

# THE PRINCIPLES & PRACTICE OF PRIMARY HEALTH CARE

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# THE PRINCIPLES OF PRIMARY HEALTH CARE

## THE THINKING BEHIND PRIMARY HEALTH CARE:

### 1 THE COMMON PATTERN OF NEED

Most countries in the South and ex-Soviet Union countries have a similar pattern of socio-economic problems:

- the country's resources, such as land, are inadequate for the population, and/or unjustly distributed;
- the overall level of literacy and education is low, infrastructure (roads, public transport, water and electricity supplies etc.) is under-developed;
- the health facilities and personnel are concentrated in one or two cities rather than in the rural areas where most people live;
- nevertheless, cities are growing but with poor immigrants from the rural areas now in situations of extreme poverty, poor housing, sanitation etc.
- the population is growing fast, whereas the Gross National Product is static or going down per head of population;
- women carry a considerable burden as bearers of children and carers of families, while suffering from poorer schooling and low status.

As health needs are studied, it becomes clear that they are rooted in these problems. One result is that the conditions presenting at the first level of health services tend to be the same:

- diarrhoea and intestinal parasites;
- respiratory diseases (these kill quite a few children);
- the infectious diseases of childhood such as measles and polio;
- other communicable diseases including HIV/AIDS. Some are common to many countries, e.g. malaria and TB (formerly common in Europe too); some are more localised, e.g. onchocerciasis or schistosomiasis;
- malnutrition;
- complications of pregnancy and childbirth.

### 2 ALMA ATA

“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 and with their full participation...”

“It means much more than the mere extension of basic health services...”

“having the aim of using only those technologies that have really proved their worth and can be afforded...”

“delivered by community health workers who understand the real health needs of the communities they serve and have the confidence of the people”

### **3 THE KEY PRINCIPLES OF PRIMARY HEALTH CARE**

#### **3.1 CARE SHOULD BE AIMED AT THE MOST NEEDY GROUPS**

This principle puts forward the need for EQUITY – resources should be distributed justly, according to need, with more going to the more needy. Who are the needy?

- Some population groups are below the poverty line, such as the landless and jobless, refugees and squatters. They, the rural dwellers and the squatters in the urban shanty towns, are not only poor but live with few or no services, including health services.
- Some groups are more vulnerable to disease, especially children under five and pregnant and nursing women.
- Some are "invisible" to planners, for example, the nomadic minorities in settled countries.

WHENEVER WE LOOK AT A PROGRAMME, WE HAVE TO ASK WHICH GROUPS ARE NOT BEING REACHED – WE CHECK THE SEX OR AGE GROUPS AT RISK, WE CHECK WHAT CLASSES OR CASTES ARE IDENTIFIABLE, WHETHER THERE ARE MINORITY GROUPS OR LIFESTYLES, AND WE LOOK TO SEE IF THEY ARE USING THE SERVICES AS OFTEN AND AS WELL AS THE "NORMALS".

#### **3.2 PHC SHOULD INCLUDE A RANGE OF ESSENTIAL, APPROPRIATE ACTIVITIES**

A number of vertical programmes have tried to combat diarrhoea, or malaria, or measles or malnutrition, usually in children under five. The sad fact is that tackling one problem may stop children dying of that problem – but they then die of something else and in the same numbers. A RANGE of services is necessary

Integration of these services is also important, or the Village Health Worker can end up trying to carry out the plans of twelve different programmes each with its own land rover, twice-yearly supervision, records, etc. Here, funders need to co-ordinate.

#### **3.3 CARE SHOULD BE ACCESSIBLE AND ACCEPTABLE TO EVERYBODY**

Think of a woman who has a smelly vaginal discharge which worries her. What might discourage her from consulting a health worker?

Distance to the clinic and time lost from work? Inconvenient hours? A male worker? A language barrier? No privacy? Carelessness or rudeness from the staff? Being sent to the Clinic for Sexually Transmitted Diseases?

All these, and others, are factors that affect accessibility and acceptability.

Definitions: distance to a clinic is a problem of accessibility (whether the patient can get to use a service); vaginal examination by a man is a problem of acceptability (whether a patient can bear to accept a service); in between, the two concepts overlap. Many problems in these areas have been quickly solved when local staff see how important it is.

#### **3.4 PHC SHOULD BE AFFORDABLE**

Some countries have free first-line health care as part of the constitution. However, the experience of the last twenty years suggests that free health care is not sustainable. A number of PHC projects sell medicines to people who are sick. This enables the health

worker to renew his stock and in some projects the profit pays for basic preventive activities such as immunisations. There is some cost-recovery, as planned in the Bamako Initiative, and some self-reliance. However, people in rural communities still pay taxes, and their cousins in the cities get first-line health care for free, paid out of taxes. PHC may be making poorer people pay twice. Most African countries have GNPs which are falling. Initial investments to set up PHC projects often amount to about \$25 per head and will continue to cost yearly for the preventive activities.

At an individual level, rural people have money at harvest time; they are poorest and sickest in the months before the harvest, which is when people may not be able to buy medicines. Payment at point of need seems less appropriate than a yearly payment after the harvest. This has been tried on a small scale in some places and in official PHC programmes, and works for as long as the programme is running. Where programmes have stopped and there is no local health care, individuals often start to collect money after harvest time and buy key medicines in bulk for their village. If this maintains a supply of e.g. soap, razor blades and chloroquine, it is a limited but sustainable initiative.

### **3.5 THERE SHOULD BE FULL COMMUNITY PARTICIPATION, AND PHC SHOULD BE CONTRIBUTING TO THE SELF-RELIANCE AND SELF-DETERMINATION OF COMMUNITIES.**

Most programmes intend that the communities will participate and most create some kind of structure to make it possible, usually village PHC committees. However, there are problems.

- First, a programme of community education and mobilisation, to give people the information and skills they need to make good choices, can take up to three months per village, and few programmes will budget for this time and investment. Few funders are prepared to wait. When they are, the results are impressive as they were in the villages trained by the GRAPPE method in French-speaking West Africa.
- Second, most programmes are not prepared to delegate any serious power or decision-making. For example, most PHC programmes invite the community to join in the identification of priority problems, but, since the programmes are funded from health budgets, they usually can do little if the community sees the need for a road as a priority. Honesty from the beginning is essential. The priorities of women can be buried at several stages of the consultation process or they can be brought forward through conscious effort.

Where the community involvement is poor, the PHC activities which are most successful are the ones such as immunisation. Here the community does not need to have active, organised involvement – it only has to turn up and stand still for a few minutes. The activities which do much less well are those in which active, co-ordinated participation over time is essential. Think of what the community would need to do in order to tackle malnutrition in the small children or raise the age of arranged marriages for their daughters.

### **3.6 PHC SHOULD BE INTEGRATED BOTH WITH OTHER PARTS OF THE HEALTH PROGRAMME AND WITH OTHER DEVELOPMENT SECTORS**

Think of the different Ministries, each with its own structure and policies. Suppose there is a real need for an integrated programme to improve malnutrition, including Vitamin A deficiency. You would want to work with the Ministry of Agriculture, promoting vegetables (nearest office the District Town) and also with the Ministry of Water and Forests, to get fruit trees planted (nearest office the Regional Capital 80 km away). Neither have petrol for their vehicles so that you can meet. And your budget comes from the Health budget of a Western

country, and is meant for health activities which do not include tree-planting. In practice, agriculture is the easiest section to work with, because it tends to have workers at village level. Even so, in reality, active working together is rare. It has to be fought for. But it is possible, and the first step to finding funding for integrated projects.

### PRIMARY HEALTH CARE AND DISTRICT HEALTH CARE:

The implementation of Primary Health Care programmes during the last fifteen years have brought up many issues:

- A number of countries have suffered from collapsing economies, war etc. The money ran out and the programmes stopped.
- In the 1980s UNICEF funding became conditional on adoption of the GOBIFF components – which do not spend time on community empowerment
- For a number of reasons such as inadequate referral services and insufficient funding, the results of PHC were not as good as had been hoped – for example the lowering of MMR did not happen.

As a result, PHC has been scaled down at village level and in many countries, the District Level is seen as the place for providing first line of care.

### MORE READING:

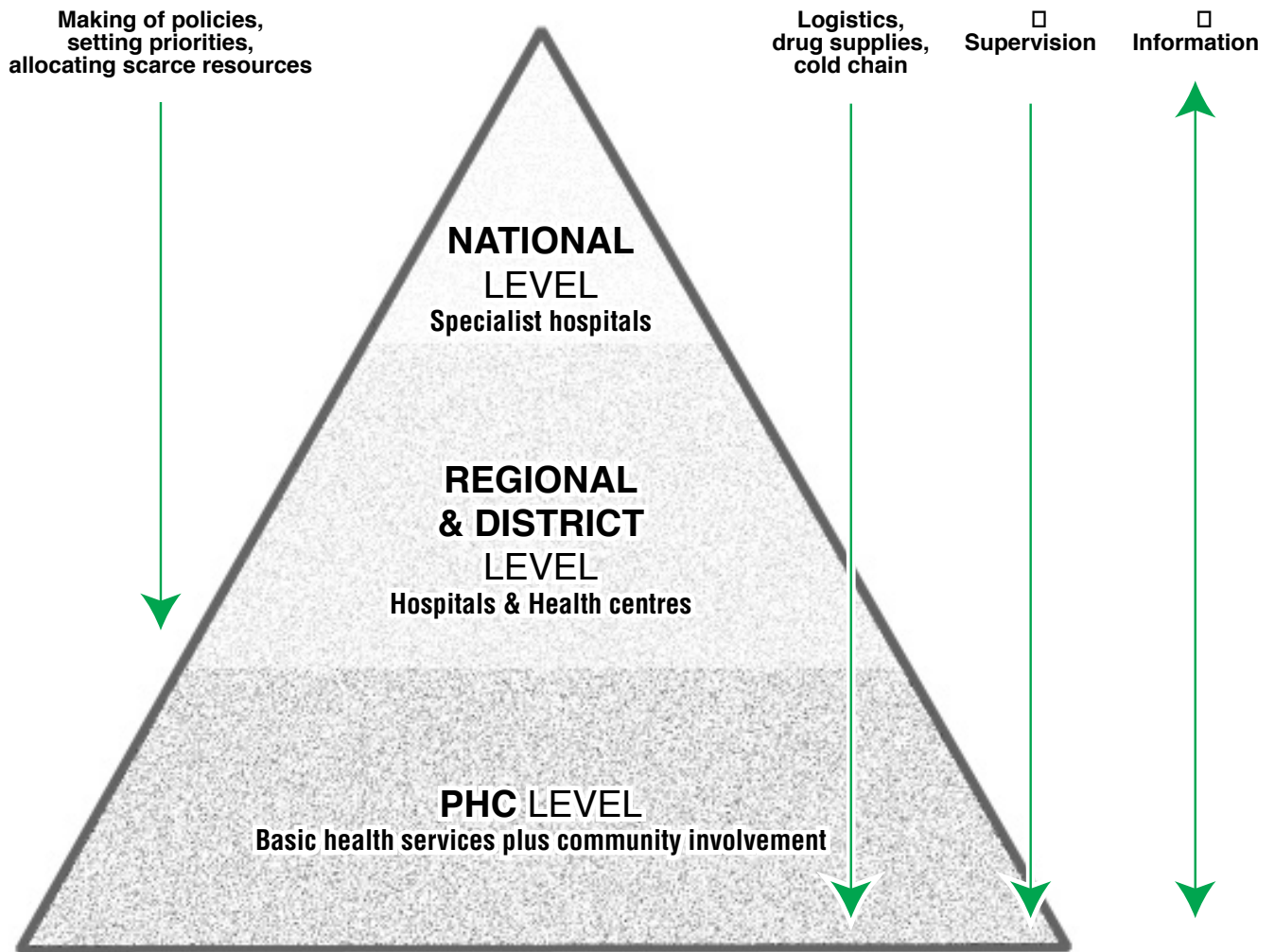
*“Better Health in Africa: Experience & Lessons Learned”* The World Bank, Washington DC, 1994. ISBN 0-8213-2817-4. (This book has to be paid for).

At the end of the manual there are further links to resources on the web covering each topic.

### MANAGEMENT:

Good Management of people, drugs and money are essential for good Primary Health Care. An excellent manual, *“On Being in Charge”*, is available from [www.networklearning.org/books.html](http://www.networklearning.org/books.html) (Free, courtesy of WHO).

SIMPLIFIED DIAGRAM OF A COUNTRY HEALTH SERVICE



# THE PRACTICE OF PRIMARY HEALTH CARE

## 1 CURATIVE CARE

### 1.1 TREATMENT OF COMMON DISEASES & INJURIES



#### HOSPITAL LEVEL

laboratory facilities allow diagnoses of, e.g. leprosy and TB



#### HEALTH CENTRE LEVEL

These may be run by nurses who have had training as diagnosticians.



#### VILLAGE LEVEL

Village health workers usually get about three months training.

Different programmes have different mixes of drugs for the village level:

The list should be of drugs which treat common conditions, are effective, and which, with training, can be used safely.

N.B. Wounds and burns are common problems in developing countries and can be very serious.

One example of a Community Health Worker Drug Kit:

- Anti-malarials for adults e.g. chloroquine tabs
- Anti-malarials for children e.g. chloroquine syrup
- Antibiotics for adults e.g. penicillin tabs
- Antibiotics for children e.g. penicillin syrup
- Anti-dehydration mix for diarrhoea e.g. sugar & salt (or packets)
- Pain-killers e.g. aspirin
- Anti-indigestion e.g. aludrox
- Anti-thread worm – e.g. piperazine
- Anti-constipation e.g. senokot
- Anti scabies e.g. benzyl benzoate
- Dressing for wounds & gentian violet.

Some programmes have started gardens for traditional herbs by village dispensaries and Health Centres but in Africa only a few are used. In India, Village Health Workers get either Ayurvedic, Unani, Siddha, or Homeopathic medicines as well as western medicines but these alternatives are often under-used.

### 1.2 PROVISION OF ESSENTIAL DRUGS

This activity involves the procurement, manufacturing and distribution of essential drugs and medical supplies to authorised public and non-profit health facilities at affordable prices on a timely, secured and sustainable basis.

Each country's health system first has to agree on an Essential Drugs List, which covers all significant conditions with medicines that are a compromise between cheapness and effectiveness. Such a list greatly reduces the number of drugs coming into the system.



Then Rational Drug Use has to be established for each significant condition to prevent over- or under-prescription; treatment protocols are printed and distributed to each level of service involved; relevant staff should receive training in the treatment protocols.

The effectiveness of essential drug provision is affected by good procurement, often overseas, correct transport and storage at every level. Many essential drugs have to be kept cool. The Cold Chain is part of this: to ensure that vaccines actually work they must be kept cool from leaving the factory, on the ship, stored on the dock, in the lorries, all the way out to the health centre where they need a refrigerator and cool boxes to take them to the villages, with care taken not to leave the opened vials lying around in the sun. Any break in this chain means measles vaccine that does not work, injected babies with no protection.

Good storage also ensures that drugs that came in first go out first and are not stored for too long.

Control of an essential drugs programme may include: checking the number of reported cases against the amount of drugs ordered; checking regularly the drug and patient records in clinics and hospitals; checking treatments against the treatment protocols

Effective programmes have good coverage of the country and its population; They are also cost-effective. In settled African countries they spend about one dollar per capita.

In the eighties UNICEF developed a different approach. In return for local currency –and many countries find it difficult to get hard currency – they started offering kits, one for a small hospital, another for a Health Centre, another for PHC villages. The PHC kit box holds all the medicines which the community Worker is likely to need in a month.

The disadvantages of this approach are:

- it is less flexible than a Community Worker visiting the District Drugs Store with a shopping list;
- it removes decision-making and management from the country and forms a relationship of dependency.

### **1.3 REPRODUCTIVE HEALTH AND MOTHER & CHILD HEALTH (MCH)**

For years the health needs of women and children were addressed through MCH clinics. Typically these offered care during pregnancy, vaccinations and contraception.

However more recently people have been finding other ways of addressing problems in this field. Reproductive Health (RH) says that both women and men have a package of needs that should be addressed. This is the result partly of the devastation caused by HIV, partly by recognition that women are more than baby-producers, and partly by the plight of refugees in Africa and Asia, pushed around by disasters and wars but spending longer periods in camps where other issues, such as sexual violence, could not be ignored. The following package has been developed by UNHCR together with all the major agencies working in Refugee Health; there are few camps where it is implemented.

#### **MINIMAL PACKAGE IN REFUGEE SITUATIONS:**

- Prevention and management of sexual- and gender-based violence; provision of emergency post-coital contraception; control of relief workers and guards who may abuse their position; understanding the cultural reasons for Female Genital Mutilation, providing BCC (Behaviour Change and Communication – or Health Education) and building community support to discourage it; prohibiting its practice in supervised clinics and hospitals



- For both men and women, enforcement of respect for universal precautions against HIV/AIDS
- Making available a choice of contraceptive methods, with condoms available free
- Ensuring Safe Motherhood; Antenatal care including TT and supplements; detection and management of complications including STDS/AIDS; delivery care including provision of birth kits; referral care integrated into PHC; post-partum care including encouragement of breast-feeding; information and services for Family Planning ; Patient-held records
- Appropriate resources including female health care providers for women.

REMEMBER, IF THIS IS THE MINIMUM PACKAGE THAT REFUGEES DESERVE, THEN SURELY IT IS WHAT EVERYBODY, FEMALE AND MALE, DESERVES

## 2 STATIC PHC PROGRAMMES:

### 2.1 EXPANDED PROGRAMME OF IMMUNISATION (EPI)

This is sometimes now called Universal Child Immunisation (UCI) because UNICEF provides a lot of funding and tends to see mothers only in relation to children.

The six targeted diseases are:

- diphtheria – this is the D of DPT.
- whooping cough or pertussis – this is the P of DPT.
- tetanus – this is the T of DPT, but the main danger is neonatal tetanus, which has to be prevented by immunising mothers before the birth with at least 2 Tetanus Toxoid injections (TT);
- polio – immunised by Oral Polio Vaccine (OPV);
- tuberculosis – BCG;
- measles.

Schedules differ between countries; here is an example:

#### Children:

- BCG: at birth or soon after.
- DPT & OPV: at 2, 3 & 4 months.
- Measles: at 9 months
- Boosters: DPT & OPV: at 18m. or 1 year after the 3rd DPT & OPV.

#### Women aged 15-45:

First TT: At first contact or early during pregnancy.

Second TT: Four weeks after the first TT.

Third TT: At least 6 months after the second TT, or during the next pregnancy.

Fourth TT: At least 1 year after the third TT, or during the next pregnancy.

Fifth TT : At least 1 year after the fourth TT, or during the next pregnancy.

THIS SCHEDULE DEMANDS FIVE CONTACTS BETWEEN THE HEALTH SERVICES AND A BABY IN ITS FIRST YEAR.

"Fully protected children" are children who have received all their immunisations against the 6 diseases. In Africa, in countries where the programme is doing reasonably well, you might find 80% or 90% of children to have had their first DPT or OPV, 55% to 65% to be fully protected by the age of five, and 50% to 55% to be fully protected by the age of one year.



### **NATIONAL & REGIONAL LEVEL RESPONSIBILITIES:**

- Importation of vaccines in good condition and their distribution so that they are used before expiry date;
- Maintenance of the cold chain. Vaccines have to be kept between 0 and 8 degrees centigrade during storage and transport. The cold chain might therefore be the following:
  - Refrigerated storage facilities in the capital, then
  - Transport in refrigerated lorries to hospitals, then
  - Storage in fridges run on electricity, then
  - Transport by land rover in insulated boxes to Health Centres, then
  - Storage in fridges run on paraffin or solar power, then
  - Transport to mobile clinic on motor bike in insulated box, then
  - Use on children.



### **STATIC OR MOBILE CLINICS:**

This is where most vaccinations are done. Staff have to ensure

- that the vaccine is not expired;
- that it has not been destroyed by warmth (especially measles vaccine);
- that equipment is sterilised.

## 2.2 ANTE-, PERI-, & POSTNATAL CARE – PART OF MOTHER & CHILD HEALTH (MCH)



### HOSPITAL LEVEL

FOR WHOM: About 10% of pregnancies are high-risk in practice and delivery should take place in or near a hospital or a facility with an ambulance. About 4% of women in some African countries will need services such as a Caesarean or a blood transfusion.

REMEMBER there are many countries where the Maternal Mortality Rate (MMR) is 10 per 1,000.

STAFF NEEDED: Doctor who can perform a Caesarean, Nurse-Midwives who can handle obstetric complications – N.B. if a Traditional Birth Attendant (TBA) brings in a woman in trouble she should be involved, not excluded.

ALSO NEEDED: Operation Room facilities; blood grouping facilities; hostels or host families where women with at-risk pregnancies can wait for the last few weeks.



### HEALTH CENTRE LEVEL WITH OUTPATIENT CLINIC

STAFF NEEDED: Nurses/Midwives. NB; If a Traditional Birth Attendant brings in a woman at risk she should be involved not excluded

ACTIVITIES:

- normal deliveries
- TT injections;
- Screening for high-risk pregnancies;
- Referral of high-risk pregnancies for hospital delivery;
- Advice on nutrition, rest, etc;
- Iron and folic acid supplements, malaria prophylaxis.

REMEMBER; professional staff only see most pregnant women once during the pregnancy; usually this chance is not used fully



### MOBILE MOTHER & CHILD (MCH) HEALTH CLINIC OR RURAL-BASED MIDWIFE

As above.



### VILLAGE LEVEL

WORKERS NEEDED : Trained Traditional Birth Attendants

ACTIVITIES:

Ante-Natal:

- advice on TT injections;
- advice on nutrition, rest etc.;
- screening for high-risk pregnancies;
- referral of high-risk pregnancies to professionals;

Perinatal:

- clean deliveries;
- no internal examination;
- sterile cord-cutting;
- organisation of transport for complications;

Post-natal:

- establishing breast-feeding quickly;
- advice on rest, food, warmth;
- checks for problems;
- advice on family planning.

## 2.3 FAMILY PLANNING, INCLUDING ABORTIONS & HELP FOR COUPLES WHO CANNOT CONCEIVE



### HOSPITAL LEVEL

Surgical facilities can be used for-Voluntary Surgical contraception (VSC), male and female.

- IUDs & Norplants.
- unblocking blocked tubes in infertile women.
- abortions (if legal), menstrual extractions, D & Cs.

Hospitals can also:

- administer RU486 (the "morning-after" pill – mainly still on trial).
- screen women for oral contraceptives.
- provide oral contraceptives, condoms, & Depo-Provera.
- examine, diagnose & treat Infertile couples (about 10% of all couples in Africa).
- advise about induced abortions if legal.
- advise about traditional FP methods (not usually done)



### HEALTH CENTRE LEVEL WITH OUTPATIENT CLINICS:

ACTIVITIES:

- screen women for oral contraceptives.
- provide oral contraceptives, condoms, Depo-Provera, IU Ds & Norplant.
- advise infertile couples on rhythm method etc. & refer if unsuccessful;
- advise about induced abortions if legal.
- advise about traditional FP methods (not usually done).



### MOBILE MOTHER & CHILD HEALTH (MCH) CLINIC

ACTIVITIES:

- screen women for oral contraceptives.
- provide oral contraceptives, condoms, Depo-Provera.
- advise infertile couples on rhythm method etc. & refer if unsuccessful.
- advise about induced abortions if legal.



### VILLAGE LEVEL

ACTIVITIES:

- Distribute condoms through Village Health Worker.
- Encourage breast-feeding
- Distribute oral contraceptives to screened women through the TBA
- Give advice on advantages of spacing and limiting families.
- give advice on traditional methods (abstinence, coitus interruptus)
- advise infertile couples on rhythm method etc & refer if unsuccessful.
- inform about induced abortions if legal.
- encourage debate on age of marriage for girls.

### 3 INTERVENTIONS TO IMPROVE NUTRITIONAL STATUS

#### 3.1 PROTEIN-CALORIE MALNUTRITION:

In most communities in South Countries, one-quarter to one-third of children under five are malnourished. Primary Health Care programmes are still looking for ways of reducing this problem. The most common intervention is the serial weighing of children using individual Road-To-Health Cards but to be effective this needs to be linked to good education and behaviour change. A few small programmes have done this; when a child falls off the road to health, the family is visited almost daily by a woman acting like an Auntie, involving the husband and giving advice that is practical within the culture.



#### HOSPITAL LEVEL

- Nutrition Rehabilitation Centres (Poor long-term results).
- Rehabilitation of extremely malnourished children.
- Education of mothers in proper feeding.
- Small weaning-food factories.



#### HEALTH CENTRE LEVEL WITH OUTPATIENT CLINICS

- Nutrition Rehabilitation Centres (Poor long-term results).
- Rehabilitation of extremely malnourished children.
- Education of mothers in proper feeding.
- Serial Weighing & identification of moderately malnourished children.
- Health Education Sessions
- Cooking demonstrations: little evidence of overall effectiveness.
- Distribution of food supplements;



#### MOBILE MCH CLINIC LEVEL

- Serial Weighing & identification of moderately malnourished children.
- Health Education Sessions
- Cooking demonstrations: little evidence of overall effectiveness
- Distribution of food supplements.



#### VILLAGE LEVEL

- encouraging good nutrition for pregnant women;
- establishing breast-feeding early.
- Upper Arm Circumference measuring & identification of malnourished children.
- Health Education – results depend on quality.
- "food aid"- communal meals or food supplement distribution ( may result in reduction of other meals).
- identification of strategies for each family with a malnourished child.
- daily visiting by "auntie" figures.
- increasing family food production (loan of cow, village vegetable gardens- -result depends on product meeting need and being given to child – it is no good growing lettuces – or growing beans for sale).
- encouraging the making and selling of high-protein energy snacks.
- identification & referral of serious cases of malnutrition.
- adjusting family eating habits -better division of sauce, separate plates for toddlers.
- special support for families with twins.
- ETC

### 3.2 MICRO-NUTRIENTS

This section covers the three nutrients most commonly lacking in whole communities:

- Vitamin A: deficiency is a major cause of blindness
- Vitamin D: deficiency causes rickets
- Iodine: deficiency causes goitres, and mental deficiency.

Iron and Folic acid is also important for pregnant women, who are frequently anaemic: see 2.1.



#### NATIONAL LEVEL

ACTIVITIES:

- Reinforcement of all commercial salt with iodine.
- Reinforcement of all commercial oils and margarines with Vitamins A and D. (more difficult and less common)



#### STATIC OR MOBILE CLINICS

ACTIVITIES:

- Distribution of Vitamin A regularly to pregnant and lactating mothers and children under 5, by injection, capsules or drops, This can be part of the EPI programme.
- Distribution of Iodine regularly through injections.
- Education on exposure to sunlight in Vitamin-D deficient areas (not only cold countries -it is a problem in some North African towns).
- Educate community on sources of Vitamin A, especially for pregnant women and children.
- Encourage gorging on seasonal fruits such as mangoes, since Vitamin A is stored by the body.
- Encourage growth of Vitamin A-rich crops.
- Encourage exposure of children to sunlight.



#### VILLAGE LEVEL

ACTIVITIES:

- Encourage use of supplementation programme, if there is one.
- Education on exposure to sunlight in Vitamin D deficient areas (not only cold countries – it is a problem in some North African towns).
- Educate community on sources of vitamin A, especially for pregnant women and children.
- Encourage gorging on seasonal fruits such as mangoes, since Vit. A is stored in the body.
- Encourage growth of Vitamin A-rich crops.

## 4 HEALTH PROMOTION

Health Promotion is the process of helping people to adopt healthier patterns of behaviour.

Terminology: the term *Health Education* is still used, but some people feel it implies only one part of this process – the giving of information and motivation. The term *Health Promotion*, which has come from the AIDS field, is commonly fashionable. *Information, Education and Communication (IEC)* is used in the Family Planning field. The newest name is *BCC – Behavioural Change and Communication*.

Classic Health Education describes the kind of short talks to groups of mothers which are given so often in PHC, about nutrition or preventing diarrhoea or whatever. Often these talks are, top-down and one-way – examples of the "empty bottles" approach that sees people as empty bottles, which only need to be filled up with scientific knowledge for them to change behaviour.

Now, workers focus on Behaviour Change; this can only happen if and when the individual gets the right skills. Take for example a young girl at risk of sexual exploitation and HIV infection. Good health BCC might help her to learn how to say "No", might point her to other ways to earn a living and support her six orphan brothers and sisters. This is done after the girl and the Educator analysis why she might make certain choices rather than others.

So the approach is to provide some new information and motivation for change; it might start by considering sessions on FP or Malaria in an MCH Clinic and conclude that:

- The information is directed at mothers, but cannot help If husbands or mothers-in-law make decisions; These people must be offered an information session as well, and at a good time.
- Health education may be used where community mobilisation is a better way to go – if malaria is the problem, a community can reduce infection with weed-clearing and smoke. Means and materials are also important – for malaria control, they need medicines, mosquito nets and the money to buy them. Perhaps a cash crop?

### EXAMPLE:

Many people in South countries lose their teeth after the age of forty because of gum disease. Regular brushing would delay or prevent the process. The classic health education solution is a session in each village, for a big group, with a talk, instructions, and a distribution of tooth brushes donated by a International NGO, which once worn out cannot be replaced.

The improved Health Promotion or BCC approach might be to:

- provide health workers with the book "Where there is no Dentist" and start discussions on the whole Issue;
- identify middle-aged people in the community who can influence others;
- with them, identify what is needed for regular brushing – indigenous tooth-brushes (trees whose twigs taste acceptable and have the right texture, like neem, or fibres from mangoes and coconuts): clean water, salt;
- discuss how brushing can be built into a daily routine; involve the school;
- with them discuss the image of toothless people (maybe it is a sign of wisdom) and whether there are differences in gender ,
- explore how people in that community feel about risk – whether they think tooth loss is likely to happen to them – and cost:benefit – how much money, time and trouble they would spend to avoid the perceived risk.



- there is more to be considered, but at this point messages, specific advice and points for discussion could be developed.



### **NATIONAL & REGIONAL LEVEL (PERHAPS PART OF HOSPITAL PROGRAMME)**

#### **ACTIVITIES:**

- Mass Campaigns with specific messages carried in one direction by mass media (radio, television, leaflets, posters) on EPI or FP.
- Social Marketing; treating a health product as a sellable article; mainly used for condoms. The product is given an attractive name and image geared at a specific target group and advertised; many outlets (chemists, small shops, bars etc)



### **(DISTRICT) HEALTH CENTRE LEVEL WITH OUTPATIENT CLINICS**

#### **ACQUIRING SKILLS AND MATERIALS**

- adaptation of educational materials;
- ensuring that all HC staff (including cleaners) are informed educators and good examples of health behaviour.

#### **ROUTINE HEALTH PROMOTION**

- group talks to mothers on normal PHC topics;
- food demonstrations;
- one-to-one talks;
- routine actions such as cleaning the grounds;

#### **ACTIVITIES INVOLVING SPECIFIC ACTORS AND BENEFICIARIES:**

- school education;
- organisation and support of groups with specific functions, e.g., peer group education on AIDS, education of communities to accept ex-leprosy patients; street theatre groups educating about alcohol misuse.



### **LEVEL OF MOBILE CLINICS**

#### **AQUIRING SKILLS AND MATERIALS:**

- adaptation of educational materials;
- ensuring that all staff (including drivers) are informed educators and good examples of health behaviour.

#### **ROUTINE HEALTH PROMOTION**

- group talks to mothers on normal PHC topics;
- food demonstrations
- one-to-one talks;



### **VILLAGE LEVEL**

#### **ACTIVITIES:**

- group talks to mothers on normal PHC topics;
- food demonstrations;
- one-to-one support of individuals e.g. mothers with malnourished children, non-compliant patients being treated for TB.

## 5 PREVENTION & CONTROL OF COMMON LOCAL DISEASES

### 5.1 MALARIA



#### HOSPITAL LEVEL

##### ACTIVITIES:

- monitoring region for foci of infection and any development of resistance to medicines;
- monitoring developments in new medicine regimes and treatments
- laboratory check on symptomatic diagnosis;
- monitoring for malaria after blood-transfusions;



#### HEALTH CENTRE LEVEL WITH OUTPATIENT CLINICS

##### ACTIVITIES:

- good supervision of Village Health workers, ensuring medicine supply, good symptomatic diagnosis and appropriate referral;
- laboratory checks on symptomatic diagnosis;
- distributing malaria prophylaxis to pregnant women and small children if Govt. policy;
- monitoring state of pregnant women;

##### MOBILE CLINICS:

- distributing malaria prophylaxis to pregnant women and small children if Govt. policy;
- monitoring state of pregnant women;



#### VILLAGE LEVEL

##### 1) Reducing Breeding Places

- Clearing village of weeds;
- Clearing village of puddles – keeping well surroundings tidy, filling in holes in the ground, removing broken pieces of pots, old tins, etc.;
- building household soak-pits (see section 6);
- tidying fringes of lakes and where still water is lying;
- for small ponds not used for drinking, putting tiny amounts of oil to form thin surface layer (blocks lava breathing tube);

##### 2) Killing Mosquitoes

Spraying is much less popular now as, overall, it proved to be ineffective: mosquitoes become resistant to DDT, and it hurts the food chain. There are safer alternatives which can be sprayed on interior walls of houses – disruptive for the village as everyone has to move out for the day.

##### 3) Reducing Biting

Strategies for the whole household:

- putting smoky herbs on the fire;
- filling in holes in walls and roofs;
- metal meshes on windows and doors (expensive but could be done for one bedroom);
- planting mosquito-repellent plants outside house e.g. citronella (? effective);

Other strategies perhaps at first for under-fives and pregnant women who are more vulnerable:

- keeping them indoors at dusk;
- wearing long-sleeved and long-legged clothes in the evening;
- anti-mosquito plants rubbed on skin (e.g. citronella);

- one double mosquito net for pregnant women and small children; works longer if impregnated with pyrethrum even when full of holes – expensive, but cost-effective

#### **4) Identifying & Treating Infection Quickly**

- trained and supervised Village Health Worker with medicines;
- trained Traditional Birth Attendant & Village Health Worker distributing malaria prophylaxis to pregnant women and small children, if Govt. policy;
- the community educated to act if any child or pregnant woman has a fever (and if necessary find the money for medicine)

## 5.2 SEXUALLY TRANSMITTED DISEASES INCLUDING AIDS



### NATIONAL & REGIONAL LEVEL– MAYBE WORKING WITH HOSPITALS

- developing mass health promotion programmes;
- importing, financing and distributing antiretroviral medicines, condoms and other materials;
- supporting innovative approaches for different therapies, for prevention, for support of People Living With AIDS (PLWAs), etc;
- organising safe blood supplies;
- making difficult policy decisions about resource distribution;
- integrating AIDS programmes with others, especially Family Planning;
- monitoring other STDs, especially with high risk groups e.g.migrant labour.



### (DISTRICT) HEALTH CENTRE LEVEL WITH OUTPATIENT & OUTREACH SERVICES

Providing the following services (and more) either directly or through supporting special projects:

- testing for HIV status and counselling;
- expanding a programme of anti-retroviral therapy for HIV+ people; monitoring adherence, managing side-effects and pain;
- delivering HIV positive women while preventing transmission to baby;
- monitoring and treating opportunistic infections such as T.B.;
- H. Education/ BCC - in schools, churches, among street kids; directed at husbands etc;
- promoting & distributing condoms & correct teaching of proper condom use;
- developing new educational media – traditional, theatre, comics;
- supplying sex workers with condoms, advice, work alternatives;
- making accessible the treatment for other STDs, especially for high-risk groups like returning migrant labourers and sex workers;
- removing stigma and have AIDS testing & counselling in integrated clinics, not STD clinics – and using fast & precise tests;
- providing high quality counselling and follow-up for HIV+ people and PLWAs
- Monitoring and treating opportunistic infections such as T.B.;
- supporting PLWAs & families at home with provision of materials such as medicines, Home Care Kits, food etc (see Palliative care);
- meeting the needs of orphans and carers for physical, psychological, spiritual support.



### VILLAGE LEVEL

#### ACTIVITIES FOR VHW & VOLUNTEERS:

Expanding a programme of anti-retroviral therapy for HIV+ people; monitoring adherence, managing side effects and pain; identifying/treating opportunistic infections

- educating on prevention;
- distributing condoms and proper teaching of their correct use -reaching couples where only one is HIV+; sex workers;
- reducing prejudice about PLWAs;
- supporting PLWAs, carers, families and orphans at home;
- educating husbands, especially migrant labourers, on AIDS and other STDs;
- supporting the dying – see Palliative care, Chapter 7.

#### ACTIVITIES for TBA:

- using gloves to prevent self-infection;
- advising on Family Planning/condom use for HIV+ women.

### 5.3 DIARRHOEA



#### NATIONAL & REGIONAL LEVEL, WITH HOSPITAL

- ensuring supply of drugs and equipment:
- treating the severe cases:
- investigating indigenous teas used for diarrhoea and incorporating them if effective into treatment patterns:
- investing in the Water and Sanitation Sector.



#### HEALTH CENTRE LEVEL WITH OUTPATIENT CLINICS

##### ACTIVITIES:

- motivate the WatSan specialists to provide quality water and latrines to villages
- carrying out same educational tasks as Village Health Worker ,
- following WHO AIB/C/DI Treatment plan (assessment of degree of dehydration, treatment,
- with IV if necessary. symptomatic treatment of dysentery. referral if fever high)
- ensuring that all health workers are honest about ORS packets – they are not medicine to cure diarrhoea.



#### MOBILE CLINIC LEVEL/VILLAGE LEVEL



##### ACTIVITIES for Village Health Worker:

- Prevention of diarrhoea:
- getting drinking & household water sources protected and safe:
- checking that water is transported cleanly from source to house:
- motivating mothers to have 2 water storage pots and clean them weekly with ash;
- checking that water is scooped out cleanly and pot kept covered;
- motivating mothers to use soap for hand washing after defecation, and after cleaning children who have defecated and before cooking or serving food:
- motivating mothers to keep cooking and eating area clean and animal-free:
- motivating mothers to keep small children on clean mat:
- motivating mothers to clean up after children, dogs etc, have defecated etc.
- motivating mothers to construct dish-rack above ground: ETC. .

##### Prevention of dehydration, malnutrition or death:

- educating every mother to take action if child has diarrhoea: to check with the VHW; to continue breastfeeding and giving normal foods and liquids; to know how to prepare and use sugar-salt mixture;
- prepare and using basic salt-sugar mix;
- knowing local medicines for diarrhoea and re
- knowing signs of moderate dehydration, and that ORS packets should be used;
- knowing signs of severe dehydration and other symptoms that require referral;
- giving advice on continuing breast-feeding, normal foods and liquids.

N.B. ORAL REHYDRATION WORKS WELL IN THEORY AND UNDER SUPERVISION, BUT MAY NEED TO BE MADE MORE ACCEPTABLE TO MOTHERS AND BABIES BY DISGUIISING THE TASTE (E.G.WITH LEMON JUICE); EXPLAINING CLEARLY WHAT ORS DOES AND DOES NOT DO, AND HELPING MOTHERS TO FIT THE EXTRA WORK INTO THEIR SCHEDULE..

## 5.4 TUBERCULOSIS.



### NATIONAL & REGIONAL LEVEL

#### ACTIVITIES:

- committing country to sustained TB control activities
- ensuring regular, uninterrupted supply of all essential anti-TB drugs



### HOSPITAL & HEALTH CENTRE LEVEL

#### ACTIVITIES:

- laboratory confirmation of diagnosis by examining sputum
- treatment: (DOTS Directly Observed Treatment Short course) now takes only six to eight months For the first two months patients can stay in the community but take daily medicines in front of a health worker.
- recording & reporting.



### VILLAGE LEVEL

#### ACTIVITIES BY VILLAGE HEALTH WORKER:

- symptomatically identifying possible cases (persistent cough, weight loss etc);
- monitoring members of the same household;
- motivating patients to continue treatment and visiting non-compliers.
- motivating community to get children vaccinated:

## 5.5 LEPROSY



### NATIONAL & REGIONAL LEVEL

#### ACTIVITIES:

- committing country to sustained leprosy control activities
- ensuring regular, uninterrupted supply of all essential anti-leprosy drugs



### HOSPITAL & HEALTH CENTRE LEVEL

#### ACTIVITIES: .

- laboratory confirmation of diagnosis
- treatment: multidrug treatment now take 6 months or one year depending on the national regime. Although medication is oral, side-effects are possible so the patient has to come to
- the Hospital or Health Centre once a month.
- rehabilitation of advanced cases with missing limbs etc.
- finding alternatives to long-stay Institutions for burnt-out cases.



### VILLAGE LEVEL

#### ACTIVITIES BY VILLAGE HEALTH WORKER WITH VILLAGE COMMITTEE:

- routine mass checks for symptoms (unpigmented, insensitive patches)
- individual symptomatic identification of possible cases:
- monitoring of members of the same household;
- education to remove the fear of leprosy and of sufferers.
- rehabilitation of institutionalised but cured community members.

## 5.6 COMMON LOCAL DISEASES RELATED TO WATER: SCHISTOSOMIASIS OR BILHARZIA

Schistosomiasis is caused by a parasite that lives for part of its cycle in water, part of its cycle in water snails and part in humans, one sort being excreted, the other passed out in urine. It is a debilitating but not fatal condition. To reduce the level of infection in a community, it seems that a number of strategies have to be combined – both decreasing the contact between parasite and humans and also treatment.



### NATIONAL AND PLANNING LEVEL

Schistosomiasis is especially associated with irrigation projects. It is possible to plan these projects to reduce the amount of infection: two possibilities are: having parallel canals, so that they can in turn be dried out and the snails will die; or having the water flow too swiftly for the snails to breed. These kinds of solutions tend to be expensive.



### REGIONAL/HOSPITAL/HEALTH CENTRE LEVEL

- laboratory diagnosis of condition;
- treatment of individuals;
- mass treatment of communities. This is a) expensive (\$2 per head), b) complicated, with each patient needing weighing to find the dose, and c) has to be well organised to have an effect.



### VILLAGE LEVEL

- symptomatic identification of possible patients (blood in urine etc);
- regular treatment of people who work in water regularly, e.g. rice farmers;
- education of community on the cause of Schistosomiasis;
- assisting the community to avoid infecting water in which they walk or swim – not urinating in the water or defecating near it. The most difficult group to control are young boys who have to learn to urinate before going swimming.



## 5.7 OTHER SIGNIFICANT VECTOR-BOURNE DISEASES

The following diseases, like malaria, are carried by biting insects, but are found in limited geographical areas: if you go to work in that region read them up:

**Onchocerciasis** or river blindness, found all over West Africa south of the Sahara. Carried by *Simulium damnosum* or black-fly, which breeds in fast-flowing rivers. The disease is caused by micro-filaria (tiny worms) passed to humans during biting, which eventually cause blindness especially among adult working males. A big eradication programme has been going on for over 20 years, spraying the Niger and Volta areas. This was very expensive but has reduced transmission and allowed land to be used which had previously been abandoned; There is also now a relatively cheap treatment; one dose twice a year stops blindness.

**Trypanosomiasis** or Sleeping Sickness; two sorts, one west and one east African; organism carried by the Tsetse fly -the East African sort is associated with cattle.

**Leshmaniasis** found in North Africa and semi-urban habitats; carried by the sand-fly.

**Yellow fever**

## 5.8 INFECTIONS PREVENTED BY BETTER WATER & SANITATION:

**Guinea-worm:** lives for part of its life cycle in cyclops, a small organism living in fresh water (it is visible and easy to identify); if this is swallowed by humans in drinking water it grows into a long worm stretching down the leg: one end emerges near the ankle in an ulcerous spot; if the ankle walks in water, it passes out eggs, which enter the cyclops etc: The cycle can be broken by filtering drinking water through a cloth, using protected sources of drinking water, keeping sore ankles out of the water or covering the sore, and by removing the worm very carefully by winding it onto a match.

**Hook-worm:** passed out in faeces; as the eggs hatch they enter any bare feet that pass. Communities that use the bush for defecation can have high infestation loads; this can make a significant contribution to malnutrition in children, Cheap shoes break the cycle; so do latrines if they are used.

**Other worms:**

- Faecal-oral infections like cholera and typhoid
- Scabies: itching and scabbing caused by a small burrowing mite; transferred skin-to-skin, e.g. by sharing beds, but also by sitting together, infected bedding etc. Can be present on most of the children and some of the adults in communities short of water, noticeably between the fingers. Ideally the whole community needs to organise a mass effort – painting everyone with benzyl benzoate, and at the same time washing clothing, exposing beds & bedding to sunlight.

## 6 WATER, SANITATION & WASTE DISPOSAL

### TOWN LEVEL (AROUND THE HOSPITAL)

#### Drinkable Water:

In towns this is usually pumped in from reservoirs or deep wells. Most larger towns see the water supply as a business and will pipe water into better class neighbourhoods and charge for it. Poorer areas will have public pumps or taps. They may also have charges. Ideally the community should be involved in the siting, maintenance and cleanliness of these water points. In villages it is essential to make the projects sustainable by strong committees collecting fees for Operation & Maintenance (O&M) and ensure good use through hygiene education

#### Latrines:

These become necessary in crowded towns. Public latrines can be constructed in poor areas, sometimes free for women and children, but with a small charge for men. Probably men will then use them for defecation only. Private latrines are often double-hole, as they fill up fast (the full hole is left for a year and the filling reduces down). If latrines are properly designed and constructed, the contents heat up and pathogens get killed. The toughest is the egg of the round-worm which needs a high temperature for several months. The holes for the latrines can be under courtyards or even unpaved roads. A sanitation project may arrange loans as latrines are built of brick and cement and are not cheap. Latrines, public and private, can be designed to produce methane gas for lighting & heating, but then plastic must not be put down the latrines. The composted contents can also be used for fertiliser, but both uses can run into cultural objections.

In villages, the cost of the concrete foot-plate may be subsidised, or involve loans. Construction of washing cubicles next to the latrines are of great benefit for women especially.

#### Waste water:

Most towns can flood badly during the rainy season and need storm drainage.

#### Rubbish disposal:

In towns with little infrastructure people can be employed to collect rubbish regularly and take it to a town dump or land-fill. These dumps are difficult to keep sanitary as poor people often scavenge. Organic waste can be composted at household level or used to make methane gas – but must be carefully sorted, or the results are dangerous. Cleaning of neighbourhoods is organised in some countries, where volunteer groups organise themselves for regular cleaning days and are able borrow tools.



### HEALTH CENTRE LEVEL

- Hospitals and Health Centres should teach by example, e.g. in their hygiene, ensuring frequent hand-washing with soap, even when water supplies are inadequate.
- Latrines for patients should be unlocked, clean, with water available and should smell OK
- Disposal of dangerous hospital waste has become more vital with AIDS and an incinerator should be available, otherwise people dispose down the latrines which quickly become full.
- The District PHC team should include an Environmental Sanitation Officer who can give practical advice to villages and communities.



## VILLAGE LEVEL

### **Water use and sanitation:**

Think of slicing through the soil vertically. Most village wells are shallow – they go down into surface water. The liquid contents of latrines which are not lined, seep down into the same layer. When it rains, infectious rubbish lying around on the surface also seep down. This is why shallow wells and latrines have to be placed at proper distances from each other.

- Rivers and lakes used for washing etc can be made safer if the community organises zones for activities, so that animals enter the water down-stream from people.
- Deep wells can be bored, ensuring safe water but much more expensive. Shallow wells can often be made much healthier with cement surrounds etc. Places where women can wash easily in private are valued and a health asset.
- Latrines are usually welcomed in villages. The cost of the concrete foot-plate may be subsidised, or involve loans. Construction of washing cubicles next to the latrines are of great benefit for women especially. Hygiene education is important to keep the latrines clean and attractive and to ensure hand washing etc.
- Waste water may allow mosquito larva to breed. It may be possible for villagers to dig drainage ditches for rain water run-off, and soak pits. These are pits into which household waste water can drain and then soak away, about 2 metres deep and filled with loose stones, either where the family washes themselves or near the kitchen for washing-up water.

## 7 PALLIATIVE CARE

Palliative care is the care of people at the end of their lives, using approaches that improve the quality of their lives and that of their families and ease their suffering. In the last twenty years, the number of people with end-stage AIDS has grown. People with cancer in South countries are increasingly recognised. But also the management of such patients is better understood:



### HOSPITAL LEVEL

- treat cancers with radiology and chemo.
- develop and evaluate appropriate packages of anti-viral medicines.
- manage pain relief
- relieve symptoms
- respect and honour local cultures and spirituality



### HEALTH CENTRE LEVEL

- ensure distribution of anti-viral medicines and condoms; medicines for symptoms and opportunistic infections
- ensure pain relief;
- deliver babies of HIV mothers while preventing transmission;
- train and support peripheral workers, volunteers and family members in preventive sex education, counselling and condom distribution; support communities;
- expand voluntary HIV testing & counselling
- supervise, supply and support mobile and village levels



### MOBILE HOME CARE TEAM LEVEL

- as for Health Centres, plus
- supervise, supply and support village level



### VILLAGE LEVEL

- train family members and caregivers in basic nursing, e.g. feeding and oral hydration, and in hygiene while doing daily tasks with the PLWA;
- provide adequate food for patient, family and local orphans;
- provide information about services and resources available;
- distribute Home Care kits: here are the contents of a typical kit: bucket; rubber gloves; rubber sheet; lengths of cotton; talcum powder; soap; petroleum jelly; bleach; ORS packages; plastic bedpan; scissors aspirin; cough mixture; antifungal cream; antibiotic ointment; sterile gauze pads; bandages; condoms
- ensure there are latrines that patients can use;
- promote alternative and traditional health methods where appropriate
- offer counselling, support and bereavement counselling to patient and families – mental, psycho-social and spiritual;
- educate villagers on HIV-related risks and reduce prejudice
- encourage community support to those living with AIDS and to orphans
- follow up and refer

## 8 ONLINE RESOURCES

The links in this section are kept updated at [www.networklearning.org/phc.html](http://www.networklearning.org/phc.html)

### 1.3 REPRODUCTIVE HEALTH AND MOTHER & CHILD HEALTH (MCH), PAGE 8

- There are a number of informative pages on [www.engenderhealth.org](http://www.engenderhealth.org), including contraceptive methods and an online/downloadable course on Sexuality.
- Resources available from the UNHCR library include *Reproductive Health in Refugee Situations: An Inter Agency Field Manual* (143 pp): [www.unhcr.ch/research/library.htm](http://www.unhcr.ch/research/library.htm) and type "Reproductive Health" into the box labelled "Search UNHCR Online".
- A free newsletter by the Hesperian Foundation: [www.hesperian.org/newsletters.htm#whx](http://www.hesperian.org/newsletters.htm#whx)
- If you want to know more about female genital mutilation go to [www.who.int/frh-whd/fgm](http://www.who.int/frh-whd/fgm)
- You can download *Child Health Dialogue*, the online Newsletter from [www.healthlink.org.uk](http://www.healthlink.org.uk) by clicking on "Publications".
- If you are starting to explore your own sexual health, a good short book is *Sexwise* – 22 pages, available in 22 languages: [www.bbc.co.uk/worldservice/sci\\_tech/features/health/sexwise/](http://www.bbc.co.uk/worldservice/sci_tech/features/health/sexwise/)
- Other sites that cover Reproductive Health (note, the language they use can be a bit 'Dictionary' but do not be put off): [www.rho.org](http://www.rho.org) , [www.cedpa.org](http://www.cedpa.org) and [www.ippf.org](http://www.ippf.org)
- At [www.fhi.org](http://www.fhi.org) there is downloadable stuff on RH and young adults – look for "Key Issues in Adolescent Health"
- At [www.path.org](http://www.path.org) click "Publications", then "Gender, Violence & Rights", then "Reaching the Hardly Reached" – which looks at the needs of prostitutes, trafficked women etc.

### 2.1 EXPANDED PROGRAMME OF IMMUNISATION (EPI), PAGE 9

- You can learn more at [www.unicef.org/infores/pubssubject.htm](http://www.unicef.org/infores/pubssubject.htm)
- About increasing coverage: [www.who.int/vaccines-documents/DoxTrng/h3train.htm](http://www.who.int/vaccines-documents/DoxTrng/h3train.htm)

### 2.2 ANTE-, PERI-, & POSTNATAL CARE, PAGE 11

- *A Book for Midwives: Care for pregnancy, birth, and women's health* by Susan Klein, Suellen Miller, and Fiona Thomson at [www.hesperian.org/midwives\\_chapters.htm](http://www.hesperian.org/midwives_chapters.htm)

## 3 INTERVENTIONS TO IMPROVE NUTRITIONAL STATUS, PAGE 13

- There are papers on community nutrition initiatives at [www.basics.org](http://www.basics.org) – click on "publications", then click on "nutrition".

### 5.1 MALARIA, PAGE 17

- Keep your knowledge up-to-date at [www.who.int/health-topics/malaria](http://www.who.int/health-topics/malaria) and [www.rph.wa.gov.au/labs/haem/malaria/](http://www.rph.wa.gov.au/labs/haem/malaria/)

## 5.2 SEXUALLY TRANSMITTED DISEASES INCLUDING AIDS, PAGE 19

- Aidsmap have simple information booklets for the general public on HIV/AIDS. The subjects are: 1. Adherence (sticking to the treatment); 2. Anti-HIV Drugs; 3. Clinical Trials; 4. Glossary; 5. HIV and Children; 6. HIV and Hepatitis; 7. HIV and Women; 8. HIV & Sex; 9. HIV and TB; 10. HIV Therapy; 11. Lipodystrophy (Changes in your fat & metabolism); 12. Nutrition; 13. Resistance; 14. Viral Load & CD4 Count: [www.aidsmap.com/en/docs/8766F941-6A4C-4F13-B5BE-A936138D4546.asp](http://www.aidsmap.com/en/docs/8766F941-6A4C-4F13-B5BE-A936138D4546.asp)
- [www.aidsalliance.org/ngosupport](http://www.aidsalliance.org/ngosupport) offer support kits of information for NGOs.
- [www.engenderhealth.org](http://www.engenderhealth.org) has an online course on HIV/AIDS (which you can also download) to bring your knowledge up to date.
- At [www.healthlink.org.uk](http://www.healthlink.org.uk) click on “Publications” to find “HIV & Safe Motherhood”, “Men’s Sexual Health Matters” and downloadable Newsletters.

## 5.3 DIARRHOEA, PAGE 20

- For more, look at *The Treatment of Diarrhoea: A Manual for Physicians and other Senior Health Workers*, available at: [www.who.int/child-adolescent-health/New\\_Publications/CHILD\\_HEALTH/textrev](http://www.who.int/child-adolescent-health/New_Publications/CHILD_HEALTH/textrev)

## 5.4 TUBERCULOSIS, PAGE 21

- Keep up to date with [www.who.int/gtb/](http://www.who.int/gtb/)
- Consider downloading *What is DOTS?* (WHO 1999, 27pp) at [www.who.int/gtb/publications/whatisdots/index.htm](http://www.who.int/gtb/publications/whatisdots/index.htm) and *A Guide for Tuberculosis Treatment Supporters* (WHO 2002): to find it, go to [www.who.int/gtb](http://www.who.int/gtb) and in the box on the right labelled “New WHO TB Publications” click on “see list”.

## 5.5 LEPROSY, PAGE 21

- Keep up to date at [www.who.int/lep/](http://www.who.int/lep/) – and consider downloading “A Guide to Eliminate Leprosy as a Public Health Problem”.

## 6 WATER, SANITATION & WASTE DISPOSAL, PAGE 24

- A big subject that requires exploration. Try [www.who.int/water\\_sanitation\\_health/index](http://www.who.int/water_sanitation_health/index).
- WHO offer a safe health-care waste management policy paper: [www.who.int/immunization\\_safety/publications/waste\\_management/en/safe\\_health\\_care\\_waste\\_management\\_policy.pdf](http://www.who.int/immunization_safety/publications/waste_management/en/safe_health_care_waste_management_policy.pdf)
- Also, *Management of solid health-care waste at primary health-care centres : a decision-making guide*: <http://whqlibdoc.who.int/publications/2005/9241592745.pdf>
- Another good website is [www.irc.nl](http://www.irc.nl) the site of the International Water and Sanitation Centre. For example they have a fact-sheet on on-site sanitation, or latrines at

[www.irc.nl/page/10371](http://www.irc.nl/page/10371) and some good articles on Community Water Management at [www.irc.nl/products/planotes35/index.html](http://www.irc.nl/products/planotes35/index.html)

## 7 PALLIATIVE CARE, PAGE 26

- A free Newsletter is “Worldwide Hospice and Palliative Care Online”. To get it, write to Anne Mason, [anne@hospiceinformation.info](mailto:anne@hospiceinformation.info)
- Palliative care: Issues and Challenges” Sue Lucas – three very useful pages: [http://www.unaids.org/NetTools/Misc/DocInfo.aspx?LANG=en&href=http%3a%2f%2fgva-doc-owl%2fWEBcontent%2fDocuments%2fpub%2fPublications%2fIRC-pub05%2fPalliative-Care\\_en%26%2346%3bpdf](http://www.unaids.org/NetTools/Misc/DocInfo.aspx?LANG=en&href=http%3a%2f%2fgva-doc-owl%2fWEBcontent%2fDocuments%2fpub%2fPublications%2fIRC-pub05%2fPalliative-Care_en%26%2346%3bpdf)
- An informative web page on Palliative Care: [http://www.cdc.gov/nchstp/od/gap/strategies/4\\_3\\_palliative\\_care.htm](http://www.cdc.gov/nchstp/od/gap/strategies/4_3_palliative_care.htm)
- Interviewing and Counselling at the Grassroots: [www.networklearning.org/books/counselling.html](http://www.networklearning.org/books/counselling.html)
- There is a website on supporting orphans and other vulnerable children. It contains over 550 documents from a wide range of organisations: [www.ovcsupport.net](http://www.ovcsupport.net)

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## www.networklearning.org

The following books covering the related fields of health care management and training are available at [www.networklearning.org/books.html](http://www.networklearning.org/books.html):

### HEALTH CARE MANAGEMENT

- Good Management of people, drugs and money are essential for good Primary Health Care. An excellent manual, *On Being in Charge*, is available courtesy of WHO.
- Some Management topics are also covered in *How to Build a Good Small NGO*: the Management cycle and Community Involvement are covered in Section A; People Management is covered in Section B; Financing is covered in Section D

### TRAINING

- Download *Teaching for Better Learning*

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- *Helping Health Workers Learn*: [www.healthwrights.org/books/HHWOnline.htm](http://www.healthwrights.org/books/HHWOnline.htm)
  - *Where There Is No Dentist*: [www.healthwrights.org/books/WTINDentistonline.htm](http://www.healthwrights.org/books/WTINDentistonline.htm)
  - *Where There is no Doctor*: [www.healthwrights.org/books/WTINDOnline.htm](http://www.healthwrights.org/books/WTINDOnline.htm)
  - *Questioning the Solution: The Politics of Primary Health Care and Child Survival* by David Werner (author of *Where there is no Doctor*) and David Sanders at [www.healthwrights.org/books/QTSONline.htm](http://www.healthwrights.org/books/QTSONline.htm)