

C PRIMARY HEALTH CARE

The essential health care based on practical scientifically sound and socially acceptable methods of technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in spirit of self-reliance and self-determination.

Concepts of PHC

The Concepts of PHC are derived from PTHC. These words were used intentionally because they convey specific messages.

1. Primary - Meaning the first, or basic or essential, or most important urgent needs.
2. Health - Is a state of complete physical, mental and social well-being of an individual and not merely the absence of disease or infirmity.
3. Care - Means looking after, protection or giving attention to or maintaining something which includes prevention, promotion, curative and rehabilitative

Primary Health Care means activities undertaken before a person develops a disease.

Secondary Care means those activities undertaken when the disease has occurred but the person is probably not acute e.g. screening to detect the disease early.

Tertiary Care is provided when a person shows signs and symptoms & dispose to prevent disability and death.

It is a MOPH policy that PHC be a cornerstone in the development of health services for the people.

The communities are viewed as focal points for action and as such all plans and resources allocation must be based on specific needs of the communities.

- The PHC approach is a logical choice by the govt as it guarantees equity, empowerment, self reliance and participation at all levels.

This strategy ensures that health choices become easy choices

EVOLUTION OF PHC / HISTORY OF PHC

In the 1950s the concept of health center and preventive and promotive services in some countries evolved.

- At the time of independence, most countries had made commitment to better health for their people and this led to development of infrastructures.
- However, lack of proper planning of these Health Center and hospitals with ^{Poor} ~~proper~~ administration initiated from colonials led to disparities.
- Many of these disparities in basic health service necessitated a different approach of health care.
- In 1975, a joint WHO-UNICEF study estimated that only 20% of rural population in developing countries received any basic health care on regular basis.
- In 1976 a study estimated that 87% of the population in developing countries lived in extreme poverty.
- It was then that the international community expressed the need for urgent action by all governments, and the world community to protect and promote health for All in the world. This was to happen through alternative strategies, one of which was through PHC as the key to attaining this target.
- In 1977, the WHO executive board sat in Geneva and discussed issues concerning social aspects in provision of health services in the world. They advocated that health be a prelude to social and economic development.
- In 1978 at Alma Ata, in Russia PHC declaration was made with the objective of Health for all by the year 2000.
- Uganda was a signatory at the conference. This means that we must mobilise and enlighten individuals, families and communities in order to ensure their full identification with PHC, their participation in planning and management.

of their full ~~introduction~~ contribution to its app

- Although born in Alina Afia Conference of 197
^{was} PHC started at Karangah Health Centre in Kalandra d
- In 1979, the 1st conference regarding PHC in Uganda was held in Mweya Safari Lodge (Mweya Pt. workshop) commonly known as Mweya Spt.
- The concept did not take off until the coming of NRM govt in 1986 with its 10 point program of which PHC was covered in point 6.

In the same year, Uganda Community Based Health Care (UCBHC) Association was formed with more than 22 programs, NGOs, Ministry of Health & Ministry of LG.

In 1990 serious discussions on PHC took off with practical implementations and this has continued improving up to date.

PRINCIPLES OF PHC

Principles are guidelines or rules or regulations ~~of~~ of PHC for it to remain relevant to the original cause.

- These are derived from the key words used in the definition

1. Essential health Care

- The health care provided must solve the main problems in a community and meet the local needs of the community.

2. Practical

- Refers to feasibility of the methods, they should be applicable e.g. facilities can use cool boxes to store vaccines in absence of fridges

3. Socially acceptable methods and technology

- The methods and technology used in delivery of health services should not interfere with the norms of the community regarding the service.

4. Accessibility

- These services have to be within reach of the communities and individuals in the community in order to promote health.

5. Full community participation.

- This is a process by which individuals and families assume responsibility for their own health and welfare. i.e. people are involved in planning, implementing and evaluation of health services.

6. Affordability

- The initial cost of service and the cost to maintain in terms of planning, implementation, Monitoring & Evaluation of PHC activities should be at a cost the community can afford for sustainability.

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1. Self reliance

There should be a sense of ownership, response and accountability. Individuals and families are encouraged to be active partners with the govt or Sowki.

2. Self determination

There should be a vision, hope and wish at all levels where PHC services are offered from smaller to higher levels. The community should be able to take action and decide on matters concerning their health & devt. eg where are we and what do we want in future.

CHARACTERS OF PHC

These are the foundation stones on which PHC stands. They are also referred to the major strategies of PHC without them, the PHC programs will not succeed.

- 1. Political will / political commitment
- 2. Full community participation
- 3. Intersectoral collaboration
- 4. Use of appropriate technology

The above 4 main principles through which the Global Goal of Health for All (HFA) was to be attained were identified by WHO during the Alma Ata Conference of 1978 September. However, individual countries were asked to formulate their own National health principles that are relevant and appropriate to their needs.

- Just like when building a house with foundation, there should be development of strong pillars to support and sustain the elements of PHC.

① Political Commitment.

• Political will is the support provided to promote PHC by those who influence decision making at various levels.

Getting political leaders actively involved in planning, implementation, monitoring, evaluation of PHC programs this can be further effected by using the authority they hold in different parts.



Policy makers eg Cabinet, parliamentarians, district and sub-county councils, parish councils

Administrators such as P.A.O, secretaries

Opinion leaders like religious, traditional and respected elders

How political commitment is expressed

Thro political statements in favour or support of PHC by highest circles in political system.
or a statement by a Minister.

• political leader mobilizing the community about PHC, soliciting resources internally about PHC.

Active involvement in actual implementation of specific activities of

Adequate budgetary allocations for PHC

Developing legally backed policies of PHC such as national health policy

ELEMENTS OF PHC (COMPONENTS)

There are the basic areas of action to attain the Health For All (HFA) goals.

At the Alma-Ata conference, they were 8.

i.e

1. Health education and Promotion

Equipping the community with knowledge and skills concerning preventing health problems and methods and controlling them. This makes people lead better life styles.

2. Promotion of adequate food supply and proper nutrition

This is the process of improving food production, processing, storage, marketing and consumption with the ultimate goal of improving the health, nutrition status and economy of the community.

3. Adequate Supply of Safe water and environmental sanitation

This caters for the amount of water, distance to the source and safety of the water.

Sanitation is the control and support of factors in the human environment that have a bearing to health.

e.g. housing, refuse and excreta disposal, food hygiene etc.

4. Maternal and Child health care including Family Planning

These services are rendered to mothers and children through Antenatal Care, Postnatal care and child spacing. The aim is to improve the health status of women and children.

5. Immunisation against major infectious diseases

This is the process of administration of vaccine to susceptible members of the community so as to raise their body immunity against infectious diseases.

6. Appropriate treatment of common diseases and minor injuries

That there should be sufficient Rx facilities for mgmt of common occurring diseases and injuries in a community.

7. Prevention and control of locally endemic diseases
diseases that are always present in the community
should be taken as PHC activity by Malaria.

8. Provision of essential drugs

The drugs required for effective management of most common conditions should always be available e.g. paracetamol.

The above were the original elements agreed upon during the Alma-Ata Conference. However, depending on the countries prevailing conditions, the numbers increased in some countries.

In Uganda, the elements below were added.

9. Mental and spiritual health

There are services directed to the care and rehabilitation of the mentally ill and preventing mental illness in the community.

10. Dental / Oral health

These services are directed to the care and rehabilitation and prevention of oral conditions.

11. Community based rehabilitative health services

These services are made care for the physically, mentally, socially and economically handicapped and disabled.

12. Occupational health

These are directed to the well-being of individuals at their places of work.

Accident prevention

These include services directed towards prevention of accidents e.g. encouraging use of protective gear such as helmets, when using machines.

14. Ophthalmology Services

There are services directed to the care and rehabilitation of those with eye defects and also prevention of ophthalmic illnesses in the community.

15. Sexual and Reproductive Health including STI's mgd.

There are services directed at management of sexually transmitted illnesses that affect reproduction and preventing their recurrence and occurrence.

16. School Health Programmes

These are activities designed by schools to assist with the aim of improving the quality of life of students, staff and the community.

PRINCIPLES OF PHC

There are levels at which PHC services are provided
They represent a referral system for health and
health related problems & a system for effective
distribution of resources.

i.e Bottom-up Approach & Top-bottom approach

1. National Level.

MOH — State ministers — PS — Director General of Health Services
- National referral hospitals eg Mulago, Butabika.
- Special ^{referral} cancer hospitals

2. Regional Level

Directorates — Departments.
- Regional referral hospitals

3. District Level

DCH — District Health Committee → HC IV
- District Hospitals
- HC IVs

4. Sub County Level

HC III — HC II
Health Centre III & II

5. Community Level

HC I i.e VHT.

VHT's include CEFIs, TBA, chairpersons of village
committees eg water user committee.

In order for PHC to succeed, different govt agencies
must cooperate e.g. MO Finance, planning & economic
dept, Ministry of LG, Ministry AAF, MoE etc'

levels of Care

Primary

- This is the 1st level of contact b/w the individual & health system.
- Majority of prevailing health problems can be managed.
- Essential health care is provided here.
- It is the closest to the people.
- It's provided by VHTs & Primary Health Centers i.e. Sub-dispensary, dispensaries, dispensary with maternity units

Secondary

- Here more complex problems are dealt with e.g. X-rays, Second lab investigations
- Comprise of Curative Services
- Provided by district hospitals

Tertiary

- Here Super specialist care is provided
- It's provided by regional or national level institutions
- They also provide training programs.

LEVELS OF PHC WORKERS

- There are 2 levels of PHC workers who largely work at levels designed for PHC service centers i.e. HC II to HC IV

1. Lower Health care workers (Barangay)
Trained CHW, TBA's, VHTs.
Currently VHTs form this level.

2. Intermediate level health workers

- Nurses, Midwives, Medical assistants, Rural sanitary Inspectors etc.

Reasons why PHC didn't achieve HFA goal

1. Lack of political will & commitment.

2. Lack of community participation.

3. Inadequate intersectoral collaboration.

4. Illiteracy rate.

5. Foreign origin of the concept.

6. Corruption.

7. Geographical accessibility.

No full utilization of PHC pillars.

How Health in 2nd day is going now:

Community Based Health Care

Community is a group of people with common interests living together within a large society.

- Objectives of CBHC:
1. This is for community to be responsible for their own health by
 - Identifying own health problems
 - Finding solutions to these problems
 - Making their own decisions
 - Identifying those outside the environment.

Importance of CBHC

1. Most common illnesses can be prevented at community level.
2. Reduction in high morbidity & mortality rates.
3. Health services are brought nearer to the community e.g. first & dental services.

Stages of Initiating CBHC

1. Vision / idea:

- Develop an idea, vision from that community you want to work.

2. Exploration:

- Explore the idea by look, listen & learn, consultations from those who have ever done or studied it.

Interview them to get more ideas on the idea.

3. Report

- Make a brief report on the findings & share them with other community members.

4. Protocol

- Observe protocol by going thru authorities (AO, RDC, LCN) & invite them to attend or participate in meetings in some activities of CBHC.

5. Community entry

- Enter the community & have a dialogue with members.

Share your vision idea, dreams, develop a consensus & identify people from the community who can assist.

e.g. Community Own Resource Persons (CORPs)

CHWs, TBAs, Elites, silent majority etc.

6. Waiting for the community members to digest, think, analyse, internalise & come up with initiating CBHC. others may reject, others may accept
7. Joint need assessment (Community dx).
 - . Meet community members to come up with actual needs
 - to community & set priorities
8. Feed back of findings to community.
 - Hold local meetings to make a report on the joint assessment findings & feedback to community.
9. Joint planning CHED to go along.
 - How to... Meet community to plan what to do in order to solve the needs identified. Set objectives, strategies, local resources & take action to meet the objectives.
10. Training front-liners
 - Identify people who can be trained to become CORPS. train them on community approach, community service provision, technical skills, how to report
11. Monitoring & evaluation.
12. Re-planning financial tool and non-financial tool
 - Re-assess whether objectives were met. check achievement, constraints & failures. Re-plan & modifications for effectiveness and efficiency in not to waste time & money
 - If there is no achievement or failure, then what about re-planning top of not consistent to goal?
 - How next work to proceed if no progress made & plan
 - What planning tools
 - last step A
- VIS-1,119,0A) Let's have with prep pd. looking forward
- and we expect some discussion or feedback with them to
- CHED to evaluate the planning

Principles of CBHC

There are guidelines / rules that govern CBHC

1. CBHC uses bottom-top approach
2. CBHC encourages community participation & involvement.
3. There is initiation & responsibilities & mobilisation & resources which are to be by the community itself.
4. Resources from outside should be invited & organised by the community members.
5. Health is defined in a broad sense which includes all aspects of daily life.
6. Promotion work corresponds to the needs identified & prioritised by the community acting together.
7. The facilitators role in CBHC is to enable & stimulate change in persons' attitudes & practices not to manipulate or dominate.
8. The community should feel the sense of ownership of belonging & the work they have done in groups about sustainability.
9. A participatory self discovery method for adults is often an effective way of changing attitudes & practices.

Qualities of a Good CBHC Leader:

1. Should possess the qualities of a good community leader:
 - Motive is developed
 - Know the community
 - Able to read & write
 - Can speak local languages
 - Willing to volunteer.
2. Explain every activity at hand to make the community members aware.
3. Build up trust with the community.
4. Should be sensitive to feelings & those he is leading.
5. Give attention to the people.
6. Allow community members to participate.
7. Should give constructive criticisms & show concern.
8. Should work, listen & learn.

Traditional Medicines

by Henni Mungoci Esther

Health problems handled by T. leaders

1. Fractures & dislocations
2. Infertility
3. RTIs
4. Skin & food allergy
5. Condom delivery
6. P. U. & PR
7. Sexual desire & impotence
8. Stress counselling
9. Snake bites
10. Vaginal dypers
11. Diarrhoea using love mud ORF

Traditionally prepared medicines

1. Syrups eg cough syrup
2. Tooth paste - Herbs for topical application
- Herbal soap & faceclie - herbs in powder form.

Modes of Operation of Traditional Healer

1. Collection of medicine

- secretly, - by elders, - with community
- lack of stealth.

2. Preserving medicine

- Boiling / cooling using water
- Sun drying
- packing in containers / bottles
- Roasting
- preserving medicine in dry envt.

3. Administration of medicines

- Oral eg syrps; herbs embedded in soil
- Topical esp on skin
- Intra vaginal esp in vaginal dypers & STDS
- Parenteral thru cutting & GJ

NB: These are not clear & concepts not clear

* Demanding for payment

- some are so cheap
- some herbalists demand what's money
- over advertising contrary to modern medicine & effi.
- Accept payment in form of e.g. food, animals, land
- some demand payment after pt is cured

Challenges of Traditional Healers / Medicine.

1. Poor packaging materials or equipments
2. Poor methods of preserving medicine
3. Unknown M.O.A of these drugs
4. Witch doctors have invaded this field !, people have lost trust in them
5. Roles are not specific & components not known
6. Lack of formal education / training in traditional medicine
7. Lack of enough research about traditional medicines
8. Misconception about traditional medicines & healers by community by calling them witch doctors
9. Lack of enough literature / books abt traditional med in African cultures
10. Impersonation by quack traditional healers
11. Lack of govt commitment abt this participation in e-national health care system inc. - discourages them
12. Lack of cooperation b/w them & trained health workers
13. Govt doesn't recognise their role & value in a health system

Possible Solutions to the problems

1. Govt shd have policies or regulations for training them & teaching them how to use traditional medicines
2. They should be fully incorporated in the health system basing on community needs
3. Trained health workers & traditional healers shd have an atmosphere of understanding, trust & respect.
4. They should have proper methods & sterilization & preservation of medicines.
5. They should try to pack their medicine well & have quality packaging materials indicating expiry dates.

Demanding for Payments

- some are so cheap
- some herbalists demand lot's of money
- : over advertising contrary to modern medicine often
- accept payment in kind e.g. food, animals, land
- some demand payment after pt is cured

Challenges of Traditional Healers / Medicine.

1. Poor packaging materials or equipment
2. Poor methods of preserving medicine
3. Unknown M.O.A & therapeutic drugs
4. Witch doctors have invaded this field !, people have lost trust in them
5. Roles are not specific & components not known
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5. They should try to pack their medicine well & have quality packaging materials indicating expiry dates.

They should document & explain M.O.A of this drugs

They should distance themselves from witch doctors

6. Indicate doses & components in herbal medicines

7. They should have a governing body that will deal with quacks & impersonators

8. They should write books to be used as reference by other people who might want to improve their products or extend services wider

Qtn: Justify the need for regulation & control of traditional practices in Uganda

PRIMARY HEALTH CARE.

SCHOOL HEALTH PROGRAMME.

- i. These are programs carried out in schools aimed at improving the quality of life & promoting healthy social behaviour of school children and staff & the community.

Examples of School Health Programs

1. Health education
2. Hospital attachments
3. Outreach programs
4. Personal hygiene
5. Oral and dental services
6. Clean Water and sanitation programs.
- etc.

Objectives of School health programs

1. To make students aware of common health problems and ways of solving and preventing them and wgt of common diseases.
2. To equip the teachers with health knowledge and skills to impart effective health education.
3. To ensure proper environmental sanitation at school including water supply.
4. To promote appropriate environmental sanitation at school including ^{clean} water supply.
5. To promote appropriate social & emotional behaviour.
6. To develop cooperation b/w school, community & govern.
7. To develop the knowledge & attitude that will help students make intelligent decisions for better health.
8. To infuse health practices & positive health among students for self health care.

Composition of School Health Program

1. Helpful school environment eg. good lab facility, suitable
2. Standard classrooms for conducive learning
3. Adequate play ground for physical fitness
4. Strategic location of the school to enable smooth running of the programs
5. Screening of school children for any anomalies.
eg. height, weight, vision, temperature, B.P., hearing by C.O.s or nurses.

Role of the Clinical Officer in STHP

1. Screening students and support staff.
2. Treatment of minor diseases
3. Immunisation
4. Health education
5. Referral services and follow up of referrals
6. Formation of a health committee
7. Preparation of a work plan and generating activities
8. Lobbying for resources
9. Generating and submission of health reports
10. Ensuring delivery and provision of Services

COMMUNITY HEALTH.

Community is a group of people with the same interests and characteristics living in a large social area.

A CHW is a member of the community residing in the same community, selected by the community, trained to help improve community health and facilitate development.

Qualities of a CHW:

Exemplary

Trustworthy (got with the people methodique)

Acceptable by community

Good communication skills

Corporative & work with others

Having good knowledge about the disease

Responsibilities / Duties of a CHW:

Mobilize community towards PHC (mobilise, support, build)

Home visiting on personal hygiene & other aspects (personal)

Encouraging community utilization on resources (resources)

Collection & info about community

Identify minor, dangerous & essential diseases & bring them to the attention of the concerned authority

Involved in dental projects

Sensitize community towards PHC

Immunization to children

Identification of common problems

Advise community on dent.

Administrative:

Accountability

- Identify risk families

Plan activities

- Referrals

Report writing

- Participation in implementation

Liaise w/ medical officers & health

monitoring & evaluation

Order & supply

Secretary to common health committee

Keep records

Types of CHW

1. Community health educators
2. Community volunteers
3. Health mobilizers
4. T.B.A (Trained by authority) or T.O (Trained by organization)
5. N.H.T (Non-hierarchical, decentralized, and mobilized, informal)
6. Community Devg & distributors.

Differences BTM PHC & CBHC

PHC

- Top-bottom approach is used
- Activities controlled externally
- Institutional based
- The vision of PHC is external
- Based on national priority
- Full of philosophy (WHO 2000)
- Expensive to implement
- Owned by support system & hence community dependence is high (members practice and foreign to culture)
- Originated & implemented by health workers

CBHC

- Bottom-top approach is used
- Activities controlled internally
- Community-based
- Vision is internal & influenced
- Based on community's priority
- More action oriented
- Cheaper to implement
- Owned by community

Community dependence is high (members practice and foreign to culture)

All activities have cultural base. Hence often conflict in consideration hence relevant

Originated & implemented by community workers

It's changing structure is gradual

existing structure is not suitable

but a dynamic structure

adjustable

1. When was the Alma-Ata Conference held? (1)
2. When did this conference take place? (1)
3. What was the main aim of this conference? (1)
4. Uganda was a signatory. When was PHC implemented in Uganda? (Ans) (1)
5. Write HFA in full. (1)
- Short Answers**
6. Outline the features of Primary Health Care. (Ans) (10)
7. Elaborate the components of PHC as stated in the Alma Ata conference. (10)
8. Why is the HFA goal not achieved yet in Uganda? (5)
9. Who is an ideal CBHC leader? (5)
10. Justify the need for regulation & control of traditional practices in Uganda. (5)
11. What are the possible strengths of PHC? (4)
12. Why is it important for community to participate in PHC activities? (5)
13. Why is the significance of intersectoral collaboration (5) in PHC?
14. Define PHC according to WHO? (4)
15. Who is a healthy person? ~~at the moment~~ (2)

IMMUNISATION.

Is the process of providing immunity to the body against infectious diseases through administration of antigenic materials in order to induce immunity against a particular disease.

The antigenic materials (vaccines) reduce or prevent the effects of the infection and are considered as the most effective and cost effective method of disease prevention.

The principle of immunisation is to increase specific immunity to infectious disease by administration of either immune serum (passive immunisation) or by administration of an antigen (Active Immunisation).

The 2 types of Immunisation are;

- Passive Immunisation
- Active Immunisation

Passive Immunisation is where ready made antibodies are administered to the body to give it immediate protection though it lasts for a short period of time.

- It is also used as Post exposure prophylaxis in immune competent individuals when immediate protection is required following exposure to infections such as Tetanus.

e.g.s of diseases for which passive immunisation is commonly applied;

- o Hepatitis B
- o Tetanus
- o Diphtheria
- o Rabies

- The major advantage with this type of immunity is that it confers immediate protection which is important in case the infectious agent is life threatening.

Diseadvantages are;

Use of antiserum has danger of transmitting blood borne infections such as Hepatitis & HIV.

2. Antisera are expensive compared to vaccines
3. Need to be kept cool & are of a short life span
4. Protection is short lived up to 6 months.
5. Immune reactions may occur if immunoglobulins are non-human.

Active Immunisation is a process of introducing micro-organisms (vaccines) or their products to stimulate certain body cells to produce antibodies with a specific protective capacity.

Aims of this form of Immunisation are;

- To protect susceptible individuals against infections
- Reducing the incidence of infection in the community
- Eliminating an infection in a particular country or world wide e.g. Polio, Polio.

→ Active immunisation gives longer protection.

Diseadvantages:

- Slow rate of action
- Not used in post exposure prophylaxis.

Indications for Immunization

1. Everybody is entitled & supposed to be immunised in order to confer prolonged immunity.
2. Travellers
3. Health workers
4. Children
5. Pregnant women
6. Adults at risk of contaminated cuts / bites

accrues

Those are special preparations of antigen that when introduced into the body are able to stimulate the development of antibodies.

Vaccination : is the administration of vaccines.

1 Types of Vaccines

1. Killed or dead vaccines: These are vaccines containing dead microorganisms which were previously virulent.
e.g. Pertussis vaccine, Polio vaccine
2. Live Attenuated Vaccines: Those vaccines use live microorganisms that have been weakened.
- Measles e.g. Measles, Mumps, Rubella, BCG, Rotavirus vaccines, yellow fever
3. Toxoid Vaccines: These are inactivated compounds.
e.g. Tetanus Toxoid & Diphtheria toxoids
4. Sub unit vaccines: These are vaccines containing a fragment of a microorganism ^{rather} that introducing either attenuated or dead microorganisms.
e.g. Hep B vaccine
5. Conjugate Vaccines: These are vaccines derived from linking poorly immunogenic structures of organisms to proteins so that the immune system can recognise them as antigens.
e.g. Hib, PCV

Advantages of live Attenuated Vaccines

- They give a longer protection than dead vaccines
- One dose is usually sufficient.

Disadvantages of live attenuated vaccines

- They are often unstable
- They may not work in presence of circulating antibodies
eg Measles vaccine has to be given at 9months of age when
maternal antibodies have gone.
- live vaccines may cause disease in immunodeficient
persons eg HIV/AIDS
- Live vaccines occasionally interfere with each other so that
immune response is not so great if given together.

PROPERTIES OF AN IDEAL VACCINE

1. Should be able to induce an appropriate immune response without causing disease.
2. Should be safe with minimal side effects.
3. Should be easy to administer
4. Should remain potent during storage & transportation
5. Should be cheap if it is to be used on large scale
6. Should be highly purified so that it contains the required antigens.

COLD CHAIN.

A cold chain is a system of manufacturing, storing and distributing vaccines in a potent state (at desired temperatures) from the manufacturer to the actual vaccination site.

HEALTH EDUCATION & PROMOTION

Information: Refers to facts that are received by a human which have some form of worth to him.

Education: Is the series of learning experiences through which an individual informs & orients himself to develop knowledge & skills.

Health: Is a state of complete physical, mental, psychological, spiritual & social well-being of a person & not merely the absence of disease or infirmity.

Health Education: Is a continuous process of learning during which Knowledge, Attitudes and skills are transmitted to individuals, families, groups of people or community for the understanding & use in order to improve and promote the standard of living thereby reducing incidence & prevalence of ill health & disease.

WHO defined health education as "Consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge and developing life skills which are conducive to individual and community health."

Health Promotion is the process of enabling people to increase control over their health and its determinants and thereby improve their health.