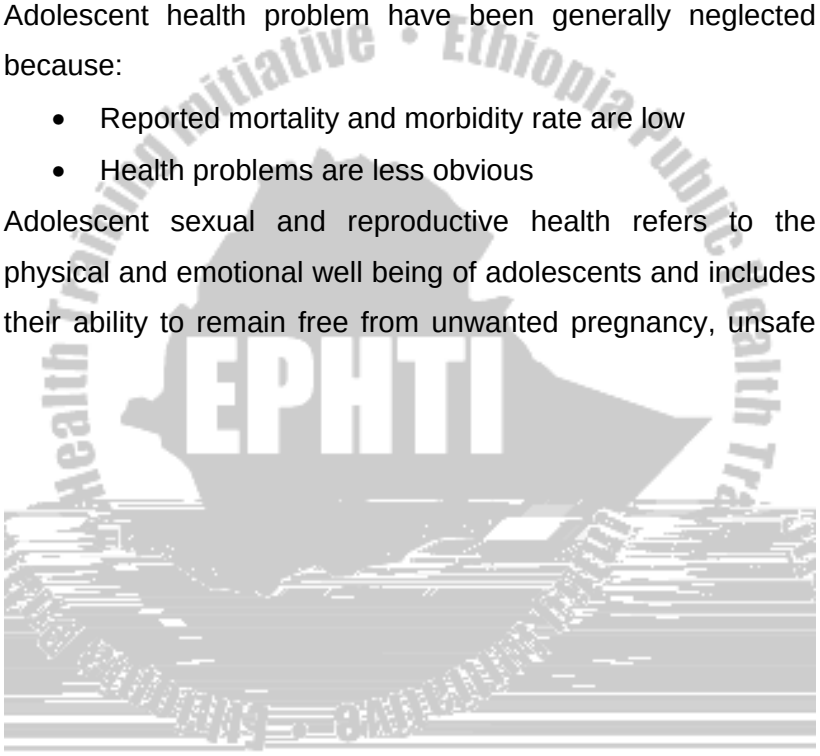
- Early marriage
- Sexual violence (Gender-violence)

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



- 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 1st 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 respe[redacted]f and others

Non-expl age dMutuality, honeslity02 /oB9nk(09g795iAbiatTw)54up1hup1 -6

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

STF401 Tm0.0007 Tc(135)Tj/TT6 1 T .72 Tm-05135

Health Training Initiative • Ethiopia Public Health Tra
EPHTI

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

- Acute or chronic alcoholism
- Respiratory tract infection
-

- Á Post traumatic stress disorders (PTSD)
- Á 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

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

Objectives of SHS

- Promote health and develop concern of there own heath.
- Detect disease and deviation from normal heath at an early stage and arrange for promote, 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 these 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

- Á Simple first Aid facilities
- Á Accident control – like –fall injury

-burn injury

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

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

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

8.4. School health program

A planned and organized school health program includes:

Á

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

8.5. Common health problems among school children

- Á Accident and injuries
- Á Communicable diseases
- Á Behavioral problems

8.6. Role of community nurse in school Health program

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

- Control the development and maintainace of a safe and healthful environment.
- Demonstrate technique for teacher's heath 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:

- 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

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 discomfor

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. How ever, it is a physiologic or psycho logic 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 on set of withdrawal symptoms.

- It is a compulsion to take subs. To prevent on set 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 require periodic or continues exposure to a substance to produce pleasure and or avoid discomfort.
- Is a continues or intermittent craving of a substances (e.g.,. coffee, chat…)

Physical (physiological) dependence:

- It is a body's biological need evidence by tolerance or with drawl 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

Ethiopia Public Health Training Initiative
EPHTI

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 ofdependence 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 subs. Taking behavior in terms of its on set, termination, or level of use.
c. A physiological with drawl state when substance users have ceased or been reduced, as evidenced by: the characteristic with drawl syndrome for the substance or use of the same (or a closely

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
-

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 Ą broken families Ą prostitution
ii. Crime (theft, hijacking, rape…)
iii. Violence
iv. Accident
v. Dangerous vagrancy

Ethiopia Public Health Training Initiative
EPHTI

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:

- sters ug drer .2(mappl)-yrevocess]TJ1.301803<0078>Tj/TT2

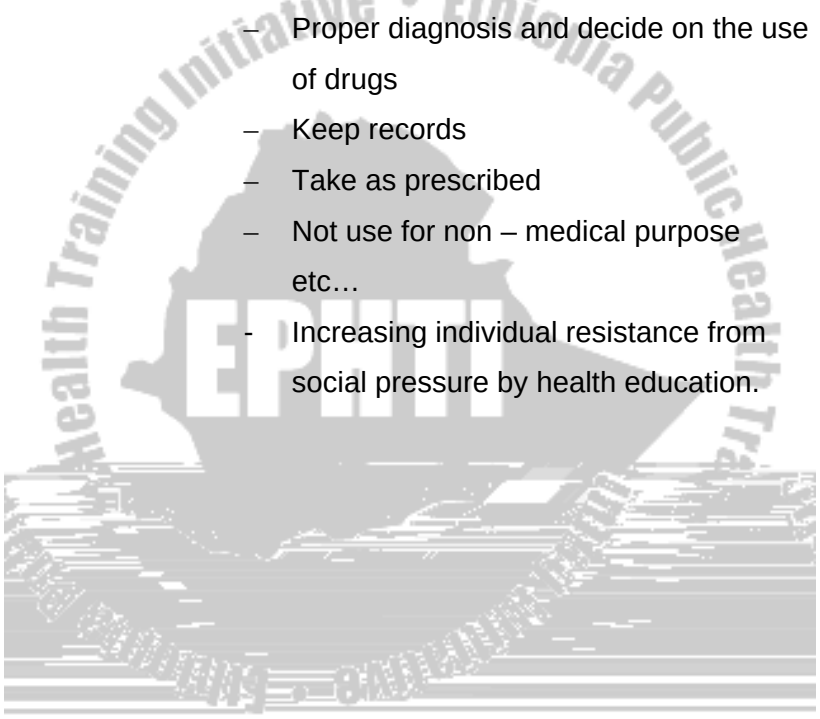
Demand reduction

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

Rational prescribing, dispensing and uses of narcotic and psychotropic drugs

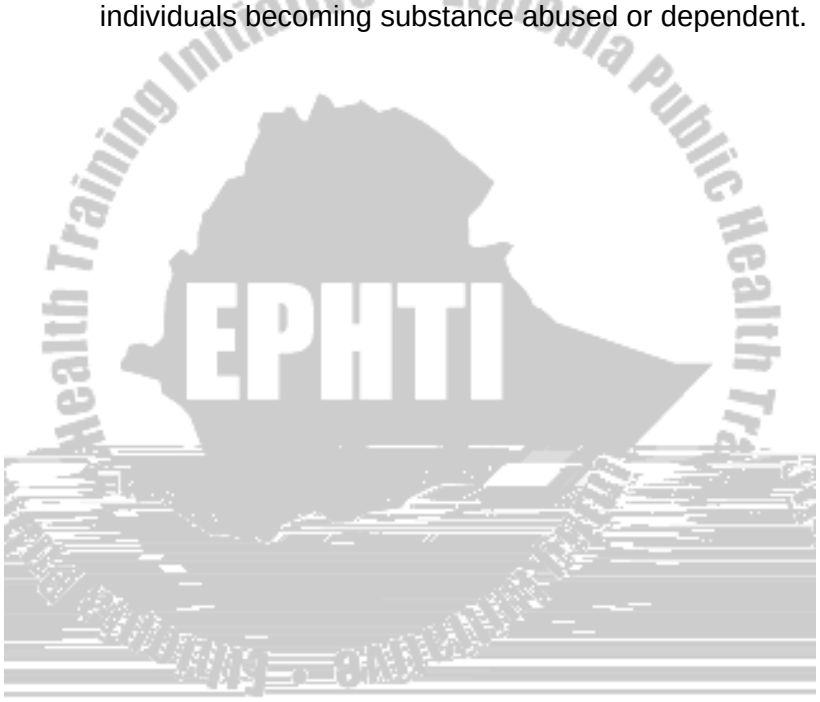
- Proper diagnosis and decide on the use of drugs
- Keep records
- Take as prescribed
- Not use for non – medical purpose etc…

- 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.

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

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.

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 chilled
- 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. Discus 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.

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

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

12.2.3. Psychological problem

-Dementia

-Dementia

Review question

1. Describe the major health problems of elderly population
2. Discus some of the health maintenance program for 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

Communiletion oAcquir2(eI2.7(eHIV/Aciency Syndro)-)]1 me -0.45T*-901. 0 TD 0103

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

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 lasting 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 I minor sign.

Major signs

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

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. Pnemocystis Carinii Pneumonia (PCP)

Commonest opportunistic infection occuring 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)

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

Antiretroviral Failure

- Main causes:

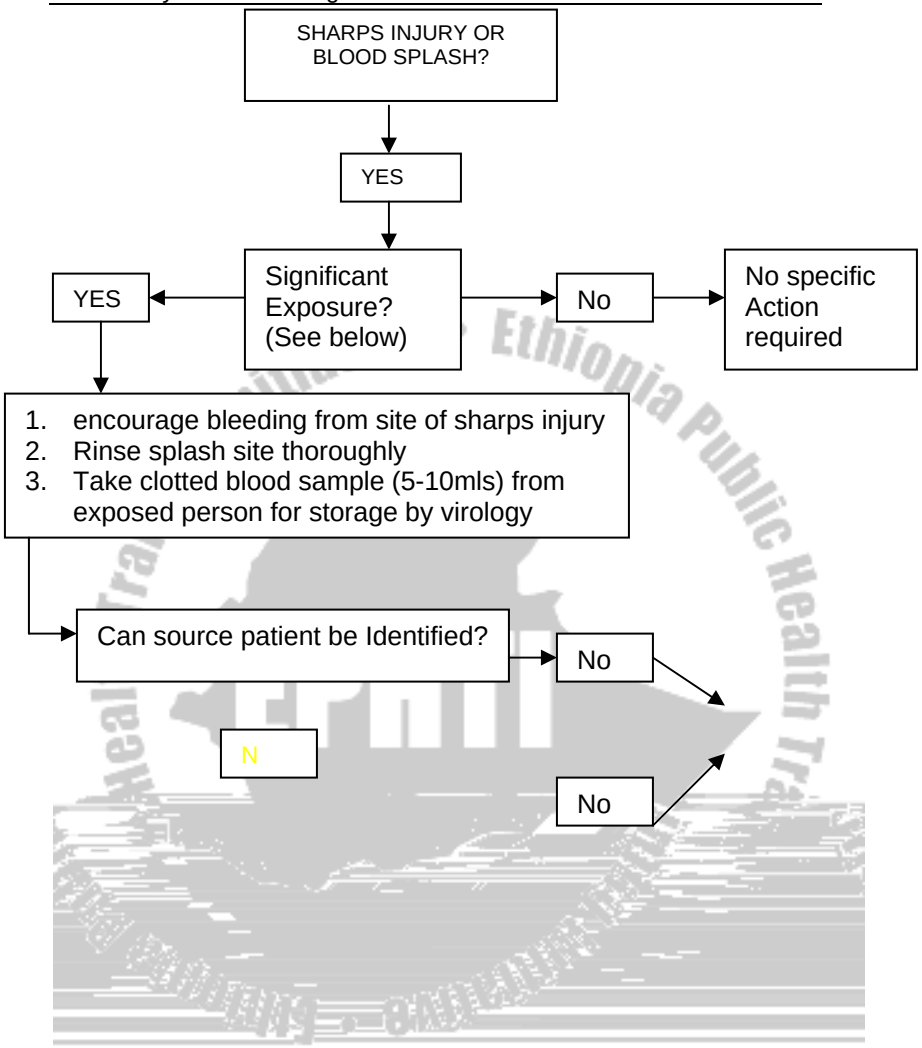


Fig. 7 Post exposure prophylaxis of HIV infection

Primary prevention

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

Care support and treatment

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

- Exclusive breastfeeding associated with early weaning
- Replacement feeding

Á Linking HIV prevention to care activities

13.5. NUTRATION 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

	Nutrition Aims	**Nutrition Intervention**
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:

FOOD SAFETY (CD4<200-boil drinking water)	1. Avoid raw meats 2. Avoid unpasteurised dairy products 3. Ensure foods are thoroughly reheated 4. never eat foods past their sell-by date, or foods that are mouldy. 5. Wash all fruit and vegetables 6. Keep cooked and uncooked foods separate 7. Keep pets out of the kitch and away from food 8. Follow good hygiene practices such as washing hands before cooking etc.
HEALTHY EATING	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. 4. Stop smoking 5. Moderate alcohol intake (social drinking can help reduce stress & 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. 6. Exercise – decrease stress, decrease fats in blood, improve muscle mass and strength, decrease fat on tummy and bottom

	2. Controversial 3. Risks –interfere with drug treatments, toxicity. 3.1 Garlic –(good for the heart) inhibits Saquinavir and possibly Protease Inhibitors 3.2 St John's Wart –(depression) not suitable with Protease inhibitors or NNRTI's. Decrease the levels of indinavir. 3.3 Vit E-megadoses have known adverse effects, ? Amprenavir 3.4 Vit A- Liver & bone damage, vomiting, hadaches 3.5 Vit C Kidney stones, diarrhea, hardening of the arteries, careful wit indinavir 3.6 Vit B6-Nerve damage, periferal neuropathy 3.7 Zinc-copper deficiency, neutropenia, may increase HIV related symptoms 3.8 Selemium – immune suppression 3.9 Calcium-hypercalcaemia

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 taking 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 the 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 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 helps 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:

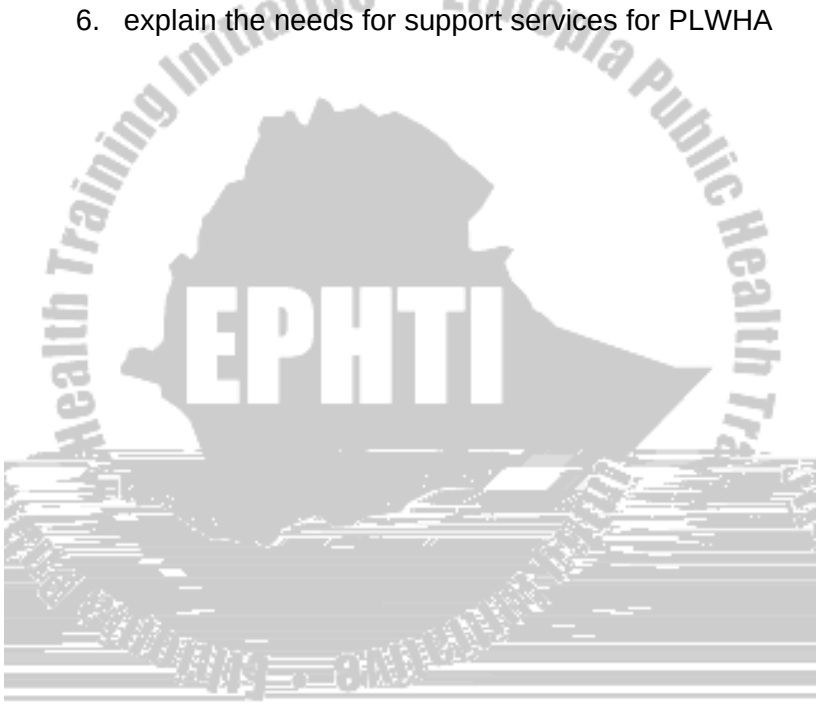
1. **Dispel myths and misinformation.** Network with the media and other health professionals to provide information, education and communication to combat ignorance, fear and stigma associated with HIV/AIDS
2. **Lobby policy makers.** Advocate for access to prevention, counseling, care and treatment, 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, mobiles 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 oldsu43.46 Ttype
hortcv

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

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.

Ethiopia Public Health Training Initiative
EPHTI

5. The health team function autonomously in the family health care provision. The family and the team develop a positively interpersonal relation ship 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
- Mebendazile
- 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

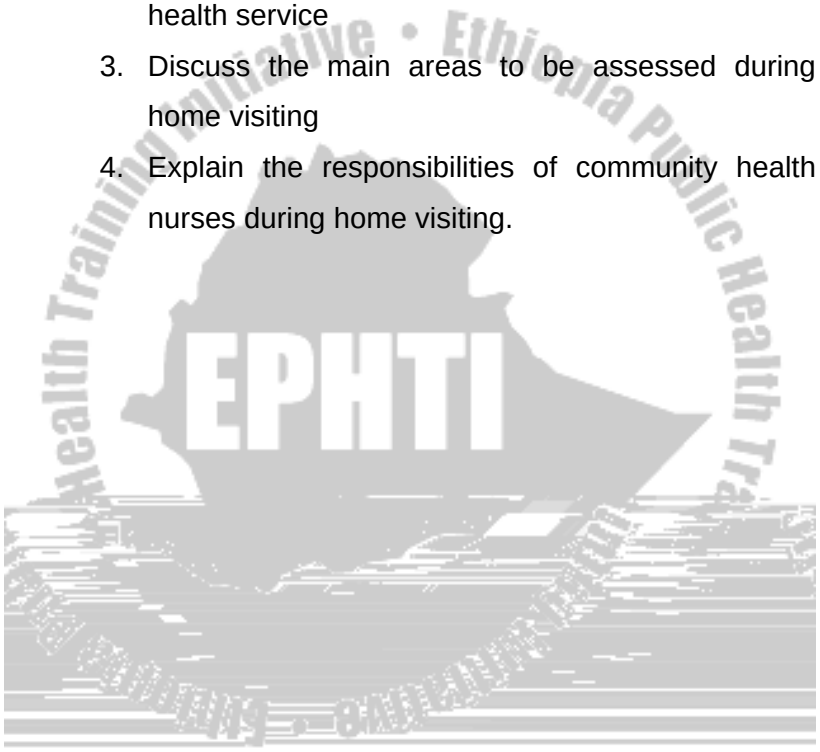
Report all broken equipment

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.



References

1. Stanhop, L. Community & Public health Nursing, 5th edition , 2000
2. Sheila, T. Barhana, R. Sarah, A. Community Health

12. Barbara W. Judith A. Community Health Nursing concept & practice 4th edit. 1996
12. Module on Sub. Abuse for the Ethiopian Health Center Team, University of Gondar
13. Bonnie Bullough, Bollugh, Nursing in the community NewYork. CV. Mosby Company 1990
14. Daviec, J.B. Meredith. Community Health Preventive mediciene & social services 4th edi.
15. Federal Democratic Ethiopia Health and Health Related indicators, MOH, 2006.