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QUESTION ONE

1. How does the concept of health translate into health promotion?

The process of enabling individuals to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

1. What advantage does the WHO definition have over the western medical model concept?

Since WHO defines health as ‘a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity’ (WHO, 1948).

The WHO definition has advantages on the western medical model because it focuses on

* Risk behaviours and healthy lifestyles
* Emphasises health education – changing knowledge, attitudes and skills
* Focuses on individual responsibility
* Treats people in isolation of their environments
* Health is the absence of disease
* Health services are geared towards treating the sick and disabled
* Health workers diagnose and treat and sanction ‘the sick role’

The belief that science could cure all illness and disease has remained a core element of modern medicine. This concept of health may be easier to understand as it makes health an attribute you can measure simply by determining if a disease is present or not. However the strong emphasis on the absence of disease as an indicator of good health, and the overdependence on the influence of medical science in health, ignores the power of other important influences. The medical model also focuses on aetiology and the belief that a disease originates from specific and identifiable causes. The causes of contemporary long-term chronic diseases in developed countries are often ‘social’. Medicine and medical practice thus recognize that disease and the diseased body must be placed in a social context. Nevertheless the professional training of many health care workers provides an exaggerated view of the benefits of treatment and pays little attention to prevention. In part this is due to the dominant concern of the biomedical model with the organic appearance of disease and malfunction as the cause of ill-health.

1. Most criticism of the WHO definition concerns the absoluteness of the word “complete” in relation to wellbeing. Firstly the problem is that it unintentionally contributes to the medicalization of society. The requirements for complete health “would leave most of us unhealthy most of the time.” Therefore it supports the tendencies of the medical technology and drug industries, in association with professional organizations, to redefine diseases, expanding the scope of the healthcare system. New screening technologies detect abnormalities at levels that might never cause illness and pharmaceutical companies produce drugs for “conditions” not previously defined as health problems. Some interventions tend to be lowered for example, with blood pressure, lipids, and sugar. The persistent emphasis on complete physical wellbeing could lead to large groups of people becoming eligible for screening or for expensive interventions even when only one person might benefit, and it might result in higher levels of medical dependency and risk.

The second problem is that since 1948 the demography of populations and the nature of disease have changed considerably. In 1948 acute diseases presented the main burden of illness and chronic diseases led to early death. In that context WHO articulated a helpful ambition. Disease patterns have changed, with public health measures such as improved nutrition, hygiene, and sanitation and more powerful healthcare interventions. The number of people living with chronic diseases for decades is increasing worldwide; even in the slums of India the mortality pattern is increasingly burdened by chronic diseases. Ageing with chronic illnesses has become the norm, and chronic diseases account for most of the expenditures of the healthcare system, putting pressure on its sustainability. In this context the WHO definition becomes counterproductive as it declares people with chronic diseases and disabilities definitively ill. It minimizes the role of the human capacity to cope autonomously with life’s ever changing physical, emotional, and social challenges and to function with fulfilment and a feeling of wellbeing with a chronic disease or disability. The third problem is the operationalization of the definition. WHO has developed several systems to classify diseases and describe aspects of health, disability, functioning, and quality of life. Yet because of the reference to a complete state, the definition remains “impracticable, because ‘complete’ is neither operational nor measurable.

QUESTION TWO

1. Since community mobilization involves community participation, so when mobilizing a community all I have to do is, By providing resources, training, and technical support, Advocate for community help build the capacity of a part which grantees to establish these fully functioning and highly effective groups of “change agents” and develop strong leaders who are able to effectively manage all aspects of the initiative. For example a route or road which most of the individuals use for them to reach a health facility is in bad shape the community is involved so that the road can be fixed because everyone benefits from the road.
2. Health promotion enables the community to have control over their health. These health concerns may prove to be difficult to navigate and identify. But in this case, in order to isolate these concerns so that they can be tackled the following must be done so that these health concerns are brought to light.

**Community health concerns**

* Health status related problems

These may be described in terms of increased or decreased morbidity, mortality, fertility or reduced capability for wellness

* Health resources related problems

Described as the lack or absence of manpower, money, materials, or institutions necessary to solve health problems.

* Health related problems

This maybe described in terms of existence of social, economic, environmental, and political factors that aggravate the illness-inducing situations in the comuinty

**Disempowerment**

There are real difficulties in involving people who are not used to making decisions, some people feel powerless, and some are over dependent on others. People given the opportunity to lead others may be unwilling to allow others to participate in decision-making. Political, religious and commercial interests and this may discourage community participation.

**Conflicts and divisions**

Most individuals include people from a wide range of social and economic backgrounds, and they associate with people from different backgrounds poor or rich with different needs and interests all from different ethnic or religious groups. A community project designed for the common good may in fact be divisive if it is seen as benefiting one section of the society more than another. Where paid employment is involved, jealousies and conflicts can orccur. There may also be conflict between individual and group interests. For example, in a highly densely-populated urban area, there’s a need to relocate some houses to make sewer lines or drainage channels that would benefit everyone. Some questions will arise on “How will the owners of the houses will be compensated” this may rise to conflicts and divisions with the individuals if proper leaders are not chosen to educate the people about the relocation of their houses.

**Poverty**

Lack of resources, ill-health and poverty prevent people from participating. Many people work seven days a week for long hours just to be able to feed their families, and may not have the time to participate. As the poorest members of the community, these are often the most vulnerable people and their opinions are most valuable. Special efforts must be made to enable them to participate.

1. Prioritizing the health of the community is the vital part of community mobilization and health promotion by doing so certain measurements or considerations should taken in account for community health concerns. The following should be should be of help to prioritize their health concerns.

* **Nature of the condition or problem presented**

Problems are classified as health status, health resources or health realeted problems e.g diseases outbreaks or environmental conditions such as pollutions

* **Magnitude of the problem**

Refers to the severity of the problem which can be measured in terms of the proportion of the population affected by the problem e.g the covid 19 outbreak it should be looked at , so that affected people are known and this should help in what will be done such as making an evacuation plan for those not affected and screening.

* **Modifiability of the problem**

This refers to the probability of reducing, controlling or eradicating the problem.

e.g With covid 19 outbreak infected people should be put in quarantine and put up certain policies like people should not make unnecessary movements to avoid the spread of the disease.

* **Preventive potential**

The probability of controlling or reducing the effects posed by the problem.

* **Social concerns**

This refers to the perception of the population or the community as they are affected by the problem and their readiness to act on the problem. This is where the community has to be involved and list their concerns on where the problem should fixed /and how the community will help e.g such as helping with communication or passing information on how the covid 19 diseases can be deadly and how people should adhere to the polices and measurements put in place.

QUESTION THREE

1. Establishing the need for, and relevance of, the hygiene education activity through an assessment that is as participatory as possible, given the nature and urgency of

The situation;

* Should be aware that a hygiene education campaign may be aimed at some people who are not or don’t have any ideas about hygiene: in such circumstances, participatory learning techniques are considered.
* Selecting and adapting methods that will suit the characteristics and interests of a particular Target, or a religious group, etc.(E.g. fables about animals may be more suitable for children than adults).
* Establishing procedures at the outset for evaluating the effectiveness of the health Promotion campaign, by selecting appropriate indicators for measuring changes In people’s health status.
* Reinforcing the existing health practices that are beneficial and discourage those that are not of need.
* Choosing messages that are positive, attractive and based on what the comunity want and what they consider would be achievable.
* Involve the community with the production of their own teaching materials (This is educational in it and will ensure that such materials are relevant and culturally appropriate).
* use the effectiveness of young people and children in teaching and mobilizing others.
* Ill-health: messages and methods must not be judgmental.

1. The situation in the question can be tackled through:

**Mass communication**

Radio, audiocassettes, television, video, newspapers, placards, plays, puppet shows

And megaphones are effective means of communicating information quickly to a large number of people and creating awareness of a problem or idea. The relevance and impact of messages, and the effectiveness with which they are communicated, need to be evaluated by discussion with a sample of people. Following a disaster, mass media may be unavailable or at least severely disrupted. However, radios may be available, and in long-term emergency settlements it may be possible to produce a camp newspaper and to make arrangements with a nearby radio station to broadcast regular programmes on health issues.

**Teaching aids**

Appropriate teaching aids include printed materials, posters, films, slides, videos, murals, Flannel graphs and flip charts. These are useful when it come to transmitting information and as reference to the spoken words, but must be accompanied with interaction and personal contact with the members of the target audience. World Resources Institute (1990).

**Person-to-person contact**

Certain audiences may be found at clinics, food-distribution centers, Water-collection points and in some work eneviroments, where health workers and trained volunteers will be able to give advice. In non-emergency periods, health clinics, schools and workplaces may provide similar audiences. Meetings may be called for specific groups, or selected individuals may be brought together for focus group discussions on specific topics, and individual families may also be visited. The influence of existing local groups or social organizations can be very useful in increasing the impact of the information. This direct approach, particularly if it involves some interaction between health workers and individuals, is most effective in tackling specific issues and encouraging particular changes in behavior, and in checking that messages are seen as relevant and useful by the people concerned. Activities suitable for person-to-person exchanges or for small groups include the discussion of personal feelings and experiences, demonstrations, story-telling, role-playing, case studies and educational games (particularly in non-emergency situations). Cernea (1991)

**Environmental health messages in emergencies**

Following disasters, environmental health is concerned with areas that include water

Supply and sanitation, waste disposal, vector control, personal hygiene, shelter and food

Safety. These, in turn, may be subdivided and specific health messages identified. It is most important that only a small number of very important messages

Are chosen for communication, based on an assessment of health risks, to avoid

Confusing the target audience, and wasting efforts on behaviour changes that have little impact on health. Chambers (1994)

* **Parent training programs**

Despite a great deal of interest in programs to improve parenting skills, research into the effectiveness of such programs is still in it infancy. Again, social circumstances including poverty would appear to have a profound influence on the success or failure of parenting generally.

* **Mental health problems**

There is evidence that screening for postnatal depression identifies the problem and that home visiting improves outcomes. Some evidence also exists for the efficacy of behavioral training programs for parents of children with conduct disorders

* **National planning**

To attain successful, public health interventions need to address all the direct and indirect influences on the community health and take action on many fronts – including public policy, local communities and families and children themselves

* **Multifactorial interventions**

There is evidence that multifactorial interventions with coordinated inputs at national and local community levels are more effective than interventions at one level only, because they recognize the complex interactions of the individual, social, economic and environmental factors that influence people’s behaviours.

* **Availability of relevant and reliable data of the target population**

Reliable, relevant data is needed to judge the success of any given program. Data collection is the starting point to knowing whether, at population level, a health promotion intervention should be instituted and whether it is effective. Such data collection needs to be at the national and regional or local level to assess epidemiological prevalence, political willingness, health-system capacity and community preferences. The indicators to be used should be scientific, robust and comparable

QUESTION FOUR

1. lack of proper medications, water and electricity, shortages of doctors and also the distance coverage especially in rural areas for people to access the primary health care. they all stand in the way of providing good quality healthcare to all. In low resource countries, healthcare is weakening simply because the healthcare sector is under funded in the least developed countries and the vast majority of these countries are unable to provide basic healthcare to the public more especially in rural areas

Health care systems around the world are facing increasingly complex challenges, such as the growing burden of chronic non communicable disease and related commercial determinants of health (e.g. the marketing of tobacco and unhealthy food), new epidemics and antimicrobial resistance. As a result, the focus has shifted from curative care to health promotion and disease prevention, and new models of primary health-care service delivery, financing and governance have been developed.

1. Effects of increased health expenditure can have both negative and positive effects. In most middle-income countries, average health spending per person is already adequate to ensure universal coverage for essential interventions. Yet such coverage does not reach many of the poor. Exclusion is often concentrated by region for whatever reason; public-sector spending on health does not attend sufficiently to the needs of the poor. Moreover, since many middle-income countries provide inadequate financial protection for large portions of their population, catastrophic medical expenses impoverish many households.
2. On the positive side, through a relatively modest financial effort and, more importantly, through the effective use of existing resources, low resource countries could improve the situation of less developed regions and groups. According to World Bank estimates, for countries in developing or middle-income countries with institutions of an acceptable quality, a 10% increase in public health expenditures as a proportion of the Gross Domestic (GDP) would be associated with a 7% decrease in the maternal mortality rate, a 0.69% decrease in child mortality rate, and a 4.14% decrease in low weight for children under five years of age. Increased high expenditure can bring about a high expectancy of life and an improved standard of living. It will also bring about the ability of people to develop to their potential during their entire lives. In that sense, health is an asset individuals possess, which has intrinsic value (being healthy is a very important source of well-being) as well as instrumental value. Health expenditure impacts economic growth in a number of ways. For example, it reduces production losses due to worker illness, it increases the productivity of adult as a result of better nutrition, and it lowers absenteeism rates and improves learning among school children. Health also allows for the use of natural resources that used to be totally or partially inaccessible due to illnesses. Finally, it permits the different use of financial resources that might normally be destined for the treatment of ill health. Barrow (1996). In summary without a doubt, the potential benefits for investing in health could be very significant as long as there are sufficient strategies for achieving the desired results
3. Health promotion can play a role of supporting governments, communities and individuals to cope with and address health challenges. This accomplished by building healthy public policies, creating supportive environments and strengthening community action and personal skills. In the context of disaster management, health promotion can play a role of working with people to prevent, prepare for and respond to disaster so as to reduce risk, increase resilience and mitigate the impact of disasters on healthy. Health promotion strategies exist to empower individuals to make healthier choices and reduce their risk of disability. At a population level, they can eliminate health disparities, improve quality of life and improve the availability of health-care and related services. Furthermore health promotions plays the role of allocating adequate financial resources for health promotion activities from the national budget and consider changes in financing options, including legislating the use of earmarked dedicated special levies from tobacco, alcohol or other sources. in summary it exists to build the capacity of both health and non-health professionals to plan, implement, monitor and evaluate health promotion interventions at national and sub national levels and to advocate for legislative frameworks, policies and strategic plans of action to promote health and monitor progress of the implementation of the health promotion priority interventions, including documentation and dissemination of lessons learnt through case studies, surveys and research.