DEPARTMENT OF HEALTH STUDIES

HEALTH IN COMMUNITIES

Only study guide for CMI-12602

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Welcome and introduction

Welcome to this second-level module on health in communities. You will learn about the concepts and theories/models involved in community health to equip you with a theoretical foundation for this module. The aim of this module is to equip you with knowledge about the life span of the individual in order to give you skills to work with families in the community. You will also gain a holistic approach towards critical issues in the community. You should grow and develop into a competent and skilful practitioner who can identify needs and problems relating to family health and respond to them in an innovative way. Working through this module will enrich your life not only professionally, but also personally.

The nature of this study guide

This study guide has been designed in an interactive way with the aim of guiding you through two prescribed books.

As you work through this study guide you should integrate the information in the study guide with the information in your prescribed books.

The Internet has a wealth of information and you are advised to use the Internet as often as possible to broaden your knowledge on certain topics.

Prescribed books

You are expected to purchase the following prescribed books for this module:


Edelman and Mandle (2006) has very valuable information on health promotion and covers the entire life span, from birth to death. In addition to your study guide, this book is very important: you will find a wealth of information.

Clark (2008) is a book on community health nursing that emphasises the **dimensions model of community health nursing** right through. This is a very valuable model which will help you to gain a holistic and systematic approach towards the individual, family and community.
The information in these two books is complementary. Together with the study guide it will help you to gain the knowledge and skills you will need to supply health care to individuals, families and communities.

Activities

The activities are planned to either reinforce content, to guide you to tackle upcoming content, or to motivate you to think about issues. You will note that in part 2 of the study guide there is only one activity at the end of each learning unit: here we want you to apply the dimensions model of community health to a member of the family. Feedback on all these activities will be given in annexure A.

This CMH2602 module runs parallel with the practice module for Community Health, CMH2126. The theory cannot be separated from the practice.

Icons

You will find a series of icons in the text to guide you as you progress with your studies.

Activity

When you see this icon, you will know that you must complete an activity. We may ask you to read a specific section in the prescribed literature, apply given information, think about topics that have not been introduced, find your own information or ask other people for information. Please read the instructions carefully.

Assessment criteria

This icon indicates the questions that you can use to assess your own understanding of the work. These questions are adapted from the outcomes. You are told what you should do to prove that you have met the learning outcomes.

Prescribed reading

When you see this icon, study or read the prescribed book as indicated, before continuing with the next section.

Learning outcome

This icon tells you how you will benefit in the field of practice if you know the content of the specific learning unit. The outcomes tell you what you will be able to do after you have studied the work.

Feedback

This icon tells you what was expected from you when you did the activity. It will not necessarily give you all the facts but will give you guidelines on how to answer the question. Not all of the activities will have feedback because many of the answers are given in your prescribed books.
Conclusion

This module is designed to enable you to work with families in the community. It is based on the needs and problems of the family. It covers individuals who are part of the family and the family as part of the community. After completion of this module, together with the practice module, you will be able to take responsibility for practising as an independent community nurse in any community setting.
PART I

THEORETICAL FOUNDATIONS IN COMMUNITY HEALTH
Learning unit 1

Concepts and theories/models in community health

Outcomes

Since theories/models provide you with the knowledge you need to practise community health in a scientific way, it is essential for you to be familiar with the various theories/models in the field to be able to apply them to community health.

When you have worked through this learning unit you will be able to:

- describe various concepts in theoretical thinking
- explain selected theories/models in detail
- describe the key concepts and themes of the selected theories/models
- apply the theories/models to community health

1.1 Introduction

While we will discuss theories/models in general in this learning unit, we will also deal with several selected theories in more depth in order to indicate how they can be applied to community health.

It is currently accepted that theories form the basis of community health. Since theories provide us with the knowledge we need to practise community health in a scientific way, it is essential for the community nurse to be familiar with the various theories/models in the field and to be able to apply them to community health.

1.2 Theoretical thinking as a language

The terms theory, model, conceptual framework, conceptual model are often used synonymously in literature. The literature reflects various conflicting opinions about the terms, their usage and meaning. According to Polit and Beck (2008:141) a conceptual model or a conceptual framework represents a more informal mechanism for organising and discussing phenomena or concepts, while theories are more formal in nature. Conceptual theories, frameworks and models are composed of concepts or constructs. These concepts or constructs are interdependent because they systematically demonstrate the relationship between variables. A model is a symbolic representation of concepts or variables with an interrelationship. A phenomenon is the abstract concept under study, often
used by qualitative researchers, while a concept is a description of the objects or events that form the basis of a theory. Both models and theories can describe and predict the relationship between phenomena. Models and theories are terms that are often used interchangeably in literature.

The term theory is often used to refer to the subject content that student nurses must be taught in the lecture room to acquire the information they need to perform the nursing tasks in practice. Researchers such as Polit and Beck (2008:768) define theory as “an abstract generalisation that presents a systematic explanation about the relationships among phenomena”. Theories include principles for explaining, predicting and controlling phenomena. In all disciplines theories serve the same purpose. This purpose is to make scientific findings meaningful, and to make it possible to generalise. A theory is composed of concepts and constructs that are systematically related and that are also goal-oriented (Stanhope & Lancaster 2006:196). Types of traditional theories include grand theories and middle-range theories. Grand theories describe and explain large segments of the human experience which are very broad. Middle-range theories explain more specific phenomena such as stress, self-care, health promotion and infant attachment. Metathory is a term used to label theory about the theoretical process and theory development (Polit & Beck 2008:141).

Metaparadigm refers to the main concepts that identify the phenomena or ideas of interest to a discipline, in this case the discipline of nursing. They provide the boundaries for the subject matter of the discipline. The metaparadigm concepts for nursing include person, environment, health and nursing (Clark 2008:67). However, current literature suggests that a four-concept metaparadigm for the discipline of nursing is too limited and suggests additional concepts such as transitions, interaction, nursing process, nursing therapeutics, self-care, adaptation, interpersonal relationships, goal attainment, caring, energy fields, human becoming and other concepts. The best-known and most used concepts are however the first four: person, environment, health and nursing.

1.3 Choosing a theory/model to apply to community health

Choosing a suitable theory or model is not always an easy task — especially when most theories are geared towards the care of individuals and were never designed to apply to groups or communities. The theory or model that is chosen must be flexible enough to be adapted to the community health situation and its aim must be to provide guidance for those who practise community health. The importance of the family or community network and the social network must both be clearly reflected, and the theory or model must be realistic and simple enough to understand and apply. In addition, the theory/model should harmonise with the community nurse’s views about the individual, the environment, personal health and community health. You may find that the theory that is chosen may not always fulfil all your expectations and that it may also not be applicable to all circumstances. You may often be required to make adjustments or to develop your own personal model on the basis of existing theories.
Activity

Explain why community health nursing should be based on a model or theory.

Feedback

You should have considered the following points:

- A systematic approach is needed.
- Theories/models assist community nurses to evaluate health status and to plan, implement and evaluate effective nursing care.
- The model/theory used directs attention to relevant aspects of the client situation and to appropriate interventions.
- Epidemiologic models help in examining factors that influence health and illness.
- Nursing models suggest interventions to protect, improve and restore health.

1.4 The dimensions model of community health nursing

Clark's (2008:69) dimensions model of community health nursing is one of the few models designed for community health. This model is described in detail in your prescribed book (Clark 2008) and will therefore only be summarised here. This model is a revision of the previously titled Epidemiologic Prevention Process Model. The dimensions model incorporates the nursing process and the levels of prevention as well as an epidemiologic perspective on the factors influencing health and illness. The dimensions model consists of three elements: the dimensions of health, the dimensions of health care and the dimensions of nursing.

The dimensions of health include:

- the biophysical dimension
- the psychological dimension
- the physical environmental dimension
- the socio-cultural dimension
- the behavioural dimension
- the health system dimension

The dimensions of health care include:

- primary prevention
- secondary prevention
- tertiary prevention

The dimensions of nursing include:

- cognitive dimension
- interpersonal dimension
- ethical dimension
- skills dimension
You should study this model to enable you to assess the health status of individuals, families or communities and to guide your nursing interventions.

Prescribed book

Study chapter 4 in Clark (2008, or later editions), on the dimensions model of community health nursing.

Activity

(1) Name the three elements of the dimensions model of community health nursing.
(2) List the dimensions included in each element.
(3) Give an example related to the dimensions in each element that addresses the health of a population group.

1.5 Orem’s self-care deficit theory of nursing

Orem proposes a general theory of nursing which she calls the theory of self-care deficit. Orem’s theory focuses on people’s ability to practise self-care. The dominant theme of her philosophy of health is that people should be empowered and encouraged to practise their own self-care by means of their own efforts or with the help of significant others. Orem’s self-care deficit theory of nursing consists of three interrelated theories: the theory of self-care, the theory of self-care deficit and the theory of nursing systems.

This theory is consistent with community health, based on the following premises:

- Individuals and groups must accept responsibility for their own health and consequently care for themselves.
- The community nurse should provide the necessary training and support that will enable individuals or communities to do this.
- The community nurse should intervene only when a deficit or need arises in the self-care framework.

The World Health Organization (WHO) also strongly emphasises that self-care and self-responsibility play an important role in achieving the goal of optimal health.

1.5.1 Theory of self-care

In order to understand the theory of self-care, one must first understand the concepts of self-care, self-care agency, basic conditioning factors and therapeutic self-care demand.

Self-care include those activities and decisions which a person undertakes in order to maintain life, health and well-being. These activities are acquired by learning, and they contribute to the maintenance of human development and functioning.
**Self-care agency** refers to the ability of a person to exercise self-care in daily life. The ability to care for oneself is affected by **basic conditioning factors**: age, gender, developmental state, health state, socio-cultural factors, health care system factors, family system factors, patterns of living, environmental factors and resource adequacy and availability.

**Therapeutic self-care demand** is the sum total of the measures which are called for at a particular time for the promotion and maintenance of health, development and general well-being. In the case of self-care, purposeful actions and steps are taken. Although self-care should benefit an individual's health, his or her perception of self-care may not always promote good health, as is the case with a person who smokes in the belief that it reduces his or her stress levels.

**Self-care requisites** refer to the reasons for which self-care is undertaken. The three categories of self-care requisites include universal, developmental, and health deviation.

**Universal self-care requirements** include those processes which are essential for the normal functioning and maintenance of health and life, such as the following processes:

- having and maintaining sufficient fresh air/oxygen, water and food intake
- finding the balance between exercise and rest, and having social interaction
- avoiding dangers and obstacles that can compromise human functioning and well-being
- promoting human functioning and development in a group
- providing care associated with elimination processes and personal hygiene
- keeping a balance between being alone and social interaction

**Developmental self-care requisites** are divided into two categories:

- The first concerns the maintenance of those conditions which are favourable to a person's normal growth and development.
- The second is concerned with the prevention of those negative conditions, forces, influences and factors which can hinder and obstruct normal development. Awareness of such requirements reflects a person's level of development and his or her general capacity for self-care.

**Health deviation self-care** is necessary for preventing illness, injury and retardation. It involves taking whatever steps are necessary for preventing or treating illness or disability effectively. The requisites for health deviation self-care include:

- seeking and securing appropriate medical assistance
- being conscious of and attending to the effects and results of pathologic conditions
- conducting medically prescribed diagnostic, therapeutic and rehabilitative measures
- attending to or controlling the negative effects of prescribed medical treatment effectively
- accepting oneself as being in a specific state of health and in need of particular forms of health care
- developing and sustaining health-optimising lifestyles

### 1.5.2 Theory of self-care deficit

The theory of self-care deficit forms the core of Orem’s general theory of nursing. According to this theory, an adult who is unable to practise self-care requires dependent care; this refers to an adult who does not have the ability to meet his or her own needs or
only has *partial ability* to take care of himself or herself. This may happen for example when a person falls ill and this illness generates new demands, requiring the implementation of complex measures and specialised knowledge. Orem cites the following examples of support or help which can be offered in such circumstances:

- acting on behalf of a person or undertaking certain activities for this person until he or she can once again care for himself or herself more independently
- providing guidance and direction in the new situation
- providing physical and psychological support
- creating and maintaining a new environment which supports personal development
- providing appropriate relevant instructions

A self-care deficit occurs where there is a discrepancy between the need for self-care and the ability to manage this self-care. In such circumstances the individual needs to be assisted and educated to administer whatever self-care he or she may need. In short, a self-care deficit occurs when a person is unable to practise appropriate self-care on his or her own or without external assistance.

### 1.5.3 Theory of nursing systems

The theory of nursing systems consists of two components: the nursing agency, and nursing systems.

The *nursing agency* refers to the characteristics of people who are trained as nurses that enable them to act, to know and to help others meet their therapeutic self-care demands by developing their own self-care agency.

*Nursing systems* are created when nurses use their knowledge and skills to plan and implement nursing care where there are deficiencies in self-care. The aim of intervention by the nurse is to compensate for the self-care activities which the individual, family or community cannot maintain at an optimal level. These compensatory activities are classified into:

- **The wholly compensatory system** where the community nurse becomes the self-care agent to compensate for the client’s inability to maintain his or her own self-care. The community nurse cares for and supports the client wholly. For example, this would happen where a person is in a coma and cannot consciously look after himself or herself.

- **The partly compensatory system** where the client is capable of certain self-care measures but only to a limited degree. The aim of health care intervention is to lend support and carry out certain activities on behalf of the client until he or she is able to resume them again.

- **The supportive/educational system** where the client can manage self-care but needs the support and guidance of the community nurse. The community nurse regulates the self-care agent’s performance and development so that he or she can function more independently (George 2002:126).

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**Activity**

(1) Describe the different components of the self-care deficit theory of nursing.
(2) Explain what is meant by a self-care deficit.
(3) A mother and her two-month-old baby visit your clinic. The baby is not gaining sufficient weight and the mother appears tired and stressed. Identify the self-care deficit in this particular case.

**Feedback**

You should have covered the following points in your answer:

1. The mother is not able to care for herself with the demands of a new baby.
2. She therefore needs health education and advice on how to handle the situation.

### 1.6 Neuman’s systems model/theory

According to Neuman, her personal philosophy of helping each other live contributed to development of the holistic systems perspective of the her systems model. Neuman’s theory is based on:

- the two main components of stress and the individual or his or her body’s reaction to that stress
- the community’s reaction to certain stress factors (stressors) in the environment

Neuman based her systems model on a general systems theory and regards the client as an open system which reacts to stressors in the environment. Stressors may be intra-personal, inter-personal or extra-personal. *Intra-personal* stressors occur within the client system boundary and correlate with the internal environment (e.g., feelings such as anxiety or anger within a person). *Inter-personal* stressors occur outside the client system boundary and have an impact on the system (e.g., stimuli between people such as role expectations). *Extra-personal* stressors also occur outside the system boundaries, but are further away from the system than the inter-personal stressors (e.g., work or finances). *Environment* includes all the external and internal influences that surround the client system.

The **external environment** exists outside the client system and the **internal environment** exists within the client system:

- The client system contains a basic structure or core construct (individual, family community) which is protected by lines of resistance. The basic structure includes system variables such as physiological, psychological, socio-cultural, developmental and spiritual variables. Penetration of the basic structure results in death.
- The normal level of health is identified as the normal line of defence which refers to the client’s usual state of wellness and represents stability over time. When the normal line of defence is invaded or penetrated, the client system reacts, for example with symptoms of illness.
- The flexible line of defence prevents stressors from invading the system and is a dynamic state of wellness that changes over time. It can for example be altered in a relatively short period of time by factors such as inadequate sleep or food.
- The lines of resistance protect the basic structure and become activated when the normal line of defence is penetrated by environmental stressors. If sufficient energy is
available, the normal line of defence is restored; but if the lines of resistance are not effective, death may follow.

- Reconstitution involves stabilisation of the system and movement backwards to the normal line of defence. Health care intervention takes place in the prevention modalities, that is the primary, secondary and tertiary levels of prevention. (Clark (2008:67))

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**Prescribed reading**

Study *Neuman’s model* in Clark (2008, or later editions).

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**Activity**

1. Explain what Neuman means by *client variables*.
2. Describe the concepts of *line of resistance* and *normal line of defence*.
3. Describe Neuman’s view on health.
4. Define the term *stressor*.

This theory/model can also be applied to community health because a preventive approach is followed and because of its flexibility.

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### 1.7 Pender’s health promotion model

Pender described a model which is applicable to community health in particular. This model is based on principles of health promotion and, to a certain extent, corresponds with the Health Belief Model. Pender’s health promotion model comprises three basic concepts, namely individual perceptions, variables which can influence healthy behaviour and the probability that actions will be taken to promote health:

- **Individual perceptions** include factors such as how important health is seen to be, perceptions on control and effectiveness, the definition of health, the state of health, the advantages inherent in preventive measures, and possible obstacles.
- **Variables** include factors such as demography, income, literacy, culture and family health patterns.
- **The probability that action will take place** includes matters such as
  - how highly the person rates or values action
  - any previous experience with health personnel
  - the availability and affordability of preventive services
  - the threat that the condition holds for the individual or family

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**Prescribed reading**

Study Clark (2008, or later editions), the section on *Pender’s health promotion model*.
Activity

(1) Name the variables which can affect the preventive actions that a family and a community may take.

(2) Write short notes on individual perceptions and indicate how they can influence health-promoting actions.

Pender’s model is applicable to community health because the promotion of health is taken as the starting point and factors which influence the measures for promoting health are defined and emphasised.

The model can guide and lead the community health nurse in promoting health. On the grounds of the variables and perceptions that are identified, she/he can make decisions on the degree of intervention that is necessary. For example a degree of knowledge and motivation may seem necessary to allow the community to take certain promotive actions, or to decide whether or not the available options are acceptable. The community health nurse’s task could then be to give the community the necessary information or to influence them to modify perceptions that are detrimental to their health. Depending on the specific problems or behaviour that deviates from a healthy living pattern, the culture of the community, the level of literacy and so on, the community health nurse can plan a programme or develop his or her own model based on Pender’s promotive model. (Clark 2008:257)

1.8 Gordon’s functional health pattern framework

Historically, conceptual models in nursing have employed Gordon’s health-related behaviours and developed them into an assessment model with 11 functional health patterns. Your prescribed book (Edelman & Mandle 2006) uses this framework throughout in the assessment of each developmental stage. The 11 functional health patterns include:

- pattern of health perception-health management
- nutritional-metabolic pattern
- elimination pattern
- activity-exercise pattern
- sleep-rest pattern
- cognitive-perceptual pattern
- self-perception-self-concept pattern
- roles-relationships pattern
- sexuality-reproductive pattern
- coping-stress tolerance pattern
- values-beliefs pattern

(Edelman & Mandle 2006:131)

Read Edelman and Mandle (2006 or later edition), the section on functional health patterns: assessment of the individual.
1.9 Conclusion
Various theories/models applicable to community health were discussed in this learning unit. It is very important that you as a community health nurse have an understanding of these theories/models and how they could be applied to community health.

Assessment criteria
(1) Define the following terms:
   — theory
   — model
   — conceptual framework
   — phenomenon
   — concept
(2) Define the different constructs of Orem’s theory.
(3) Explain the defence mechanism in Neuman’s theory.
(4) Describe the principles on which Pender’s promotion of health model are based.
(5) Name the three elements of the dimensions model of community health nursing.
(6) Name the dimensions of the dimension of health in the dimensions model of community health nursing.
(7) List the functional health patterns in Gordon’s functional health pattern framework.

Note: Application of selected models/theories will be assessed in part 2 of the study guide.
PART 2

THE INDIVIDUAL AND FAMILY AS CLIENT
Learning unit 2

The family as client

Outcomes
When you have worked through this learning unit you will be able to:

- describe the concept of family
- describe the structure of the family
- describe different family types and their characteristic features
- describe the stages of family development
- discuss family functions
- describe the family as a social system
- discuss cultural values in the family

2.1 Introduction
The family is the basic social unit in any community. Family members usually share living arrangements, responsibilities, goals, the continuity of generations, and a sense of belonging and affection. How well a family works together and meets any crisis depends on the composition of the family (the structure), the activities or roles performed by family members (the functioning) and how well the family is able to organise itself against potential threats.

2.2 Describing the concept of family
Clark (2008:318) states: “A family is a composed of two or more persons who are joined by bonds of sharing and emotional closeness and who identify themselves as being part of the family. Unlike those of other social systems, family relationships are characterized by intimacy, emotional intensity, and persistence over time.”

Santrock (2006:216) states: “[The family is] a social system, a constellation of subsystems defined in terms of generation, gender and role. Divisions of labour among family members define particular sub-units, and attachments define others. Each family member is a participant in several subsystems. Some are dyadic (involving two people) some polyadic (involving more than two people).”

Stanhope and Lancaster (2006:322) refer to the following definition: “A family refers to two or more individuals who depend on one another for emotional, physical, and/or financial support. The members of the family are self-defined.”
**Activity**

Ask different members of the multi-disciplinary health team to define *family*. Analyse the responses for similarities and differences.

### 2.3 Structure of the family

Family structure is the organised pattern or hierarchy of members that determines how they interact. Components of a family structure include the role of each family member and how they complement each other, the family’s value system, communication patterns and power hierarchy. The family structure influences the way that a family functions. (Allender & Spradley 2005:526)

The genogram shows family information graphically in order to view complex family patterns over a period of time, usually three generations or more.

**Fig 2.1 Genogram**

*Source: Allender & Spradley (2005:528)*
Activity
Draw a genogram of your own family.

2.4 Types of families

There are many family types and a family type may change over time as it is affected by birth, work, death, divorce and the growth of family members.

- **The nuclear conjugal family.** The traditional nuclear family structure consists of a husband, wife and children. Most young people move away from their parents when they marry and form nuclear families (no grandparents, aunts or uncles live in the home). The nuclear family is found in all ethnic and socio-economic groups, and is accepted by most religions. Today the number of nuclear families is declining as a result of the increase in divorce, single parenthood and remarriage, the acceptance of alternative lifestyles, and greater disparity.

- **The extended (multi-generational) family.** The extended family includes the nuclear family as well as other family members such as grandmothers, grandfathers, aunts, uncles, cousins and grandchildren. The advantage of such a family is that it means more people may serve as resources during crises and also provides more role models for behaviour and learning values.

- **The single parent family.** Single parent families consist of an adult woman or man and a child or children. Single parent families result from divorce, out-of-wedlock pregnancies, absence or death of a spouse, or adoption by a single person. A health problem in a single parent family is almost always a serious matter, because there is no backup person for childcare when the parent is ill.

- **The blended family.** The term blended family refers to a remarriage or a reconstituted family, where a divorced or widowed person with children marries someone who also has children of his or her own. Children of blended families are exposed to different ways of living and also have increased security and resources. They may become more adaptable to new situations. However, rivalry may arise among the children for the attention of a parent or there may be competition with the step-parent for the love of the biological parent.

- **The communal family.** The communal family is made up of groups of people who have chosen to live together as an extended family group. Their relationships with each other are motivated by social values or interests rather than kinship. Because of the number of people present, members may have few set traditional family roles. The values of commune members are often religiously or spiritually based and may be more oriented to freedom and free choice than those of a traditional family structure.

- **The cohabitation family.** The cohabiting family consists of two persons who are living together, but remain unmarried. They may be heterosexual or homosexual. Some such relationships are temporary but others are long-lasting. Reasons for cohabitation include the desire for a trial marriage, the increased safety that results from living together and financial factors.

- **The single alliance family.** Many single young adults live together in shared apartments, dormitories or homes for companionship and financial security. Although these relationships are often temporary, they have the same characteristics as cohabitation families.
The homosexual family. The homosexual family is a form of cohabitation where a same sex couple live together and share a sexual relationship. Such a relationship offers support in times of crisis that is comparable with that offered by a traditional nuclear or cohabitation family.

The foster family. Children whose parents are unable to care for them are placed in a foster home by a child protection agency. Foster parents usually receive remuneration for their care. Foster families may also include the parents’ own biological or adopted children. Foster care is theoretically temporary until children can be returned to their own parents (Clark 2008:318).

Prescribed reading
Read Clark (2008, or later edition), types of families.

2.5 Stages of family development

Stage 1: Beginning family
During this first stage of family development, members work to accomplish three specific tasks:

- to establish a mutually satisfying relationship
- to learn to relate well to their families of origin
- if applicable, to engage in reproductive life planning

The first stage of family life is a tenuous one, as evidenced by the high rate of divorce or separation of partners at this stage. The time frame for this stage extends from marriage to the birth of the first child.

Stage 2: The early child-bearing family
The birth or adoption of a first child is usually an exciting yet stressful event in a family. It requires economic and social role changes. The duration of this stage is from the birth or adoption of the first child to 30 months after this date. The following developmental tasks are usually accomplished during this stage:

- the establishment of a stable family unit
- the reconciliation of conflict regarding developmental tasks
- facilitating developmental tasks of family members

Stage 3: The family with pre-school children
A family with pre-school children is a busy family as children at this age demand a great deal of time related to growth and developmental needs and safety: accidents are a major health concern at this stage. The time frame for this stage is when the oldest child is two to five years of age.

Developmental tasks during this stage include:

- integration of second or third child
- socialisation of children
- beginning of separation from children
Stage 4: The family with school-age children

Parents of school-age children have the major responsibility of preparing their children to be able to function in a complex world. At the same time they have to maintain their own satisfying marriage relationship — this can be a difficult time for a family. Many families need the support of tertiary services such as friends, church organisations or counselling. The time frame for the family with school-age children is when the oldest child is 6 to 13 years old. Developmental tasks during this stage include:

- separation from children to a greater degree
- fostering education and socialisation
- maintenance of marriage

Stage 5: The family with teenage/adolescent children

The primary goal for parents with teenagers differs considerably from that of the previous developmental stages. Family ties must now be loosened to allow adolescents more freedom and prepare them for life on their own. Rapid technological advances have increased the gap between generations — this can make stage 5 a trying time for both parents and children. Violence, accidents, homicide and suicide are the major causes of death in adolescents — and death rates from HIV are growing. This places a still greater responsibility on the family. The time frame for this stage is when the eldest child is 13 to 20 years of age. Developmental tasks of this stage include the following:

- maintenance of marriage
- development of new communication channels
- maintenance of standards

Stage 6: The launching centre family

For many parents this stage when children leave to establish their own households is the most difficult. It appears as though the family is breaking up and parental roles change from those of mother and father to guideposts. The parents may experience a loss of self-esteem as they feel themselves replaced by other people. For the first time they may start feeling old and less able to cope with responsibilities. The time frame for this stage is from the time the first child leaves home to the time the last child leaves home. The following developmental tasks should be accomplished during stage 6:

- promotion of independence
- integration of in-law children
- restoring of marital relationship
- developing of outside interests
- assisting own aging parents

Stage 7: The family of middle years

At this stage a family returns to a two-partner nuclear family, as before childbearing. Some partners see this stage as the prime time of their lives with the opportunity to do things they never had time or finances for, such as travelling and hobbies. Others may experience this time as a period of gradual decline without the constant activity and stimulation of children in the home and may experience the “empty nest” syndrome. Support people may
also not be as plentiful as earlier in the parents’ lives. The time frame for this stage is from the time the last child leaves to retirement. Developmental tasks for this stage include:

- developing leisure activities
- provision of a healthy environment
- sustaining a satisfying relationship with children and grandchildren

**Stage 8: The family in retirement or older age**

The number of families of retirement age is increasing rapidly, with people living longer as a result of advanced technology, medical research and increasing health consciousness. Family members of this group are, however, more apt to suffer from chronic and disabling conditions than people in the younger age groups. The time frame for this stage lasts from retirement to death. Developmental tasks include the following (Clark 2008:323):

- maintaining satisfying living arrangements
- adjusting to reduced income
- adjusting to loss of spouse

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**Prescribed reading**

Study Duvall’s and Carter and McGoldrick’s *stages of family development* in Clark (2008, or later editions).

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### 2.6 The family as social system

All families share certain characteristics. Every family is a social system with its own cultural values, specific roles, functions and structure and each family moves through recognisable developmental stages.

A social system consists of a group of people who share common characteristics and who are mutually dependent. What affects one member affects the whole family, and vice versa. Families have certain features that differ from other social systems:

- Families last longer than many other social systems.
- Families are inter-generational social systems consisting of three or sometimes four generations.
- Family systems include both biological and affinal relationships (relationships created by law or interest).
- Biological aspects of family relationships create links to a larger kin group that are not found in other social systems.

A *social network support map* gives a detailed display of the quality and quantity of social connections. The community nurse can use this to help the family understand its support systems and to form a basis for nursing interventions.
2.7 Cultural values in the family

The cultural values in a family can have a major influence on how a family views health and health care systems. Each new generation takes on the values of the previous generation, passing traditions and cultures from generation to generation. A family’s cultural values and behaviours can either facilitate or impede the promotion of health and prevention of disease.

Prescribed reading

Read Clark (2008, or later editions), the chapter on the cultural context.

Activity

1. Apply the four principles of cultural assessment to the family.
2. Discuss culturally competent care.

Feedback

Note the following points:
(1) You needed to view the culture in the context in which it developed, examine the underlying premise of culturally determined behaviour and the meaning of behaviour in the cultural context. There is a need to recognise intercultural variation.

(2) You needed to define cultural competence, consider the characteristics and challenges of cultural competence and the modes of culturally competent care.

2.8 Family functions

Family functions are the activities that a family performs to meet the needs of its members. These needs include basic needs such as food, clothes, housing, emotional support and guidance. All families — regardless of the type of family — have in common these basic needs that require a family to function in certain ways to ensure family survival.

As the social system changes, the family system has to adapt if it is to meet individual needs and equip its members to participate in the social system. The family is a hierarchical system which is usually built on kinship, power, status and privileged relationships that may be related to age, gender, personality and health. All family functions can be reduced to two basic ones:

- ensuring the physical survival of the species
- transmitting the culture, thereby ensuring that the essential human qualities are preserved

The parents take care of the physical needs of the family by providing food, clothing, shelter, protection from danger, and the opportunity to recover from fatigue or illness; the parents are also responsible for reproduction within the family.

Note the following points (Allender & Spradley 2005:436):

- Affective functions are equally important: these include meeting emotional needs and promoting adaptation and adjustment, which are two of the family’s major functions.
- Security and acceptance functions refer to creating a secure environment.
- Instilling identity and satisfaction give members a sense of social and personal identity.
- Promoting affiliation and companionship gives members a sense of belonging throughout life.
- Social functions include culture, values, attitudes, goals and behaviour patterns and learning social and sexual roles accepting responsibility for behaviour and supporting individual creativity and initiative.

Prescribed reading

Study Clark (2008, or later editions), *family functions and related goals*.

2.9 Roles of the family

Roles of the family are discussed in learning unit 3.
2.10 Conclusion

The family is a critical resource in delivering health care. There is such a strong interrelationship of family and health status that the role of the family is crucial during every facet of health care — from preventive strategies to the rehabilitative phase.

Assessment criteria

1. Define family.
2. Describe the structure of a family.
3. Describe the different family types.
4. Discuss the different stages of family development.
5. Describe family functions.
6. Discuss the family as a social system and cultural values in the family.
7. Identify and discuss family roles.
8. Analyse your own family according to type, structure, stage of development, cultural values, functions and roles.
Learning unit 3

Assessing family health

Outcomes

When you have worked through this learning unit you will be able to:

- describe the dimensions of health from the dimensions model
- describe features of the following family assessment considerations:
  - the biophysical consideration
  - the psychological consideration
  - the physical consideration
  - the socio-cultural consideration
  - the behavioural consideration
  - the health system consideration
  - diagnosis
  - planning, implementation and evaluation

3.1 Introduction

Family health is viewed as “a dynamic, changing relative state of well-being that includes the biological, psychological, sociological, cultural and spiritual factors of the family system” (Stanhope & Lancaster 2006:322).

Excellent communication and collaboration skills are needed when you work with families. It is often necessary to teach and model effective communication with family members. Interpersonal skills often interact with elements of the ethical dimension in the care of families. Refer to the NUD 2119 module with regard to ethical principles.

3.2 Assessment of the family

Assessment of family health is the cornerstone of family nursing interventions. By using a systematic process, problem areas in the family are identified and family strengths emphasised. These can be used as building blocks for interventions. According to Allender and Spradley (2005:524) a systematic process requires three tools: (1) a conceptual framework upon which to base the assessment, (2) a clearly defined set of assessment categories for data collection, and (3) a method for measuring a family’s level of functioning.

The dimensions model of community health nursing discussed in Clark (2008) is a useful conceptual framework.
Data collection categories refer to certain basic information, which can be categorised as follows:

- family demographics
- physical environment
- psychological and spiritual environment
- family structure and roles
- family functions
- family values and beliefs
- family communication patterns
- family decision-making patterns
- family problem-solving patterns
- family coping patterns
- family health behaviour
- family social and cultural patterns

Three well-known assessment tools are the ecomap, the genogram and the social support network map.

Source: Allender & Spradley (2005:526)

The ecomap is a diagram of the connections between a family and the other systems in its ecological environment. The map is used to discuss and analyse these relationships.

![Ecomap Diagram](image)

Figure 3.1 Ecomap

Source: Allender & Spradley (2005:527)
The genogram was discussed in learning unit 2.

A social network support map was discussed in learning unit 2.

Assessment of the family can be achieved by using the dimensions of health from the dimensions model of community health nursing to facilitate care given to family members. These are the biophysical, psychological, physical, socio-cultural, behavioural and health system considerations, discussed below. (Clark 2008:327)

### 3.3 The biophysical considerations

Assessment begins with the gathering of data to identify the physical needs of the family members. The physical status of each family member should be weighed up as part of the family assessment. The physical status of each family member affects the functioning of the family and also the way members relate to one another.

Knowledge of the age, sex and race of family members as well as information related to genetic inheritance can help with the identification of problems and the planning of family care.

### 3.4 The psychological considerations

#### 3.4.1 Communication patterns

Communication patterns in the family are an indicator of the functioning of the family in the psychological dimension. Verbal and non-verbal communication modes, as well as the listening skills of family members, should be considered. The way in which members communicate values and ideas is important. The content of the communications should also be assessed: Are they superficial or does the family engage in values clarification discussions? The emotional tone of the family’s communication is another indicator of the psychological environment. The person doing the assessment should ascertain what areas of communication are taboo for family members — typical areas include feelings, sexual issues and religion. Dysfunctional communication patterns should be noted; an example would be where a family member is excluded from a discussion. The degree of communication between the family and the supra system should be considered. Is the family open to new ideas and to opinions from people outside the family?

#### 3.4.2 Family development stages

As discussed in learning unit 3, each family passes through developmental stages that have specific developmental tasks for the family to accomplish. Each family should be assessed to determine which developmental stage the family is currently going through and whether developmental tasks have been accomplished. The family’s developmental stage needs to be assessed, to provide anticipatory guidance that helps the family incorporate new members and adjust to such additions.
3.4.3 Family relationships and family dynamics

Family relationships are those bonds between family members that create identifiable patterns such as subgroups or isolated members. Assessment of family relationships is done by compiling information regarding subgroups in the family. A mother-daughter subgroup may for example exclude the father from decision making. Communication within subgroups is assessed in terms of both content and process. This is followed by identification of the relationship as supportive or close, demanding, maternal and so on. Family dynamics describe the hierarchical pattern within the family. Power and leadership are the central focus for this area of assessment. Who are the primary decision makers? Who controls conversations? Is there a leader and what leadership style does he or she employ?

3.4.4 Family emotional strengths

Evidence of family cohesion and the degree of sensitivity to others should be observed, for example the degree to which family members support and praise each other. A positive self-image of a family member is the result of daily family interactions that boost the individual's feeling of self-worth. The self-esteem of each family member can be assessed by observing non-verbal behaviour as well as communication patterns with others.

3.4.5 Coping strategies

A family uses coping strategies as behaviours that help a family adapt to stress or change; coping strategies are characterised by positive problem-solving methods that prevent or resolve crisis situations. Coping strategies may be external or internal. A family using internal coping strategies rely on resources within the family; these strategies include role flexibility, joint problem solving and the interpretation of stressful conditions. A family using external strategies relies on outside resources to meet its demands; these strategies include seeking information, maintaining community linkages, and seeking spiritual or social support.

Defence mechanisms are tactics for avoiding recognition of problems. Examples of defence mechanisms include denial, rationalisation, selective inattention, isolation, intellectualisation and projection. Defence mechanisms are not considered problematic unless they interfere with coping and may actually be helpful in allowing time to marshal resources before facing a problem. Commonly used defence mechanisms:

The following are commonly used mechanisms:

- **denial**, by ignoring threat-provoking aspects of a situation or changing the meaning of the situation to make it less threatening
- **rationalisation**, by giving a “good” or rational excuse, but not the real reason for responding to a situation with a particular behaviour
- **selective inattention**, where only those aspects of the situation that do not cause distress or pain are given attention
- **isolation**, where emotion is separated from content in a situation so that one can deal objectively with otherwise threatening or emotionally overwhelming conditions
- **intellectualisation**, meaning a focus on abstract, technical, or logical aspects of a threatening situation to insulate oneself from the painful emotions generated
- **projection**, meaning that one’s own motivation is attributed to other people
3.4.6 Child-rearing and discipline practices

Child-rearing and discipline practices can either cause psychological problems in the family or strengthen a sense of right and wrong in children. The type of discipline used, by whom it is administered and which behaviour elicits disciplinary action, should be assessed. It is also important to determine whether the parents support each other in matters of discipline.

3.4.7 Family goals

Family goals are a function of family values and reflect a family’s cultural values. They also vary with a family’s developmental stage, economic status and physical health. Families are not always consciously aware of family goals. It is, however, important to observe and assess these goals, which include the following:

- producing children and ensuring their survival
- exchanging love and affective support
- providing economic survival

3.5 The physical environmental considerations

Observational and interpretive skills are especially important when you assess the home environment. Within this setting the family develops either functional or dysfunctional relationships. A crowded, unhygienic or unsafe home can cause physical and psychological health problems among family members. The following information is important when you assess the home:

- the address
- whether the family owns or rents the home
- whether the house is big enough for the family
- the presence of safety hazards
- emergency plans for fires or disasters

Prescribed reading

Read Clark (2008, or later editions), the sections entitled physical environmental considerations and safety considerations in the family environment.

The following information should be obtained about the neighbourhood:

- types of homes in the area
- degree of industrialisation
- crime rate
- sanitation
- population density
- common occupations of neighbours
- transportation
- shopping facilities
After the assessment has been completed, the family members may be questioned about their perceptions of the environment.

3.6 The socio-cultural considerations

Assessment of the social dimension of the family will include looking at the following areas:

- roles of family members
- religion
- culture
- social class
- economic status
- employment and occupational factors
- external resources

3.6.1 Roles

The family assigns roles to members of the family, prescribed behaviours in a specific situation, in a way similar to society at large. In society people fulfil certain roles, such as those of teachers, doctors, nurses and firefighters. In the family the roles include those of breadwinner, homemaker, gardener and chauffeur or emotional roles such as those of leader, nurturer, sustainer, gatekeeper, protector and healer. A family member may fulfil more than one role. The fewer the family members, the greater the number of demands. Changes in performance roles also necessitate emotional changes (e.g. the man who takes over the household duties after being retrenched). Having the ability — and the opportunity — to perform a variety of roles is healthy. The healthy family is the one where there is the opportunity to shift roles with ease.

Roles are socially expected behaviour patterns determined by a person’s position or status in the family. A family member can occupy several roles; for example the adult woman in a family typically has the roles of wife, mother, cook and confidante. Roles may be formal or informal.

Formal roles are expected behaviours associated with family positions such as husband, wife, mother, father and child. Formal roles of the husband and father would typically be those of breadwinner, handyman and financial manager.

Informal roles are expected behaviours, not associated with a particular position, whereby emotional needs are usually met — for example, harmoniser, encourager, follower, martyr, scapegoat, pioneer, go-between and blamer. The presence or absence of these roles should be assessed and their influence on family functions and cohesiveness should also be determined.

Role conflict occurs when the demands of a single role are contradictory or when the demands attending several roles contradict or compete with each other, or when one person’s definition of a role does not correspond with another person’s.
Role overload occurs when one family member assumes multiple roles and is confronted with too many role expectations at the same time.

Flexibility of family roles and mutual respect are important matters to be considered and role adjustments may be required as the family moves through the different developmental stages.

3.6.2 Religion

Religious beliefs and practices can have an important influence on the health of the family. Strong religions may, for example, prohibit the use of contraceptives or the administering of blood transfusions. Religion may also provide a source of emotional support in times of crisis.

3.6.3 Culture

Information regarding cultural practices is an invaluable aid in the building of relationships and planning of family interventions. Principles of cultural assessment include the following:

- View all cultures in the context in which they developed.
- Examine underlying premises for culturally determined beliefs and behaviours.
- Interpret the meaning and purpose of behaviour in the context of a specific culture.
- Recognise the potential for intra-cultural variation.

Prescribed reading

Read Clark (2008, or later editions), the section on the cultural context.

3.6.4 Social class and economic status

Social class and economic status can profoundly affect the health of a family. The family's social class influences lifestyle, interactions with the external environment, and the structural and functional characteristics of a family. Economic status is closely related to social class and educational level. Assessment of the social class and economic status of a family is important in planning for referral to community resources.

3.6.5 Employment or occupational factors

Occupational factors affect family health in the following ways:

- job-related stress resulting in illness
- hazards in the workplace
- job-related problems and time constraints that might interfere with family commitments
3.6.6 External resources

External resources include those resources in the community which are available to assist the family. Examples of such resources are financial assistance, transportation, housing, health care and education. Relational support systems include kin networks, friends and neighbours.

3.7 The behavioural considerations

3.7.1 Family consumption patterns

The nutritional status of a family can be assessed by the physical assessment of each family member and by observing how they select, purchase and prepare food. If any family member is nutritionally impaired, an assessment should be done to determine the underlying causes. Cultural patterns should be determined in the selection, preparation and consumption of food.

Other consumption patterns which need to be determined include the use of alcohol, drugs, medications, tobacco and caffeine. What is the influence of the use of any of these substances on the family?

3.7.2 Rest and sleep

Rest and sleep patterns in the family may cause problems, as when there is a new baby in the house who sleeps during the day and cries at night or when one of the parents works shifts. The family can be helped to deal with these problems.

3.7.3 Exercise and leisure

High costs and low income may limit exercise and leisure activities, but should not eliminate them. Regular exercise and leisure activities are necessary for good health and, if they include the whole family, will promote family cohesion. The family that cannot afford costly activities may be assisted to plan for low-cost activities to enhance family cohesion.

3.7.4 Household and other safety practices

In the assessment of the behavioural dimension of family health, the following family practices should be considered:

- regular seat-belt use
- use of safety equipment such as eye and ear protection
- use of infant safety seats
- sleeping cot with safe spacing between rails and well-fitted mattress
- proper disposal of hazardous substances
- safety education of children
- safe use of appliances such as electrical appliances, saws, glues and drills
3.8 Health system considerations

3.8.1 Family response to illness
Assessment of the biophysical, psychological, physical, social and behavioural dimensions of the family should give a general idea of the health of the family and strategies used by family members to stay healthy. An assessment should also be done of how a family copes with illness. Sometimes folk remedies or cultural practices are used before a health care provider is consulted. These practices should be assessed to determine whether they are harmful.

3.8.2 Use of health care services
Health care services should be assessed for availability, accessibility, affordability, equity and effectiveness. Family functions differ with respect to various illnesses. In the case of an acute illness, family functions include providing or obtaining health care, re-assigning roles and supporting the sick person. With chronic illness, additional functions include avoiding or coping with medical crises, preserving the family’s quality of life and arranging treatment.

When the family is faced by a terminal illness, family functions include dealing with shock and fear, and minimising pain and discomfort. It is important to find out where the family go for health care and whether the service provides any preventive and promotive health services.

3.9 Diagnostic reasoning and the family as a client
The family diagnosis is a statement of the problem and the specific reason that brings the family and the helping person together to solve a family need. The data collected during the assessment of the family enables the person working with this family to make informed decisions on how to intervene with families that need assistance.

3.10 Planning, implementation and evaluation
When the prognosis statement has been formulated, the next step is to determine what type of intervention is needed for the family and to whom the family should be referred. The planning phase is a form of contracting with families. The contract or plan of action includes establishing goals, formulating plans of action, determining who does what and building in steps in the evaluation process. The contract or written care plan:

- ensures involvement of each person
- involves people in their own care
- increases autonomy and self-esteem of the family members

The types of plans, their implementation and the evaluation process are specific to the family and the family diagnosis. During the planning stage it is important to realise that the family has the right to make its own decisions. The family may be assisted by the following:

- providing direct care that the family is unable to provide
- removing barriers to needed services that are able to facilitate family functioning
- improving the capacity of the family to act on its own behalf and assume responsibility
Once the plan of action has been developed and all family members have given their approval to the plan, the plan is put into action. When a plan is not working well the barriers to implementation should be determined. Family apathy and indecision are often barriers to implementation.

The evaluation process contains both formative (ongoing) and summative (ending) evaluation components. The evaluation is based on the family outcomes and response to the plan, not the success of the interventions (Stanhope & Lancaster 2006:491).

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**Prescribed reading**

Study Clark (2008, or later editions), on assessing family health and family crisis.

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### 3.11 Conclusion

In order to work effectively with families, conducting assessments and providing care, healthcare workers must think “interactionally”. Although assessment is the first step in the process, data continues to be gathered throughout the provision of services, showing the dynamic, interactive and flexible nature of this process.

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**Assessment criteria**

The following scenario will be applicable for learning units 4–10, as it covers all the developmental stages. Feedback will be given in annexure A.

A schoolteacher refers one of the grade 12 pupils to the local primary health care clinic. The teacher reports that Mary often complains of headaches, that she lost a lot of weight and that her schoolwork has deteriorated. During a home visit, the nurse found the following:

- Mary is part of the X family, an extended, blended family who live in a middle-class neighbourhood in a three-bedroom house, with an outside room where Mrs X’s 70-year-old father stays.
- Both Mr and Mrs X have been married before. Mrs X has one child from her previous marriage, the nine-year-old Peter. Mr X has an 18-year-old daughter Mary, from his previous marriage. She is not married and lives with the family with her two-year-old son, Alex. Mr and Mrs X have a nine-month-old baby called Baba and Ben who is four years old.
- Mr X, 54 years old, works at a motor manufacturing plant. He works overtime every alternate weekend. He complains of dizziness and passed out twice during the last two months. His manager referred him to the occupational health clinic and the nurse observed a blood pressure of 175/130 and also that his blood sugar was very low.
- Mrs X is 36 years old and wants to find a job to contribute to the family income, but she has been unsuccessful until now. In the meantime, she looks after the baby and the two toddlers. The baby appears to be underweight and is not yet able to sit unsupported.
- Peter tells the nurse that he sometimes misses the school bus and then stays at home. He enjoys playing with Alex and Ben.
- Mary often has arguments with her father especially over weekends when her boyfriend stays over. The father has assaulted the boyfriend on several occasions.
- The grandfather is suffering from asthma which is not well controlled. He becomes agitated with Alex and Ben who stay at home during the day.

Read this scenario carefully. At the end of each learning unit (4–11), you will be expected to do an assessment of one of these family members.
Learning unit 4  
Infants from birth to 18 months

Outcomes
When you have worked through this learning unit you will be able to:
- state the developmental tasks of the infant
- explain the immunisation schedule to parents
- compile a list of the growth and development stages of the infant from one month to 18 months
- identify common parental concerns about infants

4.1 Introduction
Children in Africa and in other continents may be categorised as belonging to the First or Third World. Some are privileged, others deprived or disadvantaged, some live in urban areas and others in rural areas. In Africa, children come from different cultures and are of different nationalities.

All these children should be given the opportunity to reach their full potential, because they are our most precious asset. At a convention held in 1989 the United Nations adopted a resolution on the "Rights of the Child". The three main areas of children's rights are:
- survival
- development
- protection

4.2 Definition of child health
Kibel, Saloojee and Westwood (2007:3) state: "Child Health is concerned with the realization of an optimal state of well-being and effective functioning for children and also as adults-to-be. It aims to promote health, prevent disease and disability, ensure that disease among children is managed appropriately, and promote the optimal function of children with impairment and disabilities."

4.3 Growth and development during infancy
Physical growth and development in children can be divided into different stages. The embryonic period refers to the first eight weeks after fertilisation of the ovum. The fetus develops from nine weeks until birth. Birth occurs on average 280 days after conception.
The neonatal period begins at birth to 28 days of age. Infancy refers to the remainder of the first year of life and early childhood refers to the pre-school period between one and six years (Kibel et al 2007:48).

Prescribed reading

Study Edelman and Mandle (2006, or later editions), the chapter on the infant.

Please give attention to the following points:

- The focus of this chapter is on the infant in the family during the infant’s development period (1 to 18 months).
- The infant is totally dependent on the parents and significant others for all forms of health promotion activities.
- Growth is the increase in size. Physical development is a process of growth and differentiation (progressive change in function and/or morphology).
- Growth and physical development are multi-faceted processes involving genetic, nutritional and environmental (physical and psychological) factors.
- Disturbances in any of the above areas may alter growth and development.
- During the first two years rapid growth takes place.
- For the person working with the infant it is very important to know what normal growth and development during infancy are like, so that abnormalities can be detected early.
- Different milestones mark the period of 1–18 months: make sure you know them by heart.

4.4 Developmental tasks

The development of a child can be compared to specific tasks which should be completed by certain ages. It is important to realise that development follows a pattern, within limits which can differ from child to child. (Edelman & Mandle 2006:378)

Prescribed reading

Study the section age and physical changes of the infant in Edelman and Mandle (2006, or later editions).

The following points are important:

- The infant’s first-most basic task is survival, which includes breathing, sucking, eating, etc. This is referred to as the oral stage of development.
- There are several more developmental tasks. Parents should assist infants to achieve these developmental tasks by stimulating them and helping them to interact with the environment.
- It is important when counselling parents to stress a variety of stimuli within the infant’s environment, for example
  — auditory stimulation — (television, radio, songs, spoken voice)
  — visual stimulation — (toys, plants, colourful mobiles, etc)
• The central task of psychosocial development during infancy is the development of a sense of trust versus mistrust, first with the mother (or caretaker) then with significant people in the environment.
• Cognitive development describes the infant’s involvement in mastering simple coordination activities to enable him or her to interact with the environment.
• The infant’s growth index is important and should be measured during each routine visit to the clinic.
• The correct completion of the growth chart is important in order to determine whether the baby’s mass is increasing sufficiently according to age.
• Important factors are the discovery of nutritional problems, followed up with guidance on nutrition and promotion of breast-feeding up to 18 months.
• Mothers should be well informed about the growth chart.

4.5 Infant nutrition

Children need nutrition to support life and to provide for growth and the maintenance of health.

Prescribed reading

Study the section on nutritional-metabolic pattern of the infant in Edelman and Mandle (2006, or later editions).

The following points are important:

• Infants’ experience of drinking and eating is intense and personal. It comprises most of their socialising and is an integral part of their developmental progress.
• Feeding provides emotional and psychological benefits as well as an opportunity to gratify both sucking and nutritional needs.
• The normal newborn has active rooting and sucking reflexes.
• Essential nutrients are water, proteins, fats, carbohydrates, vitamins and minerals in the following quantities:

  — water: 0–6 months 125–150ml/kg body weight per day; 6–12 months 120–135ml/kg body weight per day
  — protein: 0–6 months 2.2g/kg per day; 6–12 months 2.0g/kg per day
  — carbohydrates: should supply 30%–60% of the energy intake during infancy
  — fat: recommended minimum of 3.8g/kcal and maximum of 6g/100kcal of fat (3% to 54% of calories/kilojoules)
  — minerals: iron may be needed from 4–6 months;
  — fluoride intake for infants: 0.25mg per day from 4–6 months onwards

• Promoting breast-feeding is very important — the WHO and UNICEF have drawn up a code of practice for hospital “clinics”. The community nurse should know The ten steps to successful breast-feeding (Edelman & Mandle 2006:386).
Prescribed reading

Study breast feeding, the introduction of solid foods, weaning, elimination pattern, activity-exercise pattern, and the sleep and rest pattern in Edelman and Mandle (2006, or later editions).

4.6 Cognitive-perceptual patterns

The cognitive development of a child runs parallel to his or her biological, adaptive and psychosocial accomplishments.

Prescribed reading

Study Edelman and Mandle (2006, or later editions), cognitive perceptual patterns of the infant.

From this section in Edelman and Mandle (2006) it is clear that:

- Cognition is the process by which the individual recognises, accumulates and organises knowledge of the environment.
- The infant’s visual impressions are unfocused, strange, unfamiliar and without meaning. Visual stimuli must be moving, bright or flashing to capture the infant’s attention. Take note of the visual development milestones (table 17.5 in Edelman & Mandle 2006:392).
- Hearing is one of the better developed senses in the infant. The ability to listen and to discriminate between sounds is an important task during infancy — study table 17.6 in Edelman and Mandle (2006:393).
- Infants make sounds during the first two months. Crying is a means of communication. At six months an infant will make bubbling sounds. At 9–10 months the infant forms two-syllable sounds. At 12 months the infant may say words such as “mama” and “bye-bye”. At 15–18 months expressive jargon with rhythmic intonations develops, but the infant rarely utters recognisable words.

4.7 Child abuse

Not all children are fortunate enough to experience a safe and happy family life.

Prescribed reading

Study Edelman and Mandle (2006, or later editions) and Clark (2008, or later editions), on child abuse.

It appears as if the following is true regarding child abuse:

- The problem of child abuse occurs on a very large scale.
- Women are more frequent abusers than men because they are the primary caregivers.
Child abuse occurs in families of every race, creed and socio-economic class. The caregiver or nurse working with infants must be alert to signs of abuse. Nursing interventions to prevent abuse of infants are of the utmost importance.

4.8 Stress in infancy

Children who experience stress during infancy are often those children who fail to thrive according to their growth chart and fail to attain the developmental stages.

Prescribed reading

Read Edelman and Mandle (2006, or later editions), the section coping-stress tolerance pattern of the infant. Give special attention to the nursing interventions needed to render assistance in stressful situations during infancy.

4.9 Pathological processes

Accident prevention and safety promotion are important issues in the child’s environment which influence the health status.

Prescribed reading

Read Edelman and Mandle (2006, or later editions), the section pathological processes in the infant.

The following guidelines are applicable to the prevention of accidents in infants:

- Falls are common after four months of age. Never place an infant unattended on a raised surface with no type of guard rails.
- Burns are the most frightening of all accidents and parents should be assisted to prevent burns from happening.
- Parents should be advised that objects like beads, coins, pins, nuts and buttons are frequently swallowed.
- Preventive measures and education regarding Acquired Immunodeficiency Syndrome (Aids) should begin with the very young.

4.10 Immunisation

According to the WHO “the two public health interventions that have had the greatest impact in the world’s health are clean water and vaccines” (Kibel et al 2007:125).

The benefits of a completed immunisation programme are that it:

- helps the child’s body to produce antibodies against specific microorganisms
- prevents the specific organism from causing serious illness or complications
- saves millions of children’s lives and prevents disability
4.10.1 The South African Expanded Programme on Immunisation

The following vaccines are provided by the South African EPI:

- **BCG.** Bacillus Calmette-Guerin vaccine. BCG is commonly used in developing countries for the prevention of disseminated tuberculosis. This vaccine consists of a freeze-dried live attenuated strain of *Mycobacterium bovis.*
- **Polio vaccine.** Two kinds of polio vaccine incorporating three types of polio virus are available for immunisation:
  - trivalent inactivated polio vaccine (TIPV) given by injection
  - live attenuated trivalent oral polio vaccine (TOPV)
- **Diptheria toxoid.** Two preparations are available:
  - an absorbed, more immunogenic, higher dose vaccine for children up to the age of four years (abbreviated as D)
  - lower dose formula intended for persons above this age (abbreviated as d)
- **Tetanus toxoid.** Tetanus toxoid is an activated, yet highly antigenic, preparation of tetanus toxin. Protective antibodies develop in over 95% of vaccines following the primary series of three vaccines.
- **Pertussis vaccine.** This vaccine is used against whooping cough and consists of a suspension of whole celled killed *Bordetella pertussis* organisms.
- **Conjugate Haemophilus influenzae (Hib) type b vaccine.** In South Africa the PRP-T Hib vaccine is used. Hib vaccine protects against Hib meningitis, pneumonia, epiglottitis and osteomyelitis.
- **Hepatitis B vaccine.** A second generation of vaccines produced by recombinant technology has been developed and is currently used in South Africa.
- **Measles vaccine.** This vaccine is derived from the Schwarz strain of the measles virus. The virus is attenuated by the multiple passage through both fertilised chicken eggs and chick embryo fibroblast culture.

The South African Expanded Programme on Immunisation (SA-EPI) follows the WHO recommended schedule and guidelines. See Annexure C.

In June 2008 the Department of Health decided to add two new vaccines to the EPI in order to prevent viral pneumonia and second viral diarrhoea in children. See Annexure D.

4.10.2 Vaccines not included in the South African EPI programme

- **Measles, mumps and rubella (MMR).** The MMR vaccine comprises a combination of live attenuated measles, mumps and rubella viruses. It is usually administered at the age of 15 months.
- **Influenza vaccine.** The WHO makes annual recommendations about the strains to be included in that year’s influenza vaccine.
- **Hepatitis A.** Two doses of the vaccine are administered by intramuscular injection separated by at least six months.
- **Pneumococcal conjugate vaccine (PCV).** The currently available PCV includes
seven of the 90 pneumococcal serotypes which are responsible for approximately 70% of all invasive pneumococcal disease in South African children.

- **Rotavirus.** Two rotavirus vaccines have been licensed for general usage — Rotarix and Rotateq. Rotavirus vaccines are live attenuated vaccines administered orally at 10 and 14 weeks.
- **Varicella vaccine.** A live attenuated varicella vaccine (Var) is now part of the routine immunisation schedule of most high-income countries.

See Annexure E for Private Vaccines Schedule.

### 4.10.3 Children with special vaccination requirements

The following cases have special vaccination requirements:

- HIV-infected children
- pre-term babies
- children at special risk of infection
- immunodeficiency owing to disease or poor treatment
- delayed or unknown immunisation status

### 4.10.4 Practical considerations

Note the following practical considerations:

- Vaccines lose their potency if they are not stored and transported correctly.
- Vaccines should be refrigerated between 2°–8° C.
- Vaccines, except for freeze-dried BCG, OPV, the lyophilised MMR vaccine, PRP-T Hib vaccine and varicella-zoster vaccines, should not be frozen.
- Diluent is never frozen.
- Some vaccines, eg BCG and reconstituted MMR, lose potency if exposed to light.
- Reconstituted vaccines should be checked regularly for signs of deterioration, such as change in colour and clarity.
- Almost all vaccines are given either by intramuscular or by deep subcutaneous injection. The exceptions are OPV given orally and BCG given by intradermal injection.
- Many vaccine injections may result in soreness, redness, itching, swelling or burning at the injection site for one or two days. Paracetamol eases this discomfort.

The only absolute contra-indications to childhood vaccines are anaphylactic sensitivity to any of the particular vaccine’s components (eg gelatine or neomycin), and an anaphylactic event following a previous dose of any vaccine (Kibel et al 2007:135).

### 4.10.5 The cold chain

Maintaining the cold chain means keeping vaccines at the right temperature throughout distribution, storage and use (Department of Health 2005:30):

The cold chain refers to the system, of all the people, equipment, transport and procedures, which is responsible for ensuring that vaccines reach the vaccinee (child or woman) having been maintained in the appropriate specified temperatures. Vaccines are heat-sensitive, but some vaccines are also destroyed by freezing. The cold chain is
therefore crucial in maintaining the potency of vaccines. Vaccines should be transported, stored and handled in the appropriate manner from the manufacturer till the point of vaccine. **Pack the cold box correctly.** Use a cold box with rigid and adequately thick walls. Note the following points:

- Remember that a cold box cannot make vaccines cold. It can only maintain the original temperature.
- Check that the cold-box seal is intact and that there are no cracks.
- Ice packs should be frozen solid for two days before use.
- You need sufficient frozen ice packs to keep the vaccines cold for twice the time that you anticipate it will be stored in the cold box. Line the bottom, sides and top of the cold box with ice packs.
- Always protect DTP, DTP-Hib, DT, TT, Hep B and Hib from freezing by wrapping them in newspaper or cloth.
- Measles and polio vaccines should be placed at the bottom of the box next to the ice packs. Next pack the BCG vaccines; above them place the wrapped DTP, DT, Hep B, DTP-Hib and TT vaccines and diluent.
- Place a thermometer in the centre of the cold box.
- Close the lid tightly and keep it closed as much as possible.

**Pack your fridge correctly** (Department of Health 2005:33):

- Store TOPV and measles vaccine on the shelf closest to the freezing compartment.
- Store BCG, DTP, DTP-Hib, DT, TT, Hep B, Hib and diluent on the middle shelves away from the freezing plate.
- Store bottles of water, with salt added to discourage drinking, on the bottom shelf, in the vegetable drawers and in the fridge door to help stabilise the temperature.
- Hang the thermometer from a shelf so that it is in the centre of the refrigerated area.
- Never store vaccines in the fridge door.
- Do not store food in the vaccine fridge.
- If there is no fridge available for other medicines, ensure that these are stored completely separated from the vaccines.
- Always plan before opening the fridge door.
- Aim to open the fridge door two or three times per day.
- Never keep expired vaccines in the fridge.
- Arrange vaccines to allow air to circulate between boxes.
- Record the temperature of the fridge twice daily.

### 4.11 Conclusion

Health promotion and disease prevention are very important during infancy. Early detection and reduction of risk factors during infancy are the ultimate goals in maintaining the infant’s health.

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**Assessment criteria**

Read the scenario at the end of learning unit 3 carefully.

Describe how you would do an assessment of an infant who is nine months old, using the dimensions of health from the dimensions model of community health.
FEEDBACK

See annexure A.
Learning unit 5

The toddler (18–36 Months)

Outcomes

When you have worked through this learning unit you will be able to:

- discuss the physical changes that occur during the toddler period and relate these changes to health hazards at this age
- discuss common behavioural problems related to eating during this period
- discuss toilet training for a toddler
- discuss a teaching plan for sleep disturbances
- explain temper tantrums
- give health education to parents on injury prevention at home
- discuss sibling rivalry in this period

5.1 Introduction

At the beginning of the toddler period the child usually becomes secure in the ability to walk and run and achieves sufficient mastery of language to enable him or her to express most needs and desires. At this stage the child is primarily engaged in developing a separate sense of self.

A child of 18 to 36 months is not yet old enough to be an active participant in personal health practices.

5.2 Age and physical changes

Prescribed reading

Read Edelman and Mandle (2006, or later editions), the chapter on the toddler.

The following are important points:

- The 24-month-old toddler appears chubby with short legs and a large head. Over the next 18 months a relative decrease in the growth of subcutaneous adipose tissue occurs and extremities grow more rapidly than the trunk.
- The toddler has a marked lordosis and a protuberant abdomen.
- By 24 months the head is four-fifths of adult size, and height is approximately half of final adult height for the individual.
By 36 months the toddler may be knock-kneed and has a flat-footed gait:
- These are normal characteristics at this age.
- During the toddler years otitis media is a very common infection affecting more than two-thirds of children by age three.

5.3 Nutrition in toddlers

Prescribed reading
Read Edelman and Mandle (2006, or later editions), the section on the nutritional-metabolic pattern in toddlers.

The following points are important:
- Weaning from the breast or bottle has occurred.
- Toddlers need approximately 408 kilojoules/kg of body weight.

5.4 Elimination and exercise patterns

Prescribed reading
Read Edelman and Mandle (2006, or later editions), the section on elimination pattern and activity-exercise pattern of the toddler.

The following are important points:
- Toilet training is often a problem in the family. The child’s ability to master toilet training depends on sufficient neurological and psychological maturation.
- Note the developmental milestones of toddlers.

5.5 Sleep and rest pattern

Prescribed reading
Read Edelman and Mandle (2006, or later editions), the section on sleep and rest pattern of the toddler.

The following points are important:
- The toddler requires less sleep than the infant. Night sleep is about 8–12 hours at age two.
- Many toddlers have a bedtime ritual at this age. It is important to follow this ritual (eg snack, bath, brush teeth, story time, kiss parents, lights out) because it gives the toddler a sense of security.
- Many toddlers will try to delay sleep by calling for water, etc. Parents must be firm after the final “good night” has been said.
- Some toddlers are fearful of the dark. A night light or a favourite toy can help.
5.6 Cognitive-perceptual pattern

Prescribed reading

Read Edelman and Mandle (2006, or later editions), the section on cognitive-perceptual pattern of the toddler.

The following points need attention:

- The child from 18–24 months old solves problems by a process of trial-and-error or experimentation.
- From about 24 months until the early preschool years the toddler enters the pre-conceptual phase, which is the beginning of symbolic thinking where a word, gesture or image stands for an object, person or event.
- Toddlers experience a major transition in imitation and play.
- Toddlers are very egocentric.
- Toddlers are becoming more proficient as problem solvers and use some symbolic thinking. These skills enable them to mentally manipulate reality and begin to contemplate the future and recall the past.
- Milestones for vision development of the toddler should be noted. Signs of possible visual problems are amblyopia and strabismus (holds books close to eyes, etc).
- Hearing. The toddler does not always respond to being called. This should be investigated but it is often “selective inattention” to parental demands, which is typical of this stage.
- Taste and smell. Toddlers refuse to taste anything they don’t like the look of. Certain odours become extremely offensive to children in some cultures (eg sweat or excrement).

5.7 Self-perception-self-concept pattern, roles-relationships pattern, child abuse, sexuality-reproductive pattern, coping with stress, and values and beliefs

Prescribed reading

Read Edelman and Mandle (2006, or later editions), the section on self-perception, roles-relationship, sexuality, coping-stress and values-beliefs patterns of the toddler.

The following points are important:

- According to Erikson, the developmental task of toddlers is to acquire a sense of autonomy and relinquish the dependence on others.
- Sibling rivalry is apparent.
- Parent training is important.
- Health-care providers must be alert to signs of abuse.
- Sexuality — parents should not punish their toddler for masturbation, but can suggest or offer other activities as a distraction.
- The infant copes with stress mainly through motor activity, but may also develop many new ways to respond to stress.
Separation anxiety and regression are the two most characteristic responses to stress.
Development of moral integrity is strengthened if toddlers believe they are valued.

5.8 Pathological processes

Prescribed reading
Read Edelman and Mandle (2006, or later editions), the section on pathological processes in toddlers.

The following points are important:

- Unintentional injuries are the most frequent cause of childhood disability and death.
  It is important to make the home “childproof” by removing hazards (eg household chemicals, medicines or pesticides) from the child’s environment, locking gates or doors on all stairs, seeing that windows have safety glass and bars, keeping chairs away from counters or tables, etc.
- Make sure toys are safe.
- Lock away firearms.
- Swimming pools should be fenced and have self-closing gates and latches.
- Children in boats should wear properly fitting life jackets.
- Toddlers must constantly be supervised when near water.
- Burns must be prevented — the sun, hot water, stoves, open fires, etc, are all dangerous.
- Motor vehicles should be crash-tested and approved toddler car seats used.

5.9 Social processes

Prescribed reading
Read Edelman and Mandle (2006, or later editions), the section on social processes in toddlers.

The following points are important:

- It is very important to select the best caregiver or daycare centre for your child. A child must be able to develop physically and emotionally in any setting.
- There must be ongoing evaluation of the daycare setting.
- Setting of limits and discipline are also often culturally determined. Certain cultures expect very young children’s unquestioning respect for adults. This kind of respect for parental authority may rarely be seen in the independent toddler.

5.10 Conclusion
The toddler period can be an exciting and challenging time for the parents and their child, who has to grow and develop into a more independent individual.
Assessment criteria

Read the scenario at the end of learning unit 3 carefully.

Describe how you would do a full assessment of the two-year-old toddler, Alex, according to the dimensions of health from the dimensions model of community health nursing as described in Clark (2008).

FEEDBACK

See annexure A.
Learning unit 6

The pre-school child

Outcomes

When you have worked through this learning unit you will be able to:

- discuss the physical and psychological changes that occur during the pre-school years
- discuss typical sleep disturbances
- explain the cognitive development of the pre-schooler
- discuss appropriate vision and hearing screening tools for the pre-schooler
- compare the coping skills of the pre-schooler with those of young children

6.1 Introduction

The pre-school child from the age of three to six has a more mature body structure and better motor control. Children of this age also have a facility with language that more closely resembles that of adults.

Traditionally boys have always been encouraged to take more risks than girls and this means they have more accidents than pre-school girls.

Race may influence dietary choice because of cultural preferences. Financial resources also have an influence.

6.2 Age and physical changes

Prescribed reading

Read Edelman and Mandle (2006, or later editions), the section on age and physical changes in the pre-school child.

Please give attention to the following points:

- Be aware of the developmental and behavioural milestones of the pre-school child.
- Be aware of the dietary pattern of pre-school children.
- Most pre-school children are capable of using the toilet independently. Pre-schoolers who have occasional “accidents” should not be teased or punished.
- Play and exercise are important to the pre-school child. Many children of this age spend long periods each day watching television, which experts agree cannot
engage the child’s mind in the same way that participatory involvement with play activities and people can.

- Parents should choose appropriate television programmes for their children to watch. The child should have the opportunity for discussion and for asking questions.
- The pre-school child needs 8-12 hours’ sleep at night. If bedtime rituals take more than an hour and behaviour has been a problem for a year or more this situation needs special attention.
- Night terrors may start at age two but are more common in the pre-school years. The child will sit up in bed and will often scream, stare at imaginary objects, breathe heavily, perspire and show obvious distress. The child is often not fully awake and may be inconsolable for 10 minutes or more, then relaxes and returns to a deep sleep. Night terrors rarely occur in older children.
- Nightmares or anxiety dreams are a common cause of night wakening.
- Parents should go to the child who is having a nightmare, listen to descriptions of the dream and give reassurance that it was only a dream and that the child needs to go back to sleep.

### 6.3 Cognitive-perceptual patterns

*Prescribed reading*

Read Edelman and Mandle (2006, or later editions), the section on *cognitive-perceptual patterns in the pre-school child*.

The following are important points:

- Note Piaget’s theory, with special attention to the pre-operational stage, egocentrism, behaviour termed centering, irreversibility and transductive reasoning.
- Play as a learning methodology is important for the pre-school child. It provides the foundation for later social competence and the refinement of socialisation skills — discuss the different play activities.
- You should describe the landmarks of speech, language and hearing ability during the pre-school period.
- Environmental education and promotion are important to pre-schoolers.

### 6.4 Self-perception-self-concept pattern, roles-relationships pattern, sexuality-reproductive pattern, coping-stress pattern and values-beliefs pattern

*Prescribed reading*

Read Edelman and Mandle (2006, or later editions), the section on *self-perception, roles-relationships, sexuality-reproductive, coping-stress and values-beliefs patterns of the pre-school child*. 
Note the following points:

- By reinforcing skills and successfully accomplishing tasks, the pre-schooler builds self-esteem.
- Child care settings should be evaluated.
- The influence of parental divorce on the pre-school child should be noted.
- Child abuse is a complex social process within the family and community.
- Pre-schoolers may be very curious about other people's bodies and sexual functions. Their questions should be answered simply and factually.
- Coping mechanisms in the pre-schoolers are important.
- Pre-schoolers do not have a fully developed conscience, but they begin to demonstrate some internal control over their actions.
- Environmental safety and the pre-schooler should be considered.

### 6.5 Pathological processes

**Prescribed reading**

Read Edelman and Mandle (2006, or later editions), the section on *pathological processes in the pre-school child*.

The following points are important:

- Pre-schoolers continue to need supervision while playing, to prevent injuries.
- Parents should set reasonable limits about the use of bicycles.
- Approved car seats systems should be used by young children at all times.
- Appropriate hand-washing techniques should be taught to children from a very young age.
- Continued efforts to vaccinate all children are needed.
- More than half of all poisonings occur in children under the age of six years.
- Cancer represents the leading cause of death from disease under the age of 15 in the United States of America.

### 6.6 Social processes

**Prescribed reading**

Read Edelman and Mandle (2006, or later editions), the section on *social processes in the pre-school child*.

The following points are important:

- Pre-schoolers test their independence, interactive skills, and self-discipline as they function in a group.
- Cultural differences provide an excellent learning opportunity.
- Community nurses should be conversant with legislation on children in the country where they practise.
- Poverty influences the pre-school child as it does any other child; he or she can start to learn the concepts of earning and spending.
6.7 Conclusion

The early exposure of pre-school children to health care information and the reinforcement of such information form a necessary part of their education and could lay the foundation for a healthy lifestyle and healthy habits in later years.

Assessment criteria

Read the scenario at the end of learning unit 3 and describe how you would do an assessment of four-year-old Ben, according to the dimensions of health from the dimensions model of community health nursing as described in Clark (2008).

FEEDBACK

See annexure A
Learning unit 7

The school-age child

Outcomes

When you have worked through this learning unit you will be able to:

- discuss the wide range of normal values related to physical changes that occur in the child during the school years
- screen the school-age child for health risk factors
- discuss with families some common sleep-related problems, such as enuresis, sleepwalking and talking in sleep
- describe the school-age child’s cognitive stage of development as related to academic skills learnt at school
- discuss with parents how they can enhance their child’s self-concept
- discuss possible coping behaviours for a school-age child who is undergoing stress
- discuss the influence of peers on the school-age child
- explain to parents the school-age child’s need for social relationships and the impact this will have on family discipline practices
- discuss the possible influence of poverty on a school-age child

7.1 Introduction

For most people the school-age years are the healthiest time of their lives. The child develops new motor skills and perfects them through practice. Mental abilities grow remarkably, with the child able to learn reading, writing, mathematics and other subjects. The child’s motor and mental abilities increase, and a sense of competence develops.

7.2 Age and physical changes

Prescribed reading

Read Edelman and Mandle (2006, or later editions), the section on age and physical changes in the school-age child.

The following points are important:

- Consider the physical changes that occur in the school-child; note the changes in the fat distribution, average weight gain, growth spurts with alternating periods of minimal growth, how the child’s head continues to grow, and the way the child’s hair often darkens in colour.
By puberty all endocrine functions, except those regulating reproduction, are approaching adult capacity.

Between six and 13, the child loses and gains about four teeth per year. A 13 year old should have 28 teeth to replace the 20 deciduous teeth lost. When deciduous teeth come out only the crown is lost; the root has been reabsorbed into the developing permanent tooth.

Some children will develop orthodontic problems and should be referred for the necessary treatment.

Study the motor development of the school-age child.

Girls tend to mature and enter puberty earlier than boys. From birth, they have more fat than boys. After puberty fat makes up a high percentage of their body weight. Nutritional information is very important at this stage.

Rate of growth in the schoolchild appears to be genetically influenced. When assessing a child’s height, before looking at standardised growth chart, look at the child’s family.

The school-age child needs a well-balanced diet, with an average of 2 400 calories or about 9 600 kilojoules per day. Good nutrition is important at this stage.

Between the ages of six and 12 years a child needs physical exercise.

The majority of school-age children have no difficulty in sleeping; needs vary from 8–12 hours per night. Children, like adults, experience rapid eye movement (REM) sleep alternating with non-REM sleep.

The most common sleep disturbances are sleepwalking, talking in their sleep and enuresis. Parents should be reassured that most children outgrow sleepwalking and talking in their sleep.

### 7.3 Cognitive-perceptual pattern

**Prescribed reading**

Read Edelman and Mandle (2006, or later editions), the section on the cognitive-perceptual pattern of the school-age child.

The following points are important:

- Many factors influence the schoolchild’s ability to learn. The child needs to continue to develop cognitive skills, the basic senses such as vision and hearing must be intact, language skills should expand and memory capabilities must increase.
- Reflect on Piaget’s theory on cognitive perceptual patterns.
- The child’s sensory abilities continue to develop during the school-age years. Visual capacity should peak by age six to seven. Acuity should be maximally developed or at least 20/30 in each eye, as measured by the Snellen Chart.
- There are children who need glasses for myopia (nearsightedness), hyperopia (farsightedness) and astigmatism. They are surprised and delighted when they are able to see the world in proper focus and discover the wealth of detail it contains. The school nurse must test the eyes of all schoolchildren and refer them to an optician or eye specialist.
- The child’s hearing is almost fully developed by seven years of age; children with chronic otitis media or fluid in the middle ear may have a hearing deficit in the early school years. All school-age children should have periodic hearing evaluations; these are normally done at school.
- Language. The school-age child makes strides in understanding of syntax (grammar) and semantics (meaning of language). The child should be able to recognise and correct spelling and grammatical errors by eight or nine years of age.
- Both the short-term and the long-term memory improves in school-age children.
- Study the concept of intelligence (IQ) and take note of the role played by heredity and environment.
- Some children have learning disabilities or learning difficulties; these are called Specific Developmental Disorders. Examples are developmental arithmetic disorder, expressive writing disorder, receptive language and reading disorders.
- The community nurse or the school nurse and teacher must help with detection of the problem, consultation during evaluations and support and counselling for the child and the family.

7.4 Self-perception-self-concept pattern, roles-relationships pattern, sexuality-reproductive pattern, coping-stress pattern and values-beliefs pattern

Prescribed reading

Read Edelman and Mandle (2006, or later editions), the section on self-perception, roles-relationship, sexuality-reproductive, coping-stress and values-beliefs patterns in the school-age child.

The following points are important:
- Self-esteem is the extent to which an individual believes himself or herself to be capable, significant, successful and worthy.
- The bases for a child’s development of a high self-esteem are the family and parents with a high self-esteem. Parents who are affectionate, supportive and firm in setting behaviour guidelines and have a strong relationship with each other can help a child to develop high self-esteem.
- The peer group’s influence on self-esteem is unquestionable. Acceptance and a sense of belonging to a peer group add to the child’s feeling of self-esteem.
- Girls need stronger adult support than boys for self-esteem.
- Strong self-esteem is seen in school-age girls with fathers who have encouraged them to take risks, to question traditional behaviours and to get in touch with their aesthetic side through music and art.
- The family provides the child with a sense of security and from this haven of safety the child begins to cope with the external environment.
- Parents should set clear limits and clearly spell out expectations for children. This makes it easier for children to comply with the norms of the family and society.
- Positive reinforcement can be used to reward well-behaved children.
- Punishment is a form of negative reinforcement. It may stop undesirable behaviour but often only until the child is able to repeat the action without being caught.
- Child abuse and neglect are common societal problems. The community nurse must be able to identify victims of sexual assault.
- One should reflect on the school-age child’s use of defence mechanisms.
- Somatisation and depression in school children should be identified timeously.
7.5 Pathological processes and social processes

Prescribed reading
Read Edelman and Mandle (2006, or later editions), the section on pathological and social processes in the school-age child.

The following points are important:
- safety concerns specific to the school-age child
- water safety practices, fire prevention, playground safety, street safety principles and bike safety for school-age children
- biological, chemical and radiological agents that affect the health of the school-age child
- culture and ethnicity in school-age children
- health education during this phase

7.6 Conclusion
The school-age child develops from the immature pre-schooler to the beginning of adolescence. The child’s cognitive abilities increase and so does his or her capacity to develop moral judgment. The child’s world expands beyond the family unit as the school and peers begin to exert a major influence.

Assessment criteria
Read the scenario at the end of learning unit 3 and describe how you would do an assessment of the nine-year-old Peter, according to the dimensions of health of the dimensions model of community health nursing as described in Clark (2008).

FEEDBACK
See annexure A.
Learning unit 8

The adolescent

Outcomes
When you have worked through this learning unit you will be able to:

- explain to a group of young adolescents the body changes that can be expected in puberty
- describe the stages in the development of secondary sexual characteristics of adolescents
- plan and describe several nutritious menus for adolescents, taking into account their nutrient needs and food preferences
- discuss with a group of adolescents the course and treatment of acne
- describe the cognitive abilities of the adolescent
- describe Erikson’s earlier stages of development, which are repeated as the adolescent establishes an identity
- discuss the adaptive and maladaptive coping mechanisms commonly used by the adolescent
- describe the various stages of moral development of which you might find examples in a group of 15 year olds
- describe the community nurse’s role in primary and secondary prevention of drug use and misuse by the adolescent
- discuss with a group of adolescents the pros and cons of sexual activity, pregnancy and contraception
- discuss current legislative issues that affect adolescents

8.1 Introduction
Adolescence is often defined as beginning with the onset of puberty and ending with the achievement of certain levels of independence. It also refers to the period characterised by psychological, emotional, social and spiritual changes that result in the transition from childhood to a young adulthood. It begins just before puberty and lasts until the roles and responsibilities of young adulthood are assumed.

8.2 Age and physical changes: Gordon’s functional health patterns

Prescribed reading
Study Edelman and Mandle (2006, or later editions), the section on age and physical changes of the adolescent.
The following points are important:

- Note the physical changes that occur in the adolescent.
- Scoliosis is a progressive disease stimulated by the adolescent growth spurt. Early intervention is important. Screening must be done by the school health nurse and community nurse.
- Acne can have severe physical and emotional consequences for the adolescent. Intervention is required.
- Note the developmental stages of secondary sex characteristics in the female and the male.
- Preparation for menarche should begin in late childhood. The time of onset varies widely. Amenorrhoea and dysmenorrhoea are common complaints.
- There are genetic disorders, such as Turner’s syndrome and Klinefelter, which are discovered during the assessment of a child with delayed pubertal development. Make sure that you are familiar with these disorders.

8.3 Gordon’s functional health patterns in adolescents

Prescribed reading
Read the section on *Gordon’s functional health patterns in adolescents* in Edelman and Mandle (2006, or later editions).

The following points are important:

- Adolescents are often associated with risk-taking behaviour which results in deleterious health care choices and outcomes.
- Eating disorders need special attention. At one end of the spectrum we find anorexia nervosa, bulimia nervosa and at the other end obesity. A holistic approach is needed that will address environmental, psychosocial and physiological factors.
- Regular exercise is important to improve the adolescent’s endurance, appearance and general state of health. These positive effects may extend into adulthood.
- Sleep and rest patterns change during adolescence; the adolescent must get enough rest and sleep.
- Note Piaget’s theory of cognitive perceptual patterns.
- Note Erikson’s theory on the establishment of identity.
- Time orientation, language skills and body image develop.
- Roles and relationship patterns change. Parents feel that they have less influence as teenagers spend more and more time with their peers. This can lead to a family crisis if parents set unreasonably strict limits and ask intrusive questions about their children’s friends or ideas. Another typical response is for parents to drop all rules and limits.
- Teenagers first fantasise about the pleasures of sex and then gradually experiment with dating, petting and non-coital and coital contact, depending on their values, beliefs and customs. They become sexually active for a variety of reasons. Contraception, HIV/AIDS, sexually transmitted diseases, pregnancy and abortion must be discussed in depth with them.
- The sexually active teenager may come into contact with new groups of organisms. These include gonorrhea, syphilis, genital warts, genital herpes virus type 2, Chlamydia trichomoniasis, Candida and HIV infection. The young person needs to be aware of how to prevent these conditions, and also to be informed about early
detection, diagnosis and treatment. Prevention is primarily through avoidance of sexual contact with an infected person or abstinence from sex.

- The risk of breast cancer among adolescent girls is very small but the discovery of a “normal” lump in her breast may cause an adolescent girl anxiety. Teach girls how to perform breast self-examination or get them to make an appointment with a nurse or her family doctor.

- Cervical cancer can be detected by means of a pap smear. Sexually active teenage girls should have a pap test done yearly.

- Testicular cancer is one of the most common cancers between 20 and 35 years. Adolescent boys should learn to do testicular self-examination and continue this practice once a month for the rest of their lives. Each testicle is rolled gently between the thumb and fingers. Any abnormal lumps should be noted. The epididymis located at the back of each testicle should be identified and not mistaken for an abnormal lump.

- Physical and psychological changes in the adolescent produce stress. The adolescent uses different mechanisms to cope with stress.

- Feelings of sadness are usual among adolescents, and depression is quite common.

- Suicide is the third leading cause of death in adolescence and has increased 40% over the past 10 years.

### 8.4 Pathological processes in the adolescent

**Prescribed reading**

Read Edelman and Mandle (2006, or later editions), the section on *pathological processes* in adolescents.

The following points are important:

- Sports activities are extremely important during adolescence. They provide opportunities for physical, moral, social and personality development and help to develop the adolescent’s self-esteem. However, teenagers are particularly prone to sports injuries. Sport-related injuries are likely to involve the head, spine and extremities. Head, brain and spinal cord injuries can result in long-term disability or death. Knee and ankle injuries are common. Primary prevention is important: proper safety equipment should be used, physical examinations for participants should be compulsory and strict regulations prohibiting an injured player from further participation until appropriate rehabilitation has been completed should be enforced.

- The risk of dying violently increases greatly between the ages of 15 and 19, when factors are present that contribute to violence.

- Motor vehicle accidents increase during the adolescent years, and driver-education classes could be offered at school. The motorcycle accident rate is high. The use of protective helmets is important. Cyclists should also use correct protective helmets. The use of safety belts is compulsory and drinking and driving is strictly prohibited.

- Substance abuse does not start abruptly in adolescence, but it is more widespread during the adolescent years. School-age children may try alcohol, tobacco or easily available drugs.

- As a community nurse, you must be able to recognise the signs of substance abuse.
Peer group pressure is a real problem. Young teens need to learn effective social skills to deal with peer pressure and they need to develop self control.

The best way for the community nurse and parents to help teenagers to stop smoking is to serve as a role model.

8.5 Social processes

Prescribed reading
Read Edelman and Mandle (2006, or later editions), the section on social processes in the adolescent.

The following points need attention:

- The school setting provides many positive experiences for the adolescent. It is also a source of negative experiences. Adolescents need to experience some degree of success in their academic lives. Failure to achieve at school may result from the overwhelming need to experience group approval.
- Culture and ethnicity influence the health of the adolescents in the community in which you are working. Community nurses need to recognise and assess additional stresses experienced by adolescents as they wrestle with their own as well as their cultural identities.
- Economic resources can be a major conflict between parents and adolescents.

8.6 Conclusion
Adolescence is a period of great change. It is a time of rapid physiological and psychological change. It is a time of enormous pressure from the peer group. Gender identity and sex roles develop. The period of adolescence does not have to be a crisis for either the parents or the adolescent. The adolescent needs a lot of love and support from the parents. Furthermore, both the adolescent and the parents need support from outside agencies.

Assessment criteria
Read the scenario at the end of learning unit 3 and describe how you would do an assessment of Mary who is in grade 12, according to the dimensions of health from the dimensions model of community health nursing as described in Clark (2008).

FEEDBACK
See annexure A for feedback.
Learning unit 9

Gender health

Outcomes
When you have worked through this learning unit you will be able to:

- name at least two factors in each of the dimensions of health as they relate to the health of women
- name at least four health problems common to women
- describe at least three unique considerations in assessing the health needs of the lesbian client
- name at least five concerns in primary prevention for women
- describe three areas of secondary prevention measures for women
- describe two dimensions of secondary prevention of physical abuse of women
- describe at least two measures that the community nurse could take to provide more sensitive and effective care to the lesbian client
- describe at least five conditions that are important to the assessment of the biophysical dimension of health in men
- describe four areas for consideration when assessing the behavioural dimension of health in men
- name at least two effects of the health care system on men's health
- describe at least three factors that contribute to adverse health effects for male homosexual clients
- name at least four areas in primary prevention for male clients
- describe at least four secondary prevention considerations for male clients
- name at least three areas that should be emphasised in tertiary prevention for male clients

9.1 Introduction
Women have unique health care needs, not only because of their reproductive function and anatomy but also because of their vulnerability within society. Women need special health care facilities to provide for physical care, psychological and social care as well as care around their economic needs.

Currently, attention is also given to men's health and the provision of health services is therefore aimed at preventing typically male health problems or at detecting and treating problems at an early stage. Men differ both physically and psychologically from women and are inclined to interpret health in terms of their role. Men also adopt a different approach to the promotion of health and the utilisation of health services.
9.2 The status of women

Increasing international emphasis on human rights has focused attention on the widespread discrimination that exists against women among certain populations and groups. Women themselves have become more involved in all facets of society; they are increasingly aware of the special role they fulfil, and of the needs of women which are not generally addressed by communities and governments.

Internationally, the spotlight was turned on women as a result of the United Nations’ Decade of the Woman from 1975 to 1985. Various international organisations and branches of existing organisations specially aimed at promoting the interests of women were founded during that period. These include the following:

- The World Health Organization launched projects that focus specifically on the health and development of women.
- Amnesty International launched projects to address the rights of women in prison and deal with violence.
- The United Nations afforded recognition to women by declaring the Decade of the Woman, a project which focused on the equality of the sexes, the development of women, and peace.
- Health Action International is based in the Netherlands and provides inputs regarding the pharmaceutical needs of women, such as contraceptives.
- The Women’s Global Network for Reproductive Rights (also based in the Netherlands) promotes the rights of women with regard to reproduction (infertility, family planning, information, abortion, sterilisation, safe childbirth services, etc).
- The International Women’s Health Coalition is based in New York and is an autonomous nonprofit-making organisation which concentrates on the rights of women in developing countries with regard to reproduction.
- The Safe Motherhood Initiative was founded in Nairobi, Kenya, in 1987, with the aim of reducing the high maternal mortality rate in the developing world.
- The Women’s International Public Health Network was founded in 1987 during a meeting of the World Federation of Public Health Associations held in Mexico. Its aim is to empower all women in the discipline of public health by means of information and training networks so as to improve the health status of women worldwide.
- The Latin American and Caribbean Women’s Health Network promotes the health status of women by means of information and training networks.

A milestone in the history of women’s rights and the improvement of their status was reached when the biggest congress in history was held by the United Nations in September 1995. More than 13 000 delegates from all over the world attended the congress in Beijing. Various documents were approved which would be used as instruments in the social, political and economic development of women.

In the main document, “Platform for Action”, the following 12 priority areas are addressed:

- women and poverty
- education and training of women
- women and health
- violence against women
- women and armed conflict
- economic empowerment of women
In South Africa various organisations — such as the National Women's Bureau and the Woman's Health Project (based at the Centre for Health Policy, Department of Community Health, University of the Witwatersrand) — are actively engaged in promoting the interests of women, including the health of South African women, in the light of the decisions made in Beijing.

9.3 Women's health status

It is well known that age distribution, socio-economic factors and level of education are of the greatest significance to the health status of women and, thus, indirectly to the health status of families and communities. Large sections of the South African population belong to the lower socio-economic group, and in some areas the illiteracy level is as high as 80% among women. Urbanisation, cultural practices and prejudices, unemployment and inequality in educational opportunities and health services all contribute to the fact that women's health has been identified as a priority in the National Health Plan and the RDP.

Diseases of the circulatory system (hypertension and strokes), cancer (cervix and breast), conditions directly linked to pregnancy and childbirth (haemorrhage, placenta abruptio, and infections) and arthritis are among the principal diseases occurring among women, while tuberculosis remains the most common communicable disease. The incidence of HIV/AIDS is increasing among women.

Most single parents are women. The physical, psychological and socio-economic demands made on single parents frequently influence the health status of these women.

Women normally have a longer life expectancy than men, and in developing groups the majority of elderly people are women. People in the older age group have specific health needs, and this makes special demands on health services.

As a result of economic and other factors, a higher percentage of women are now active in the labour market, both formally and informally. Yet society expects the woman to fulfil her duties in the home as wife and mother. This means that she has a dual workload, which may lead to greater susceptibility to headaches, gastro-intestinal conditions, nausea, tiredness, listlessness, menstrual ailments and other stress-related conditions.

A survey of the health status of women in the informal sector in Gauteng found that 75% of women work at least six days a week. The working day of 44% of women is longer than nine hours, 51% have to handle heavy objects by themselves, 89% of them have no protection against wind and weather, most women work in an unhygienic and noisy environment, 23% have no access to toilet facilities and 74% have to travel long distances to their place of work.

It is obvious that women's health presents a special challenge to the community nurse.

The promotion of a woman's health status starts as early as adolescence.
Various factors are important to the promotion of the health of adult women, and an integrated approach to these factors is required:

- Biological and psychological changes occurring from puberty to menopause
- Social and psychological matters, including sexuality, ideals, abuse and violence
- Lifestyle, including dieting, smoking, drug and alcohol abuse, and sexual habits
- Accessibility and affordability of health services, and the planning of services to fulfil the needs of women
- Primary and secondary prevention, and the evaluation of health services for women
- Reproductive health and problems: reproductive services involve more than family planning and should include
  - Comprehensive family planning programmes
  - Provision of safe facilities for abortion (if abortion is legalised and if the woman in question has no moral or religious objections), emergency treatment centres for complications resulting from abortion, and abortion counselling facilities
  - Appropriate screening programmes for infections, sexually transmittable diseases and cancer
  - An educational programme and facilities specifically for the youth
  - An information programme and facilities aimed at men, who should realise that women also have a say in their sexuality
  - Comprehensive confinement services which integrate traditional and cultural customs with modern technology and which protect human dignity

Prescribed reading

Study Clark (2008, or later editions), the chapter on the health of women.

Study Edelman and Mandle (2006, or later editions), the chapters on the young adult and the middle-aged adult.

9.4 The lesbian/gay, bisexual and transgender (LGBT) client

Prescribed reading

Study Clark (2008, or later editions), on the epidemiology of health for lesbian, bisexual and transgender women.

9.5 Men's health status

Social expectations that men should display masculinity can impair men's health, since they feel obliged to be strong and to keep a stiff upper lip. This prevents them from seeking medical help in time so that complications set in before help is obtained. Further, men are inclined to take more notice of an acute, physical pain than to seek treatment for an encroaching problem such as hypertension. Men's genetic structure makes them more susceptible to alcoholism, hypertension, cardiovascular conditions, suicide and suicidal tendencies.
Prescribed reading

Study Clark (2008, or later editions), the chapter on the health of men.

Read Edelman and Mandle (2006, or later editions), the chapters on the young adult and the middle-aged adult.

9.6 The epidemiology of health for gay, bisexual and transgender men

Prescribed reading

Study Clark (2008, or later editions), the section on the epidemiology of health for gay, bisexual and transgender men.

9.7 Conclusion

The health care worker is in a position to improve the quality of women’s health. Health promotion and protection are aimed at the personal habits and lifestyle of women in order to improve their biological, spiritual and psychosocial development.

Men’s health is very important to the community nurse. Little effort has been made to provide a comprehensive health service for men. The prevention of diseases like testicular and prostate cancer, as well as cardiovascular disorders, is very important. The community nurse needs to provide holistic health care to male clients.

Assessment criteria

Read the scenario at the end of learning unit 3 and answer the following questions:

1) Describe how you would do an assessment of Mrs X according to the dimensions of health from the dimensions model of community health nursing as described in Clark (2008).

2) Compile a health care programme for Mrs X to meet her health needs at a primary, secondary and tertiary preventive level.

3) Describe how you would do an assessment of Mr X according to the dimensions of health from the dimensions model of community health nursing as described in Clark (2008, or later editions).

Feedback

See annexure A.
Learning unit 10

Care of the client in the work setting

Outcomes

When you have worked through this learning unit you will be able to:

- describe at least three advantages to providing health care in the work setting
- name at least six of the ten leading health problems encountered in the work setting
- name at least five types of health and safety hazards encountered in work settings
- describe four spheres of social influence on the health of employees
- compare and contrast internal and external health systems in occupational health
- describe four types of internal health care programmes in the work setting
- describe the three main areas of emphasis in primary prevention in the work setting
- describe three major considerations in secondary prevention in the work setting
- describe three important points in tertiary prevention in the work setting

10.1 Introduction

The health of people in the workplace is an important focus in the provision of health care, and community nurses must have the know-how and skills to function effectively in this area. They should have the necessary skills to do a physical assessment and diagnosis and to prescribe treatment. Knowledge of appropriate legislation and of labour relations, of the guidelines of the National Occupational Safety Association and of ergonomics is indispensable.

Stanhope and Lancaster (2006:632) define occupational health nursing as follows:

[It is] the speciality practice that focuses on the promotion, prevention and restoration of health within the context of a safe and healthy environment. It involves the prevention of adverse health effects from occupational and environmental hazards. It provides for and delivers occupational and environmental health and safety services to workers, worker populations and community groups. It is an autonomous speciality and nurses make independent nursing judgments in providing health care.

Prescribed reading

Study Clark (2008, or later editions), the chapter on clients in the work setting.
10.2 The objectives of occupational health

Note the following objectives of occupational health (Stanhope & Lancaster 2006:646):

- to reduce deaths from work-related injuries
- to reduce work-related injuries resulting in medical treatment, lost time from work, or restricted work activity
- to reduce cases of injury and illness involving days away from work due to overexertion or repetitive motion
- to reduce pneumoconiosis deaths
- to reduce deaths from work-related homicides
- to reduce work-related assault
- to reduce the number of persons who have elevated blood lead concentrations from work exposures
- to reduce occupational skin diseases or disorders
- to increase the proportion of worksites employing 50 or more persons that provide programmes to prevent or reduce employee stress
- to reduce occupational needle-stick injuries among health care workers
- to reduce new cases of work-related noise-induced hearing loss

**Activity**

Compile a list of the various members of the occupational health team and discuss their roles and functions in the occupational setting.

10.3 The occupational health nurse’s scope of practice

The scope of practice of the occupational health nurse includes the following matters (Stanhope & Lancaster 2006:632):

- worker/workplace assessment
- primary health care
- case management
- counselling
- health promotion
- administration and management
- research
- legal-ethical monitoring
- community orientation

10.4 Nursing care of working populations

The occupational health nurse is often the first health care provider seen by the employee with a health problem. He or she is therefore in a key position to intervene with workers at all levels of prevention:

- Primary prevention is directed toward promoting health and averting a problem. In the occupational health setting, health promotion serves to maintain or enhance the well-
being of individuals or groups of employees and the company in general. This may include programmes such as enhancing good nutrition or coping skills.

- Secondary prevention occurs after the disease has already begun. It is aimed at early detection, prompt treatment and prevention of further limitations. Health surveillance and periodic screening are examples of secondary prevention in the workplace.
- Tertiary prevention is intended to restore health to its full potential and assist individuals to achieve their maximum level of functioning. A rehabilitation programme such as allowing a person to return to work after a heart attack is an example of tertiary prevention.

10.5 Conclusion

Over the years employers have come to appreciate healthy employees. Although the work environment contributes to a wide variety of health problems it also provides opportunities for occupational health nurses to influence a major segment of the population regarding personal health behaviours.

Assessment criteria

Read the scenario at the end of learning unit 3. Compile a primary, secondary and tertiary health care programme for Mr X.

FEEDBACK

See annexure A for feedback.
Learning unit 11

The older adult

Outcomes

When you have worked through this learning unit you will be able to:

- name the changes associated with normal ageing in the older person
- evaluate morbidity data according to age, gender and race
- discuss nutritional factors that affect health promotion of the older person
- analyse environmental factors that have an impact on older adults
- list the risk factors associated with the daily activities of later adulthood
- enumerate the five most prevalent conditions and the five leading causes of mortality among older persons
- discuss environmental, biological, physical and mechanical agents that contribute to disability, morbidity, and mortality in later adulthood
- analyse political and social issues that influence the well-being of the older person
- list the leading causes of injury among older persons and suggest preventive measures
- name major resources available for health education for the older person

11.1 Introduction

It is important to distinguish between the terms geriatrics and gerontology.

Geriatrics is the branch of medical science concerned with the physiology of ageing and with the diagnosis and treatment of diseases affecting the older person.

Gerontology is the study of all aspects of the ageing process, including economic, social, clinical and psychological factors and their influence on older adults in the community. Gerontology involves a broad, multi-professional approach and is the discipline with which the community nurse is concerned.

Owing to improved medical treatment and technological advances, the number of older people has increased considerably over the past few decades. Because of the increasing number of older persons, especially in developed countries, the health of older men and women needs special attention to ensure that this sector of the population remains in good health.

We should guard against negative stereotyping of the older person. Although some of them can no longer function effectively and need help at this stage of their lives, a great number of older persons, given their experience of life, can make valuable contributions to the
development of communities, care for themselves and for others, and carry out intellectually stimulating activities.

The objective of health care services for the older person should therefore be to enable them to function independently in their own environment for as long as possible, and to improve their quality of life. Care should be taken to include the older person in all decision making relating to their own health.

The older we become, the greater the risk that we may get chronically ill and dependent or bedridden, thus placing a heavy burden on the household, family and health services. It is therefore crucial to provide promotive and preventive services, including services aimed at ensuring financial self-sufficiency, as early as in the adult phase of life, so that the older person is able to enjoy a healthy and independent old age.

In the case of older people who do need care, health care services should be a source of information and support to their next of kin and others who take care of them.

The government annually spends large amounts of money on subsidising social services and pensions for the older person. Pensions do not, however, keep abreast of inflation, so that many older persons live in poverty and suffer from malnutrition, social isolation, lack of proper housing and supervision, and the inability to afford health services. Although the current health policy does address the health of the older person, most of the funds are earmarked for children’s health services. This implies that the community has a greater responsibility to become involved in caring for the older person.

Common diseases of the older person include diseases of the circulatory system (eg heart failure, hypertension and cerebrovascular incidents), cancer, rheumatoid arthritis, senile dementia, malnutrition and osteoporosis. Other problems that the community nurse would have to deal with are injuries as a result of accidents: falling, burning oneself, slipping and taking medicine in the incorrect dose, for example.

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**Prescribed reading**

Study Clark (2008, or later editions), the chapter on *older clients*.

Edelman and Mandle (2006, or later editions), the chapter on the *older adult*.

### 11.2 Age and physical changes

The following points are important:

- the basic changes accompanying ageing and their possible relationship to the illnesses, symptoms, signs and problems typical of the older person
- chronic health problems of the older person
- health promotion practices which vary by cultural background
11.3 Goals of health promotion
These goals focus on increasing health promotion programmes and decreasing morbidity and mortality rates among older people.

11.4 Pattern of health perception-health management
The following factors are important:
- maintaining the older adult’s motivation
- focusing on major activities to promote health and prevent frailty

11.5 Nutritional metabolic pattern
The following points are important:
- Many older adults do not have access to adequate food.
- Normal changes of ageing compound problems around having access to nutritious food.
- Living environment affects the nutritional status of the older adult.
- Health education about food needed to maintain optimal nutritional status is of utmost importance.

11.6 Elimination pattern
The following points are important:
- Bowel and bladder functions are altered by normal changes of ageing.
- Medications taken by the older adult may cause elimination concerns.
- Constipation is a major problem for older adults.
- Urinary incontinence affects many older adults.

11.7 Activity-exercise pattern
The following points are important:
- The benefits of regular exercise should be emphasised.
- Adherence to an exercise routine is a major problem for all people.

11.8 Sleep-rest pattern
The following points are important:
- There is high prevalence of sleep disorders in the older population.
- Teaching about normal changes in the sleep pattern can provide reassurance.
- Sleep medications may be helpful for short-term use.
11.9 Cognitive-perceptual pattern
The following points are important:
- Dementia is an illness of the cognitive system and is not accepted as a normal change of ageing.
- Older adults experience various age-related changes in all the five senses.

11.10 Self-perception-self-concept pattern
The following points are important:
- Factors of culture, environment, family, lifestyle and heredity combine to form the self-concept.
- Erikson’s theory should be studied with regard to the older adult.

11.11 Roles-relationships pattern
The following points are important:
- Loss of roles can cause depression in the older adult.
- New roles often evolve, such as becoming grandparents.
- Older adults who remain engaged in a variety of activities and relationships are happier and healthier.

11.12 Sexuality-reproductive pattern
The following points are important:
- Society generally believes that older people do not participate in sexual relationships.
- No data have been found to show that older men and women lose interest in sexual activity.
- Medical conditions can make the expression of sexuality difficult.
- Community nurses are in an ideal position to help older adults fulfil their sexual desires with health education about disabling medical conditions and medications.

11.13 Coping-stress tolerance pattern and values-beliefs pattern
The following points are important:
- The rate of depression rises sharply with age.
- Suicide rates increase with age.
- Spiritual values help older adults to gain a significant quality of life.

11.14 Pathological processes
The following points are important:
- Falls are one of the leading causes of morbidity and mortality among older adults.
Older adults are prone to injuries as a result of motor vehicle accidents, falls, suffocation, fires and poisoning.

Influenza, pneumococcal infections and tuberculosis can be prevented by immunisations.

The way in which medications are absorbed, distributed, metabolised and cleared from the body is affected by old age.

Drug-drug interactions increase as a person ages.

Older people are more vulnerable to the effects of alcohol.

Cigarette smoking contributes to various kinds of cancer and to chronic lung disease.

11.15 Social processes

The following points are important:

- Environments of care, long-term care or community settings should be noted.
- Health care providers need to be aware of cultural diversity.
- Different countries have different health care delivery systems.
- Health care services should be accessible, within reach, acceptable and affordable. Frequently neglected factors are the social needs of the older person (especially those who live on their own) and preparation for death. The community nurse may act as a facilitator in making optimal use of other resources in the community in order to fulfil the needs of the older person.
- The aim of providing health services is to promote the health of the older person and to prevent disease and accidents. Regular screening in order to detect and treat ailments at an early stage is essential to prevent complications or debilitation.
- Older persons should be fully informed about the services and facilities available to them so that they can seek and obtain help in time.
- Community nurses can make a significant contribution to maintaining the health of the older person, since they frequently come into contact with older persons in the normal course of their duties. These nurses are familiar with the resources to which older clients can be referred and can help older persons proactively and in a creative manner to remain active, productive and healthy for as long as possible.
- Community nurses should make an extensive survey of all the older persons and their health and other needs in the area or region for which they are responsible. They have the advantage of being able to make home visits and so determine what the problems and needs of their older clients really are.

11.16 Conclusion

It is important to keep older persons active in society as long as possible. The emphasis must be on the quality of their lives. The community must handle the older client with love and dignity and help make their last days happy and free from loneliness.

Assessment criteria

Read the scenario at the end of learning unit 3.
Describe how you would do an assessment of the 70-year-old grandfather according to the dimensions of health from the dimensions model of community health nursing as described in Clark (2008, or later editions).

FEEDBACK

See annexure A for feedback.
PART 3: THE COMMUNITY AS CLIENT
Learning unit 12

Health promotion in the community

Outcomes

When you have worked through this learning unit you will be able to:

- define the concept of community
- define the concept of community health
- describe the goals of community-oriented practice
- name strategies to improve community health
- describe community partnerships
- describe assessment of the community
- describe the following:
  - community health diagnosis
  - the planning phase for community health
  - implementation activities for community health
  - evaluation of interventions for community health

12.1 Introduction

Understanding of the dynamic and complex nature of communities and ability to collect certain information about them are important prerequisites for the effective planning, implementation and coordination of health promotion activities. Certain facts can be gathered about communities and used to plan and implement action that promotes and protects community health. Because health needs and concerns vary in each community, the type of health promotion activities will also vary.

12.2 Definition of a community

Maurer and Smith (2005:341) define the term community as an open social system that is characterised by people in a place over time who have common goals.

Stanhope and Lancaster (2006:217) give the following definition from the WHO:

A community is a social group determined by geographical boundaries and/or common values and interests. Its members know and interact with one another. It functions within a particular social structure and exhibits and creates norms, values and social institutions.

In most definitions the concept of community includes three dimensions: a location, a population and a social system. The location is the geographical dimension, the population
is the residents of the community and the social system refers to the aims and activities of the community (Allender & Spradley 2005:407).

12.3 Defining the term community health

Community health entails the meeting of collective needs by identification of problems and management of interactions within the community itself and between the community and society at large (Stanhope & Lancaster 2006:215).

Community health has also been defined as “the identification of needs and the protection and improvement of collective health within a geographically defined area” (Allender & Spradley 2005:6).

12.4 The community as a client

The community as a client refers to the concept of a community-wide group of people as the focus of nursing service (Stanhope & Lancaster 2006:219). Although the units served may be individuals, families or interacting groups, the resulting changes are intended to affect the whole community. Change for the benefit of the community as a client often has to occur at several levels, ranging from the individual to the societal.

Viewing the community as a client and thus as the target of service means including two key concepts: community health and partnership for community health.

12.5 Goals of community-oriented practice

The concept of community health has three common characteristics: status, structure and process. Each of these characteristics or dimensions has a unique effect on community health as the goal of community-oriented practice.

12.5.1 Status

The status or outcome approach to community health is the best-known and most widely accepted approach, including physical, emotional and social components. The physical component of community health is often measured by traditional morbidity and mortality rates, life expectancy indicators and risk factor profiles. The emotional component of health status can be measured by consumer satisfaction and mental health indicators. The social component of community health is reflected by crime rates and functional levels. Worker absenteeism and infant mortality rates reflect the effects of all three components.

12.5.2 Structure

The structural perspective of community health usually comprises community health services and resources as well as attributes of the community structure itself. Community health services and resources are measured by indicators such as utilisation patterns and treatment data from various health institutions and provider/client ratios. Information gathered from these data may have serious gaps, such as inequities in access to care and quality of care, which cannot be measured by this information. Less well known but equally problematic is the wrong assumption of a direct causal relationship between the provision of health care and improved health. These problems necessitate the cautious use of health services and resources as measures of community health.
Attributes of the community structure are commonly identified as social indicators, or correlates of health. Demographic characteristics such as socio-economic, racial distributions and educational levels are measures of community structure.

12.5.3 Process

The view of community health as the process of effective community functioning or problem solving is well established. The concept of community competence provides a basic understanding of the process dimension of community health. Community competence is a process whereby the components of a community — organisations, groups and aggregates — are able to collaborate effectively in identifying the problems and needs of the community. These groups must be able to achieve a working consensus on goals and priorities, agree on ways and means to implement the agreed-on goals, and collaborate effectively in the required actions (Stanhope & Lancaster 2006:219).

See the concept of community health specified in table

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Measures</th>
<th>Examples of Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status</td>
<td>Vital statistics (live births, neonatal deaths, infant deaths, maternal deaths)</td>
<td>Census data</td>
</tr>
<tr>
<td></td>
<td>Incidence and prevalence of leading causes of mortality and morbidity</td>
<td>State health department annual vital statistics</td>
</tr>
<tr>
<td></td>
<td>Health risk profiles of selected aggregates</td>
<td>Census date</td>
</tr>
<tr>
<td></td>
<td>Functional ability levels</td>
<td>State health department</td>
</tr>
<tr>
<td>Structure</td>
<td>Health facilities such as hospitals, nursing homes, industrial and school health services, health departments, voluntary health associations, categorical grant programs, and prepaid health plans</td>
<td>Local Chamber of Commerce</td>
</tr>
<tr>
<td></td>
<td>Health-related planning groups</td>
<td>United Way</td>
</tr>
<tr>
<td></td>
<td>Health manpower, such as physicians, dentists, nurses, environmental sanitarians, social workers</td>
<td>U.S. Department of Labor</td>
</tr>
<tr>
<td></td>
<td>Health resource use patterns, such as bed occupancy days and client/provider visits</td>
<td>Local newspapers</td>
</tr>
<tr>
<td>Process</td>
<td>Commitment to community health</td>
<td>Local government</td>
</tr>
<tr>
<td></td>
<td>Awareness of self and others and clarity of situational definitions</td>
<td>Real estate agencies (turnover/vacancy rates, for example)</td>
</tr>
<tr>
<td></td>
<td>Conflict containment and accommodation</td>
<td>Local history</td>
</tr>
<tr>
<td></td>
<td>Participation</td>
<td>Neighbourhood help organizations</td>
</tr>
<tr>
<td></td>
<td>Management of relationships with society</td>
<td>Local/neighbourhood newspapers and radio programs</td>
</tr>
<tr>
<td></td>
<td>Machinery for facilitating participant interaction and decision making</td>
<td>Local government</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social services department</td>
</tr>
</tbody>
</table>

Source: Stanhope & Lancaster (2006:221)
12.6 Strategies for improving community health

Specific strategies for improving community health often depend on whether the status, structure or process dimension of community health is being emphasised. If the emphasis is on the status dimension, the most appropriate strategy is usually at the level of primary prevention as the objective is either to prevent the disease or to treat it in its pre-symptomatic stage — an example is immunisation programmes which would be reflected in morbidity and mortality measures. Intervention strategies focused on the structural dimension are directed either to health services or to demographic characteristics. Interventions directed towards altering health services might include programme planning, whereas interventions aimed at influencing demographic characteristics might include community development. When the emphasis is on the process dimension, the most appropriate strategy is usually health promotion (Stanhope & Lancaster 2006:219).

12.7 Community partnerships

Partnerships are defined as agreements between people (and agencies) to benefit a joint purpose. A partnership can be large, involving a multi-national corporation, government and several hospitals; or the partnership can be more modest involving a group of older people and a nursery school (Allender & Spradley 2005:430). Partnership is “a relationship between individuals, groups or organizations in which the parties are working together to achieve a joint goal ... [o]ften used synonymously with coalition and alliances, although partnerships usually have focused goals, such as jointly providing a specific programme” (Stanhope & Lancaster 2006:216).

12.8 Community-focused nursing process

12.8.1 Data collection and assessment

The primary aim of data collection is to acquire usable information about community health. Existing data and missing data are collected and interpreted to identify community health problems and capabilities. Assessing community health includes the following activities:

- gathering of relevant existing data
- locating of missing data
- data collection and interpretation
- problem analysis
- assessment issues

- Gathering of relevant existing data. Data gathering is the process of obtaining existing, readily available data. These data usually describe the demography of a community such as characteristics of age, gender, socio-economic level, racial distribution, vital statistics, community institutions and health human resources.

- Locating of missing data. Data generation is the process of developing data that do not exist already and are difficult to acquire. These data are usually not of a statistical nature and include information about a community’s knowledge and beliefs, values and sentiments, goals and perceived needs, norms, problem-solving processes and power,
leadership and influence structures. Interviews and observation are mostly used to collect these data and the research done is qualitative in nature.

- **Data collection and interpretation.** A composite database is created by combining the collected and generated data. The interpretation of data seeks to give meaning to the data. Data are analysed and synthesised and themes are identified. Community health problems and needs, strengths or capabilities are determined. The nurse and the community, working in partnership, identify the problems.

Thereafter, the resources available to meet the needs are identified.

- **Problem analysis.** Problem analysis explains the nature of the problem and should be done for each identified problem. This often requires a special group of people including the community nurse and other persons with expertise who can assist with the problem. Both content and process specialists must participate to identify factors contributing to the problem. Relationships between each factor and the problem should be explained. Useful results are usually produced if the following conditions are met (Stanhope & Lancaster 2006:222):
  - Problems are carefully selected.
  - Participants in the process are deliberately selected and closely monitored.
  - Justified and reasonable levels of consensus are expected.
  - Findings are used as guides to decisions.

- **Assessment issues.** Entry or acceptance into the community is perhaps the biggest challenge in the assessment of a community. Entry can be gained by participating in community events, observing and listening carefully, visiting key figures in the community, employing an assessment guide and using a peer group for support. Once entry has been gained into a community, role negotiation can become an issue. The concept of role includes values, behaviours, or goals that govern an individual’s interactions with others. Persons working in the community can facilitate role negotiation by a thoughtful and consistent presentation of the reasons for their presence and by sincere demonstrations of their commitment to the community. It is important to respect an individual’s right to choose whether he or she will participate as well as to maintain confidentiality.

### 12.8.2 Community-oriented diagnosis

Assessment activities and the development of a composite database will result in the identification of community health problems. Each problem should be identified clearly and stated as a community health diagnosis. The development of the community health diagnosis helps to clarify the problem and is an important precursor to planning. Community health diagnoses make it clear who the recipient of care is, they provide a statement identifying problems faced by the recipient and they identify factors contributing to the problem.

### 12.9 Planning

The planning phase for community health includes the following:

- analysing community health problems
- establishing priorities
12.9.1 Problem prioritisation

Problem prioritisation refers to the ranking process in which problems are evaluated and priorities established according to predetermined criteria. Contributions from community members, substantive experts, administrators and resource controllers are taken into consideration.

Criteria helpful in prioritising identified problems include the following:
- community awareness of the problem
- community motivation to resolve or manage the problem
- the community nurse's ability to influence the problem solution
- availability of expertise relevant to the problem
- severity of consequences if problem remains unresolved
- speed with which resolution can be achieved

12.9.2 Establishing goals and objectives

Once problems have been prioritised, goals and objectives are developed. Goals are generally broad statements of desired outcomes and objectives are the specific statements of the desired outcomes. Objectives must be precise, behaviourally stated, incremental and measurable.

Establishing these goals and objectives involves close collaboration between the community nurse and the representatives of the community groups affected by both the problem and the proposed intervention. This often requires considerable negotiation among all participants. An important advantage is that people affected by the outcomes have a vested interest in those outcomes and therefore are supportive and committed to the success of the intervention.

12.9.3 Identifying intervention activities

Intervention activities are those strategies by which objectives are met, the ways of bringing about change and the ways in which the problem cycle will be interrupted.

12.10 Implementation

Implementation comprises the activities aimed at achieving the goals and objectives.

12.10.1 Factors influencing implementation

Implementation is determined by the community nurse’s chosen roles, the type of health problem, the community’s readiness to participate and characteristics of the process of social change:

- The role of the community nurse. Community nurses can act as content experts, assisting communities to select and attain task-related goals. Content-dominated roles are often considered to be change agent roles and process roles are termed change
partner roles. Change agent roles involve gathering and analysing facts and implementing programmes, whereas change partner roles emphasise the functions of enabler-catalyst, teacher of problem-solving skills and activist-advocate (Stanhope & Lancaster 2006:229).

- **The problem.** The role the community nurse chooses depends on the nature of the health problem, the community’s decision-making ability and personal and professional preferences. Some community health problems clearly need specific intervention roles. A community may lack democratic problem-solving skills, and in such a case the community nurse would select the roles of teacher, facilitator and advocate. The community nurse would then demonstrate and explain problem-solving skills so that the community becomes empowered to assume responsibility for promoting change on its own behalf. The community’s history of collaboration in decision making is very important. Different roles may be required if the community lacks problem-solving skills or has a history of unsuccessful attempts to introduce change.

### 12.10.2 The process of social change

The role of the health care worker also depends on the process of social change. Not all communities are open to innovation. Innovation is often related to high socio-economic status, a need for change, liberal, scientific and democratic values and a high level of community participation. Many complex and different factors contribute to the implementation process. Therefore the health care worker needs to be adaptable and flexible and should be skilled in a variety of implementation mechanisms.

### 12.10.3 Implementation mechanisms

Implementation mechanisms are the vehicles or means by which innovations are transferred from the planners to the community. Important implementation mechanisms include small interacting groups, lay advisors, the mass media and health policy.

Small interacting groups, formal or informal, are essential implementation mechanisms. Examples of informal groups in the community are social networks, friendships and neighbourhood groups. Formal groups have an identified membership and specific purpose and include schools, churches and business groups.

Lay advisors are persons in the community who are influential in the approval or rejection of new ideas and from whom others seek advice and information. Lay advisors are characterised by conformity to community norms, values, heavy involvement in social activities, specific areas of expertise and a slightly higher status than their fellow community members.

Mass media like newspapers, television and the radio represent an impersonal and formal type of communication and can be used to disseminate information quickly to a large number of people. The mass media represent a cost-effective way of reaching targeted populations and can also be effective aids in intervention.

Health policy is another very important factor in the adoption of community health changes. The main aim of public policy in the health field is to attend to collective human needs. Examples are the compulsory wearing of seat belts in vehicles, lower speed limits and restraining seats for children.
Each and every mechanism used for implementation must be documented.

12.11 Evaluation
Evaluation is the appraisal of the effects of some organised activity or intervention. Evaluation includes the assessment of progress by contrasting the objectives and the results. Evaluation starts in the planning phase when goals and objectives are stated and implementation activities are identified. Costs in terms of money and time must also be evaluated. During evaluation the whole process is open to re-negotiation, the goal being to achieve community health.

12.12 Conclusion
Health promotion must be a collaborative effort. The community nurse also uses the nursing process to promote health in communities and assists people in the community to become more self-directed and motivated to take action that promotes and maintains health and well-being.

Assessment criteria
(1) Assess the community where you live according to the dimensions or characteristics of community health under the following headings:
   o Status
   o Structure
   o Process
(2) Discuss the following statement: “Partnership is the informed, flexible and negotiated distribution of power among all participants in the process of change for improved community health.”
(3) Discuss the process of data gathering and interpretation in the assessment of community health.
(4) Identify the community health problems in your own community and describe how you would plan, implement and evaluate goals and objectives set for a healthy community.
Learning unit 13

Interventions for health promotion in the family

Outcomes

When you have worked through this learning unit you will be able to:

- define the following concepts:
  - health promotion
  - screening
  - health education
- name the advantages and disadvantages of screening
- list the characteristics of a successful screening programme
- discuss why screening is important as a health promotion intervention
- describe the purpose and objectives of health education
- explain the barriers to learning
- describe educational principles
- discuss guidelines for the instructor
- describe the educational process

13.1 Introduction

The need to shift the emphasis from illness to wellness is increasing among health care practitioners. In the community it is clear that although illness and disease affect the health of individuals, families and communities, there are many other factors that play a part.

This change requires community nurses and consumers to become skilled in working together as partners and it allows clients to have a choice and exercise control in the promotion of their health status.

13.2 Definitions of health promotion

Stanhope and Lancaster (2006:38) refer to the following definition: “activities that have as their goal the development of human attitudes and behaviours that maintain or enhance well-being”. Health promotion has been defined by the World Health Organization as “the process of enabling people to increase control over and improve their own health” (Clark 2008:255).
13.3 Interventions for health promotion

13.3.1 Screening

Screening is the preliminary examination or testing of a person to determine whether he or she might possibly be suffering from a certain condition and whether further diagnostic testing is necessary. The primary objective of screening is the detection of a disease in its early stages, so that it can be treated and prevented from progressing. Another important objective of screening is to reduce the cost of treatment, by avoiding the more vigorous interventions required in the later stages. Screening procedures are not diagnostic — they serve to indicate whether a specific disease is present or not. Positive screening results always indicate the need for further diagnostic tests. Screening is usually done with large population groups as it is less expensive than conducting a battery of diagnostic tests when the majority of people are expected to have negative results. Screening tests have been used for breast and cervical cancer, testicular cancer, colorectal cancer, cholesterol levels, hypertension and diabetes. Another form of screening is the periodic examination in the occupational setting, where the person is examined for signs and symptoms of several diseases or have eye and hearing tests in the school situation (Edelman & Mandle 2006:200). In South Africa, however, screening is not done as a routine. Individual health assessments are usually done according to health problems.

13.3.2 Health education

According to Edelman and Mandle (2006:219) health education is any combination of learning experiences designed to facilitate voluntary adaptations of behaviour conducive to health. This definition includes three key concepts:

- the use of learning strategies
- the fact that learners maintain voluntary control over the decision to make changes in their actions
- the focus on behaviour changes that have been found to improve health status

Clark (2008:262) defines health education as follows: “Health education is a participatory learning process that enables people to make informed decisions about health.” There has been a shift in health education from an emphasis on providing information and motivating clients to comply with suggested health behaviours to a focus on empowering clients with the knowledge and skills to make their own decisions regarding health-related behaviours.

13.4 The purpose of health education

The purpose of health education is to help clients to make appropriate health-related decisions. There are three types of decisions:

- decisions about self-care
- decisions about the use of available health resources
- decisions about community health issues

Other important purposes of health education include the following:

- to help individuals, families and communities to achieve optimal states of health through their own actions and initiative
- to detect illness, and provide treatment, rehabilitation and long-term care
to encourage healthy lifestyles that can prevent acute and chronic disease, decrease disability and enhance wellness

- to guide people through the stages of problem solving and decision making
- to empower the client

Two major objectives of health education are to change health behaviour and to improve the health status.

The promotion of health and prevention of disease includes three activities:

- health education
- health protection
- preventive health service

These three categories of activities must be integrated to improve health and social conditions in the community (Edelman & Mandle 2006:220; Clark 2008:263).

Prescribed reading

Read Edelman and Mandle (2006, or later editions), the chapter on health education.

Activity

Discuss the three types of health-related decisions clients can make as a result of health education. Give examples.

13.5 The health educator

All the members of the multidisciplinary health team, that is doctors, nurses, social workers, physiotherapists, health inspectors and pharmacists, should participate in health education. Other members of the public who also have a moral obligation to involve themselves in health education as a result of their training and the position they hold in the community are teachers, agriculturists and nutritionists, as well as voluntary organisations such as the Red Cross, The South African National Tuberculosis Association and the Cancer Association of South Africa.

13.5.1 Barriers to learning

Stanhope and Lancaster (2006:307) describe two broad categories of barriers to learning: educator-related barriers and learner-related barriers.

Educator-related barriers include the following:

- Educators may fear public speaking.
- Educators may think they are not credible authorities on a certain topic.
- Educators may have limited experience of a health topic.
- Educators may have to deal with difficult learners.
Educators may have difficulty in eliciting participation.

Educators may have problems in the timing — presentations may be too long or too short.

Educators may feel uncertain about how to adjust instruction, to identify needs of learners and to request feedback.

Educators may feel uncomfortable when learners ask questions.

Educators may want feedback from learners.

Educators may be concerned about whether visual aids, materials and facilities will function properly.

Educators may have difficulty with introducing and closing sessions.

Educators may be too dependent on their notes.

Learner-related barriers include the following:

- low literacy levels
- lack of motivation

### 13.5.2 Application of health education models and theories

The health practitioner must select the most appropriate model or theory for educational programmes. Theories and models of health behaviour change are at the heart of health education and may be used by the health practitioner to plan educational interventions.

Points to consider when planning for health education include the following (Clark 2008:267):

- the process of making decisions about
  - what topic to address
  - what problems to attack
  - where to direct time and resources
- how to prioritise learning needs
- how to develop goals and objectives
- how to select content and teaching/learning strategies
- language and health literacy
- use of the Internet as a teaching medium

### 13.5.3 Identifying educational needs

A systematic and thorough needs assessment should be performed to determine the clients’ health educational needs. The steps of a needs assessment include (Stanhope & Lancaster 2006:205):

- identifying what the client wants to know
- determining how the client wants to learn
- discerning what will enhance the client’s ability and motivation to learn
- collecting data systematically from the client, family and other sources
- analysing data to identify cognitive, affective and psychomotor learning needs
- encouraging client participation in the learning process
- assisting the client to prioritise learning needs
- establishing educational goals and objectives
Goals and objectives to guide the educational programme must be identified. Goals are broad, long-term expected outcomes and objectives are specific, short-term criteria that should be met as steps toward achieving the long-term goal. Objectives must be stated clearly and expected outcomes must be defined in measurable terms.

13.5.4 Selection of appropriate educational methods
Educational methods should facilitate the successful accomplishment of the programme’s goals and objectives. Methods should also match the strength and needs of the clients. The simplest, clearest and most readily understandable manner of presentation should be used and age, educational level, knowledge of the subject, developmental disabilities and size of the group should be considered.

13.5.5 The process of instruction
Health education can be planned systematically to give learners the opportunity to gain as much as possible from the instruction. The following instructional principles may help to maximise learning experiences:

- Gaining attention. The learner must be convinced that the information to be presented is important and beneficial.
- Informing the learner of the goals and objectives of the health education. Learners should develop expectations about what they are to learn.
- Stimulating recall of previous learning. This helps learners to link new knowledge with prior knowledge.
- Presenting the stimulus. A topic should be presented in a clear, organised and simple way. Teaching materials should be presented according to the needs, strengths and limitations of the learners.
- Providing learning guidance. With guidance from the educator, the learner can store information in long-term memory.
- Eliciting performance. Learners should be encouraged to demonstrate what they have learnt.
- Providing feedback. Learners should receive feedback on what they have learnt so that they can modify their thinking patterns and improve their knowledge and skills.
- Assessing performance. Learning should be evaluated and formally assessed with the expectation that new information has been understood.
- Enhancing retention and transfer of knowledge. Learners should be assisted to apply new knowledge to new situations.

13.6 Principles for health education
The following six basic principles can guide the effective teacher:

- **Send a clear message.** The material should be presented in a clear, understandable and organised way. The educator should reassess learner readiness and be aware of possible barriers to effective communication such as emotional stress and physical illness.
- **Select the most appropriate format.** A format should be selected that matches the goals and objectives of the programme. It should also meet the needs of the learners.
Create a conducive learning environment. The objectives of the programme should be carefully considered and information regarding the culture, beliefs and educational level of the target group should guide the educator in creating a positive, supportive and pleasant atmosphere so as to maximise learning.

Organise learning experiences. Learning material should be presented in a logical, integrated way, from simple concepts to the more complex ideas. The principles of continuity, sequencing and integration are important aids in the organisation of learning programmes.

Encourage participatory learning. Active participation in learning increases motivation, flexibility and learning rate. Participatory learning should involve the cognitive, affective as well as the psychomotor domain. Role play, story-telling and demonstrating are good examples of participatory learning.

Provide evaluation and feedback. Evaluation and constructive feedback throughout the learning process are essential to motivating learners as well as to enabling the necessary modifications to be made.

13.7 Implementation of the educational plan
Implementation includes the following:

- control over starting, sustaining and stopping each method and strategy in the most effective and appropriate time and way
- control and coordination of both environmental factors and the flow of presentation
- control of materials so that they are logically related to the theme and programme goals

13.8 Evaluation of the educational process
Evaluation of the educational process includes the following areas:

- educator evaluation
- process evaluation
- product evaluation

13.8.1 Educator evaluation
The learners’ evaluation of the educator should take place throughout the learning programme. This allows the educator to modify the teaching process according to learners’ needs. Feedback may be received verbally, non-verbally or in a written form. Ultimately, it is the responsibility of the educator to ensure the success of the educational process and the development of learner knowledge, skills and abilities.

13.8.2 Process evaluation
Process evaluation uses information from the educator as well as from the learners’ evaluations and assesses the dynamics of their interactions. Process evaluation is essential right through the educational programme to assess whether goals and objectives are being met.
13.8.3 Product evaluation

The educational product is the result of the educational process. The product is measured both for quality and for quantity. Evaluation of the product can be divided into three components: evaluation of health and behavioural changes, short-term evaluation and long-term evaluation:

- **Evaluation of health and behavioural changes.** Health and behavioural changes can be evaluated with the aid of a variety of approaches, methods and tools, which include questionnaires, surveys, demonstrations, testing, subjective client feedback and direct observation. Qualitative or quantitative strategies may be used, depending on the nature of the expected educational outcome. Changes in behaviour, knowledge, skills, abilities, health status and quality of life can be measured.

- **Short-term evaluation.** Short-term evaluation is done throughout the learning process to determine whether each step has been completed successfully. Short-term objectives are usually easy to evaluate — an example is whether a client can perform a return demonstration of breast self-examination. Short-term evaluation requires minimal energy, expense or time.

- **Long-term evaluation.** Long-term evaluation is directed towards the assessment of the status of the individual, family or community over a period. The goal of the evaluation is to analyse the effectiveness of the education programme, not the specific health status of the client (Stanhope & Lancaster 2006:207).

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**Activity**

1. Define the concept of *health education*.
2. Review the phases of the educational process and apply this process to an individual with hypertension, to a family with a child with attention deficit disorder, and to a community in which tuberculosis is on the increase.
3. Develop a short-term and long-term evaluation of the educational product of a programme designed to teach elementary school learners health-promoting behaviours, such as eating a well-balanced diet and exercising regularly.

13.9 Conclusion

Health promotion and disease prevention are focused on providing community members with a positive sense of health that enhances physical, mental and emotional capacities. Individuals in communities must become involved in health promotion — as well-informed, motivated community members, they must participate in planning, implementing and evaluating health care programmes.

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**Assessment criteria**

1. Define the following concepts:
   - health promotion
   - health education
(2) Describe the purpose and objectives of health education.
(3) Explain the barriers to learning.
(4) Describe educational principles.
(5) Discuss guidelines for the instructor.
(6) Describe the educational process.
Learning unit 14

Issues in community health

Outcomes

When you have worked through this learning unit you will be able to:

- discuss HIV/AIDS as a health problem in the community
- describe the management of tuberculosis in the community
- discuss the influence of poverty on the health of the community
- describe the results of homelessness in the community
- discuss the influence of violence on community health
- describe home-based care in the community

14.1 Introduction

There are many critical health issues in the community. However, only a few issues will be discussed in this learning unit: HIV/AIDS, tuberculosis, poverty, displaced people and violence. As a result of these issues, home-based care has become an essential part of community health. Most of these issues are discussed in detail in your prescribed books and will therefore be discussed only briefly in this learning unit.

14.2 Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (Aids)

HIV/AIDS continues to have a major political and social effect on communities. The majority of infected people live in developing countries.

14.2.1 Natural history of HIV

The natural history of HIV includes the following stages:

- the primary infection (approximately within one month of infection)
- clinical latency, a period when the body shows no symptoms
- the final stage of symptomatic disease

When HIV enters the body, flu-like symptoms may appear like myalgias, sore throat, lethargy, rash, fever and lymph-adenopathy. If left untreated, 80%–90% of HIV-infected people survive about 10 years. During this prolonged incubation period, clients usually have a gradual deterioration of the immune system. Aids is the last stage of HIV infection and may result from damage caused by HIV, secondary cancers or opportunistic organisms. Opportunistic infections may be caused by bacteria, fungi, viruses or protozoa.
Because HIV/Aids is a chronic disease, affected persons continue to live and work in the community. Community nurses therefore have a major role to play in the prevention, treatment and care of HIV/Aids clients. Nursing actions include the following (Stanhope & Lancaster 2006:536):

- identifying resources such as social and financial support services
- interpreting school and work policies assisting employers by educating managers about HIV/Aids

**Prescribed reading**

Read the chapter on communicable diseases in Clark (2008, or later editions) and the section on People living with HIV/AIDS in Edelman and Mandle (2006, or later editions).

### 14.3 Tuberculosis (TB)

The WHO estimates that approximately one-third of the world's population is infected with TB and that it is the second leading cause of death worldwide among infectious diseases. Tuberculosis is a mycobacterial disease caused by *Mycobacterium tuberculosis*. Transmission usually occurs by exposure to the tubercle bacilli in airborne droplets from persons with pulmonary TB during talking, coughing or sneezing. Symptoms include cough, fever, haemoptysis, chest pains, fatigue and weight loss. The incubation period lasts 4–12 weeks and the most critical period for development of clinical disease is the first 3–12 months after infection. Clients with TB should be treated promptly with the appropriate combination of multiple antimicrobial drugs. Treatment failure is often the result of poor adherence by clients taking the medication and may result in multi-drug resistant (MDR) TB or, if further neglected, in extreme drug-resistant (XDR) TB which is fatal.

Any form of immuno-suppression increases the risk of reactivating dormant organisms and currently HIV infection is the most potent cause of the progression of TB infection. Consequently there is an astonishing increase in the incidence of TB throughout sub-Saharan Africa.

The Directly Observed Therapy Short Course (DOTS) strategy plays an important role in the management of TB. The elements of DOTS include the following (Stanhope & Lancaster 2006:549; Kibel et al 2007:398):

- sustained political commitment to increase human and financial resources and make TB control a nationwide priority
- access to quality-assured TB sputum microscopy for case detection
- standardised short-course chemotherapy for all cases of TB including direct treatment observation and socially supportive treatment services
- uninterrupted supply of quality-assured drugs
- recording and reporting system enabling outcome assessment of all patients and assessment of overall programme performance
14.4 Poverty

According to Clark (2008:548) poverty is having insufficient money, goods or means of support. The term poverty is usually defined in terms of moral and political judgments based on what people are entitled to in society. Poverty needs to be viewed as a situation of being so deprived that the individual or group concerned cannot live a fully human life. The key to poverty is therefore a state of disempowerment or a limited ability to change one’s circumstances. Those affected usually lack a political voice and also have a lack of resources.

Poverty can affect both urban and rural communities. Characteristics of poor communities include higher rates of unemployment, more single-parent families and lower wages. Residents living in poor neighbourhoods are also more likely to be victims of crime, substance abuse, racial discrimination and police brutality.

Poverty directly affects health and well-being because of its effects (Stanhope & Lancaster 2006:441; Kibel et al 2007:22):

- higher rates of chronic illness
- higher infant morbidity and mortality
- shorter life expectancy
- more complex health problems
- more significant complications resulting from chronic diseases such as asthma, diabetes and hypertension
- higher hospitalisation rates

Prescribed reading

Read the chapter on communicable diseases in Clark (2008, or later editions) and selected sections on tuberculosis in Edelman and Mandle (2006, or later editions).

14.5 Homelessness

Homelessness and poverty are often mentioned in the same context as they usually go together. Worldwide, 20–40 million urban families are homeless and many others live in temporary structures. Each year several million people are forcibly evicted from the places where they are living. There are between 10 000 and 12 000 homeless children in South Africa, the majority of whom live on the streets of major cities (Clark 2008:549; Kibel et al 2007:448).

Community nurses have a critical role in the delivery of health care to homeless people. Community nurses need strong physical and psycho-social assessment skills, current knowledge of available resources and the ability to convey respect, dignity and value to each person. The following strategies are important when you work with homeless or poor people (Stanhope & Lancaster 2006:458):

- Create a trusting environment.
- Show respect, compassion and concern.
- Do not make assumptions.
- Coordinate a network of services and providers.
- Advocate accessible health care services.
- Focus on prevention.
- Know when to walk beside the client and when to encourage the client to walk ahead.
- Develop a network of support for yourself.

14.6 Violence

Violence is usually defined as those non-accidental acts, inter-personal or intra-personal, that result in physical or psychological injury to one or more persons (Stanhope & Lancaster 2006:486). Violence is a public health problem and community nurses are in key positions to detect and intervene in community and family violence.

Prescribed reading

Read the chapter on societal violence in Clark (2008, or later editions).

Give attention to the following points:

- trends in societal violence, namely family violence, assault and homicide and suicide
- areas to be addressed in examining factors contributing to societal violence, including biophysical, psychological, physical, environmental, socio-cultural, behavioural and health system considerations
- planning and implementing interventions for societal violence

14.7 Community resources

Your Community Health practice module (CMH2126) includes visits to community resources such as support groups, self-help groups, care groups, community projects and rehabilitation services. With the above-mentioned issues, these resources are essential to the community nurse and she or he must know when and where to refer clients. Another important community resource is home-based care which is becoming indispensable in the delivery of health care services.

The WHO defines home-based care as the provision of health services by formal and informal caregivers in the home in order to promote, restore and maintain a person’s maximum level of comfort, function and health, including care towards a dignified death. Home-care services can be classified into preventive, promotive, therapeutic, rehabilitative, long-term maintenance and palliative care categories (Department of Health 2001:1).
14.7.1 Rationale for home-based care

Because of the Aids epidemic, the increase in non-communicable diseases, their complications and an ageing population’s impending impact on communities and on South Africa as a whole, it is necessary to consider how best to provide care for healthy people, people with disease and their families. As more people become ill, many will not be able to stay in hospitals, hospices or other care institutions.

South Africa also has limited health care resources and situations will arise where hospital or other institutional care may not be available to people who need it.

Reasons for this situation include:

- shortage of hospital beds
- inadequate number of health care professionals
- lack of resources for treatment and drugs
- increasing demands made by people with curable conditions on existing institutional care
- hospitals that are often not suitable for managing patients with terminal or long-term diseases
- cost of institutional care

14.7.2 Principles of home-based care

The principles for home-based care include the following characteristics:

- holistic: physical, social, emotional, economic and spiritual
- person-centred: sensitive to culture, religion and value systems
- comprehensive, multi-disciplinary and multi-sectoral; preventive, promotive, therapeutic, rehabilitative and palliative
- empowering: allowing capacity building
- giving access to comprehensive support services
- covering total life span
- sustainable and cost-effective
- ensuring quality of care, safety, commitment, cooperation and collaboration
- allowing choice and control over to what extent partners will participate
- recognising diversity
- promoting and protecting equal opportunities
- being specific about needs and outcomes
- focusing on basic and essential components of PHC
- adhering to basic principles of community involvement

14.7.3 Goals and objectives of home-based care

Goals and objectives of home-based care include the following:

- to shift the care to the beneficiaries — the community
- to ensure access to care and follow-up through a functional referral system
- to integrate a comprehensive care plan into the informal, non-formal and formal health system
- to empower the family/community to take care of their own health
to empower the client, the carers and the community through appropriate education and training
- to reduce unnecessary visits to health facilities
- to eliminate duplication of activities
- to be proactive in approach

14.7.4 Some advantages of home-based care

Some advantages of home-based care include the following:
- to reduce the pressure on hospital beds and other resources
- to promote feelings of ownership and accountability
- to enable family members to gain access to support services
- to create awareness of health in the community
- to see that commonly occurring diseases/conditions are effectively managed at home
- to promote job creation especially in the non-formal system
- to ensure that caregivers and all key participants are well informed, receive adequate skills training and make good use of other partners in care

14.7.5 Some challenges of home-based care

Some challenges of home-based care include the following (Department of Health 2001:10):
- restricted social environment set beliefs and customs, ideologies and local conflicts, inappropriate housing
- emotional and physical strain and stress experienced by caregivers
- inadequate support structures for the caregiver
- economic constraints and exhaustive care needs

14.8 Conclusion

A few critical issues in community health were discussed in this learning unit. The community nurse should have the knowledge and skills to deliver quality health service to clients experiencing any of these issues.

Assessment criteria

(1) Discuss the role of the community nurse with regard to the HIV/Aids issue in communities.
(2) Describe how you as a community nurse will manage tuberculosis in your community.
(3) Discuss the influence of poverty on community health.
(4) Describe the role of the community nurse in a homeless population.
(5) Discuss the role of the community nurse in the prevention of violence.
(6) Describe how you would assess a client for home-based care.
BIBLIOGRAPHY


Feedback on scenario in learning unit 3
(for learning units 4–12)

The most common developmental issues for each life stage should be assessed, as well as issues mentioned in the scenario.

BIOPHYSICAL DIMENSION

**Baba**, a nine-month-old infant, should be assessed for the following:

- growth and development (e.g., weight doubled by 5 months, length 20 cm longer than birth length and head circumference increased by about 10 cm)
- neuro-physical and muscular development (problem of sitting alone) and normal milestones at this age (crawling, chewing and biting objects, drinking from a cup with assistance, pulling self to standing position, using index finger and thumb in pincer grasp)
- normal hearing and vision
- the immunisation schedule

**Alex** is a two-year-old toddler and should be assessed for growth and development, including the following:

- weight which should be four times his birth weight, gaining another 10 cm in length and another 2–3 cm in head circumference
- the immunisation schedule
- neuro-physical abilities such as the ability to kick or throw a ball, open doors, walk up and down stairs
- dental caries and the mother’s knowledge of and ability to ensure dental health

**Ben**, the four-year-old pre-school child, should be assessed for the following:

- weight gain from 3–6 years, about 2 kg per year; height about 7 cm per year
- appearance of permanent teeth and possible dental caries
- musculo-skeletal and neurological development (e.g., effortless running and climbing, dressing with supervision, holding a pencil with good control, drawing of recognisable pictures, counting from 1–5, singing songs, building a tower of 10 or more cubes)
- tiredness and palpable lymph nodes, which may be indicative of cancer
- vision and hearing, in preparation for school

**Peter** is the nine-year-old schoolchild and he should be assessed for the following:

- high energy levels characteristic of schoolchildren
normal oral development in terms of losing and gaining teeth and normal development of the jaw and facial structure

- increased muscle mass and muscle strength
- growth spurts and development of sexual characteristics
- scabies and lice, prevalent in schoolchildren

**Mary** is an adolescent with a two-year-old boy and must be observed for the following:

- eating disorders such as anorexia nervosa or bulimia
- scoliosis and skin changes due to active sebaceous glands leading to acne
- hormonal functioning, breast cancer, cervical cancer and sexually transmitted diseases (being sexually active)

**Mrs X**, the 36-year-old mother of a large family, should be assessed in terms of general health for the following:

- previous illness
- current health status (eg blood pressure and body weight)
- referral for assessment of sexually transmitted diseases, breast cancer, osteoporosis and hormonal functioning
- sexual lifestyle and management of her reproductive life

**Mr X**, a 54-year-old, middle-aged adult man and head of a family, must be assessed for the following:

- previous illness
- current health status — blood pressure, body weight and blood glucose level
- referral for assessment of cholesterol level, sexually transmitted diseases, prostate cancer and colon cancer

**Grandfather**, who is 70 years old, should be assessed for the following:

- current health status, such as blood pressure and blood glucose
- normal physical changes of growing old such as impaired hearing and vision, wearing down of teeth, problems with bowel movements and constipation
- referral for current condition of asthma

The above can be determined by assessing the activities of daily living, which include having meals, bathing, dressing, going to the toilet, doing laundry, cooking, housekeeping, taking medication and going shopping.

**PSYCHOLOGICAL DIMENSION**

Assess whether **Baba** can speak at least two words, give a toy or object on request, give affection and indicate wants, show fear of being left alone, and copy/use facial expressions of adults.

Assess **Alex’s** ability to imitate household tasks, using 2–3 word sentences, and parallel play — playing alongside and not necessarily with someone. Assess the ways in which he expresses frustration, and relates to family members and strangers. Assess the parent’s ability to teach Alex coping skills appropriate to his age and temperament. Assess the mother’s ability to provide routine and set limits for behaviour and to build Alex’s self-esteem (eg by praise and positive reinforcement).
Assess Ben's ability to operate from rules. Observe his internal reactivity patterns, his self-esteem and discipline, as well as coping abilities. Assess the parent's understanding of egocentrism and the importance of imaginary and fantasy play, which is characteristic of a pre-school child. Also assess the parental expectations of Ben.

With Peter, assess peer identification and sexual identification, body concept and development of a positive self-perception. Negative self-image may be evident in self-punishment, which must be observed. Family interaction should be observed. Learning disabilities must be assessed, which often manifest in the condition of ADHD — attention deficit hyperactive disorder.

Consider Mary's position as young mother and adolescent; assess peer pressure and her relations with her peer group. Assess her coping skills and observe for signs of depression and suicidal tendencies. Assess the parent's skills in supporting her, building her self-esteem, and motivating her to complete school. Assess her coping skills in maintaining healthy relations in the family and with her boyfriend.

Assess Mrs X for stress levels: she has a large family, with different generations in one household, is a stepmother, is grandmother to her husband's grandson, cares for the baby and toddler on full-time basis, does not earn her own income and probably does not have enough financial resources to care for the family. Assess her coping skills. Assess the way she experiences her sexuality. Assess her self-image and self-motivation to assist her in pursuing a career.

Assess Mr X for stress levels: he has a large family to provide for, and is an industrial worker. Heading an extended, blended family may bring about a lot of stress, for example identifying family roles, maintaining discipline and coping with the boyfriend of his 18-year-old daughter. Caring for his father-in-law and for his children complicates family life and may cause excessive stress. Assess his coping skills.

Assess grandfather's cognitive-perceptual patterns to determine the possibility of dementia. Assess his self-perception and stress levels due to his physical circumstances and because he is part of an extended family. Assess stress levels which may lead to depression and suicide.

**SOCIO-CULTURAL DIMENSION**

**Baba:** Observe and assess parental coping and parent-child interaction (eg disciplinary measures, authority, trust and affection). Assess attachment and bonding between mother and Baba. Assess family interaction between Baba, Alex the toddler and Ben the pre-school child. Assess pre-verbal communication by Baba. Observe for signs of child abuse (eg haematoma).

Assess Alex for signs of regression, because of the attention given to Baba, and assess the parent's ability to cope with it. Observe and assess parent-child interaction (eg disciplinary measures, authority, trust and affection). Assess for consistency in disciplinary methods, agreed upon by both parents. Assess the increasing need for autonomy and how the parents deal with it (eg providing safe choices for Alex). Assess mealtime behaviour and the parent's knowledge of the importance of eating together as a family to ensure socialisation of children in an acceptable way. Observe for signs of child abuse.
Ben: Interaction with siblings and other young children must be assessed, now that peers are becoming as important as family members. Assess how Ben is trying out normal gender expectations during this phase. Assess social competency by observing Ben’s drawings and response to comments or questions. Assess the adult’s role modelling of cultural and ethnic behaviour which will be observed and internalised by Ben. Observe for signs of child abuse.

Assess the reasons why Peter does not attend school regularly and assess the parent’s understanding of the importance of school attendance for normal development. Assess enjoyment in competitive games and activities accompanied by a sense of success, which characterises the social interaction of schoolchildren. Assess the parent’s understanding that authority should be scaled down as the schoolchild becomes more independent and responsible, although limits should be set. Observe positive reinforcement of good behaviour.

Assess how much attention Peter receives amidst the three younger children and the role he fulfils as part of a large family. Assess for moral behaviour, problems such as lying or cheating that may develop during school-age years. Observe for signs of child abuse and sexual abuse.

Assess Mary for contact with friends and possible isolation because of the baby and the boyfriend. Observe her role within the family and assess the parent’s ability to guide her in balancing her role as mother and adolescent. Assess her coping skills.

Mrs X and Mr X: Assess the definition and expectations of different family roles and how they cope with their respective roles within the family. Do they have time for social interaction outside the family? If so, how much? Assess time spent together alone and communication between them. Assess their discipline styles. Assess the importance of cultural values and practices and how they are put into practice.

Grandfather: Assess his coping with role changes, namely being retired, living with his children yet not being the head of the family, and relocation to one room in the backyard. Assess contact with peer group and support groups in the community. Assess his role and function within the family.

BEHAVIOURAL DIMENSION

Baba

- Nutrition: Baba seems to be under-weight. Assess the type of feeding and the quality of feedings (eg breast or formula/bottle feeding). Have solids been introduced in the diet? Can Baba drink from a cup? Assess the mother’s knowledge about feeding and introduction of solid foods.
- Elimination pattern: Assess Baba for hydration status — voiding 6–12 times per day and having a bowel evacuation in accordance with the type of feeding.
- Activity and exercise: Assess opportunities for spontaneous play and exploration. Observe parental stimulation (like talking to and singing lullabies to Baba, providing colourful objects and inexpensive objects to play with, eg lids and spoons).
- Sleep and rest: Baba should sleep at least 12 of every 24 hours. Assess the mother’s knowledge about clues that Baba needs rest, the sleep cycle and the importance of routine and rituals to comfort baby before bedtime.
Alex

- Nutrition: Assess weaning and the inclusion of a variety of solid foods.
- Elimination pattern: Assess the mother’s knowledge and understanding of physical and emotional readiness for toilet training.
- Activity and exercise: Assess activities such as running, pushing, pulling and play as part of the normal exploration of the surroundings.
- Sleep and rest: Assess mother’s knowledge of the importance of 1–2 shorter naps per day and the continuous need for routine. Assess for night terrors which may occur at this age.

Ben

Assess for nutritional status, exercise, voiding problems such as occasional bedwetting, and sleep disturbances such as night terrors and sleepwalking

Peter

- Assess nutritional status and observe for signs of obesity.
- Assess for possible nocturnal enuresis and diurnal enuresis.
- Assess for sleep disturbances such as sleepwalking.
- Assess the home environment to allow for at least eight hours of sleep (e.g., in terms of noise levels).

Mary

- Nutrition: Assess her diet and energy demands, because of completing school and being a mother. Assess for eating disorders.
- Sleep and rest: Consider the demands of the baby and the demands in terms of school work; assess the quality of rest and sleep.
- Risky behaviour: Assess for possible substance abuse such as smoking, use of drugs or risky sexual behaviour.
- Violence: Assess for violent behaviour in the family and from boyfriend.
- Assess coping skills.

Mrs and Mr X

- Nutrition: Assess whether taking a balanced diet to supply the energy demanded by a large family, with calcium supplement to prevent osteoporosis and providing for low cholesterol, low salt and low saturated fats. Guard against overweight or obesity.
- Sleep and rest: Assess hours and quality of night sleep.
- Exercise and leisure: Assess the time and means to engage in these activities and to include the rest of the family, to reduce stress levels, promote quality of life and strengthen family ties.
- Use of substances: Assess the use or abuse of tobacco, alcohol and drugs.
- Sexuality and reproductive patterns must be assessed to assist the couple with potential problems such as impotency, unwanted pregnancy and menopause.

Grandfather

- Nutrition: Assess whether he has a balanced diet, adapted for taste and texture to accommodate physical impairments of old age. Avoid too much alcohol and caffeine.
- Sleep and rest: Assess sleep routine, hours and quality of night sleep and whether taking a short nap during the day.
Exercise and leisure: Assess appropriate ways to engage in these activities, to keep mentally alert and physically as fit as possible, to reduce stress levels, promote quality of life and strengthen family ties.

Use of substances: Assess the use or abuse of tobacco, alcohol and use of prescribed and over-the-counter medication.

PHYSICAL ENVIRONMENTAL DIMENSION

Safety issues in the home and environment are discussed for the family as a whole. The following areas should be assessed.

**House:** The size seems too small for a family of this size and composition. Do family members have the privacy that they need, especially at night time? Assess noise levels, especially in terms of quiet times for sleep and rest for the young ones and for Mr and Mrs X at night. Assess areas where school work can be done without interruptions.

**Safety:** This is especially important in terms of the baby, toddler and pre-school child. Assess the structural safety (e.g. safe stairs and floor covering, and that the roof does not leak and electrical sockets are out of reach). Are cleaning chemicals and medicines stored in a safe place out of reach of the young ones? Will the fence or wall keep the young ones inside the yard?

Assess **general hygiene** and safety: availability of safe and clean water, standard of electricity provision and removal of household refuse.

Assess **room temperature**, especially in the outside room where the grandfather who has asthma is living.

Assess the **outside environment**, because the older children are often outside the house: for example road safety and safety at the nearby shopping centre. Peter should not be allowed to go the shops alone (in case of loitering).

HEALTH SYSTEM DIMENSION

Utilisation of health services is discussed for the family as a whole.

Note and respect the family’s preference in terms of culturally acceptable services and choice between public and private health services.

Assess the availability, accessibility and effectiveness of nearby health services. The family’s knowledge of the following services should be assessed:

- PHC clinics for family planning, immunisation and hypertension treatment
- school health services for routine screening at specific ages
- occupational health services at the father’s workplace
- referral services which may include psychologists for stress management, physiotherapist for assisting the grandfather, dietician to assist in terms of Baba, Mary and Mr X, and the district hospital for treatment of the grandfather’s asthma
- social worker to assist with grants for the children, day care for the young ones, obtaining more suitable housing and financial assistance for the grandfather
PRIMARY, SECONDARY AND TERTIARY PREVENTION PROGRAMME FOR MRS X

Primary prevention for Mrs X

The following points should be considered:

- Maintain balance, perspective and priorities in her daily life, for example take needed time for herself.
- Develop and maintain healthy relationships with all the other members of the family (e.g., be observant of any abuse which might occur, and maintain healthy communication).
- Develop and maintain a healthy sense of self (e.g., help her to find a job).
- Develop and maintain a physically healthy body and prevent acute and chronic diseases (e.g., encourage healthy nutrition, rest and exercise, and give information on contraception and safe sex).

Secondary prevention for Mrs X

The following points should be considered:

- Routine screening should be done for breast and cervical cancer.
- Diagnose and treat existing problems: Advise Mrs X to be observant of any abnormal signs and symptoms, and that she might be overtired and stressed because of financial worries.
- Refer to appropriate resources.
- Make sure that Mrs X is aware of existing health care facilities in the case of emergencies.

Tertiary prevention for Mrs X

The following points should be considered:

- Make sure that she is happy with her contraceptives.
- Give information on STDs and sexual abuse.
- Give information on the menopause.
- Give counselling or refer to a social worker if stress levels are too high.
- Assist Mrs X to find a job or to start with some or other home industry.
- Refer Mrs X for skills training in order to find a job.
FACTS ABOUT IMMUNISATION

IMMUNISATION SAVES LIVES
Immunisation is one of the greatest medical achievements in human history, and has saved millions of lives in the 20th century.

Many serious childhood diseases are preventable by using vaccines routinely recommended for children. Since the introduction of these vaccines, rates of diseases such as polio, measles, hepatitis B, rubella, diphtheria, pertussis (whooping cough), and meningitis caused by haemophilus influenzae type B (Hib) have declined by 90%.

According to the World Health Organisation (WHO), immunisation currently saves an estimated three (3) million lives per year worldwide. Pertussis vaccine saves over 600,000 lives. Diphtheria has almost disappeared in some major regions of the world. The Hib related infections in children are said to have almost disappeared in the United States within 10 years of immunisation. Hepatitis B immunisation has caused a significant drop in the incidence of hepatocellular carcinoma (liver cancer).

Before immunisation, hundreds of thousands of children were infected and thousands died each year from these diseases.

IMMUNISATION PREVENTS THE SPREAD OF DISEASE
Vaccination not only protects the individual but also curbs the spread of disease within the community (i.e. provides herd immunity). For vaccines to provide herd immunity, a certain percentage of individuals within a community need to be immunised.

If immunisation coverage drops for conditions like measles, outbreaks may occur. It is important to maintain a high level of immunisation coverage even when the condition is becoming rare. Failure to maintain measles immunisation coverage can lead to re-emergence and outbreaks, as it happened in United States in 1989-1991. The measles epidemic was responsible for 55,000 cases and more than 120 deaths.

IMMUNISATION IS SAFE
Immunisation is safe and getting safer and more effective, all the time as a result of medical research and ongoing review by medical scientists. Immunisation is given to keep people healthy. It should however be remembered that no drug is absolutely free of side effects. Similar to drugs, vaccines may also give side effects.

The number of vaccines recommended for Expanded Programme on Immunisation has increased; as a result children are now protected from more infectious diseases than before including Hepatitis B and Hib.
All vaccines used in the Expanded Programme on Immunisation in South Africa (EPI-SA), are manufactured according to strict safety guidelines and are evaluated by the Medicines Control Council (MCC) to ensure efficacy, quality and safety before registration and approval for marketing. In addition, these vaccines meet WHO standards of quality, safety and efficacy.

**IMMUNISATION SAVES MONEY**

Immunisation currently remains one of the most cost effective health interventions. According to WHO every dollar spent on vaccine saves seven dollars in medical costs and 25 dollars in overall costs related to vaccine preventable diseases. Current estimates of direct medical costs and indirect (work loss) costs of hepatitis B related liver disease exceed $500 million annually. In South Africa terms this would mean that every R10 spent on vaccines saves R70 in medical costs and R250 in overall costs.

**IMMUNISATION OFFERS EFFECTIVE PROTECTION**

Immunisation provides the most important and effective means through which parents can protect their children against serious diseases. Children who have not been immunised are at high risk of becoming infected with serious diseases. A recent study showed that children who had not received the measles vaccine were 35 times more likely to get the disease. Without immunisation, the diseases we are now protected from will return in epidemic or pandemic proportions to kill many children. There are no effective alternatives to immunisation for protection against some serious and sometimes deadly infectious diseases.

**DID YOU KNOW**

Small pox was the first infectious disease to be globally eradicated by immunisation in 1980. WHO set a goal to eradicate Polio worldwide by 2005. In South Africa the last polio case due to the wild poliovirus was reported in 1989. The final countdown to a polio free South Africa was launched on 11 April 2002. **All cases with sudden weakness or lameness of either arm or/and leg in children under the age of 15 years (not caused by injury) should be reported immediately to the nearest health care centre.**

Vaccines are free of charge at public local clinics and community health centres of South Africa. NB. Immunisation is one of the health care components. All children have a right to basic health care. The government of South Africa currently devotes more than R80 million per year on vaccines. Only when a disease has been completely eradicated worldwide can immunisation be discontinued safely. The first week of August has been declared the National Immunisation Awareness Week in South Africa.

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The Revised Expanded Programme on Immunisation in South Africa (EPI-SA) Schedule

1 February 2008

The Department of Health will this year introduce a vaccine called Diftavax (Td) to be administered to children at the age 6 and 12 years. Diftavax (Td) replaces tetanus diphtheria (TD) and is composed of tetanus toxoid and a lower concentration of diphtheria toxoid, compared to the diphtheria in the tetanus diphtheria (TD) vaccine that it will replace. TD vaccine has up to now been administered to children at the age of 5 years.

The Td dose at 12 years is a new addition to the schedule. It is to ensure the correct number of tetanus toxoid doses and a long enough interval between doses, thus allowing maximum duration of protection against tetanus, which is expected to be lifelong. Furthermore the revised schedule will allow for prolonged protection against diphtheria.

Tetanus is a condition that is caused by tetanus germs (spores). Tetanus spores are commonly found in the environment as they are the normal inhabitants of the intestines of animals, and thus are normally found in animal droppings/faeces.

Tetanus affects the nerves after an open wound is infected by tetanus spores. The infected person will have stiffness of the jaw, the neck and severe muscle spasms of the abdomen and back.

Neonatal tetanus is a condition that occurs in the first month of a child’s life caused by unhygienic cord care practices. Similarly, unhygienic delivery and wound care practices can cause a mother who is not fully protected against tetanus to get tetanus after birth, called maternal tetanus.

As tetanus cannot be eradicated, there is a need to continue with immunisation for both pregnant women and children. The revised policy aims to ensure that over a period of time, the young girls who are immunised under this schedule will be fully protected against tetanus as they grow.

Thus this generation of girls will not need tetanus toxoid immunisation during pregnancy, when they become mothers.

The Td vaccine is safe and effective. The potential risks associated with the natural infections of tetanus and diphtheria are much greater than the potential risks that may be associated with the administration of the Td vaccine.

The National Department of Health would like to encourage and urge parents and caregivers to ensure that their children are fully immunised against childhood vaccine preventable diseases, and to report any cases of neonatal tetanus at the nearest health facility.

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Blantina Mabuela 082 3332225
Issued by the Chief Directorate: Communication
For more information contact: Fidel Hadebe 012 312 0663/079 517 3333 Or Bhungani Mzolo 012 312 3331/083 589 4999
# Expanded Programme on Immunisation (EPI) Revised Childhood Immunisation Schedule

<table>
<thead>
<tr>
<th>Age of Child</th>
<th>Vaccines needed</th>
<th>How?</th>
</tr>
</thead>
<tbody>
<tr>
<td>At Birth</td>
<td>Polio Vaccine</td>
<td>Drops by mouth</td>
</tr>
<tr>
<td></td>
<td>BCG (Bacilles Calmette Guerin)</td>
<td>Intradermal injection</td>
</tr>
<tr>
<td></td>
<td>Anti-tuberculosis Vaccine</td>
<td></td>
</tr>
<tr>
<td>6 Weeks</td>
<td>Polio Vaccine</td>
<td>Drops by mouth</td>
</tr>
<tr>
<td></td>
<td>DTP-Hib (Diphtheria, Tetanus, Pertussis and Haemophilus influenza type b)</td>
<td>Injection left thigh</td>
</tr>
<tr>
<td></td>
<td>Hepatitis B Vaccine</td>
<td>Injection right thigh</td>
</tr>
<tr>
<td>10 Weeks</td>
<td>Polio Vaccine</td>
<td>Drops by mouth</td>
</tr>
<tr>
<td></td>
<td>DTP-Hib (Diphtheria, Tetanus, Pertussis and Haemophilus influenza type b)</td>
<td>Injection left thigh</td>
</tr>
<tr>
<td></td>
<td>Hepatitis B Vaccine</td>
<td>Injection right thigh</td>
</tr>
<tr>
<td>14 Weeks</td>
<td>Polio Vaccine</td>
<td>Drops by mouth</td>
</tr>
<tr>
<td></td>
<td>DTP-Hib (Diphtheria, Tetanus, Pertussis and Haemophilus influenza type b)</td>
<td>Injection left thigh</td>
</tr>
<tr>
<td></td>
<td>Hepatitis B Vaccine</td>
<td>Injection right thigh</td>
</tr>
<tr>
<td>9 Months</td>
<td>Measles Vaccine</td>
<td>Injection right thigh</td>
</tr>
<tr>
<td>18 Months</td>
<td>Polio Vaccine</td>
<td>Drops by mouth</td>
</tr>
<tr>
<td></td>
<td>DTP (Diphtheria, Tetanus and Pertussis)</td>
<td>Injection left arm</td>
</tr>
<tr>
<td></td>
<td>Measles Vaccine</td>
<td>Injection right arm</td>
</tr>
<tr>
<td>6 Years (Both Boys and Girls)</td>
<td>Polio Vaccine</td>
<td>Drops by mouth</td>
</tr>
<tr>
<td></td>
<td>Td (Tetanus and reduced amount of diphtheria) Diftavax</td>
<td>Injection left arm</td>
</tr>
<tr>
<td>12 Years (Both Boys and Girls)</td>
<td>Td (Tetanus and reduced amount of diphtheria) Diftavax</td>
<td>Injection left arm</td>
</tr>
</tbody>
</table>
ANNEXURE D

Plans to add two new vaccines to prevent pneumonia and diarrhoea in babies

Issued by: National Department of Health

30 June 2008

The Department of Health has decided to add two new vaccines to the Expanded Programme on Immunisation (EPI) in order to prevent viral pneumonia and second viral diarrhoea in children.

The Minister of Health Dr Manto Tshabalala-Msimang made this announcement at the 2008 Donor Consultation Forum, which was held in Johannesburg today, to review the current donor support being offered to South Africa to strengthen the health system of this country.

The Minister plans to launch this initiative as soon as the Department is able to source these vaccines in Ukhahlamba district in the Eastern Cape, which has recorded an increase in the deaths of children under 5 years in the first three months of 2008 compared to 2007.

The Department of Health’s investigation into these deaths found a number of challenges, which include the following:

- There are challenges in the provision of clean water and sanitation
- The area is very poor and hence food insecure and,
- There are a number of health system issues that need to be strengthened.

The Department has approached the World Health Organisation (WHO) to assist to better understand these challenges.

The Minister made a request to other development partners to assist as well, and appealed that they should ensure that all efforts were co-ordinated and under the leadership of the Department.

For more information contact Charity Bhengu 083 670 7424
### Private Vaccines Schedule

<table>
<thead>
<tr>
<th>Age of Child</th>
<th>Vaccines needed</th>
<th>Product</th>
</tr>
</thead>
<tbody>
<tr>
<td>At birth</td>
<td>TB Vaccine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oral Polio Vaccine</td>
<td>OPV-Mérieux&lt;sup&gt;R&lt;/sup&gt;</td>
</tr>
<tr>
<td>6 Weeks</td>
<td>Diphtheria, Tetanus, Acellular Pertussis, <em>Haemophilus influenzae</em> type b and inactivated Polio Vaccine</td>
<td>Pentaxim&lt;sup&gt;R&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Hepatitis B Vaccine</td>
<td>Heberbiovac BH&lt;sup&gt;R&lt;/sup&gt; 10µg</td>
</tr>
<tr>
<td></td>
<td>Conjugated Pneumococcal Vaccine</td>
<td></td>
</tr>
<tr>
<td>10 Weeks</td>
<td>Diphtheria, Tetanus, Acellular Pertussis, <em>Haemophilus influenzae</em> type b and inactivated Polio Vaccine</td>
<td>Pentaxim&lt;sup&gt;R&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Hepatitis B Vaccine</td>
<td>Heberbiovac HB&lt;sup&gt;R&lt;/sup&gt; 10µg</td>
</tr>
<tr>
<td></td>
<td>Conjugated Pneumococcal Vaccine</td>
<td></td>
</tr>
<tr>
<td>14 Weeks</td>
<td>Diphtheria, Tetanus Acellular Pertussis, <em>Haemophilus influenzae</em> type b and Inactivated Polio Vaccine</td>
<td>Pentaxim&lt;sup&gt;R&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Hepatitis B Vaccine</td>
<td>Heberbiovac HB&lt;sup&gt;R&lt;/sup&gt; 10µg</td>
</tr>
<tr>
<td></td>
<td>Conjugated Pneumococcal Vaccine</td>
<td></td>
</tr>
<tr>
<td>9 Months</td>
<td>Measles Vaccine</td>
<td>Rouvax&lt;sup&gt;R&lt;/sup&gt;</td>
</tr>
<tr>
<td>12 Months</td>
<td>Hepatitis A Vaccine (Paediatric)</td>
<td>Avaxim&lt;sup&gt;R&lt;/sup&gt; 80</td>
</tr>
<tr>
<td></td>
<td>Varicella Vaccine (Chickenpox)</td>
<td></td>
</tr>
<tr>
<td>15 to 18 Months</td>
<td>Measles, Mumps, Rubella Vaccine</td>
<td>Trimovax&lt;sup&gt;R&lt;/sup&gt;</td>
</tr>
<tr>
<td>18 Months</td>
<td>Diphtheria, Tetanus, Acellular Pertussis, <em>Haemophilus influenzae</em> type b and inactivated Polio Vaccine</td>
<td>Pentaxim&lt;sup&gt;R&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Hepatitis A Vaccine (Booster)</td>
<td>Avaxim&lt;sup&gt;R&lt;/sup&gt; 80</td>
</tr>
<tr>
<td>6 Years and older</td>
<td>Tetanus diphtheria and inactivated Polio Vaccine (Booster every 10 years thereafter)</td>
<td>Td Polio&lt;sup&gt;R&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Measles, Mumps, Rubella Vaccine</td>
<td>Trimovax&lt;sup&gt;R&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>R</sup> Pentaxim<sup>R</sup>: Injection. Each 0.5ml dose after reconstitution contains: Purified diphtheria toxoid 30 IU, Purified tetanus toxoid 40 IU, Purified pertussis toxoid 25 µg, Purified pertussis filamentous haemagglutinin 25 µg, inactivated type f poliovirus D antigen 40D units, inactivated type 2 poliovirus D antigen 80 units, inactivated type 3 poliovirus D antigen 32 D units. *Haemophilus influenzae* type b polysaccharide conjugated to tetanus protein 10 µg.

<sup>AV</sup> Avaxim<sup>R</sup> 80: Each dose (0.5 ml) contains 80 antigen units of inactivated Hepatitis A Vaccine. Preservatives 2-Phenoxyethanol 2.5µl (0.0005% v/v), Formaldehyde 12.5µg (0.0025% w/v), Aluminium hydroxide (expressed as aluminium) 0.15mg. This vaccine contains traces of neomycin. Reg. No. 35/30.1/0401.
Trimovax<sup>1h</sup>: .5 ml contains live attenuated Measles virus $\geq 1$ 000 TCID<sub>50</sub>, Mumps virus $\geq$ 5 000 TCID<sub>50</sub> and Rubella virus $\geq$ 1 000 CCID<sub>50</sub>. Reg. No. T30.1/0510.

Td Polio<sup>2h</sup> injection: Each dose (0.5ml) contains purified diptheria toxoid – not less than 3IU purified tetanus toxoid – not less than 20IU; inactivated poliovirus type 1 - 40 D antigen units, inactivated poliovirus type 2.8 D antigens units; inactivated poliovirus type 3-32 D antigens units. Reg. No. 34/30.1/0510.

OPV-Mérieux<sup>3h</sup>: Each immunising dose (0.1 ml) contains: Poliomyelitis virus type 1 not less than 1 000 000 CCID<sub>50</sub>, Poliomyelitis virus type 3 not less than 600 000 CCID<sub>50</sub>. Reg. No. 27/30/0531.

Rouvax<sup>4h</sup>: Each single dose contains not less than 1 000 TCID<sub>50</sub> live attenuated measles virus (Schwartz strain) cultivated in chick-embryo tissue. Reg. No. T/30.1/688.

Heberbiovac HB<sup>5h</sup> 10μg Hepatitis B virus recombinant-DNA surface antigen per 0.5 ml solution for injection. Reg. No. 36/30.1/0358.