AUXILIARY NURSING & MIDWIFERY (ANM)
FIRST YEAR STUDY MATERIAL

SUB: COMMUNITY HEALTH NURSING

CONCEPTS OF HEALTH

Health and its changing concept

Health is a common theme in most cultures. In fact, all communities have their concepts of health, as part of their culture. Among definitions still used, probably the oldest is that health is the "absence of disease". In some culture, health and harmony are considered equivalent, harmony being defined as "being at peace with self, the community, god and cosmos". The ancient Indians and Greeks shared this concept and attributed disease to disturbances in bodily equilibrium of what they called "humors".

CHANGING CONCEPTS

In recent years, we have acquired a new philosophy of health, which may be stated as below:

- Health is a fundamental right
- Health is the essence of productive life, and nit the result of ever increasing expenditure on medical care
- Health is intersectoral
- Health is an integral part of development
- Health is central to the concept of quality of life
- Health involves individuals, state and international responsibility

- Health and its maintenance is a major social investment
- Health is a worldwide social goal.

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Definition of Health

According to World Health Organization (WHO) "Health is a state of complete physical, mental and social well-being and not merely an absence of disease or infirmity".

DIMENSIONS OF HEALTH

Health is multidimensional. The WHO definition envisages some specific dimensions- the physical, the mental, the social and spiritual.

(1) Physical dimension

The physical dimension of health is probably the easiest to understand. The state of physical health implies the notion of "perfect functioning" of the body.

The sign of physical health in an individual are: "a good complexion, a clean skin, bright eyes, lustrous hair with a body well clothed with firm flesh, not too fat, a sweet breath, a good appetite, and sound sleep, regular activity of bowels and bladder and smooth, easy, coordinated bodily movements.

(2) Mental dimension

Mental health is not mere absence of mental illness. Good mental health is the ability to respond to the many varied experiences of life with flexibility and a sense of purpose. More recently, mental health has been defined as "a state of balance between the individual and the surrounding world, a state of harmony between oneself and other, a co-existence between the realities of the self and that of other people and that of the environment".

(3) Social dimension

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Social well-being implies harmony and integration within the individual, between each individual and other member of the society and between individuals and the world in which they live. It has been defined as the "quantity and quality of an individual`s interpersonal ties and the extent of involvement with the community".

(4) Spiritual dimension

Proponents of holistic health believe that the time has come to give serious consideration to the spiritual dimension and to the role this plays in health and disease. Spiritual health in this context, refers to that part of the individual which reaches out and strives for meaning and purpose in life.

(5) Others

A few other dimensions have also been suggested such as:

- Philosophical dimension
- Cultural dimension
- Socio-economic dimension
- Environmental dimension
- Educational dimension
- Nutritional dimension
- Curative dimension
- Preventive dimension

DETERMINANTS OF HEALTH

Health is multifactorial. The factors which influence health lie both within the individual and externally in the society in which he or she lives. It is a truism to say that man is and to what disease he may fall victim depends on a combination of two sets of factors – his genetic factors and environmental factors to which he is exposed.

1. **Biological determinants**

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The physical and mental traits of every human being are to some extent determined by the nature of his genes at the moment of conception. The genetic make-up is unique in that it cannot be altered after conception.

2. **Behavioral and socio-cultural conditions**
   The term “lifestyle” is rather a diffuse concept often used to denote “the way people live”, reflecting a whole range of social values, attitudes and activities. It is composed of cultural and behavioral patterns and lifelong personal habits that have developed through processes of socialization.

3. **Environment**
   The environmental factors range from housing, water supply, psychosocial stress and family structure through social and economic support systems, to the organization of health and social welfare services in the community.

4. **Socio-economic conditions**
   Socio-economic conditions have long been known to influence human health. For the majority of the world`s people, health status is determined primarily by their level of socio-economic development.

PRIMARY HEALTH CARE

Primary Health Care, or PHC refers to "essential health care" that is based on scientifically sound and socially acceptable methods and technology.

Definition

“Primary Health Care is essential health care made universally accessible to individuals & acceptable to them, through their full participation & at a cost the community & country can afford”.

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The Alma Ata conference has put forward **eight important** aspects of **primary health care**. They are: **Health education, adequate of safe drinking water, nutrition, immunization, provision of essential drugs, availability and distribution of medicine, treatment of communicable diseases.**

Principles of PHC

- Equitable distribution
- Community participation
- Health human resources
- Use of appropriate technology
- Multi-sectional approach

Components of PHC

- Providing education concerning prevailing health problems and methods of preventing and controlling them.
- Provision of food supply and proper nutrition.
- Adequate supply of safe and clean drinking water and basic sanitation.
- Provision of maternal and child health care.
- Immunisation against major infectious diseases.
- Prevention and control of local epidemic diseases.
- Appropriate treatment of common diseases and injuries.
- Provision of essential drugs.
- Promoting health education in schools and colleges.

SERVICES IN PRIMARY HEALTH CARE

- ❖ Education concerning prevailing health problems and the methods of preventing and controlling them.
- ❖ Promotion of food supply and proper nutrition.
- ❖ An adequate supply of safe water and basic sanitation.
- ❖ Maternal and child health care, including family planning.
- ❖ Immunization against major infectious diseases.
- ❖ Prevention and control of locally endemic diseases.

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- ❖ Appropriate treatment of common diseases and injuries.
- ❖ Provision of essential drugs

Significance of PHC

The main role of primary health care is to provide continuous and comprehensive care to the patients. It also helps in making the patient available with the various social welfare and public health services initiated by the concerned governing bodies and other organizations. The other major role of a primary health care center is to offer quality health and social services to the underprivileged sections of the society.

Community Application

"**Primary health care** is a practical approach to making essential **health care** universally accessible to individuals and families in the **community** in an acceptable and affordable way with their full participation". It also has social and sectoral dimensions requiring sectoral integration.

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UNIT2- HEALTH CONCEPTS OF PEOPLE AND HEALTH CARE PROVIDERS

Health is a common theme in most cultures. All communities have their concept of health, as a part of their culture. Oldest definition of health in all communities is “absence of disease”. There are different types of CONCEPT S:-

1. **Biomedical concept :** Traditionally , health has been viewed as an “absence of disease “, and if one was free from disease ,then the person was considered healthy. this is “ biomedical concept”
2. **Ecological concept:** Health implies relative absence of pain and discomfort and a continuous adaptation to the environment to ensure optimal function.
3. **Psychosocial concept**: Developments in the field of social sciences revealed that health is not only a biomedical phenomenon, but one which is influenced by social psychological ,cultural, economic & political factors of people concerned.

According to Healthcare providers: understanding of their patients’ healthcare beliefs, values, and preferences is an important feature of patient-centered care. There are several reasons why this understanding is essential. Acquiring a better awareness of a patient’s health beliefs may help healthcare providers identify gaps between their own and the patient’s understanding of his or her health situation.

Healthcare providers often have a modest understanding of their patient’s beliefs with respect to patients’ preferences for involvement in making decisions about their health, desire for information, perceptions of health condition, interest in life-sustaining treatments, beliefs about treatment effectiveness and diagnosis, level of health literacy and emotional conditions.

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Health Behaviors, belief and cultural practices of community

Community and behavioral health focuses on the lifestyle behaviors and aspects of our social environment that affect our health and looks for ways to encourage people to make healthy choices. Some of these ways include promoting walk-to-school programs to reduce childhood obesity and using text messaging to teach teenagers about sexuality.

Community and behavioral health also seeks to improve the public's health through the application of social and behavioral sciences. Through studying behavior, community health specialists are able to modify the incidence, prevalence, and mortality rates of many diseases that affect the communities in which we live. Additionally, community health specialists promote more efficient uses of health services, adopt self-care practices, and participate actively in the design and implementation of health programs.

Public health issues addressed by Community and Behavioral Health include:

- Prevention of Sexually Transmitted Diseases and HIV
- Maternal and Child Health
- Health Communication
- Tobacco Control and Prevention
- Injury control
- Mental Health
- Global Health
- Drug and Alcohol Abuse
- Cancer Prevention
- Nutrition

Practitioners and researchers in this field use theory and evidence based practices to seek out ways to encourage people to make **healthy** choices. These are as follows:-

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1. Encouraging children to eat fruits and vegetables in schools
2. helping college students understand the dangers of binge drinking and promoting tobacco cessation are all aspects of community and behavioral health.

Strategy

Behavior change communication (BCC) : is an approach to behavior change focused on communication. It is also known as social and behavior change communication, or SBCC. The assumptions is that through communication of some kind, individuals and communities can some how be persuaded to behave in ways that will make their lives safer and healthier.

ETHICS & BEHAVIOR RELATED TO COMMUNITY

Ethics is defined as the moral responsibility to tell right and wrong

Behavioral ethics is a new field of social scientific research that seeks to understand how people actually behave when confronted with ethical dilemmas. It refers to behavior that is judged according to generally accepted norms of behavior.

Behavioral ethics lead to the development of ethical models such as the so-called "bystander intervention", which describes ethical behavior as far harder to display because of what we learn from social institutions such as family, school, and religion

Behavioral ethics and education

In ethics teaching and research are "next big thing" because its investigation agenda has generated many knowledge on why and how people choose and act when being confronted with ethical subject, which was unknown previously.

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Ethical issues in community

A number of **ethical** and social **issues** may apply to toxicogenomics. These **issues** include privacy and confidentiality, **issues** related to socially vulnerable populations, health insurance discrimination, employment discrimination, individual responsibility, **issues** related to race and ethnicity, and implementation.

Home visiting

A **home visit** is a family –nurse contact which allows the health worker to assess the **home** and family situation in order to provide the necessary nursing care and health-related activities.

Definition

A **home visit** is defined as the process of providing the nursing care to patients at their doorsteps.

Steps/ Methods for Effective Home Visits

1. Greet the patient and introduce yourself
2. State the purpose of visit
3. Observe the patient & determine the health record
4. Put the bag in a convenient place
5. Perform nursing care needed
6. Record all important date, observation & nursing care rendered.
7. Make appointment for a next visit

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UNIT3- OVERVIEW OF HEALTH PROBLEMS IN INDIA

HEALTH PROBLEMS IN INDIA

Assessment of health status and health problems is the first requisite for any planned effort to develop health. The data care services. required for the analysis of health situation and health problems comprise of mortality, morbidity, demographic conditions, socioeconomic factors etc.

HEALTH

Acc to WHO:- health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity

"Health problem is a state in which we are unable to function normally (state of ill health, unhealthiness)"

MAJOR HEALTH PROBLEMS

Major health problems that are present in India ar e as follows :-

1. COMMUNICABLE DISEASE PROBLEMS

Communicable diseases are continue to be the major health problem in India. The diseases continue to be of greater importance are :-

i) Malaria:- It is caused by a parasite that is Female Anopheles.

Symptoms: Anemia, Bloody stools, Chills, Coma, mosquitoes Convulsion, Fever, Headache, Jaundice, Muscle pain, Nausea, Sweating, Vomiting

Diagnostic Tests: During a physical examination, the doctor may find an enlarged liver or enlarged spleen. A complete blood count (CBC) will identify anemia if it is present.

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Treatment: Chloroquine, for chloroquine-resistant infectionsn(quinine plus doxycycline, tetracycline, or clindamycin)

ii) **Tuberculosis :-** (TB) is a contagious bacterial infection that involves the lungs, but may spread to other organs.

Causes: Mycobacterium tuberculosis (M.tuberculosis)

Symptoms:- Cough (usually cough up mucus),- Coughing up blood,- Excessive sweating, especially at night,- Fatigue, Fever, Unintentional weight loss,- Breathing difficulty,- Chest pain,- Wheezing

Diagnosis:- Biopsy of the Sputum examination and cultures, Bronchoscopy, Chest CT scan, Chest x-ray, affected tissue Tuberculin skin test Thoracentesis

Treatment: Isoniazid, Rifampin, Pyrazinamide, Ethambutol , Amikacin, Ethionamide, Moxifloxacin, Para-aminosalicylic acid, Streptomycin

iii) **Diarrhoeal disease:-** is the second leading cause of death in children under five years old.

Causes: malnutrition in children under five years old. Infection (bacterial, viral and parasitic organisms),

Prevention and treatment:- access to safe drinking-water- improved sanitation,- exclusive breastfeeding or the first six months of life,- good personal and food hygiene,- health education about how infections spread rotavirus vaccination.- Rehydration, Zinc supplements, Nutrient-rich foods, Consulting a health worker if there are signs of dehydration.

iv) **ARI: Acute respiratory infections** are causes of mortality and morbidity in children below 5yrs of age. It is estimated that about 13.6% hospital admissions and 13% inpatient deaths in paediatric ward are due to ARI.

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Causes: Streptococcus pneumonia, Haemophilus influenzae, Staphylococcus aureus and other bacterial species, measles virus, human parainfluenza viruses, influenza virus and varicella virus.

V) AIDS refers to **acquired immunodeficiency syndrome**. With this condition, the immune system is weakened due to HIV (**Human immunodeficiency virus).**

Risk :- HIV is spread primarily by unprotected sex (including anal and oral sex), contaminated blood transfusions, hypodermic needles, and from mother to child during pregnancy, delivery, or breastfeeding. Some bodily fluids, such as saliva, sweat and tears, do not transmit the virus. HIV is a member of the group of viruses known as retroviruses.

Methods of prevention include safe sex, needle exchange programs, treating those who are infected, pre- and post-exposure prophylaxis, and male circumcision

NUTRITIONAL PROBLEMS

i) **PROTEIN ENERGY MALNUTRITION:** PEM refers to the deficiency of energy and protein in the body. 1-2% of preschool children in India suffer from PEM.

CAUSES: Inadequate intake of food both in quantity and quality, Infections (Diarrhea, Respiratory infections, measles, intestinal worms).

TYPES: MARASMUS, KWASHIORKER

ii) NUTRITIONAL ANEMIA: India has probably the highest prevalence of nutritional anaemia in women and children. About one half of the anaemia in women and children. non-pregnant women and children are estimated to suffer from anaemia. 20-40% of maternal deaths

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are 60-80% of pregnant women are anaemic. Mostly the anaemia is of iron deficiency and attributed to anaemia. less frequently is of folate and vitamin B12 deficiency.

III) LOW BIRTH WEIGHT :-N This is the major public health problem in developing countries. About 30% of the babies are born of low birth weight as compared to about 4% in some developed countries.

Causes: Inadequate nutritional. intake during pregnancy. Maternal malnutrition and anaemia .

iv) XEROPHTHALMIA:- About 0.04% of total blindness in India are attributed to nutritional deficiency of Vit. A. Keramalacia has been the major cause of nutritional blindness in children usually between 1-3 years of age.

ENVIRONMENTAL SANITATION

The two main problems i) lack of safe water in many areas of the country 2.) primitive methods of excreta disposal. Beside these, there has been a growing concern about the impact of new problems resulting from population explosion, urbanization and industrialization leading to hazards to human health in the air, in water, and in food chain.

TRENDS & DEVELOPMENT IN NATIONAL HEALTH PROGRAMMES & POLICIES

The **health** priorities are changing. Although maternal and child mortality have rapidly declined, there is growing burden on account of non-communicable diseases and some infectious diseases. The second important **change** is the

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emergence of a robust **health** care industry estimated to be growing at double digit. Many trends from the past 2 years continue, it in a transformed way

because of the effect of unknown change in the public (ie, government) sector market, along with the tax reform legislation. Information technology remains important, but its user base and timing to deliver information are shifting, along with potential disruptive applications that will, in their own way, transform market trends. In addition, technology innovations will need to demonstrate a positive return on investment. A clear consumer focus has emerged, along with efforts to transform the healthcare experience to more positively use a mostly unchanged delivery system and supply chain.

1) **Rural Healthcare**

Unique problems of rural healthcare are the decreasing number of physicians, the growth of high-deductible health plans (HDHPs), a lack of choices of private exchanges, and the opioid epidemic.

2) **Consumerism in Healthcare**

Healthcare consumerism is defined as, “transforming an employer's health benefit plan into one that puts economic purchasing power—and decision-making—in the hands of participants. This is best achieved by supplying employees with the decision-making information and support tools they need, along with financial incentives, rewards, and other benefits that encourage personal involvement in altering health and health care purchasing behaviors.”

3) *Convergence and collaboration between health systems and health plans will become more important:*
4) *Health systems will continue to focus more on the patient rather than the illness*

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5) *Technology could help move patients to the center:* Physicians spend 21 percent of their time on non-clinical paperwork.
6) *More patients could consider virtual health:* Very few of us really enjoy going to the doctor, which causes some people to wait until a condition worsens before seeking care.
7) *There will be more focus on population health:* Population health takes a broad look at the management of outcomes for all of a health system's patients. Specifically, population health includes efforts to use health care resources more effectively and efficiently to improve the lifetime health and well-being of a specific population.

NATIONAL HEALTH PROGRAMMES & ITS IMPLEMENTATION AT COMMUNITY LEVEL.

NATIONAL IODINE DEFICIENCY DISORDERS CONTROL PROGRAMME (NIDDCP)

Iodine is an essential micronutrient required daily at 100-150 micrograms for normal human growth and development. Deficiency of iodine can cause physical and mental retardation, cretinism, abortions, stillbirth, deaf mutism, squint & various types of goiter.

In August, 1992 the National Goitre Control Programme (NGCP) was renamed as National Iodine Deficiency Disorders Control Programme (NIDDCP) with a view of wide spectrum of Iodine Deficiency Disorders like mental and physical retardation, deaf mutisim, cretinism, still births, abortions etc.

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Goal :

1. To bring the prevalence of IDD to below 5% in the country
2. To ensure 100% consumption of adequately iodated salt (15ppm) at the household level.

Objectives:

1. Surveys to assess the magnitude of Iodine Deficiency Disorders in the districts.
2. Supply of iodated salt in place of common salt.
3. Resurveys to assess iodine deficiency disorders and the impact of iodated salt after every 5 years in the districts.
4. Laboratory monitoring of iodated salt and urinary iodine excretion.
5. Health Education and Publicity

National Mental Health Programme

Government of India has been implementing National Mental Health Program (NMHP) since 1982. The district Mental Health Program was added to the Program in 1996.

Objectives

1. To ensure the availability and accessibility of minimum mental healthcare for all in the foreseeable future;
2. To encourage the application of mental health knowledge in general healthcare and in social development;
3. To promote community participation in the mental health service development; and
4. To enhance human resource in mental health sub-specialties.

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Components:

1. **District Mental Health Program:**

a. Envisages provision of basic mental health care services at the community level:

i. Service provision: provision of mental health out-patient & in-patient mental health services with a 10 bedded inpatient facility.

ii. Out-Reach Component:

- Satellite clinics: 4 satellite clinics per month at CHCs/ PHCs by DMHP team
- Targeted Interventions:

- Life skills education & counseling in schools,
- College counseling services,
- Work place stress management, and
- Suicide prevention services

Mental Health Services:

- For those activities, state or district specific, which need to be added to the package of activities carried out by the district mental health team.

Such mental health services will be delivered through government mental hospitals or medical colleges/hospitals with department of psychiatry.

- Under the overall supervision of the Head of Psychiatry Department.
- Financial support of up-to Rs. 15.00 lakhs per year per medical college/hospital/mental hospital

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National Programme for Control of Blindness

National Programme for Control of Blindness was launched in the year 1976 as a 100% Centrally Sponsored scheme with the goal to reduce the prevalence of blindness from 1.4% to 0.3%.

Goals

- To reduce the prevalence of blindness (1.49% in 1986-89) to less than 0.3%
- To establish an infrastructure and efficiency levels in the programme to be able to cater new cases of blindness each year to prevent future backlog.

Objectives

1. To reduce the backlog of blindness through identification and treatment of blind at primary, secondary and tertiary levels based on assessment of the overall burden of visual impairment in the country.
2. Develop and strengthen the strategy of NPCB for "Eye Health" and prevention of visual impairment; through provision of comprehensive eye care services and quality service delivery.
3. Strengthening and up gradation of RIOS to become centre of excellence in various sub-specialties of ophthalmology
4. Strengthening the existing and developing additional human resources and infrastructure facilities for providing high quality comprehensive Eye Care in all Districts of the country;
5. To enhance community awareness on eye care and lay stress on preventive measures;
6. Increase and expand research for prevention of blindness and visual impairment
7. To secure participation of Voluntary Organizations/Private Practitioners in eye Care.

Causes of blindness

1. Cataract (62.6%)
2. Refractive Error (19.70%)
3. Corneal Blindness (0.90%)

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4. Glaucoma (5.80%)
5. Surgical Complication (1.20%)
6. Posterior Capsular Opacification (0.90%)
7. Posterior Segment Disorder (4.70%)
8. Others (4.19%)
9. Estimated National Prevalence of Childhood Blindness /Low Vision is 0.80 per thousand.

Strategies

 Decentralized implementation of the scheme through District Health Societies (NPCB)

 Reduction in the backlog of blind persons by active screening of population above 50 years, organising screening eye camps and transporting operable cases to eye care facilities

 Development of eye care services and improvement in quality of eye care by training of personnel, supply of high-tech ophthalmic equipment, strengthening follow up services and regular monitoring of services;

 Screening of school age group (Primary &Secondary) children for identification and treatment of Refractive Errors, with special attention in under-served areas;

 Public awareness about prevention and timely treatment of eye ailments;

 Special focus on illiterate women in rural areas. For this purpose, there should be convergence with various ongoing schemes for development of women and children;

 To make eye care comprehensive, besides cataract surgery, provision of assistance for other eye diseases like Diabetic Retinopathy, Glaucoma Management, Laser Techniques, Corneal Transplantation, Vitreoretinal Surgery, Treatment of Childhood Blindness etc.

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PULSE POLIO PROGRAMME

Pulse Polio Immunization programme was launched in India in 1995. Children in the age group of 0-5 years administered polio drops during National and Sub-national immunization rounds (in high risk areas) every year

Objective

1) To achieving hundred per cent coverage under Oral Polio Vaccine.
2) It aimed to immunize children through improved social mobilization, plan mop-up operations in areas where poliovirus has almost disappeared and maintain high level of morale among the public.

Steps under taken by PPP

- Maintaining community immunity through high quality National and Sub National polio rounds each year.
- An extremely high level of vigilance through surveillance across the country for any importation or circulation of poliovirus and VDPV is being maintained. Environmental surveillance (sewage sampling) have been established to detect poliovirus transmission and as a surrogate indicator of the progress as well for any programmatic interventions strategically in Mumbai, Delhi, Patna, Kolkata Punjab and Gujarat.
- All States and Union Territories in the country have developed a Rapid Response Team (RRT) to respond to any polio outbreak in the country. An Emergency Preparedness and Response Plan (EPRP) has also been developed by all States indicating steps to be undertaken in case of detection of a polio case.
- To reduce risk of importation from neighbouring countries, international border vaccination is being provided through continuous vaccination teams (CVT) to all eligible children round the clock. These are provided through special booths set up at the international borders that India shares with Pakistan, Bangladesh, Bhutan Nepal and Myanmar.

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- Government of India has issued guidelines for mandatory requirement of polio vaccination to all international travelers before their departure from India to polio affected countries namely: Afghanistan, Nigeria, Pakistan, Ethiopia, Kenya, Somalia, Syria and Cameroon. The mandatory requirement is effective for travellers from 1st March 2014.
- A rolling emergency stock of OPV is being maintained to respond to detection/importation of wild poliovirus (WPV) or emergence of circulating vaccine derived poliovirus (cVDPV).
- National Technical Advisory Group on Immunization (NTAGI) has recommended Injectable Polio Vaccine (IPV) introduction as an additional dose along with 3rd dose of DPT in the entire country in the last quarter of 2015 as a part of polio endgame strategy.

Rashtriya Kishor Swasthya Karyakram (RKSK)

The ***Rashtriya Kishor Swasthya Karyakram*** was launched on 7th January, 2014.

Objectives

Improve nutrition

- Reduce the prevalence of malnutrition among adolescent girls and boys
- Reduce the prevalence of iron-deficiency anaemia (IDA) among adolescent girls and boys

Improve sexual and reproductive health

- Improve knowledge, attitudes and behaviour, in relation to SRH
- Reduce teenage pregnancies
- Improve birth preparedness, complication readiness and provide early parenting support for adolescent parents

Enhance mental health

- Address mental health concerns of adolescents

Prevent injuries and violence

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- Promote favourable attitudes for preventing injuries and violence (including GBV) among adolescents

Prevent substance misuse

- Increase adolescents' awareness of the adverse effects and consequences of substance misuse

Strategies

Strategies/interventions to achieve objectives can be broadly grouped as:

- Community based interventions
- Peer Education (PE)
- Quarterly Adolescent Health Day (AHD)
- Weekly Iron and Folic Acid Supplementation Programme (WIFS)
- Menstrual Hygiene Scheme (MHS)

Facility based interventions

- Strengthening of Adolescent Friendly Health Clinics (AFHC)

Convergence

- **Within Health & Family Welfare -** FP, MH (incl VHND), RBSK, NACP, National Tobacco Control Programme, National Mental Health Programme, NCDs and IEC

ASHA

ASHA Stands for **accredited social health activist** (**ASHA**) is a community health worker instituted by the government of India's Ministry of Health and Family Welfare (MoHFW) as a part of the National Rural

Health Mission (NRHM). The mission began in 2005; full implementation was targeted for 2012.

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Roles and responsibilities of ASHA

ASHAs are local women trained to act as health educators and promoters in their communities. The Indian MoHFW describes them as:-

1) Health activist(s) in the community who will create awareness on health and its social determinants.
2) Mobilize the community towards local health planning and increased utilization and accountability of the existing health services.
3) Motivating women to give birth in hospitals, bringing children to immunization clinics, encouraging family planning.
4) ASHAs are also meant to serve as a key communication mechanism between the healthcare system and rural populations.

Selection

1) ASHAs must primarily be female residents of the village .

11) Married, widowed or divorced women are preferred .

ASHA's preference for selection is between the ages of 25 and 45, and are selected by and accountable to the gram panchayat (local government). If there is no suitable literate candidate, these criteria may be relaxed. Although ASHAs are considered volunteers, they receive outcome-based remuneration and financial compensation for training days.

Functions of ASHA

1. **Maintenance of Village Health Register:** A village health register is maintained by the AWW which is not always complete. ASHA can help AWW to complete and update this register by maintaining a daily diary. The diaries, registers, health cards, immunization cards may be provided to her from the untied funds made available to the Sub-Centres.

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2. **Organization of the Village Health and Nutrition Day:** All State Governments are presently organizing monthly Health and Nutrition day in every village (Anganwadi centers) with the help of AWW/ANM. ASHA along with AWW should mobilize women, children and vulnerable population for the monthly health day activities like immunization, nutritional status of pregnant/lactating women, newborn & children, ANC/PNC and other health check-ups of women and children, taking weight of babies and pregnant women etc. and all range of other health activities.

3. **Co-ordination with SHG Groups**: ASHA would be required to interact with SHG Groups, if available in the villages, along with AWW, so that a work force of women will be available in all the villages.

4. **Meeting with ANM**: ANM should have a monthly meeting with the ASHAs stationed (5-6 ASHAs) in the villages of her work area at the Anganwadi Centre during the monthly Health and Nutrition Day to assess the quality of their work and provide them guidance.

5. **Community monitoring:** Periodic surveys are envisaged under NRHM in every village to assess the improvement brought about by ASHA and other interventions.

6. **Meeting with ANM**: ANM should have a monthly meeting with the ASHAs stationed (5-6 ASHAs) in the villages of her work area at the Anganwadi Centre during the monthly Health and Nutrition Day to assess the quality of their work and provide them guidance.

7. **Monthly meetings of ASHAs:** A meeting of ASHA could be organized on the day monthly meetings are organized at the PHC level to avoid unnecessary travel expenditure and wastage of time. The idea is that apart

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from the meeting with officials they should be given opportunity to share sometime of their own experience, problems, etc.

Anganwadi worker

Anganwadi is a type of rural child care centre in India. They were started by the Indian government in 1975 as part of the Integrated Child Development Services program to combat child hunger and malnutrition. *Anganwadi* means "courtyard shelter" in Indian languages.

The main **role** of the **Anganwadi worker** is to assist health staff (such as the ANM) to maintain records, motivate the parents, and organize immunization sessions.

Anganwadi centre provides basic health care. It is a part of the Indian public health-care system. Basic health-care activities include contraceptive counseling and supply, nutrition education and supplementation, as well as pre-school activities.

Functions :-

1. A typical Anganwadi centre provides basic health care in a village. It is a part of the Indian public health care system. Basic health care activities include contraceptive counseling and supply, nutrition education and supplementation, as well as pre-school activities.
2. The centres may be used as depots for oral rehydration salts, basic medicines and contraceptives.
3. These centres provide supplementary nutrition, non-formal pre-school education, nutrition and health education, immunization, health check-up and referral services of which the last three are provided in convergence with public health systems.

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Supervision

A Mukhya Sevika supervises between 40 and 65 Anganwadi workers, providing them with on-the-job training. Mukhya Sevikas' other duties include keeping track of people of lower economic status benefiting from the program.

Age: 25-35 years (the upper age limit for all categories shall be extended by 5 years for widows, destitute and candidates in hill areas.

DAI

Dai is also known as **traditional birth attendant (TBA)**, also known as a **traditional midwife**, **community midwife** or **lay midwife**, is a pregnancy and childbirth care provider. Traditional birth attendants provide the majority of primary maternity care in many developing countries, and may function within specific communities in developed countries.

Role :-

1. **Traditional birth attendants** are often older women, respected in their communities. They consider themselves as private health care practitioners who respond to requests for service. Traditional midwives provide basic health care, support and advice during and after pregnancy and childbirth.
2. They usually work in rural, remote and other medically underserved areas.
3. TBAs may not receive formal education and training in health care provision, and there are no specific professional requisites such as certification or licensure. A traditional birth attendant may have been formally educated and has chosen not to register.
4. The focus of their work is to assist women during delivery and immediately post-partum.

Function

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1. The **dai**, or traditional birth attendant (TBA), remains the primary health care provider during pregnancy and childbirth in much of rural India.
2. The preference of home delivery is due to a variety of factors, including accessibility of care, **community** trust, and negative perceptions of government health facilities.
3. **Dais** are already playing a broader **role** as health workers in many states. They are involved in mobilizing communities for health education, immunization, family planning, tuberculosis and HIV/AIDs control and awareness, and for health insurance to mention a few.

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UNIT4- HEALTH ORGANIZATION

Organization of SC, PHC, CHC & District Hospitals

The Primary Health Care Infrastructure has been developed as a three tier system with Sub Centre, Primary Health Centre (PHC) and Community Health Centre (CHC) being the three pillars of Primary Health Care System.

1. **Sub Centre :** Most peripheral contact point between Primary Health Care System and Community
2. **Primary Health Centre (PHC) :** A Referral Unit for 6 Sub Centers
3. **Community Health Centre (CHC) :** A Referral Unit for 4 PHC

Population norms for rural healthcare infrastructure

The three tier infrastructure is based on the following population norms:

	Population Norms	
Centre	Plain Area	Hilly/Tribal/Difficult Area
Sub Centre	5000	3000
Primary Health Centre	30,000	20,000
Community Health Centre	1,20,000	80,000

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Sub Centers

The Sub Centre is the most peripheral and first contact point between the primary health care system and the community.

Sub Centers are assigned tasks relating to interpersonal communication in order to bring about behavioral change and provide services in relation to maternal and child health, family welfare, nutrition, immunization, diarrhoea control and control of communicable diseases programmes.

One lady health visitor (LHV) is entrusted with the task of supervision of six Sub Centers. Government of India bears the salary of ANM and LHV while the salary of the Male Health Worker is borne by the State governments.

PHC (PRIMARY HEALTH CENTRE)

PHC is the first contact point between village community and the medical officer.

The PHCs were envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care. The PHCs are established and maintained by the State governments under the Minimum Needs Programme (MNP)/ Basic Minimum Services (BMS) Programme.

As per minimum requirement, a PHC is to be manned by a medical officer supported by 14 paramedical and other staff. Under NRHM, there is a provision

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for two additional staff nurses at PHCs on contract basis. It acts as a referral unit for 6 Sub Centers and has 4-6 beds for patients.

The activities of PHC involve curative, preventive, promotive and family welfare services.

Community Health Centers

CHCs are being established and maintained by the State government under MNP/BMS programme.

As per minimum norms, a CHC is required to be manned by four medical specialists i.e. surgeon, physician, gynecologist and pediatrician supported by 21 paramedical and other staff. It has 30 in-door beds with one OT, X-ray, labour room and laboratory facilities.

It serves as a referral centre for 4 PHCs and also provides facilities for obstetric care and specialist consultations.

District Hospital

A **district hospital** is a secondary referral level responsible for a **district**. To build a **district hospital**, adequate planning, design, management and maintenance are required.

Functions

A district hospital has the following functions:

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1. It provides effective, affordable health care services (curative including specialist services, preventive and promotive) for a defined population, with their full participation and in
   cooperation with agencies in the district that have similar concern.
2. It covers both urban population (district head quarter town) and the rural population in the district.
3. Function as a secondary level referral centre for the public health institutions below the district level such as Sub-divisional Hospitals, Community Health Centers, Primary Health Centers and Sub-centers.
4. To provide wide ranging technical and administrative support and education & training for primary health centers.

Referral system

Referral system involves sending a patient to another physician for ongoing management of specific problem , with the exception that the patient will continue to see the original physician for coordination of total care.

Definition

A process in which the P.H.C physician who has lesser facilities to manage clinical condition seeks the assistance of specialist partner with resources to guide in managing clinical episode.

When to refer

- When the family physician need specified investigation or advice.

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• When the family physician is dissatisfied with the patient's progress or unsure of the diagnosis.

• When the patient or his family shows doubt or lack confidence in the of diagnosis or management.

• Medical-legal concerns by the physician, the patient or both.

STEPS OF THE REFERRAL PROCESS:

1. Establish a good relationship with the patient.

2. Establish the need for a referral.

3. Set objectives for the referral.

4. Explore resources availability.

5. Patient decides to use or not use.

6. Make pre-referral treatment.

7. Facilitate, coordinate referral.

8. Evaluate and follow up. Steps of Referral Process

Benefits of referral

- ❖ For the patient - Prompt diagnosis and management - Save time, money and effort.
- ❖ Better outcome For the family physician - learning and training
- ❖ Gaining self confidence.

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- ❖ Increase communication between the health care staff For the Consultant
- ❖ Improve the quality of the patient's management.
- ❖ Increase communication between the health care staff Benefits of Referral

Organization of the Health Care Delivery System at different level

National level - The organization at the national level consists of the Union Ministry of Health and Family Welfare, DGHS, Central council of health and family welfare.

State Level - The organization at State level is under the State Department of Health and Family Welfare in each State headed by Minister and with a Secretariat under the charge of Secretary/Commissioner (Health and Family Welfare) belonging to the cadre of Indian Administrative Service (IAS).

District Level - The district level structure of health services is a middle level management organization and it is a link between the State as well as regional structure on one side and the peripheral level structures such as PHC as well as sub-centre on the other side.

Block level - one Community Health Centre (CHC) has been established for every 80,000 to 1, 20,000 population, and this centre provides the basic specialty services in general medicine, pediatrics, surgery, obstetrics and gynecology.

HEALTH CARE ORGANISATION AT THE CENTRE LEVEL

Health care organization at the Centre comprised of the three organs. These are:

1. Union Ministry of Health and Family Welfare.

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2. DGHS.
3. Central council of health

1. **Union ministry of health and family welfare**: The union ministry of health and family
   welfare at the center plays a vital role in the governmental efforts to enable the citizen

to live a healthier and useful life.

Organization

The ministry is headed by cabinet ministry, a ministry of state and deputy health ministry. The secretary is assisted by a number of Additional, Joint, Deputy and Assistant Secretaries and various other administrative staff. Currently the Union Ministry of health and family welfare is comprised of departments namely: **i) The department of health. ii) The department of family welfare.**

Functions:

1. International health relations and administration of port quarantine.
2. Administration of central institutes such as the All India Institute of hygiene and public health, Kolkata.
3. Promotion of research through research centers and other bodies.
4. Regulation and development of medical, pharmaceutical, dental and nursing professions.

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5. Establishment and maintenance of drug standards.
6. Census and collection and publication of other statistical data.
7. Immigration and emigration.
8. Regulation of labour in the working of mines and oil field.

2. Directorate General Of Health Services

Organization

The Directorate General of Health Services is the principal adviser to the union govt. in both medical and public health matters. He is assisted by an additional director general

of health services, a team of deputies and a large administrative staff.

Functions:

The general functions are surveys, planning, coordination, programming and appraisal of all health matters in the country**.**

3. Central Council of Health

The union govt. has mainly an advisory, guiding and coordinating function. The union govt. has launched various National Health Programme which are be implemented with the active participation of states.

Functions

1. To make proposal for legislation in the field of medical and public health matters.

2. To lay down the pattern of development in the country as a whole.

3. To make recommendations regarding distribution of available grants-in-aid.

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4. To establish any organization for promoting and maintaining cooperation between the central and state health administration.

Health Care Organization at the State Level

The organization structure at the state level is on the similar pattern as that the central level. Each state has organized the structure to provide health care services with some variations or the other. Although there are 29 states and 7 union territories. The organization structure is as under:

Health Care Organization at the District Level

Each state has developed its own pattern according to their own requirements. In general district health organization is headed by chief medical officer of health. In order to appreciate the health care setup at the district and block level, it is necessary to understand organizational structure of district. It is as under:

Administrative set up

A tehsil or a talukka has a number of villages ranging from 200-600. Each district is under the administrative charge of collector, each subdivision is in the charge of assistant collector or sub-collector and each tehsil/ taluk is in the charge of Tehsildar.

Panchayat Raj System: PRI is a 3 tier structure f rural local self-government in India, linking the village to the district.

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- At the village level - panchayat
- at the block level - panchayat samiti
- at the district level – zila parishad

HEALTH CARE ORGANIZATION AT THE BLOCK LEVEL

The organization structure at the block level is developed to provide health care services in the rural areas and is part of the rural health scheme. It is a three tier structure comprised of community health centers, primary health centers, sub-centers and village health posts. Each block has one community health centre covering a population of 80, 00- 1, 20,000.

The CHC is considered as the first referral unit(FRU) for referring patients. Each CHC has 3-4 PHC. Each PHC covers a population of 30,000 in plain areas, 20,000 in hilly and tribal areas.

The PHC functions cover all the eight essential elements of PHC.

Each PHC has 5-6 sub centers. Each sub-center covers a population of 5000 in general & 3000 in hilly, tribal and backward areas. Each sub-centre is manned by a team of male &female health worker/ ANM.

HEALTH AGENCIES

WORLD HEALTH ORGANIZATION

The WHO is a specialized, non-political international health agency of the United Nations. Its headquarters is in Geneva, Switzerland. The Constitution of WHO

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came into force on 7 April, 1948, which is celebrated every year as “World Health Day”.

Objective

The objective of WHO is “the attainment by all peoples of the highest level of health”.

Membership

Membership in WHO is open to all countries. In 1948, there were 56 members: presently, the membership rose to 193. Each Member State contributes yearly to the funds of the WHO, and each obtains the services and aid according to its needs which the Organization can provide.

Functions

(1) The WHO is the world’s directing and coordinating authority on all international health work. Through the WHO, the nations help each other on raising health standards.

(2) The WHO’s most important function is to help countries strengthen and improve their own health services. The WHO provides advisory services.

(3) The WHO provides central technical services. These are –

(a) Epidemic warnings and disease surveillance

(b) Administration of International Health Regulations

(c) Health statistics on a global scale

(d) International standardization of medical substances and biological

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(e) Technical publications, publications of Expert Committee Reports, monthly journals, periodicals, and magazines

(f) Supporting research on health problems

Structure

(1) THE WORLD HEALTH ASSEMBLY: This is the supreme governing body of the WHO.

(2) THE EXECUTIVE BOARD: The Executive Board consists of 31 members, all technically qualified.

(3) THE WHO SECRETARIAT: The WHO Secretariat is in Geneva. It is headed by the Director General, WHO. The secretariat has 14 Divisions.

UNICEF (United Nations International Children's Emergency Fund)

UNICEF is one of the specialized agencies of the United Nations. It was established in 1946. Formerly known as UNICEF (United Nations International Children's Emergency Fund), it is now called "U.N. children's Fund", but the title UNICEF is retained. The headquarters of UNICEF is in New York; it has a regional office in New Delhi.

UNICEF works in close collaboration with WHO, and other specialized agencies of the United Nations. The main concern of UNICEF is to improve the health of mothers and children, and to assist programmes which would directly or indirectly benefit child health.

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Functions of UNICEF

UNICEF is giving aid to India for programmes benefitting children in the following spheres:

(1) Educations

(2) Health

(3) Nutrition

(4) Water supply and

(5) Social welfare.

Leadership by UNICEF

In recent years, UNICEF has provided leadership in the following campaigns:

(1) Primary Health Care

(2) Health for all by 2000 AD

(3) Universal Child Immunization

(4) Promotion of Growth charts

(5) Breast feeding

(6) Oral rehydration therapy

(7) Child Survival and Development Revolution

FAO (Food and Agriculture Organization)

The Food and Agriculture Organization (FAO) is a specialized agency of the United Nations. It was established in 1945 with headquarters in Rome. The chief aims of FAO are:

(1) To help nations raise their living standards.

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(2) To increase the efficiency of farming, forestry and fisheries.

(3) To better the condition of rural people.

The FAO has organized a World Freedom from Hunger Campaign (FFHC) in 1960. The main object of the campaign is to combat malnutrition and disseminate information and education.

THE RED CROSS

The Red Cross is a Non-political, non-official international humanitarian organization devoted to the service of mankind in peace and war. It was founded by a Swiss businessman, Henry Dunant in 1864.

The Indian Red Cross was established in 1920 with the triple objective of the improvement of health, prevention of disease and mitigation of suffering. There is a Red Cross Home at Bangalore for disabled ex-servicemen. During disaster, the Red Cross supplies vitamin tablets, cod liver oil and a hundred other items. The Red Cross has done pioneering work in the development of MCH Services in India. The Junior Red Cross trains boys and girls in activities like village uplift, first aid and anti-epidemic work. The Red Cross promotes international friendliness, understanding and cooperation.

THE COLOMBO PLAN

Colombo plan was formed in 1950 by Indian and six other Commonwealth countries. The plan today has over 20 members besides India. Colombo plan philosophy is that freedom and progress of Asia`s emerging nations can best be achieved through economic, social and cultural cooperation with the industrial

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nations. The plan's motto is "planning prosperity together". The bulk of Colombo Plan assistance goes into industrial and agricultural development. The All India Institute of Medical Sciences at Delhi was established with financial assistance from New Zealand.

CARE

CARE (Co-operative for Assistance and Relief Everywhere) is a non-profit organization. It was created in 1945 for the immediate purpose of sending food from American donors to needy people in other countries. CARE began its operations in India in 1950. Since 1961, CARE is helping India in the mid-day meal scheme for primary children. CARE is also helping in the fields of medicine, literacy, vocational training and agriculture. In India, CARE supported activities include construction of orphanages, co-operatives and the popularization of improved agricultural implements. Since 1961, CARE is helping India with the provision of mid day free lunches to school children. CARE distributes dried milk, wheat, rice, corn, cottonseed oil and other foodstuffs donated by the U.S. Govt.

WORLD BANK

The World Bank is a specialized agency of the UN. Its function is to provide financial and technical assistance for the development of its poorer member countries. It supports projects designed to raise living standards, viz. agriculture, education, rural development, industry, energy and electric power.

USAID

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The United States Agency for International Development (USAID) is the United States federal government agency primarily responsible for administering civilian foreign aid. Responding to President Obama's pledge in his January 2013 State of the Union address to "join with our allies to eradicate extreme poverty in the next two decades,"

Activity: The US government is assisting in a number of projects designed to improve the health of Indian people.

- Malaria eradication
- Medical education
- Nursing education
- Health education
- Water supply and sanitation
- Control of communicable diseases
- Nutrition
- Family planning

UNFPA

The UNITED NATIONS POPULATION FUND (**UNFPA**), formerly the United Nations Fund for Population Activities, is a UN organization. They do following activities:-

- Training health workers to deliver quality family planning services
- Supplying contraceptives in emergency situations

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- Ensuring youth-friendly reproductive health care
- Providing counseling and choices to women who want to avoid or delay pregnancy
- Educating men on the benefits of birth spacing

DANIDA

Danish International Development Agency (**DANIDA**), is the brand which the Ministry of Foreign Affairs of Denmark, uses when it provides humanitarian aid and development assistance to other countries, with focus on developing countries. There is no distinct Danida organisation within the Ministry

Four main priority areas:

- Human rights and democracy
- Green growth
- Social progress
- Stability and protection

UNDPA

UNDPA stands for United Nations Department of Political Affairs. Their work involves the improvement of reproductive health; including creation of national strategies and protocols, and birth control by providing supplies and services. The

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organization has recently been known for its worldwide campaign against child marriage, obstetric fistula and female genital mutilation.

ILO

The **International Labour Organization** (**ILO**) is a United Nations agency whose mandate is to advance social justice and promote decent work by setting international labour standards. The ILO became the first affiliated specialized agency of the United Nations in 1946.

The International Labour Organization has developed a system of international labour standards aimed at promoting opportunities for women and men to obtain decent and productive work, in conditions of freedom, equity, security and dignity.

NATIONAL /VOLUNTARY HEALTH AGENCIES IN INDIA

INDIAN RED CROSS SOCIETY:

The Indian Red Cross Society was established in 1920. It has a network of over 400 branches all over India. It has been executing programmes for the promotion of health, prevention of disease and mitigation of suffering among the people. Its activities are :

a) **RELIEF WORK**: When disaster strikes any part of the country in the shape of earth-quake, floods, drought, epidemics etc., the Red Cross Society immediately mobilize all its resources and goes to the rescue of the affected people.

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b) **MILK & MEDICAL SUPPLIES**: A number of hospitals, dispensaries, maternity and child welfare centers, schools and orphanages receive assistance from the society every year. The assistance given consists mainly of milk powder, medicines, vitamins and other supplies.

c) **ARMED FORCES**: The care of the sick & the wounded among the members of the forces is one of the primary obligations of the Red Cross.

d) **MATERNAL & CHILD WELFARE SERVICES**: There are a large number of maternity & child welfare centers all over India.

e) **FAMILY PLANNING: Several** states in India are running family planning clinics under the auspices of the Indian Red Cross.

f) **BLOOD BANK & FIRST AID**: Some of the State branches have started blood banks. The St. John Ambulance Association in India which is part of the Red Cross has trained several Lakh men & women in first-aid, home nursing and allied subjects.

INDIAN COUNCIL FOR CHILD WELFARE

Indian council for child welfare was established in 1952. It is affiliated with the International Union for Child Welfare. Since its formation, the I.C.C.W. has built up a network of State Councils and district councils all over the country. The services of I.C.C.W. are devoted to secure for India's children those "opportunities & facilities, by law and other means" which are necessary to enable them to develop physically.

FAMILY PLANNING ASSOCIATION OF INDIA:

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The family planning association was formed in 1949 and its headquarters at Mumbai. It has done pioneering work in propagating family planning in India. The association has branches all over the country. These branches are running family planning clinics with grants- in- aid from the government. The Association has trained several hundred doctors, health visitors and social workers. One of the activities of the headquarters is to answer enquiries on family planning by correspondence or by personal interviews.

NON GOVERNMENT ORGANIZATION

TUBERCULOSIS ASSOCIATION OF INDIA

The Tuberculosis Association of India was formed in 1939. It has branches in all the states in India. The activities of this Association comprise organizing a T.B. Seal campaign every year to raise funds, training of doctors, health visitors & social workers in Antituberculosis work, promotion of health education & promotion of consultations and conferences.

BHARAT SEVAK SAMAJ:

The Bharat Sevak Samaj which is a non-political and non-official organization was formed in 1952. One of the prime objectives of the Bharat Sevak Samaj is to help people to achieve health by their own actions and efforts. The B.S.S. has branches in all the States and in nearly all the districts. Improvement of sanitation in villages is one of the important activities of the B.S.S.

THE KASTURBA MEMORIAL FUND

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Created in commemoration of Kasturba Gandhi, after her death in 1944, the fund was raised with the main object improving the lot of women, especially in the villages, through gram –sevikas. The trust has nearly a crore of rupees, & actively engaged in various welfare projects in the country.

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UNIT5-TEAM CONCEPT AND FUNCTIONS OF THE HEALTH TEAM

Meaning of Health Team

Healthcare is a **team** effort. Each **healthcare** provider is like a member of the **team** with a special role. Some **team** members are doctors or technicians who help diagnose disease. Others are experts who treat disease or **care** for patients' physical and emotional needs.

Definition

A health team is a group of persons who work together to promote better health in the community.

CONCEPT OF HEALTH TEAM

 The practice of modern medicine has become a joint effort of many groups of workers both medical and non medical. The paramedical personnel includes :

1. Physician.

2.National Social Workers.

3. Health Assistants and Dias.

4. Village Health Guides.

5. Panchayat leaders.

6. Teachers.

7. Post Masters.

8. Woman Health Leader.

COMMUNITY HEALTH TEAM

It refers to a group of people working together for common goal in order to provide preventive, promotive, curative, rehabilitative, restorative services to the individual, family and community.

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Functions of Health Team

1. Address concerns or answer questions that patients have about their **health** and well-being.
2. Help patients take **care** of their **health** by discussing such topics as proper nutrition and hygiene.
3. Diagnose and treat injuries or illnesses. Some doctors, like surgeons, can operate on patients to treat injuries.
4. Maternal and Child Health services.
5. Family planning.
6. Medical Termination of pregnancy
7. Control and prevention of communicable disease.
8. Registration of vital events.

Role and Responsibilities of ANM

ANM will carry out the following Role and Responsibilities:

1. **Maternal and Child Health**
   - I. Register and provide care to pregnant women throughout the period of pregnancy.
   - II. Ensure that every pregnant woman makes at least 3 visits for Ante-natal check-up.
   - III. Refer all pregnant women to PHC for RPR test for syphilis.
   - IV. Conduct deliveries in her area when called for
   - V. Supervise deliveries conducted by Dais and assist them whenever called in.
2. **Family planning**
   - I. Spread the message of family planning to the couples and motivate them for family planning individually and in groups.

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II. Establish female depot holders, and provide a continuous supply of conventional contraceptives to the depot holders.
III. Build rapport with acceptors, village leaders, ASHA, Dais and others and utilize them for promoting family welfare programme.
IV. Identify women leaders and help the Health assistant (Female) to train them.

3. Medical Termination of Pregnancy

I. Identify the women requiring help for medical termination of pregnancy and refer them to nearest approved institution.
II. Educate the community of the consequences of septic abortion and inform them about the availability of services for medical termination of pregnancy.

4. Nutrition

I. Distribute Iron and Folic Acid tablets as prescribed to pregnant women.
II. Administer Vitamin A solution to children as per the guidelines.
III. Educate the community about nutritious diet for mothers and child.
IV. Coordinate with Anganwadi Workers.

5. Universal Programme on Immunization (UIP)

I. Immunize pregnant women with tetanus toxoid.
II. Administer DPT vaccine, oral poliomyelitis vaccine, measles vaccine and BCG vaccine to all infants and children, as per immunization schedule.
III. Ensure injection safety.

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Code of Ethics For ANM

The **Code of Ethics for Nurses** consists of two components:

1. the provisions
2. the accompanying interpretive statements.

The Code of Ethics for Nurses

Provision 1

1. Respect for human dignity
2. Relationships to patients
3. Thenature of health
4. The right to self-determination
5. Relationshipswith colleagues and others

Provision 2

1. Primacy of the patient's interests
2. Conflict of interest for nurses
3. Collaboration
4. Professional boundaries

Provision 3

1. Protection of the rights of privacy and confidentiality
2. Protection of human participants in research
3. Performance standards and review mechanisms
4. Professional competence in nursing practice
5. Protecting patient health and safety by action on questionable practice
6. Patient protection and impaired practice

Provision 4

1. Authority, accountability,and responsibility
2. Accountability for nursing judgment, decisions,and action
3. Responsibility for nursing judgment, decisions, and action
4. Delegation of nursing activities or tasks

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Provision 5

1. Duty to self and others
2. Promotion of personal health, safety, and well-being
3. Wholeness of character
4. Preservation of integrity
5. Maintenance of competence and professional growth
6. Personal growth

Provision 6

1. The environment and moral virtue and values
2. The environment and ethical obligation
3. Responsibility for the healthcare environment

Provision 7

1. Contributions through research and scholarly inquiry
2. Contributions through developing maintaining, and implementing professional practice standards
3. Contributions through nursing and health policy development

Provision 8

1. Health is a universal right
2. Collaboration for health, human rights,and health diplomacy
3. Obligation to advance health and human rights

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4. Collaboration for human rights in complex and extraordinary practice setting.

Provision 9

1. Articulation of values
2. Integrity of the profession
3. Integrating social justice
4. Social justice in nursing and health policy

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UNIT6- STRUCTURE OF COMMUNITY

RURAL COMMUNITY

India is a land of villages. There are 640867 villages. Out of every 1000 population, 690 live in villages. The average population of an Indian village is about 550 or 100 families. The villages are self -sufficient. The rural people depend primarily upon agriculture. Caste, religion, ritual, kinship, marriage, economy are some of the important aspects of Indian village society.

Characteristics of rural community

The characteristics of rural community are following:

1. Rural area is sparsely populated because many people leaves rural areas and settles in the urban areas for more facilities.
2. These society has homogeneity. in its profession that is their only source of earning is agriculture and this is transmitted from generation to generation.
3. There is homogeneity in dress, language and customs. It means all these remain same because their culture is same they belong to the same area.
4. These areas have got slow means of communication.
5. Rural areas have very slow rate of change because of lack of education and modern technology.
6. Areas have got simple culture transmitted from generation to generation.
7. Rural areas have got informal social life that is they spent their life in a. simple way.

Changes in village community development

The **change in village community** may be seen in different spheres:

(i) Caste System: The British rule in India gave a serious blow to the caste system in the **villages**. Thus caste system has now lost its traditional hold in the **villages**, however, casteism is getting strengthened on account of selfish political interests.

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(ii) **jajmani system:**Jajmani system is a traditional feature of the village community in India. Jajmani system refers to the system of offering service and accepting service.

(iii) Marriage system: The village community also witnesses changes with regard to marriage. Although endogamy largely prevails in the rural areas, what is novel and interesting is that there is a trend towards an increase in love-marriages and inter-caste marriages.

(iv) Family system: The most important feature of rural family in India is the practice of joint family system. As a result of certain factors such as impact of western philosophy and growing individualism, joint families are gradually disintegrating.

(v) **Economic system:** Several changes are noticeable in the economic sphere. The farmers are increasingly making use of better seeds, manures, fertilizers, pesticides, tractors etc with a view to increase agricultural production both quantitatively and qualitatively.

Major Rural Problems

In a community, there are both individual and social problems. When individual problems affect a large number of people, they become social problems. Some of the present day social problems are:-

1. Alcoholism
2. Drug dependence
3. STD
4. Vagrancy
5. Juvenile delinquency
6. Prostitution

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Social problems are solved by social and political action that is by social welfare programmes, social assistance, and social legislation in the community to curb the social evils. The prevention of Immoral Traffic Act, The Medical Termination of pregnancy Act, The prevention of Food Adulteration Act.

URBAN COMMUNITY

Towns and cities comprise the urban society. They are relatively large, dense and permanent settlements of people. According to the 2011 census, there are 7935 towns and cities in India. It has been said civilization means the city, and the city means civilization. The city represents the way of living of man in modern age. The occupational pattern of the urban people is different. They depend less on agriculture. There is an occupational diversity. The social life is impersonal and less intimate.

Characteristics of urban community

The characteristics of urban community are following:

1. Urban society is thickly populated because many people comes from rural areas and settles down here for better facilities of life.
2. This society has homogeneity in profession it means that there are many professions through which people can earn.
3. In urban areas there is difference in dress, language and customs because there are a variety of people having different backgrounds.
4. have got fast means of communication that is they Gets aware of what is happening around the world rapidly.
5. The areas have got fast rate of change because of education and modern technology.
6. These areas have got complex culture because of mixing of other cultures in it.
7. Urban areas have got formal social life.

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8. Urban areas have got weak interactions and ties on the basis of their complex.

Changes & Adjustments to Urban Environment

Environmental Effects of Urbanization:

Urban populations interact with their environment. Urban people change their environment through their consumption of food, energy, water, and land. And in turn, the polluted urban environment affects the health and quality of life of the urban population

Although **urban sprawl** has its benefits, such as creating local economic **growth**, **urban sprawl** has many negative consequences for residents and the **environment**, such as higher water and air pollution, increased traffic fatalities and jams, loss of agricultural capacity, increased car dependency

Migration is the demographic process that links rural to urban areas, generating or spurring the growth of cities. The resultant urbanization is linked to a variety of policy issues, spanning demographic, economic, and environmental concerns. Growing cities are often seen as the agents of environmental degradation. Urbanization can place stress on the land through sprawl; coincident industrial development may threaten air and water quality

Impact of Urbanization on Environment

1. Urban lifestyles, which tend to be consumptive, requiring great natural resources and generating increasing amounts of waste also lead to increased levels of air, water and soil pollution.
2. Approximately 97% of the earth's water is stored in the oceans, and only a fraction of the remaining portion is usable freshwater. The consequences of urbanization are a decrease in the volume of water that percolates into the ground; and a resulting increase in volume and decrease in quality of surface water.

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3. Air pollution often plagues industrialized cities, particularly during their early development. Episodes of high levels of sulfurous smog killed or sickened thousands
4. Urbanization has led to reduced physical activity and unhealthy nutrition. The World Health Organization predicts that by 2020, non-communicable diseases such as heart disease will account for 69 percent of all deaths in developing countries.
5. Consequences of urban industry, emissions from cars, and the electricity demand. Around the world, companies use fossil fuels such as coal and petrol to generate electricity. Burning these compounds leads to an increase in air pollutant and greenhouse gas emissions.

Major Urban Problems

Poor air and water quality, insufficient water availability, waste-disposal **problems**, and high energy

consumption are exacerbated by the increasing population density and demands of **urban** environments

Drug addiction: Drug addiction is defined as a state of periodic or chronic intoxication

detrimental to the individual and society produced by the repeated intake of habit forming drugs.

Alcohol abuse

Alcoholism is a worldwide social and medical problem. Over the past 30 to 40 years, alcohol consumption has increased in quantity and frequency. The age at which people start drinking has also declined.

VILLAGE : PHYSICAL STRUCTURE

From the prehistoric times, the village has been enjoying an important place as the unit of Indian social structure. India can righty be called a land of villages. A

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large proportion of India lives in villages. India can rightly be called the land of Villages.

The rise of the village is bound up with the rise of agricultural economy in history. The emergence of a village signified that man passed from the nomadic mode of collective life to a settled one.

ON THE BASIS OF STRUCTURE:

1. The **Nucleated Village**: Habitation area is well marked. The boundaries of the village together with its fields are never perceived. The fields owned by one village merge into those owned by another except where a hillock or stream or a highway forms a boundary. These villages are situated on high plateau of the Deccan Village
2. **The Linear Village** : These villages are strung along length-wise on two sides of the road. The houses stand on their own compounds with their gardens and are fenced from all sides One walks or drives through on both sides of the road all the time .
3. **DISPERSED VILLAG**E: The houses are situated in their own fields in clusters of two or three huts all belonging to a single close kinship group. They are either huts of the father and grown up sons or brothers and their wives. The next cluster of huts may be as far as a furlong or too away depending upon how big the holding of each cluster is. The habitation area is not distinguished from the cultivated area and the widely scattered houses of these villages.
4. ON THE BASIS OF RESIDENCE: Migratory Village , Semi-permanent Agricultural Village, Permanent Agricultural Village

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5. ON THE BASIS OF ORGANISATION: Co-operative Villages, Semi-Collective Villages, Collective Villages.
6. ON THE BASIS OF LAND OWENERSHIP: Landlord Villages

UNIT 7-DYNAMICS OF COMMUNITY

Social Processes

Socialization is the process of internalizing the norms and ideologies of society. Socialization encompasses both learning and teaching and is thus "the means by which social and cultural continuity are attained"

Individual & Process of Socialization

Socialisation is known as the process of inducting the individual into the social world. The term socialisation refers to the process of interaction through which the growing individual learns the habits, attitudes, values and beliefs of the social group into which he has been born.

Socialization is a **process** that introduces people to social norms and customs. This **process** helps individuals function well in society, and, in turn, helps society run smoothly. Family members, teachers, religious leaders, and peers all play roles in a person's **socialization**.

Socialization is important in the process of personality formation. While much of human personality is the result of our genes, the socialization process can mold it in particular directions by encouraging specific beliefs and attitudes as well as selectively providing experiences.

Process of Socialization

Process of Socialization “Begins At Birth, Ends with Death” The Human Infantϖ comes into the world as biological organism. He is gradually moulded into a social being by the groups in society. He learns social ways of acting and feeling by

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imitating others. The process of moulding into a person is known as "Socialization."

Interaction between different social group in the village

Social Group

According to MacIver and Page "Any collection of human beings who are brought into social relationship with one another".

According to Green, "A group is an aggregate of individuals which persist in time, which has one or more interests and activities in common and which is organised."

Social relationships involve some degree of reciprocity and mutual awareness among the members of the group.

Characteristics of Social Groups:

1. **Similarity of Behaviour:**

For the fulfillment of common interest, the members of a group behave in a similar way. Social group represents collective behaviour. The-modes of behaviour of the members on a group are more or less similar.

2. **Sense of Unity:**

Each social group requires sense of unity and a feeling of sympathy for the development of a feeling or sense of belongingness.

3. **Mutual Awareness:**

The members of a social group must be mutually related to one another. A more aggregate of individuals cannot constitute a social group unless reciprocal awareness exist among them. Mutual attachment, is therefore, regarded as its important and distinctive feature. It forms an essential feature of a group.

4. **Group Norms:**

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Each and every group has its own ideals and norms and the members are supposed to follow these. He who deviates from the existing group-norms is severely punished.

Different Social groups in villages

1. **Primary Group** : The Primary group is the most simple and universal form of association. It is nucleus of all social organization. It is a small group in which a small number of persons come into direct contact with on another.
2. **Secondary Group:** The Secondary groups are of special significance in modern industrial society. "The secondary groups can be roughly defined as the opposite of everything already said about primary groups."
3. **Reference Group:**

A reference group may or may not be a membership group. The term reference was introduced "An Outline of Social Psychology".

TRADITION & CUSTOMS

Tradition : A **tradition** is a belief or behavior (**folk custom**) passed down within a group or society with symbolic meaning or special significance with origins in the past.

Custom : A custom is defined as a cultural idea that describes a regular, patterned behavior that is considered characteristic of life in a social system. Shaking hands, bowing, and kissing—all **customs**—are methods of greeting people.

Today's custom is tomorrow's *tradition*.

Influencing Factors of Customs & Tradition on health

1. The influence of custom on health is vast. It affects perceptions of health, illness and death, beliefs about causes of disease, approaches to health promotion, how illness and pain are experienced and expressed, where patients seek help, and the types of treatment patients prefer.

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2. Culture is a pattern of ideas, customs and behaviours shared by a particular people or society. It is constantly evolving.
3. Both health professionals and patients are influenced by their respective cultures.
4. Cultural bias may result in very different health-related preferences and perceptions. Being aware of and negotiating such differences are skills known as 'cultural competence'.
5. The amount of money you make has an effect on your health. People with higher incomes tend to be healthier and live longer than people with low incomes.
6. People who are continually exposed to poor living conditions have a higher risk of developing health problems. It is important that home is safe and free from hazards .
7. Housing can contribute to health when it provides you with a safe place to be.
8. It can be influenced by family, culture, society, environment, religious belief and ethnicity.

SOCIAL STRATIFICATION

Social stratification refers to society's categorization of its people into groups based on

Socioeconomic factors like wealth, income, race, education, gender, occupation, and **social** status, or derived power.

Influence of Class, Caste and race on health and health practices

Caste is one in which people are born into their social standing and will remain in it their whole lives. People are assigned occupations regardless of their talents, interests, or potential.

In the Hindu caste tradition, people were expected to work in the occupation of their caste and to enter into marriage according to their caste.

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Class : It consists of a set of people who share similar status with regard to factors like wealth, income, education, and occupation.

Race" refers to physical differences that groups and cultures consider socially significant, while "ethnicity" refers to shared culture, such as language, ancestry, practices, and beliefs.

Influencing Factors of caste on health & health practices

1. Caste is a major indicator of health outcomes and mandates the need for interventions that change social structures.
2. The restricted access **of** those from the lower **castes** to clean water, sanitation, nutrition, housing, education, **health** care and employment is due to a toxic combination **of** poor social policies and programs, unfair economic arrangement and bad politics.
3. Waiting time at health facility belongs to lower caste
4. Not treated good compare with other higher class
5. Inequality is the biggest issue.

Influencing Factors of class on health & health practices

The higher level of education, marital status, number of family members, medical security type, housing type, economic activity, private pension or life insurance, subjective health condition, and chronic disease are the influential factors.

Influencing Factors of race on health & health practices

The studies has proven that racial categories depending on different factors such as: phenotype, ancestry, social identity, genetic makeup and lived experience facing alots of problems in getting health facility .

Problems faces by special race are:

African Americans have higher rates of diabetes, hypertension, and heart disease than other groups. Nearly 15 percent of African Americans have diabetes

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compared with 8 percent of whites. Asthma prevalence is also highest among blacks.

THE FAMILY AND MARRIAGE

The family is a primary unit in all societies. It is a group of biologically related individuals living together and eating from a common kitchen. The term family differs from household in that all the members of a household may not be blood relations, e.g. servants.

TYPES OF FAMILIES

Family units throughout the world are not the same. Industrialization, urbanization, democratization and acculturation have affected the family structure and life. Social scientist have described three main types of families-

(1) **NUCLEAR FAMILY**
(2) **JOINT FAMILY**
(3) **THREE GENERATION FAMILY**

(1) NUCLEAR FAMILY

Nuclear family consists of the married couple and their children while they are still regarded as dependents. In nuclear family, the husband usually plays a dominant role in the household. The husband wife relationship is likely to be more intimate in the nuclear family than in the joint family.

(2) JOINT FAMILY

The joint family is a kind of family grouping which is common in India, Africa, the Far East and Middle East. It is more common in agricultural areas than in urban areas

The main characteristics of a typical joint family are-

(I) It consists of a number of married couples and their children who live together in the same household.

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(II) All the property is held in common. There is a common family purse to which all the family income goes and from which all the expenditures are met.

(III) All the authority is vested in the senior male member of the family. He is the most dominant member and controls the internal and external affairs of the family.

(3) THREE GENERATION FAMILY

The three generation family is confused with the joint family. It is fairly common in the west. This tends to be a household where there are representatives of three generations. Thus, representatives of three generations related to each other by direct descent live together.

Changes & Legislation on family & marriage in India - Marriage ACT

The **Special Marriage Act, 1954** is an Act of the Parliament of India enacted to provide a special form of marriage for the people of India and all Indian nationals in foreign countries, irrespective of the religion or faith followed by either party. The Act originated from a piece of legislation proposed during the late 19th century.

objectives:

1. To provide a special form of marriage in certain cases.
2. To provide for registration of certain marriages.
3. To provide for divorce

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Applicability

1. Any person, irrespective of religion.
2. Hindus, Muslims, Buddhists, Jains, Sikhs, Christians, Parsis, or Jews can also perform marriage under the Special Marriage Act, 1954.
3. Inter-religion marriages are performed under this Act.
4. This Act is applicable to the entire territory of India and extends to intending spouses who are both Indian nationals living abroad.
5. Indian national living abroad

Conditions For Marriage

- Each party involved should have no other subsisting valid marriage. In other words, the resulting marriage should be monogamous for both parties.
- The groom must be at least 21 years old; the bride must be at least 18 years old.
- The parties should be competent in regard to their mental capacity to the extent that they are able to give valid consent for the marriage. The parties should not fall within the degree of prohibited relationship

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UNIT 8- Community Needs Assessment

A community needs assessment identifies the strengths and resources available in the community to meet the needs of children, youth, and families. The assessment focuses on the capabilities of the community, including its citizens, agencies, and organizations.

Scope of community needs **assessment**

A **community** needs **assessment** provides **community** leaders with a snapshot of local policy, systems, and environmental change strategies currently in place and helps to identify areas for improvement.

Importance

- Community assessment is an important tool in community development
- Each community is unique with its own set of goals, preferences, assets, issues, resources, past history, and potential for the future. A proper assessment can help a community make decisions that are appropriate to its unique set of circumstances.
- It is useful in identifying community assets, opinions and goals.
- Planning for the future
- It helps in identifying local resources.
- Encouraging local participation.
- Marketing your community
- Identifying community needs

Methods of Community Health Needs Assessment

Step 1: Identify and engage stakeholders.

Step 2: Define the community.

Step 3: Collect and analyze data.

Step 4: Select priority community health issues.

Step 5: Document and communicate.

Step 6: Plan improvement strategies.

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Step 7: Implement improvement plans.

Step 8: Evaluate progress.

Survey

The **Survey method** is the technique of gathering data by asking questions to people who are thought to have desired information. A formal list of questionnaire is prepared.

Principles of Data Collection

The basic principles of data collection include:

1. Keeping things as simple as possible.
2. Planning the entire process of data selection, collection, analysis and use from the start; and ensuring that any data collected is valid, reliable and credible.
3. It is also important that ethical issues are considered.

Planning Preparation of tool for survey:

INTERVIEW

" A method of data collection in which one person (interviewer) asks the questions from another person (respondent); which is conducted either face to face or telephonically".

or

"An interview is a conversation between two or more people (interviewer and interviewee) where questions are asked by interviewer to obtain information from the interviewee".

Types of interview

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Basically interview can be classified as following

1. ***Structured interview:(directive interview):*** It is a means of data collection in which interviewer has interview schedule which lists the questions which are to be answered in the same order.

2. **Unstructured interview:** Unstructured interview is a method where questions can be changed to meet the respondent intelligence, understanding and beliefs.

3. ***Semi-structured interview:*** Semi-structured interview is a flexible method that allows new questions to be brought up during the interview depending upon the situation needs.

4. ***In-Depth interview:*** This is an intensive and searching interview. Requires more training and interpersonal skills.

5. ***Focused group interview:*** Focused group interview is a unstructured group interview technique where 8-12 members are brought together under the guidance of a trained interviewer, to focus on a specific concept.

6. ***Telephone interview:*** Telephone interviewing is a non-personal method of data collection. This method of collecting information consists in contacting respondents on telephone itself.

QUESTIONNAIRE

"A Questionnaire is a structured instrument consisting of a series of questions prepared by researcher that a research subject is asked to complete, to gather data from individuals about knowledge, attitude, beliefs and feelings".

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Types of questions

1. ***Open format questions*** **:** Open ended questions are those questions which provide opportunity to sample to express their opinions and answer in their way.
2. ***Closed format questions*:** These questions offer respondents a number of alternative replies, from which the subjects must choose the one that most likely matches the appropriate answer.
3. ***Dichotomous questions*** *:* These require the respondent to make a choice between two responses such as yes/no or male/female.
4. ***Choice questions****:* These questions require respondents to make a choice between more than two response alternatives.
   Example: Q. which of the following diseases is sexually transmitted?

CHECKLIST

Checklist method consists of a series of statements, both positive and negative, that the evaluator answers "yes" or "no," checks if the employee exhibits that behaviour or leaves it unchecked if she does not.

TYPE Of CHECKLIST

1. Simple Checklist: is the employee regular on the job-Yes/No
2. Forced Choice Checklist

a. Regularily on the job
b. Always regular
c. Never Regular
d. Remains absent without prior notice

3. Weighted Checklist Traits

a. Attendance knowledge of the job
b. Quantity of the work
c. Quality of the work
d. Dependability

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e. Interpersonal relations

FOCUS GROUP DISCUSSION

A **focus group discussion** involves gathering people from similar backgrounds or experiences together to **discuss** a specific topic of interest. It is a form of qualitative research where questions are asked about their perceptions attitudes, beliefs, opinion or ideas.

Advantages

1. They are useful to obtain detailed information about personal and **group** feelings, perceptions and opinions.
2. They can save time and money compared to individual interviews.
3. They can provide a broader range of information.
4. They offer the opportunity to seek clarification.
5. Easily Measure Customer Reaction

Disadvantages

1. There can be disagreements and irrelevant **discussion** which distract from the main **focus**.
2. They can be hard to control and manage.
3. They can to tricky to analyze.
4. They can be difficult to encourage a range of people to participate.

Importance

1. Focus group **research** is used to develop or improve products or services.
2. The main purpose is to provide data to enhance, change or create a product or service targeted at a key customer group.
3. The above example targeted improving the experience of parents of sick children

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CASE STUDY

A **case study** is a research method involving an in-depth, and detailed examination of a particular case. Generally, a case can be nearly any unit of analysis, including individuals, organizations, events, or actions.

Case studies can be produced by following a formal research method. These case studies are likely to appear in formal research venues, as journals and professional conferences, rather than popular works. Case study research can mean single and multiple case studies, can include quantitative evidence, relies on multiple sources of evidence, and benefits from the prior development of theoretical propositions.

Advantages:

1. They are efficient for rare diseases or diseases with a long **latency** period between exposure and disease manifestation.
2. They are less costly and less time-consuming
3. They are advantageous when exposure data is expensive or hard to obtain.

Disadvantages:

1. The first is that they are subject to bias
2. All **case studies** are useless when used as evidence
3. The data collected cannot stand on its own if one wishes to make generalizations.

PARTICIPATORY LEARNING FOR ACTION (PLA)

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Participatory Learning for Action (PLA) is a community-based approach to research and consultation that gives priority to the views of local people, on the basis they are the experts, and are best placed to come up with a programme of collective action.

It is an approach for **learning** about and engaging with communities. In contrast, PLA tools combine the sharing of insights with analysis and as such, provide a catalyst for the community themselves to act on what is uncovered.

Importance

Participatory Learning for Action is a family of approaches, methods, attitudes, behaviours and relationships, which enable and empower people to share, analyse and enhance their knowledge of their life and conditions, and to plan, act, monitor, evaluate and reflect.

Principles

1. It is highly participative and interactive : It relies on conversations, and dialogue, rather than people just ticking boxes.
2. It is inclusive: PLA will always involve a wide range of people taking part.
3. It will be a process : PLA needs to be part of a programme of consultation and engagement, with different activities at activities being focussed on different parts of the community.
4. It is community led : Agencies and service providers are key partners, but it is the residents/stroke community that should drive the process .
5. It is flexible and adaptable : there are a range of techniques and methods available, designed to work in different situations, with different groups)

ANALYSIS OF DATA

Data analysis is a process of inspecting , cleansing , transforming and modelling data with the goal of discovering useful information, informing conclusion and supporting decision-making.

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Analysis can be applied to whole society or groups defined by criteria such as: Education, nationality, religion and ethnicity.

STEPS OF ANALYSIS OF DATA:

1. **EDITING:** It is a first step of data analysis. It helps to compile the data more relevant and useful. After editing the data acquire the following characteristics.
   - **Accurate**
   - **Consisting**
   - **Uniformly**
   - **Complete**

2. **CODING:** it is assigning the no. of symbol to make the data more simple and understandable. In this the data must be categories based on certain criteria are:
   - ✓ **Appropriateness of data in the research**
   - ✓ **Briefing the data**
   - ✓ **The data should not be duplicated**

3. **DATA ENTRY:** in this step the coded data enters into the computer system to analyse it the destructive and inferential statistics can be used to analyse the data and provide sufficient knowledge on demography and help status of people in the country.

Most Important Things to Remember About Data Analysis

1. Develop a plan before you analyze data.
2. Specify how good is good enough.
3. Specify what you will do with each kind of data, including when you will combine categories and how you will present results (as numbers, %s or categories).
4. Figure out how you will handle missing data. 2
5. Develop some dummy tables or lists to hold your analyzed data – share those with others.

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6. Identify the most important findings from your data, summarize them and then use the specific results (e.g., a table or list of data) to clarify your findings.
7. Present your analysis in an orderly, meaningful, simple way.

Preparation of Report

When writing report a good outline is:

1) Overview of the problem

2) Data and modeling approach

3) The results of data analysis (plots, numbers, etc)

4) Substantive conclusions.

Most Important Things to Remember About Report Writing

1. Follow the report writing outline in your manual. Feel free to be somewhat flexible with the order, but don't leave out whole sections.

2. Make your own internal outline including who is responsible for which sections. Be sure that you leave time for stakeholders to help you with editing/making revisions.

3. Be economical in your decisions about what to include in your report. Shorter is better.

4. Avoid excessive use of jargon.

5. Read work – if you can't understand it, chances are others won't be able to either. Think, in simple terms, about what you are trying to say, and then write that.

6. Use tables and Graphs to help illustrate findings

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UNIT 9-COMMUNICATION METHODS & MEDIA

COMMUNICATION

Communication can be regarded as a process by which two or more persons exchange or share ideas, facts, feelings or impressions. The important word is sharing.

Process of Communication

The **process of communication** refers to the transmission or passage of information or message from the sender through a selected channel to the receiver overcoming barriers that affect its pace. The **process of communication** is a cyclic one as it begins with the sender and ends with the sender in the form of feedback.

The different elements in the process of communication are:

- Sender
- Message
- Encoding
- Channel
- Receiver
- Decoding
- Feedback

Sender

The person who transmits or sends the message is known as sender. He is the sender of the message which may be a thought, idea, a picture, symbol, report or an order and postures and gestures, even a momentary smile. The sender is therefore the initiator of the message that need to be transmitted.

Message

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Message is referred to as the information conveyed by words as in speech and write-ups, signs, pictures or symbols depending upon the situation and the nature and importance of information desired to be sent.

Encoding

Encoding is putting the targeted message into appropriate medium which may be verbal or non-verbal depending upon the situation, time, space and nature of the message to be sent. The sender puts the message into a series of symbols, pictures or words which will be communicated to the intended receiver.

Channel

Channel refers to the way or mode the message flows or is transmitted through. The message is transmitted over a channel that links the sender with the receiver.

Receiver

Receiver is the person or group who the message is meant for. The receiver is as significant a factor in communication process as the sender is.

Decoding

Decoding refers to interpreting or converting the sent message into intelligible language. The receiver after receiving the message interprets it and tries to understand it in the best possible manner.

Feedback

Feedback is the ultimate aspect of communication process. It refers to the response of the receiver as to the message sent to him/her by the sender. Feedback is necessary to ensure that the message has been effectively encoded, sent, decoded and comprehended.

METHODS OF COMMUNICATION

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1. **One-way communication**
   The flow of communication is one-way, that is from the sender to the receiver. There is no feedback; learning is passive.
2. **Two-way communication**
   In this method the learner listens to the message. He may raise questions to be sure he has understood. He may add his own information, ideas and opinions. This is called feed-back.
3. **Verbal communication**
   The verbal means of communication includes the use of language – whether spoken or written. Written communication may not be as persuasive or personal as the spoken word.
4. **Non-verbal communication**
   It includes a whole range of gestures, facial expressions (e.g. smile, raising eye brows, winking, staring, gazing), postures, bodily movements, and even silence.
5. **Listening**
   Many educators spend more time in talking, and less in listening. Listening is not simply hearing, but hearing with understanding. The ability to listen carefully with understanding is a communication skill.

Principles

1. Clarity in Ideas
2. Appropriate Language
3. Attention
4. Consistency
5. Adequacy
6. Proper Time
7. Informality
8. Feedback

The chief purpose of **communication** is the exchange of ideas among various people working in the organization.

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INTERPERSONAL RELATIONSHIP

Meaning: A strong bond between two or more people refers to interpersonal relationship.

Definition: An **interpersonal relationship** is a strong, deep, or close association or acquaintance between two or more people that may range in duration from brief to enduring.

Forms of Interpersonal relationship

An interpersonal relationship can develop between any of the following:

- Individuals working together in the same organization.
- People working in the same team.
- Relationship between a man and a woman (Love, Marriage).
- Relationship with immediate family members and relatives.
- Relationship of a child with his parents.
- Relationship between friends.

Relationship can also develop in a group (Relationship of students with their teacher, relationship of a religious guru with his disciples and so on)

COMPONENTS:

1. **Passion:** Passion refers to the physical and sexual attraction between two individuals. Individuals must feel physically attracted to each other for the charm to stay in relationship for a much longer period of time.
2. **Intimacy:** The amount of closeness between two individuals in a relationship refers to intimacy. Partners must gel with each other and a strong bond between them is essential.
3. **Commitment:** The decision of two individuals to stay together forever is called commitment. Commitment is nothing but two people deciding to be with each other life-long either by staying together or by entering the wedlock.

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If any of the above factors is missing from a relationship, love fades away in a short span of time giving rise to troubles and sorrows.

Interpersonal Relationship between a man and a woman

A strong interpersonal relationship between a man and a woman leads to friendship, love and finally ends in marriage.

- A sense of commitment is essential in marriages and love affairs.
- Partners must feel attached to each other and most importantly trust each other.

Relationship between friends

- Friends must be honest to each other.
- Stand by your friends at times of need.
- Avoid leg pulling, criticism and making fun of your friends.
- Try not to mix friendship with love as it creates problems and misunderstandings.

Interpersonal relationships with Health Team Members:

An association between individuals working together in the same organization is called interpersonal relationship. One needs people to talk to and discuss various issues at the workplace.

Patient safety is compromised by medical errors and adverse events related to miscommunications among healthcare providers. Communication among healthcare providers is affected by human factors, such as interpersonal relations.

The way medical personnel responds to the needs and requests of patient & health team membersit helps to boosts performance, contributing to an increase in the prestige of the medical unit and the growing interest of patients-customers in it.

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AUDIO-VISUAL AIDS

According to the Webster dictionary, **audio-visual aids** is **defined** as "training or educational materials directed at both the senses of hearing and the sense of sight, films, recordings, photographs, etc. used in classroom instructions, library collections or the likes".

No health education can be effective without audio-visual aids. Audio-visual aids can be classified into 3 groups-

(1) Purely auditory
(2) Purely visual
(3) Combined audio-visual

1. AUDITORY AIDS
   Tape recorders
   Microphones
   Amplifiers
   Earphones

2. VISUAL AIDS
   Blackboard
   Flannel graph
   Models
   Specimens
   Posters
   Slides
   Film strips
   Epidiascope
   Overhead projector
3. COMBINED AUDIO-VISUAL AIDS
   Sound films
   Slide tape combination
   Television

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Computer & Internet

A Knowledge of the advantages, disadvantages and limitations of each audio-visual aid is necessary in order to make proper use of them. Audio-visual aids are means to an end; not an end in themselves.

Uses of AV-AIDS

1. Audio visual aids are important tools for teaching learning process.
2. It helps the teacher to present the lesson effectively and students learn and retain the concepts better and for longer duration.
3. It helps to improves students' critical and analytical thinking.
4. Audio visual aids are used in classrooms to encourage teaching learning process and make it easier and interesting.
5. Audio -visual aids are the best tool for making teaching effective and the best dissemination of knowledge .

FOLK MEDIA

The word **'FOLK' h**as been derived from a German word 'YOLKS' which means the people. Folk Media is media of the people.

Definition : Folk Media refers to traditional media based on sound, image and sign language. It is expressed in the form of traditional music, drama, dance and puppetry.

Traditional folk media is a term used to denote 'people's performances'. This term refers to the performing arts which can be described as the cultural symbols of the people. **Folk** dance, rural drama and musical variety of the village people, all come under **traditional media**.

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Use of Traditional Local and Folk Media in Disseminating Health Message

Media:

The means of communication to the large audience through newspapers, television and radio etc.

Traditional Media:

- It is the time privileged, predictable means of the mass communication which includes the mediums of communication before the dawn of internet such as newspapers, television, magazines etc. It is also known as the old way of communication.
- Communication is the key to human development. For the development process people's participation is the key element to the progress. Communication is the essential to the development task in many ways.
- Only with the process of communication the project recipients will become the major performers to make development programs successful and for this purpose
- Traditional media is a very important and operative component in the way of communication for the development process. Traditional media procedures are portion of the means of life of a community and deliver satisfactory means of fetching development issues on its own terms into the community.
- Media is known as the source of entertainment but with the quotient of entertainment it can be a revolutionary giant in the society.
- In the society media can highlight the different issues of the society and can expose the corruption and made people realize about the certain things and led them to the way of development.

Behavior Change Communication

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Behavior change communication (BCC) is the strategic use of **communication** approaches to promote changes in knowledge, attitudes, norms, beliefs and behaviors.

Importance

1. BCC helps to trigger and stimulate people for adopting positive **behavioral** approaches.
2. BCC promotes appropriate and essential attitude **change**.
3. BCC strategies and messages are tailored for specific target groups, these strategies are efficient and effective.
4. To develop communication strategies to promote positive behaviors which are appropriate to their settings and there by solve world's most pressing health problems.

STEPS:

BCC / SBCC (Sustained behavior change communication) is the comprehensive process in which one passes through the stages:

1. State program goals
2. Involve stakeholders
3. Identify target populations
4. Conduct formative BCC assessments
5. Segment target populations
6. Define behavior change objectives
7. Define SBCC strategy & monitoring and evaluation plan
8. Develop communication products
9. Pretest
10. Implement and monitor
11. Evaluate
12. Analyze feedback and revise

Influencing Factors of BCC

Behavior change is influenced by motivation from others (external influence) as well as from within oneself (internal influence). Internal

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influence plays a significant role in creating more enjoyment of a behavior change, instilling a sense of ownership of the new behavior, which in turn instills a sense of ownership of the changed behavior.

IEC

Information, Education and Communication abbreviated as IEC.

It is a strategy to spread awareness through communication channels to a target audience to achieve a desired positive result. It is a strategy of sharing information through the broadcast or the print media, or interpersonal communication in a manner, appropriate to the target group's culture and values.

Aims

1. To encourage people to adopt and sustain health promoting life style and practices.
2. To promote the proper use of health services available to them.
3. To arouse interest, provide new knowledge, improve skills and change attitudes in making rational decisions to solve their own problems.

Importance

1. It is important for advocacy, to motivate policy and decision-makers to create environments conducive for behavioural changes.
2. To provide the needed services such as condoms, counseling and treatment of sexuallytransmitted diseases.
3. It has proven powerful tools for bringing social change and development.

Approaches: The approaches of IEC are based upon following fields or subjects

1. Diffusion theory
2. Social marketing
3. Behavioural analysis

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4. Instructive design
5. Anthropology

Scope

1. Health care prevention
2. control on communicable diseases
3. Reproductive health/maternal and child health services
4. Family welfare
5. Nutritional services
6. Personal hygiene

Activities:

1. Information Education Communication (**IEC**) is used for generating awareness.
2. It means process of working with individuals, communities & societies to develop communication strategies to promote positive behaviour that are appropriate to their settings.
3. IEC programs engage on different channels of communication, which is exceedingly advantageous for the dissemination of message to varied target groups.

Benefits

1. **Cost Effective:** Printed IEC materials are cheap and inexpensive, thus are suitable for low budget programs. Messages intended for the masses are conveyed on broadcast medium like television, which are effective in disseminating the information to a large audience.

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2. **Building Capacity:** IEC programs ushers in information, skills and knowledge to the target groups which is essential for positive health measures.

3. **Target Specific:** The participatory nature of IEC programs provide a sublime opportunity to engage with the local communities, establish good rapport and to define their specific needs. This enhances the effectiveness of the programs, provides ambient environment for evaluation, improvement and sustenance.

4. **Feedback:** IEC programs have feedback which is vital for clarifying questions, reinforcement and solving issues.

5. **External Support:** These programs can avail support from other counterparts, government, community leaders, opinion leaders, and local support groups which are tremendously helpful in monitoring, sustaining and achieving success of the programs being implemented.

TEACHING LEARNING PROCESS

INTRODUCTION- Teaching and learning activities are twin activities involve in the total educational process. Teaching cannot be thought without an idea of learning and learning is not possible without teaching activities.

STEPS IN LEARNING PROCESS-

Motive of Learner

↓

Stabilizing the goal

↓

Teacher student adjustment

↓

Change in behavior of pupil

↓

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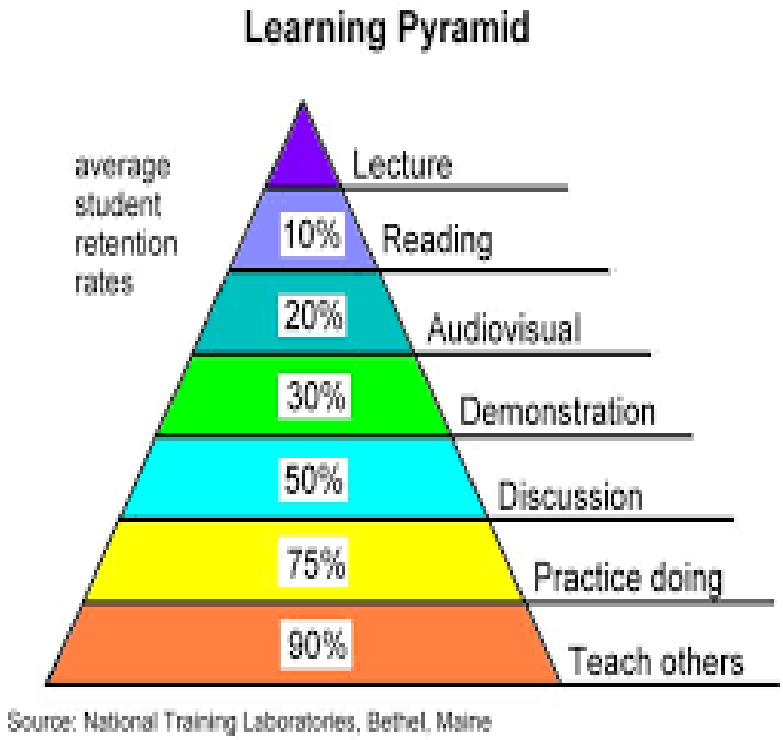
Fixation or stabilization of behavior

CONCEPT OF LEARNING-



CHARACTERISTICS OF LEARNING-

- **Learning is unitary-** The process of learning helps the learner response as a whole person in a unified way to the whole situation or total pattern.
- **Learning is individual and social-** Learning is entirely an individual matter. It is social because it takes place as a type of response to an individual social environment.
- **Learning is purposive-** Learning helps the individual achieve goal or purpose in life.
- **Learning is creative-** Learning helps man to be more creative in life.
- Learning modifies the behavior of individual
- Learning helps in organization of experiences- Learning involves organization and evaluation of learning material.

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- Learning helps make choices in life- Learning is a lifelong process because as changes in life takes place every day, learning is also needed every moment to make best choices and decision in life.
- Learning helps bring changes in life.
- Learning helps in continuous professional development in life.
- Learning helps keep in touch with trends and development in particular field.

TEACHING

Teaching is stimulation, guidance, direction and encouragement of learning. (Clarke)

OR

Teaching is concerned with growth and development of whole personality of the student, his/her mind, character and affective behavior. (Thomas. P Green)

Principles

- Encourage contact between students and faculty.
- Develop reciprocity and cooperation among students.
- Encourage active learning.
- Give prompt feedback.
- Emphasize time on task.
- Communicate high expectations.
- Respect diverse talents and ways of learning.

Methods of Teaching

- Lecture Method
- Lecture cum discussion method
- Recitation oral questions by teacher answered orally by student
- Discussion groups conducted by selected student chairpersons
- Lecture-demonstration by another instructor

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- panel Discussion
- Seminar
- Workshop
- Direct **Instruction**
- Flipped Classrooms
- Differentiated **Instruction**
- Inquiry-based Learning
- Expeditionary Learning
- Personalized Learning
- Game-based Learning

HEALTH EDUCATION

Health education has been defined as a process which effects changes in the health practices of people and in the knowledge and attitudes related to such changes.

Aims of Health Education

The WHO has formulated the aims of health education as follows:

(1) To ensure that health is valued as an asset in the community;

(2) To keep equip the people with skills, knowledge and attitudes- to enable them solve their health problems by their own actions and efforts;

(3) To promote the development and proper use of health services.

Planning of Health Education

Health education is as wide as community health. Every aspect of community health has an educational component.

(1) Human Biology: The structure and function of body are always a marvel to the layman. Ignorance in this field can be removed only by health education.

(2) Nutrition: Education in nutrition holds an important place in the fight against malnutrition. People are ignorant about balanced diets and

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optimum nutrition. In nutrition education, the primary aim is to remove prejudices and impart good dietary habits.

(3) **Hygiene:** There are two aspect of hygiene- personal and environmental. Both are important areas for health education. Personal hygiene includes bathing, clothing, washing hands after toilet, care of feet, nails and teeth. Environmental hygiene has two aspects- domestic and community.

Domestic hygiene comprises that of the home, use of soap and water, lighting and ventilation etc. In community hygiene, we teach the drainage, good housing, town planning etc.

(4) **MCH and family planning:** The fears of the mother about pregnancy and childhood can be dispelled only by health education. Mothers need to be taught about balanced diets, baby care, infant feeding, weaning and immunization, family planning. If we educate the mothers, we educate the whole family.

(5) **Prevention of communicable diseases:** Information is given about the mode of spread of common communicable diseases and protection by immunization against these diseases.

(6) **Prevention of accidents:** Accidents occur in three main areas – the home, the road, and the place of work. Safety education should be directed to these areas. The main factor in accidents is careless, and the problem can be solved only by health education.

(7) **Use of health services:** one of the declared aims of health education is to educate people, to make the best use of the community health services.

(8) **Mental Health:** An area of increasing importance is mental health. Alcoholism, drug dependence, juvenile delinquency, crime and violence are on the increase in many countries. These are special areas needing health education of the people.

ROLE AND RESPONSIBILITIES OF ANM

ANM will carry out the following Role and Responsibilities:

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6. Maternal and Child Health

VI. Register and provide care to pregnant women throughout the period of pregnancy.

VII. Ensure that every pregnant woman makes at least 3 visits for Ante-natal check-up.

VIII. Refer all pregnant women to PHC for RPR test for syphilis.

IX. Conduct deliveries in her area when called for

X. Supervise deliveries conducted by Dais and assist them whenever called in.

7. Family planning

V. Spread the message of family planning to the couples and motivate them for family planning individually and in groups.

VI. Establish female depot holders, and provide a continuous supply of conventional contraceptives to the depot holders.

VII. Build rapport with acceptors, village leaders, ASHA, Dais and others and utilize them for promoting family welfare programme.

VIII. Identify women leaders and help the Health assistant (Female) to train them.

8. Medical Termination of Pregnancy

III. Identify the women requiring help for medical termination of pregnancy and refer them to nearest approved institution.

IV. Educate the community of the consequences of septic abortion and inform them about the availability of services for medical termination of pregnancy.

9. Nutrition

V. Distribute Iron and Folic Acid tablets as prescribed to pregnant women.

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VI. Administer Vitamin A solution to children as per the guidelines.
VII. Educate the community about nutritious diet for mothers and child.
VIII. Coordinate with Anganwadi Workers.

10.Universal Programme on Immunization (UIP)

IV. Immunize pregnant women with tetanus toxoid.
V. Administer DPT vaccine, oral poliomyelitis vaccine, measles vaccine and BCG vaccine to all infants and children, as per immunization schedule.
VI. Ensure injection safety.

UNIT10- COUNSELING

Concept of counseling-

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-interviewing and communication technique

- Problem solving

-Crisis intervention

-Stress management

-Behavioral modification

Aims of counseling –

-Help the client to come out psychological dilemma

-Help the client to take the decision

Principles of counseling –

-Study the client's behavior

-Identify client's like or dislikes

-Spending more time with client

-accepting his/her fear as real to individual

-Listen attentively to client

-Encourage client to express the emotion and feeling

-Be honest and sincere to the client

-Avoid sensitive matters

-Showing concern and positive interest

-Talk with purpose so as to achieve the goal

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-Reassure the client to build up his confidence

-Don't give false hopes

-Maintain realistic nurse –patient relationship

-Assess the emotional as well as intellectual respectively of the client.

Technique of counseling-

1- **Problem solving technique –**
It will help the individuals in solving their problems
It involves following steps-
-Problem identification
-Gathering information
-Decision making
-Implementation
-follow-ups

2- Decision Technique-

The decision is a co-operative attack on a common set of problems based on common set of data or information material and experiences in which the problem is pursue to as complex and deep level as possible.

3- Role playing technique- it takes the form of socio-drama or psycho-drama

4- Lectures

5-case conferences- In this problems faced by majority are discussed as a case.

6- Operant conditioning – It is believed that if proper rewards are given for accepted behaviors then it can be promoted and continued

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7-Aversive conditioning –

8-Reciprocal inhibition- person is asked to shift his imagination from fearful condition to less threatening.

9-Deseysutuzatuib- Patients are gradually exposed to a situation they fear, either in a role-playing situation or in reality.

10- Relaxation

Counseling in the community

Identifying needs-

There are several problems in community which needs counseling by the health care providers

A community health nurse must identify the cases which need counseling. Common problems in community:-

- Psychiatric problems of adolescents like alcohol schizophrenia, anxiety, eating disorder, sexual problems, drug abuse.
- Post partum psychosis and depression.
- Physically handicapped.
- Victims of abuse and violence.
- Mental health problems in elderly
- Psychiatric aspects of HIV/AIDS
- Genetic counseling

Role of counselor

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It is very important for a counselor to understand his /her job.

***Active listening**

Attend closely to the verbal and non- verbal message convey by the client.

***Risk identification**

Counselors need to be identifying risk factors in the client's presentation as well as protective factors to weigh them against.

***Decision- making support**

Provide Information about alternatives and facilitate discussion with other family members.

***Emotional support**

Provide reassurance, acceptance and encouragement during the decision-making process.

Be non- judgmental and convey empathy.

***Referral**

Arrange for referral services if required and prepare referral forms.

***Follow – up care**

Provide follow – up care and support to patient and family.

Role of ANM as counsellor

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***Proper and adequate treatment**

Advice the client about propercare and treatment of the disease.

***Various alternatives**

Discuss various alternatives of treatment with the client. Explain the advantages and dis advantages of alternatives.

***Decision – making support**

Help the client to take his own decision.

***Care required by family members**

Educate the other family members to support the client.

***Maintain privacy and confidentiality.**

Do not discuss anything to anybody about client.

***Adaptation of healthy life style**

Educate the client and family members about adopt the healthy life style .

***Regular follow up**

Provide regular follow ups to check the client and effectiveness of the treatment / counseling.

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UNIT 11-COMMUNITY BASED REHABILITATION

Heath Conditions needing Rehabilitation

Definition

Rehabilitation: The process of helping a person who has suffered an illness or injury restore lost skills and so regain maximum self-sufficiency.

Or

Rehabilitation is the act of restoring something to its original or pre illness stage .

Heath Conditions needing Rehabilitation

Rehabilitation is care that can help to get back, keep, or improve abilities that *need* for daily life. These abilities may be physical, mental, and/or cognitive (thinking and learning). It may be lost because of a disease or injury, or as a side effect from a medical treatment.

Need of Rehabilitation

There are many reasons for a person who need care related to rehabilitation. The circumstances that bring patients to inpatient and outpatient rehabilitation centers are life-changing, and need help to recover as soon as possible. These can be :-

- **Injuries and trauma** such as:
  - Burns
  - Limb loss or amputation
  - Fractures, including multiple fractures to the long bones in the limbs and fractures of the hip, spine, or skull
  - Traumatic brain injury (TBI) or concussion (mild TBI)
  - Spinal cord injury
  - Loss of sight or hearing

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- **Diseases and conditions** that can cause loss of mobility function, such as:
    - Muscular dystrophy
    - Spina bifida
    - Cerebral palsy
    - Arthritis
    - Scoliosis or curvature of the spine
    - Damage to muscles, ligaments, tendons, or cartilage
    - Knee arthroplasty/replacement
    - Hip replacement
    - Stroke
    - Multiple sclerosis
    - Parkinson's disease and related degenerative disorders
- **Surgery or prolonged treatment for other diseases or illnesses** that can cause loss of function, such as:
    - Chronic pain/neuropathy
    - Severe infection
    - Diabetes
    - Cancers (including chemo- and radiation therapies)
    - Peripheral artery disease
    - Cardiac arrest

Community Resources Available

Community Based Rehabilitation (CBR) is used to promote, support and implement rehabilitation activities at the community level and facilitate referrals to access more specialized rehabilitation services.

Rehabilitation services are managed by government, private or nongovernment sectors. In most countries, the ministry of health manages these services.

There are various resources available in community that helps in rehabilitation. They are describe as follows:

1. **Transportation :** Most patients are not ready to drive after they leave inpatient rehab. Fortunately, our community is home to several

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transportation options. For those who live in rural areas Connections **Van** may also be an option.

2. **Human service agencies :** Health team of professionals are also available who delivered treatment to patients at their door steps.
3. Services at Rehabilitation Centres: These services may include physical therapy, occupational therapy, speech and language therapy, cognitive therapy, and mental health rehabilitation services.
4. Publications : The *best* source for publications that enable people with disabilities and chronic conditions to remain independent.

Educate Individual, Family & Community related to Rehabilitation

❖ **For Individual**

1. Rehabilitation can be of significant benefit to an individual who is experiencing a change in his or her physical abilities.
2. Rehabilitation addresses many of the issues and challenges experienced by individuals.
3. The rehabilitation help persons to learn how to care for a body that now works differently, maintain a high level of health that avoids the secondary complications and reintegrate oneself into the community.
4. Safety precautions and the prevention of pressure sores are also vital issues that are promoted through rehabilitation.
5. Rehabilitation is vital in helping you get your life back after an event - physical or psychological.
6. Improves co-ordination for better mobility and easier movement.
7. Improves your flexibility physical therapy for injury can help you achieve a full range of motion in the joints and muscles.
8. Reduces swelling in the affected joints and muscles. Helps improve your balance.

For Family

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Family acceptance and support can help a patient deal with issues related to self-esteem and self-image following disability. Positive attitudes and reinforcement from loved ones often help the individual work towards recovery.

Family members are also affected by disability. In many cases, they may become co-managers of care. They may undergo many changes as a result of your disability. For example, family members may also grieve loss of ability. Family Members must be supported in following way

1. **Building Confidence** – An accident or brain stroke can have a drastic impact on patients. It can leave them feeling severely depressed about their health condition. It is in times like these that you can boost their confidence with positive words and also by your active participation.
2. **Educating Oneself** – The healing process for a patient depends on several factors. As a family member, you can educate yourself on certain factors. For instance, the patient's recovery time from the ailment or injury along with the treatment procedures. Also important is paying attention to and learning about post-treatment care, rehabilitation goals, etc.
3. **Aspect of Cognitive Therapy** – Addressing the emotional aspects of a therapy primary depends on the patient's response to them. The patient's family can take in the Cognitive Behavioral Therapy sessions and understand the entire procedure.
   A patient's impairment and disability can be better explained with coping strategies, their mood and stress handling levels. Family members, with their positive words can help patients in recognizing and recovering from their symptoms.

For Community:

By working together with the rehabilitation team, Individual and his family can help reduce some of the adverse effects of disability.

Aim

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Aim of **community-based rehabilitation (CBR)** is to help people with disabilities, by establishing community-based medical integration, equalization of opportunities, and **Physical therapy .**

Importance

1. The strength of CBR programs is that they can be made available in rural areas, with limited infrastructure, as program leadership is not restricted to professionals in healthcare, educational
2. CBR programs involve the people with disabilities themselves, their families and communities, as well as appropriate professionals. Some are doing their own works.

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