MAIN COURSE

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COURSE GUIDE

NSC 316
PUBLIC-COMMUNITY HEALTH NURSING I

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INTRODUCTION

Hello, welcome to this course. We are happy to have you doing NSC 316 – Public-Community Health Nursing I. You are going to learn more about the health of the public as a larger population of people and about the wellbeing of every community where people interact more closely. You are a member of at least one community and you will be able to use your community, yourself and others around you as sources of gaining more insights into in the health of our people and communities. Please, enjoy the course. You are going to meet three of us who will be interacting with you as to facilitate your learning.

COURSE DESCRIPTION

This course introduces you to the fundamentals of public/community health nursing practice. It introduces you to basic information about the community with the intention of helping you gain insight into how the nature of the community determines the total health of the population hence the interrelatedness of public and community health. It provides you with both theoretical and practical realities of what contribute to the health of the community. Through this course, you will acquire appropriate skills and attitudinal disposition to analyze the socio-cultural, political, economic, ethical and environmental factors that influence individual, family, community health. The course also introduces you to many concepts that would help you understand, explain and engage in actions that will contribute to the achievement and sustenance of the health of a typical community. The course has both the theory and practice components. Some of the topics to be covered include distinguishing from public and community health, community dynamics, health promotion, primary health care, family health, population health issues, tools in community health nursing practice. You will have opportunities for practical application of the knowledge that you will acquire doing this course. The knowledge acquisition components will be done mainly using e-learning while practical session at the community level will be facilitated by appointed preceptors who will be working with you at the communities where you will have your practical life experiences.

COURSE OVERVIEW

Public-Community Health Nursing (P-CHN) is a specialized area of nursing practice with peculiar conceptual and theoretical underpinnings from basic life sciences, nursing theories and practice, public health sciences, community dynamics, and information communication

technology in modern times. The community health nurse draws on the knowledge from these diverse areas and develops competencies in health promotion, anticipates and works with communities to prevent and manage deviations from health of people/populations and facilitate community action for change. Public/Community health nursing recognizes the contextual contributions of individual, family, groups, community, social, economic, political dynamics to health as such get moderated by the biological and psychosocial environment. Public/Community health nursing (P/CHN) practice is implemented within group actions to improve the health status of the individuals and families and populations To be able to conduct appropriate assessment, make relevant diagnoses and implement relevant interventions to meet the health needs of the individual, family and community, the nurse in addition to acquiring sound knowledge in relevant subject areas must understand the basic principles and theories of community health nursing and must be able to apply nursing knowledge to resolve community health challenges and meet the needs of consumers of health throughout the life span. All Practical experiences in various community settings are essential component of this course to help learners experience the realities of the roles that community/public health nurses should play in assuring access to health and drive health promotion at the community level.

COURSE OBJECTIVES

At the completion of this course, you should be able to:

1. Explain the context of a community.
2. Discuss the dynamics of community health.
3. Explain the dynamics of public and community health nursing nationally and internationally.
4. Discuss community health nursing process
5. Analyse the various roles that the community health nurse plays in meeting the health promotion, disease prevention, early diagnoses and management of common endemic diseases within the context of primary health care.
6. Discuss relevant theories and frameworks that are applicable in community health nursing practice.
7. Apply the concept of health promotion and other theories in service planning for community health promotion.
8. Utilize relevant tools in information management and service delivery planning and implementation at the community level.

9. Apply the knowledge and skills acquired in conducting community health assessment, plan and implement jointly planned intervention with community members to achieve set goals and objectives.

DOING THE COURSE

The course will be delivered adopting the blended learning mode. You will have hard and soft copies of course materials, you will also have online interactive sessions, face-to-face sessions with instructors and preceptors in clinical/community sites and very limited campus face-to-face activities. The interactive online activities will be available to you on the course link on the Website of NOUN. There are activities and assignments online for every unit every week. It is important that you visit the course sites weekly and do all assignments to meet deadlines and to contribute to the topical issues that would be raised for everyone's contribution.

You will be expected to read every module along with all assigned readings to prepare you to have meaningful contributions to all sessions and to complete all activities. There will be opportunities for group work, case analysis and presentations. In this course, you will need to report some of your real life experiences working with people at the community level for health promotion activities. We would also learn how to do academic critiquing of each other's work, as individuals and groups, in professional manners demonstrating high level of respect and efforts to help each other grow. We would demand that you recognize cultural diversity and respect cultural differences and treat your classmates, facilitators, preceptors and community members with respect and dignity.

COURSE REQUIREMENTS AND EXPECTATIONS OF YOU

Attendance of 95% of all interactive sessions, submission of all assignments to meet deadlines; participation in all CMA, attendance of all clinical/community postings with evidence as provided in the log book, submission of reports from all clinical postings and attendance of the final course examination. You are also expected to:

1. Be versatile in basic computer skills.
2. Participate in all field experiences and attend all teaching and practice sessions up to 95%.
3. Submit personal reports from field experiences on schedule.
4. Log in to the class online discussion board at least once a week and contribute to ongoing discussions.

5. Contribute actively to group seminar presentations.

EQUIPMENT AND SOFTWARE NEEDED TO ACCESS COURSE

You will be expected to have the following tools:

1. A tablet
2. Internet access, preferably broadband rather than dial-up access
3. MS Office software – Word PROCESSOR, Powerpoint, Spreadsheet
4. Browser – Preferably Internet Explorer, Moxilla Firefox
5. Adobe Acrobat Reader 8

NUMBER AND PLACES OF MEETING (ONLINE, FACE-TO-FACE, CLINICAL POSTINGS)

The details of these will be provided to you at the time of commencement of this course

DISCUSSION FORUM

There will be an online discussion forum and topics for discussion will be available for your contributions. It is mandatory that you participate in every discussion every week. You participation link you, your face, your ideas and views to that of every member of the class earns you some mark.

COURSE EVALUATION

There are two forms of evaluation of the progress you are making in this course. The first are the series of activities, assignments and end of unit, computer or tutor marked assignments, community posting experience and report that constitute the continuous assessment that all carry 40% of the total mark.

Take note - Field Experiences: You will be expected to gain experience in community assessment, planning and mobilization for action and will be expected to work with community organs, to resolve jointly identified health challenges in the community but you will do this as a group. You will be assigned to groups and will be expected to share your experiences in seminar presentations. Reports of the field experiences with evidences, will be graded along with seminar presentations for the group. Every student

will be expected to present 2 case studies of families worked with in the community of posting with evidence (photographs taken with family members during sessions with permission formally taken from relevant persons).
The second is a written examination with multiple choice, short answers and essay questions that take 60% of the total mark that you will do on completion of the course.

Learner-Facilitator-Community evaluation of the course
This will be done through group review, written assessment of learning on the field; teacher-learner joint review of experiences, community members assessment of contribution/benefit from being part of the course and activities at the community level.

GRADING CRITERIA

Grades will be based on the following Percentages:

Tutor Marked Individual Assignments		10%	
Computer marked Assignment		10%	
Group assignment	5%		40%
Discussion Topic participation		5%	
Clinical/Community Postings		10%	
End of Course examination	60%		

GRADING SCALE

A = 70-100
B = 60 - 69
C= 50 - 59
F = < 49

COURSE REQUIREMENTS AND EXPECTATIONS

Pre-requisite Courses
NSC 202 Physical and Health Assessment
NSC 217 Epidemiology
NSC 218 Environmental Health

CONCURRENT COURSES

NSC 327 Concepts and Strategies in Public/Community Health Nursing
NSC 302 Nutrition in Health and Disease

NSC 341 Health Statistics
NSC 320 Nursing Ethics and Jurisprudence
NSC 322 Medical Surgical Nursing II
NSC 326 Clinical Pharmacology and Chemotherapy

COURSE MODE – BLENDED (70% online class sessions; 30% practical of face-to-face working with preceptors)
Online: Students to register for course as indicated by the School of Science and Technology Website

SITES OF PRACTICAL - As would be specified at the time of registration for the course.

MODULE 1 INTRODUCTION TO PUBLIC/COMMUNITY HEALTH NURSING

UNIT 1 CONCEPT OF COMMUNITY

CONTENTS

1.0 INTRODUCTION

Public health nursing is community-based and, most importantly, it is population-focused. It is a sub-speciality in nursing that has the potential to shape the quality of community health services and improve the health of the general public. As a community/ public health nurse your care involves going into the community (homes, schools, recreational facilities, work settings, parishes, and even street corners) that are common place to your clients and the place might be unfamiliar to you. The community has been described as one of the most fruitful areas for improving the health of the people. It is a fact that social, physical and cultural aspects of the community have a major influence on an individual's health status. The duty of community/public health nurse include: assessment, planning, teaching, coordinating, evaluating and referring. For effective discharge of your duty you must possessed critical thinking skill. In public/community

health nursing practice care is not only rendered to individual but also to family and community at large.

2.0 OBJECTIVES

At the end of this unit you should be able to:

- define community and identify the types of communities
- identify the functions of a community
- describe the characteristics of a community
- identify types of communities
- describe the communities that have relevance to community health practice.

3.0 MAIN CONTENT

3.1 Definition of a Community

Community suggest a shared pattern of feelings, behaviours, and lifestyle together with close and frequent personal relationship with one another (Little Wood, 1985). Human beings are social creatures. All of us, with rare exception, live out our lives in the company of other people. "In sociology, the concept of community has led to significant debate, and sociologists are yet to reach agreement on a definition of the term. There were ninety-four discrete definitions of the term by the mid-1950s. Traditionally a "community" has been defined as a group of interacting people living in a common location. The word is often used to refer to a group that is organized around common values and is attributed with social cohesion within a shared geographical location, generally in social units larger than a household. The word can also refer to the national community or global community.

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The word "community" is derived from the Old French communité which is derived from the Latin communitas (cum, "with/together" + munus, "gift"), a broad term for fellowship or organized society." (http://en.wikipedia.org/wiki/Community)

"**Community**: The origin of the word "community" comes from the Latin munus, which means the gift, and cum, which means together, among each other. So community literally means to give among each other." (http://www.seek2know.net/word.html)

Ultimately, there are different meanings of community depending on the perspective you are looking. From one perspective, the term ***community refers to a collection of people who interact with one another and whose common interests or characteristics form the basis for a sense of unity or belonging.*** It can be a society of people holding common rights and privileges (e.g., citizens of a town), sharing common interests (e.g., a community of farmers), or living under the same laws and regulations (e.g., a prison community).

However, most of the meaning of '***community has to deal with people dwelling together; it means an organization of human beings framed for the purposes of serving together. The concept of community holds that a group of interactingorganisms that share an inhabited setting may form a unit with a sense of belonging.*** Human communities may have common beliefs, preferences, needs, threats and a number of other entities that influence the livelihood of the members.

A community could also be a collection of interdependent people with residential ties to specific localities. The term 'community' denotes almost uniformly and permanently shared lives of people over a definite region. It can also be considered as a permanent local aggregation of people having diversified as well as common interests and served by a constellation of institutions. An individual from a geographically identified city might be a member of many overlapping communities, such as professional societies, a political party, a religious group, a cultural society, a neighbourhood, and the city itself. Even those who try to escape community membership always begin their lives in some type of group, and usually they continue to depend on groups for material and emotional support. Communities are an essential and permanent feature of the human experience. A community can refer to the context or arena in which change operates, or it can be the source of environmental or social factors viewed as less than desirable. Community is a collection of people who share some important feature of their lives. A community consists of a collection of people located in a specific place and is made up of institutions organized into a social system. The function of any community includes its members' collective sense of belonging and their shared identity, values, norms, communication, and common interests and concerns (Anderson & McFarlane, 2004).The communities in which we live and work have a profound influence on our collective health and well-being (World Health Organization [WHO], 2006a). for example, a tiny village are composed of people who share almost everything. They live in the same location, work at a limited type and number of jobs, attend the same churches, and make use of the sole health clinic with its visiting physician and nurse. Other communities, such as members of Mothers

Against Drunk Driving (MADD) or the community of professional nurses, are large, scattered, and composed of individuals who share only a common interest and involvement in a certain goal, although most communities of people share many aspects of their experiences.

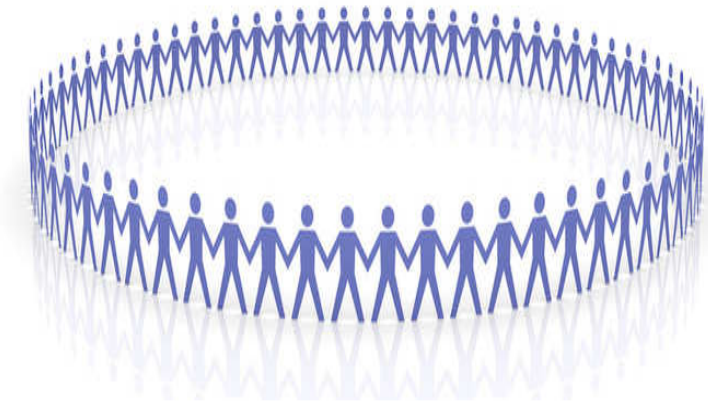

Figure 1 – Community as a group of people adopted from http://www.photo-dictionary.com/photofiles/list/3796/5114community.jpg

Community has been defined in many ways and below are some of the definitions:

"Community is a group of people who live together, who belong together, so that they share, not ties or that particular interest, but as a whole set of interest, wide enough and complete enough to include their lives." He included in "community" small aggregation such as villages, and large ones, such as cities, tribes and nations" (Maclver).

"A community may be defined as a permanent local aggregation of people having diversified as well as common interest and served by a constellation of institution." (Lumbi).

"A community is a unit of territory within which is distributed a population which possessed the basic institutions in their simple and more specialized form by means of which a common life is made possible." (Dawson and Gettys).

Sutherland defines 'community' as a local area over which people are using the same language, conforming to the same feelings, more or less the same sentiments and acting upon the same attitude. This means community is a

social group of any sizes whose members reside in a specific locality, share a government and have a common cultural and historical heritage.

World Health Organization defines 'community' as a social group determines by geographical boundaries and /or common values and interests. Its members know and interact with each other. It functions within a particular social structure and exhibits and creates certain norms, values and social institution.

Sanders viewed community in three ways: as a place, as a social system, as a collection of people.

1. It is a place then the environment, housing, transportation etc., are all related to geographical location, as are population composition and distribution, health services, resources and facilities.
2. It is a social system because actually, community is a combination of all the social units and systems which has been developed to carry out its major functions with its pattern of interactions.
3. It is a collection of people, where the health workers will find both individual who are well (healthy) and who are ill (unhealthy).

3.2 Functions of Community

The community is basically the medium for the development of its inhabitant. It provides ways whereby the community imposes its expectations on the inhabitants. The environment of the home or neighbourhood is influence by the character of the community which in turn influences the outcome of the community. Subsequently, a community is judged by the kind of people it produces.

Warren (1987) described five main functions of a community. These include Production – distribution – consumption; Socialization; Social control; Social participation and Mutual support.

i. Production, distribution and consumption of goods and services provide for the economic needs of the members of the community. It includes not only the supplying of food and clothing but also the provision of water, electricity and fire protection and the disposal of refuse. In this function a community is usually interdependent with other communities and with business and organisations outside the boundaries.

ii. Socialization is the process of transmitting values, knowledge, culture and skills to others. Communities usually contain a number of established institutions like families, churches, mosques, schools, media, voluntary and social organizations and so on. These institutions contribute to the upbringing of the members of the community.

iii. Social control this refers to the way order is maintained in the community. Laws are enforced by the police; public health regulations are implemented to protect people from certain diseases. Social control is also exerted through the family, religious institutions and schools.

iv. Social inter-participation or community participation is refers to community activities that are designed to meet people's needs for companionship. Families and religious institutions have traditionally met these needs; also many public and private organizations also serve this function.

v. Mutual support refers to community ability to provide resources at time of illness and disaster. Although the family is usually relied on to fulfil this function, health and social services may be necessary to augment the family's assistance if help is required over an extended period.

In short the functions of a community can be summarized as:

1. Determining the use of space for living and other purposes.
2. Making available the means for production and distribution of necessary goods and services.
3. pProtecting and conserving the health, life resources and property of individuals
4. Educating and acculturating newcomers, i.e. children and immigrants
5. Transmitting information, ideas and beliefs
6. Providing opportunities for interactions between individuals and groups

3.3 Characteristics of a community

There is no community that is self-sufficient because the character of today community is very complex. Politically, socially and economically no community can be self-sufficient in any way. The basic characteristics of a community are as follows:

(1) Group of people: A group of people is the most fundamental or essential characteristic of a community. This group may be small or large but community always refers to a group of people. Because without a group of people we can't think of a community, when a group of people live together and share a common life and bonded by a strong sense of community consciousness at that moment a community is formed. Hence a group of people is the first pre-requisites of community.

(2) Territorial character: A community is a territorial group and that is why a group of people alone can't form a community. A community is always considered in relation to a physical environment of a territory. A group of people forms a community only when they reside in a definite territory. This characteristic is most marked in the case of primitive communities which consisted of a small clearly defined group of individuals relatively independent of the other communities for the good required by the prevailing standards of life and also territorial distinction of such communities very marked. A group of people like nomadic people may change their habitations. But majority communities are settled and a strong bond of unity and solidarity is derived from their living in a definite locality.

(3) Home instinct of special attachment: Home instinct in a sense it lays the foundation of our attachment to a particular house, community or nation itself. When people live together for some time uniformity in the mode of their lives takes place by their daily interactions. These bring about a strong sense of awe feeling among the members or a feeling of belonging together which some author referred sentiment of common living that exists among the members of a locality. These relationships bring about those social impulses which manifest themselves and get in course of time related to the community environment and then determine its external structure which distinguishes them from the members of other community.

(4) Naturality: Communities are naturally organized. It is neither a product of human will nor created by an act of government. It grows spontaneously. Individuals became the member by birth.

(5) Common life: It is a fact that the life of the people in a community is near about the same. Due to their inhabitation on a particular geographical area, they develop a kind of emotional and cultural uniformity. Community is an outcome of the social uniformity among individuals and is never formed with a particular aim. It becomes an association the moment a community is formed with any particular aim.

(6) Community-feeling: the external structure of a community is mainly the expression of social impulses which a particular locality sets into play. Thus, the psychological feelings of a community are more important than the physical appearances. For instance, whenever human beings are thrown together or separated in whole or in part from the world outside so that they must live their lives in one another's company. The effects of these social impulses bring men into community which is referred to the formation of 'community sentiment'. This process is not only involves physical factors alone but also involve psychological factors like hopes, aspirations and destinies may also become important demarking factors. The psychological sentiment of a community is a complex of a various attitudes and emotions and this complex is formulated and developed by the process of socialization. Its first acts by ways of compulsion but when the initial period of an individual is over, the community feeling becomes a part of his integrated personality and community sentiment becomes a part of his emotional build up. For instance when an individual early training period is over, community sentiment is not an outer compulsion but an inner necessity always a part of his individual. Even when he revolts against some of its code, as he often does, he still belongs in feeling to some community. He cannot escape the impact of a socializing experience found wherever man has built a common life.

(7) Permanence: communities are never formed with any particular aim and object as associations are formed. It is not temporary like that of a crowd or association. Community is always a permanent group because it has developed itself. The proof of this assertion lies in the existence of age-old communities in the modern era.

(8) Feeling of oneness: The members of a community are similar in a number of ways. As they live within a definite locality they lead a common life and share some common ends. Among the members similarity in language, culture, customs, and traditions and in many other things is observed. Similarities in these respects are responsible for the development of community sentiment.

(9) Role feeling: one dominant characteristic of human nature is the sense of satisfaction in life. People want to play a definite role in the reciprocal exchange of the community. Generally this process of role finding involves a sub-ordination of our personal interest and aims, if not completely to those of the community as a whole. This factor helps the functional harmony of the community and at the same time weaves the personalities of the members into a mutually balancing system.

(10) Wider Ends: A community has wider ends. Members of a community associate not for the fulfillment of a particular end but for a variety of ends. These are natural and not artificial.

(11) Dependency feeling: Human beings feel a sense of dependency right from birth. The dependency feeling involves both a physical dependency and psychological dependency for his material want as well as emotional wants

(12) No Legal Status: A community has no legal status because it is not a legal person. It has no rights and duties in the eyes of law. It is not created by the law of the land.

(13) Spontaneous growth: No community ever comes into existence with the making by a certain group or some committee, but every community grows its self-spontaneous. A kind of natural automatic force acts behind the origin and development of communities. Various factors like customs, conventions, religious beliefs bind the individual together.

(14) A Particular Name: Every community has a particular name unlike society because community is the group of people living at some particular place with common culture. Community is always known with a particular name by which it is known to the world and members of a community are also identified by that name.

3.4 Characteristics of a Healthy Community

Healthy communities impact the health of their populations. Just as health for an individual is relative and will change, all communities exist in a relative state of health. A community's health can be viewed within the context of health being more than just the absence of disease, and including things that promote the maintenance of a high quality of life and productivity.

A healthy community is defined as one that "continuously creates and improves both its physical and social environments, helping people to support one another in aspects of daily life and to develop to their fullest potential" (CDC, 2009). Another description of a healthy community, first

described by Cottrell (1976) as a competent community, is one in which the various organizations, groups, and aggregates of people making up the community do at least four things:

- They collaborate effectively in identifying the problems and needs of the community.
- They achieve a working consensus on goals and priorities.
- They agree on ways and means to implement the agreed-on goals.
- They collaborate effectively in the required actions.

World Health Organization (2009) defined a healthy community as "one that is continually creating and improving those physical and social environments and expanding those community resources that enable people to mutually support each other in performing all functions of life and in developing their maximum potential"

The ten basic characteristics of a healthy family are as follows:

1. The physical environment is clean and safe.
2. The environment meets everyone's basic needs.
3. The environment promotes social harmony and actively involves everyone.
4. There is an understanding of the local health and environment issues.
5. The community participates in identifying local solutions to local problems.
6. Community members have access to varied experiences, interaction and communication.
7. The health services are accessible and appropriate.
8. The historical and cultural heritage is promoted and celebrated.
9. There is a diverse and innovative economy.
10. There is a sustainable use of available resources for all.

3.5 Types of Communities

There are different types of communities but those discuss in this study materials are those that are relevance to community health practice. For instance an individual can belong to several different communities at the same time; e.g. a faith community, a business community and a neighbourhood community.

i) **Geographic communities**: shared physical space, so that residents come into contact with each other by virtue of proximity, rather than intent. A community often is defined by its geographic boundaries

and thus is called a geographic community. A city, town, or neighbourhood is a geographic community. However, to be a "real" community, residents must feel a sense of belonging and hold at least some values and symbols in common. For example, a feature of the natural landscape, such as a river, that is important to many, or a local claim to fame; such as an internationally known theatre company. In geographic communities how power is distributed has a significant impact on how the community develops.

Consider any community around its located within a city. The community is set in the city environment, far removed from any urban centre and in a climatic zone different. With a population of approximately 15000 to 2,4000 as the case may be, such community is considered as a rural community. The population has certain identifiable characteristics, such as age and sex ratios, and its size fluctuates with the seasons: summers bring hundreds of seasonal residents. The families, schools, clinics, churches, mosques, stores, and government institutions are linked in a complex network. This community, like others, has an informal power structure. It has a communication system that includes gossip and may be the “co-op” store bulletin board as the case may be. In one sense, then, a community consists f a collection of people located in a specific place and is made up of institutions organized into a social system. Local communities such as Imesi-Ile in Osun State of Nigeria vary in size.

Around this local community are several other communities, like Otan-Ile, Ilare, Ijebu-Ijesha along with other towns and isolated farms, form a larger community called Ibokun Local Government. If a nurse worked for a health agency serving only Imesi-Ile, that community would be of primary concern; however, if the nurse worked for the Ibokun Local Government, this larger community would be the focus.

A public health nurse employed by the State Health Department of Osun State would have an interest in in Ibokun Local Government and Imesi-Ile, but only as part of the larger community of Osun State. Frequently, a single part of a city can be treated as a community. Cities are often broken down into census tracts, or neighborhoods.

Benefits of Geographical Community

A community demarcated by geographic boundaries, such as a city or community, becomes a clear target for the analysis of health needs.

Available data, such as morbidity and mortality figures, can augment assessment studies to form the basis for planning health programs.

Media campaigns and other health education efforts can readily reach intended audiences. For example distributing educational information on safe sex, self-protection, the dangers of substance abuse, or where to seek shelter from abuse and violence.

A geographic community is easily mobilized for action. Groups can be formed to carry out intervention and prevention efforts that address needs specific to that community. Such efforts might include: shelters for battered women, work site safety programs in local hazardous industries, or improved sexuality education in the schools.

Health actions can be enhanced through the support of politically powerful individuals and resources present in a geographic community.

On a larger scale, the world can be considered as a global community. Indeed, it is very important to view the world this way. Borders of countries change with political upheaval. Communicable diseases are not aware of arbitrary political boundaries. A person can travel around the world in less than 24 hours, and so can diseases. The world is one large community that needs to work together to ensure a healthy today and a healthier and safer tomorrow.

ii) Communities of interest: are sometimes referred to as "communities within communities". A collection of people, even if they are widely scattered geographically, can have an interest or goal that binds the members together. Members of these communities choose to associate with each on the basis of a common interest. The members of an international nursing professional organization and women who have had mastectomies are all common-interest communities. Sometimes, within a certain geographic area, a group of people may develop a sense of community by promoting their common interest. Disabled individuals scattered throughout a large city may emerge as a community through a common interest in promoting adherence to federal guidelines for wheelchair access, parking spaces, toilet

facilities, elevators, or other services for the disabled The residents of an industrial community may develop a common interest in air or water pollution issues, whereas others who work but do not live in the area may not share that interest. Communities form to protect the rights of children, stop violence against women, clean up the environment, promote the arts, preserve historical sites, protect endangered species, develop a smoke-free environment, or provide support after a crisis.

Benefits of Communities of Interests
These kinds of shared interests had lead to the formation of communities widely.

Common-interest communities whose focus is a health-related issue can join with community health agencies to promote their agendas and provide solution to any of their agitations.

They can mobilize force for action in time of crises.
Many successful prevention and health promotion efforts, including improved services and increased community awareness of specific problems, have resulted from the work of common interest communities.

iii) **Community of solution**: This is a type of community encountered frequently in community health practice in which a group of people come together to solve a problem that affects all of them. The shape of this community varies with the nature of the problem, the size of the geographic area affected, and the number of resources needed to address the problem. For example, a water pollution problem may involve several communities whose agencies and personnel must work together to control upstream water supply, industrial waste disposal, and city water treatment. This group of communities forms a community of solution focusing on a health problem. In another instance, several schools may collaborate with law enforcement and health agencies, as well as legislators and policy makers, to study patterns of substance abuse among students and design possible preventive approaches. In recent years, communities of solution have formed in many cities to attack the spread of HIV/AIDS, and have worked with community members to assess public safety and security and create plans to make the community a safer place in which to live.

4.0 CONCLUSION

Traditionally a "community" has been defined as a group of interacting people living in a common location. The word is often used to refer to a group that is organized around common values and is attributed with social cohesion within a shared geographical location, generally in social units larger than a household.

5.0 SUMMARY

This unit deals with definition of community, functions of community, characteristics of community, characteristics of a healthy community and finally types of community that are relevance to community health practice.

Unit 1 is an introduction to concept of Community and its relevance to community health nursing. This unit enables the nurse to have an understanding of community as a concept and the influence of the community to community health practice.

TUTOR-MARKED ASSIGNMENT

Identify a small community near your place of abode and share the characteristics of such communities with colleagues in the online discussion forum. Use the knowledge you have acquired to present the characteristics of the community and justify whether the community you have chosen is healthy or not by documenting the facts that confirm the state.

SELF ASSESSMENT EXERCISE

Fill in or tick the correct options appropriate for the questions below (LO (i)

1. A community is _____

2. Tick the correct options

A community may be defined based on (a) geographical location _____(b) common interest _____ (c) language _____ (d) share the same government _____(e) common culture _____ (f) common historical heritage _____

Answer True (T) or False (F)

A community is a social system _____

The hospital is a community _____

A community comprises individuals from different towns _____

3. Define community and identify the types of communities

4 .Identify the functions of a community
5. Describe the characteristics of a community
6. dentify types of communities
7. Describe the communities that have relevance to community health practice

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UNIT 2 NATURE OF HEALTH AND BEHAVIOURAL DIMENSIONS OF HEALTH MANAGEMENT FROM COMMUNITY PERSPECTIVES

CONTENTS

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1.0 INTRODUCTION

Health in the abstract refers to a person's physical, mental and spiritual state; it can be positive as being in good health or negative as being in poor health. It can be viewed as an important resource both of individuals and communities. Health is widely accepted as desirable, although the exact nature of health is often unclear and ambiguous. Community health practitioners placed emphasis on wellness which was included in the WHO definition of health which we will see shortly. Health can also be seen as presence of a positive capacity to develop one's potential and to lead an energetic, fulfilling and productive life. Understanding health holistically there is needs to recognise the relationship of health to environment. There is an increasing awareness of the strong relationship of health to environment although this is not a new concept. Almost 150 years ago, Florence Nightingale explored the health and illness connection with the environment. She believed that a person's health was greatly influenced by ventilation, noise, light, cleanliness, diet, and a restful bed (Allender, Rector and Warner, 2014).

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2.0 OBJECTIVES

At the end of this unit you should be able to:

- describe the concept of health
- explain the various models of health
- describe wellness and well-being.

3.0 MAIN CONTENTS

3.1 Concept of Health

Health is a state of well-being of an individual or community. Individual has different perspective of health and different experts view health according to their own field of interest. Health is a dynamic state in which the person is constantly adapting to change in the internal and external environment.

Generally people describe health as good even when they may have one or more diagnosed ailment. Health is refers to being fit and that means ability to fulfil activity of daily living that are both necessary and desirable. The only acceptable definition of health widely known is the definition given by World health organization (WHO) which state as a The World Health Organization (WHO) defines health positively as "a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity". Health, in this perspective, refers to a holistic state of wellbeing, which includes soundness of mind, body, and spirit. This definition showed that physical health implies a mechanistic functioning of the body; mental health is the ability to think clearly and coherently and ability to deal with one challenge while social health is the ability to make and maintain relationship with others and interact well with people and the environment. WHO definition of health also see health as an absolute or ultimate state, however, all individuals cannot achieve the same level of health because of innate differences for instance people born with severe physical and mental limitation. This further shows that the WHO definition of health is unattainable goal.

Factors Influence an Individual's Definition of Health

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Developmental status: the idea of health to an individual depends on the person's level of development. The ability of the individual to conceptualise a state of health and also respond to changes in health are

directly related to his/her age. The nurse's knowledge of an individual's developmental status can facilitate assessment of the appropriateness of the person behaviour and help anticipate future behaviour.

Social and cultural influence: cultural and social interactions influence a person's notion of health. Each culture has ideas about health and these are often transmitted from parent to children.

Previous experiences: individual perception of health sometimes depend on his/her experiences with health and illness. For example pain or dysfunction can be seen as normal because the individual has previously experience it. Knowledge gained from these past experiences helps determine people definition of health.

Expectation of self: some people define health as the ability to function physically and psychosocially at a high level always. Perceived alteration in this level of functioning is seen as illness by some people whereas, others expect variation in their performance level and their definition of health accommodates those variations.

Nurses should be aware of their own personal definitions of health and should appreciate that other people have their own definitions as well. Individual definition of health influences behaviour related to health and illness. Nurses understanding of client's perception of health and illness will make them render care that will make the client attain optimal health.

3.2 Health and the community

There is an increasing awareness of the strong relationship of health to environment. Health can be viewed as an important resource, both for individuals and communities.

It is man's greatest possession as is formed his basis of living. Good health is important for economics and technological growth and development. A healthy community is the infrastructure upon which economical viable of the society is built. Good health is prerequisite to human productivity and development. Good health lies in recognizing that each of us is part of a wider web of life. No one person or community is an independent entity. Each is intimately linked to the environment, frequently in ways we have never imagined. Consequently, environment influences health, directly and indirectly. Conversely, human activities affect the health of the environmental system. This is not a new concept as Florence Nightingale explored the health and illness connection with the environment. She

believed that a person's health was greatly influenced by ventilation, noise, light, cleanliness, diet, and a restful bed.

One of the focuses of community health nursing is to maintain equilibrium between man and environment as National health promotion and diseases prevention objectives include: reducing preventable death and disability nationwide, enhancing quality of life and greatly reducing disparities in the health status of populations. This calls for a shift in focus from treating preventable illness and functional impairment to making resources available for promoting health, preventing disease and disability. Presently it is not only possible to promote health, preventing disease and disability, but it is mandatory and our responsibility to do so. Healthy people make healthy communities and a healthy society.

3.3 Models of health

A model or paradigm is an abstract outline or theoretical interpretation of a complex phenomenon. There are various models to explain health and in some instances its relationship to illness or injury.

1. The clinical model: this model view health as the absence of physiological disease or the absence of disequilibrium. This model sees persons healthy when there is no manifestation of disease. It is a state of not being 'sick'. This model was described by Dunn as a relatively passive state of freedom illness and a condition of relative homeostasis. Medical science identified health as absence of signs and symptoms of disease and many medical practitioners used this model. The focus of medical practice is the relief of signs and symptoms of disease and the elimination of malfunctioning and pain. Medical practitioners considers a person health restored when the signs and symptoms is no longer present. In this model health is motivated by the absence of diagnosable disease. In this model client may say if I eat better I can avoid getting a heart attack. Nursing responsibility is to conduct routine health screening to foster early detection of disease and stress the need for health promoting behaviour that may prevent the onset of disease
2. The role performance model: this model combines social and psychological standards to the concept of health. It defined health as individual ability to fulfil societal roles. In this model if the individual cannot perform the societal role expected, it means he/she has illness even if he is clinically healthy. Illness is determined by the capacity to function and to perform ones daily activities. For instance a man who works all day at his job as expected is healthy

even though an X-ray film of his lung indicates tumour. The problem of this model is the assumption that a person's vital role is the work roles. In this model health is motivated by being able to fulfil responsibilities as work, home, community. Client may make statement like as long as I can work and fulfil my obligation to my family, work and community, I consider myself healthy. Nursing role here is to reinforce influence of health promotion and risk reduction behaviours on ability to fulfil role expectations.

3. The adaptive role: this model incorporates both the clinical and role performance model. Individuals are actively and continually adapting to their environment. It's become necessary for individual to have sufficient knowledge to make informed choices about their health and also the income and resources to act on choices. The model believes that complete well being is unobtainable. Health is perceived as a condition in which the person can engage in effective interaction with the physical and social environment. There is an indication of growth and change in this model i.e., health is a state of well being in which the person is able to use purposeful, adaptive responses and processes, physically, mentally, emotionally, spiritually and socially in response internal and external stimuli (stressors) in order to maintain relative stability and comfort and to strive for personal objectives and cultural goals. This model defined health as the ability to interact effectively within the physical and social environment. The disease state represents a failure in adaptation and ineffective coping with environmental changes. The client statement may be 'I get sick when I am no longer able to cope with the stresses in my environments'. The nursing response is to explore with client lifestyle or environmental changes that can be made protect health and reduce the risk of illness.
4. Eudaemonistic model: Eudaemonistic is a term derived from Greek word 'Eudemon' meaning 'fortunate or 'happy'. The eudaemonistic perspective defines health as the realization of one potential for complete development. Actualization is the apex of the fully developed personality. The highest aspiration of people according to this model is fulfilment and complete development i.e. actualization. In the words of Dubos (1978), health is a primarily the measure of each person's ability to do what he want to do and become what he want to become. Illness in this model is conditions that prevent self-actualization. According to eudaemonistic model health is motivated by joy, self-fulfilment, client statement in this model will be to be healthy is to realize my full potential. The nursing response is to explore with client health promoting behaviours such as diet,

exercise etc that foster self-esteem and a sense of personal accomplishment.

3.4 Wellness and Well-Being

Wellness aimed at achieving physical, emotional, intellectual, spiritual and environmental well-being. Dunn (1977) described wellness as an integrated method of functioning which is oriented towards maximizing the potential of which the individual is capable within the environment where he is functioning. Dunn in 1959 differentiate good health from wellness: good health can exist as a relatively passive state of freedom from illness in which the individual is at peace with his environment i.e. a state of relative homeostasis while wellness is an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable within the environment where he is functioning. Wellness is difficult to quantify for objective evaluation although the following indications can be use:

i. The capacity of the person to perform to the best of his ability
ii. The ability to adjust and adapt to varying situations
iii. A reported feeling of well-being
iv. A feeling that everything is together and harmonious

Wellness, health, and illness are dynamic processes that changes with time and social pattern hence continuous evaluation is necessary. The wellness process can be pursued to: prevent illness; assist in rehabilitation, enhance the quality of life and to maximize one's potential.

Well-being
Well-being is a subjective perception of balance, harmony and vitality (Leddy and Peper 1989). According to Leddy and Peppper well-being can be described objectively and measured. Well-being occurs in levels as having the highest level of well-being at the top of a plus 3 scale and this is when a person feels satisfied and have a sense of contributing while the lowest levels is when an individual sees himself as ill and may place their state of well-being at the bottom of a minus 3 scale. Health which encompasses well-being, illness, disease and non-disease is an evolving potential that cannot be quantified.

4.0 CONCLUSION

Health is a dynamic state in which the person is constantly adapting to change in the internal and external environment.

5.0 SUMMARY

This unit deals with concept of health, health and the community, models of health,well-ness and well-being. Unit 2 deals with nature of Health and behavioural dimensions of health management from community perspectives. This unit enables you to have an understanding of concept of health, wellness and well-being, illness and disease in order to provide appropriate care to an individual, family and community at large.

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TUTOR-MARKED ASSIGNMENT

Online discussion: Give your own definition of health and what informed your definition
Check your portal for your assignment
Assignment:
Search for five other experts' views on health

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UNIT 3 CONCEPT OF PUBLIC AND COMMUNITY HEALTH NURSING

CONTENTS

1.0 INTRODUCTION

As a specialty field of nursing, community health nursing adds public health knowledge and skills that address the needs and problems of communities and aggregates and focuses care on communities and vulnerable populations.

Public health nursing is grounded in both public health science and nursing science, which makes its philosophical orientation and the nature of its practice unique. Community health nursing, then, as a specialty of nursing, combines nursing science with public health science to formulate a community-based and population-focused practice (Anderson & McFarlane, 2012). “Public health nursing is the practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences” (ANA, 2007, p. 5). Community health nursing practice has adapted to accommodate the needs of a changing society, yet it has always maintained it initial goals of improve community health. Community health nurses provide care to individuals, families and communities. They are committed to social justice, health promotion, health protection, disease prevention and facilitation of healing. Public health nurses integrate community involvement and knowledge about the entire population with personal, clinical understandings of the health and illness experiences of individuals and families within the population. They translate and articulate the health and illness experiences of diverse, often vulnerable individuals and families in the population to health planners and

policy makers, and assist members of the community to voice their problems and aspirations.

2.0 OBJECTIVES

- define community health nursing
- define public health nursing
- explain the characteristics of community health nursing
- describe the historical antecedents of public and community health nursing practice internationally and nationally.

3.0 MAIN CONTENTS

3.1 Concept of Community and Public Health Nursing

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During the first 70 years of the 20th century, community health nursing was known as public health nursing. The PHN section of the American Public Health Association's definition of a public health nurse is a "nursing professional with educational, preparation in public health and nursing science with a primary focus on population-level outcomes" and notes the primary focus for public health nursing is to "promote health and prevent disease for entire population groups" (1996, p. 2). The later title of community health nursing was adopted to better describe where the nurse practices Community health nursing is a synthesis of nursing practice and public health practice applied to promoting and preserving the health of populations. The community health practice is general and comprehensive; it is not limited to a particular age group or diagnosis it is continuing and not episodic. The dominant responsibility is to the population as a whole, nursing directed to individuals, families or groups, contribute to the health of the total population. Health promotion, health maintenance, health education and management as well as coordination and continuity of care are utilized in a holistic approach to the management of the health care of individuals, families and groups in the community (American Nurses Association, 1980).

The primary purpose of community health nursing is to help determine the health needs of individuals, families and communities and to offer comprehensive quality of nursing services that will help them of attain, maintain and regain high level wellness. Community health nursing strives to meet this purpose by using systematic approach- the nursing process to meet the basic health needs of individuals, families and communities.

The terms community health nursing and public health nursing have different meanings. The term community health nursing is used to include the body of public health knowledge that is associated with the term public health nursing. There is a general believe that there is a significant difference in the scope of practice of community health versus public health nursing, i.e. community health nurses provide direct primary care in settings outside the health care institutions such as home, work places, clinics, schools, and/or recreational settings. In contrast public health nurses function in a community base setting established to address the health problems of specific identified population. The public health nurse engages in identifying high risk population and instituting programmes to prevent disruption, or if health has already been affected, to intervene as quickly as possible to reduce further illness or disability. The focus of community health nursing is the community; the direction and nature of nursing programme is shaped by the needs of the community as a whole and by the nature of the total community health efforts. Community health nurses as public health personnel are experts in health problem identification, disease and disability prevention and health promotion. Community health nursing require the integration of many general areas within nursing, such as the use of nursing process, interpersonal skills and leadership principles.

Public Health Nursing Section, American Public Health Association [1996] give the roles of public health nursing as follow:

1. Public health nurses integrate community involvement and knowledge about the entire population with personal, clinical understandings of the health and illness experiences of individuals and families within the population;
2. Public health nurses translate and articulate the health and illness experiences of diverse, often vulnerable individuals and families in the population to health planners and policy makers, and assist members of the community to voice their problems and aspirations.
3. Public health nurses are knowledgeable about multiple strategies for intervention, from those applicable to the entire population, to those for the family, and the individual.
4. Public health nurses translate knowledge from the health and social sciences to individuals and population groups through targeted interventions, programs, and advocacy.
5. Public health nursing may be practiced by one public health nurse or by a group of public health nurses working collaboratively. In both instances, public health nurses are directly engaged in the interdisciplinary activities of the core public health functions of assessment, assurance, and policy development. Interventions or

strategies may be targeted to multiple levels, depending on where the most effective outcomes are possible. They include strategies aimed at entire population groups, families, or individuals.

6. Public health nurses focuses on the prevention of illness, injury, or disability; the promotion of health; and the maintenance of the health of populations.

The basic concepts to the philosophy of community health nursing:

1. Everyone regardless of race, creed, sex or sexual preference has a right to good health and a long productive life
2. Everyone has some kind of health learning need
3. Some people and communities need help to recognise that they need assistance to regain, maintain or attain a high level of wellness.
4. There is a continuous search for new knowledge that serves current purposes. Thus, knowledge must have meaning
5. Health and health care enable a society to be productive and perpetuate culture, which affects the standard of living of its people
6. Health is only one of the competing values of people and thus holds a different place in their priority systems at different times
7. Humans are flexible and change with changing external and internal demands
8. Community health nursing accomplishes this goal of using systematic process
9. Different cultural groups, religious groups, and groups with different concepts and values of health
10. Overtime new health knowledge and technology evolve to meet changing health needs
11. Individual and community autonomy vary over time and place
12. Community health nursing remains an effective force in society by utilizing and participating in the development of health knowledge and technology.

3.2 Significance of Community Health Nursing

Community health nursing practice promotes and preserves the health of population by integrating the skills and knowledge relevant to both nursing and public health. Community health nursing practice is a systematic process by which:

i. The health and health care needs of a population are assessed in order to identify subpopulations, families and individuals who would

benefit from health promotion or who are at risk of illness, injury, disability or premature death

ii. A plan for intervention is developed with the community to meet identified needs that takes into account available resources, the range of activities that contribute to health and the prevention of illness, injury, disability and premature death.

iii. The plan is implemented effectively, efficiently and equitably

iv. Evaluations are conducted to determine the extent to which the interventions have an impact on the health status of the individuals and population

v. The result of the process are used to influence and direct the current delivery of care, deployment of health resources and the development of local, regional, state, and national health policy and research to promote health and prevent disease.

Public health nursing organization (1999) developed eight principles of public health nursing to advance the goal of promoting and protecting the public health. These set of principles define the uniqueness of population-based, community oriented practice carried out by public health and community health nurses. They reflect the uniqueness of community health nursing is related to its philosophy and scope of practice rather than the settings in which community health nurses function.

The following are the tenet of community health nursing:

i. Population-based assessment, policy development and assurance processes are systematic and comprehensive

ii. All processes must include partnering with representatives of the people

iii. Primary prevention is given priority

iv. Intervention strategies are selected to create healthy environmental, social, and economics conditions in which people can thrive

v. Community health nursing practice includes an obligation to actively reach out to all who might benefit from an intervention or service

vi. The dominant concern and obligation is for the greater good of all of the people or the population as a whole.

vii. Stewardship and allocation of available resources support the maximum population health benefit gain

viii. The health of the people is most effectively promoted and protected through collaboration with members of other professions and organizations.

The scope of community health nursing practice is broad and involves the continuum of preventive health services aimed at enhancing the health of individuals, families, groups and communities. Community health nurses place priority on primary prevention because the effective way to address community health problems is to prevent them from occurring. In providing preventive services to an individual's, the community health nurses view these services within the context of the family and the community, because the health of individuals can affect the health of families and communities.
WHO identified three necessary components of community health nursing to show the uniqueness of this nursing speciality (WHO, 1974):

- Community health nurses are responsible for ensuring that needed health services are provided in the community. This does not imply that the community health nurses provide all of these services. Rather it focuses attention on the need for nurses to participate in community assessment efforts that identify community health concerns and health planning activities that address community health problems
- The care of vulnerable groups in a community is a priority. A major reason for involvement in the health care of populations at risk is their vulnerability, the long involvement of community health nursing is the care of mothers, children and the disadvantaged groups is based on this belief
- The client (individual, family, group or community) must be a partner in planning and evaluating health care.
  Community health nurse collaborate with communities, families, individuals, other professionals, voluntary organization, self-help groups, informal health care providers, government and the private sector

3.3 Characteristics of Community Health Nursing

1. The client or "unit of care" is the population.
2. The primary obligation is to achieve the greatest good for the greatest number of people or the population as a whole.
3. The processes used by public health nurses include working with the client(s) as an equal partner.
4. Primary prevention is the priority in selecting appropriate activities.
5. Selecting strategies that create healthy environmental, social, and economic conditions in which populations may thrive is the focus.
6. There is an obligation to actively reach out to all who might benefit from a specific activity or service.

7. Optimal use of available resources to assure the best overall improvement in the health of the population is a key element of the practice.
8. Collaboration with a variety of other professions, organizations, and entities is the most effective way to promote and protect the health of people. (ANA, 2005)

SELF-ASSESSMENT EXERCISE

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What are the differences between hospital staff nurses and community health nurses?

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3.4 Historical antecedents of public and community health nursing practice internationally and nationally

Public and community health nursing has evolved nationally and internationally over the years. Public health nursing has encompasses continuous changes and adaptation since its inception in Europe, and more recently in America. Historically the summary of public health nursing made in the early 1900s still holds true: It is precisely in the field of the application of knowledge that the public health nurse has found her great opportunity and her greatest usefulness. In the nationwide campaigns for the early detection of cancer and mental disorders, for the elimination of venereal disease, for the training of new mothers, and the teaching of the principles of hygiene to young and old; in short, in all measures for the prevention of disease and the raising of health standards, no agency is more valuable than the public health nurse. (Central Hanover Bank and Trust Company, 1938, p. 8)

In tracing the development of public health nursing and, later, community health nursing Four general stages mark the development of community health/public health nursing internationally: (1) the early home care nursing stage, (2) the district nursing stage, (3) the public health nursing stage, and (4) the community health nursing stage. Based on these stages some literature used public health nursing and community health nursing interchangeably.

Early Home Care Nursing (Before Mid-1800s) women are called upon to attend to any member of family that is sick at home and this formed the model of community-based nursing. The focus of this care was to reduce suffering and promote healing. Early home-care nursing began with religious and charitable groups and during this period emergency care was also provided. For instance in 1244, a group of monks in Florence, Italy,

known as the Misericordia provided first-aid care for accident victims on a 24-hour basis and the Knights Hospitalers were warrior monks in Western Europe who provided protection and cared for pilgrims on their way to Jerusalem. The contributions of these men to the early practice of nursing have been long overlooked and lack of attention to these early works cause the notion that nursing is a woman profession. In Paris in 1617, St. Vincent de Paul started the Sisters of Charity, an organization composed of nuns and lay women dedicated to serving the poor and needy. The ladies and sisters, under the supervision of Mademoiselle Le Gras in 1634, promoted the goal of teaching people to help themselves as they visited the sick in their homes with aim of determining causes and solutions for clients' problems.

This laid the foundation for modern community health. Unfortunately, the years that followed these accomplishments marked a serious setback in the status of nursing and care of the sick. From the late 1600s to the mid-1800s, the social upheaval after the Reformation caused a decline in the number of religious orders, with subsequent curtailing of nursing care for the sick poor. Babies were delivered at home by self-declared midwives, most of whom had little or no training this resulted into high maternal mortality rates. This prompted the commencement of midwifery programme which begun in Paris 1n 1720 and another in London by Dr. William Smellie in 1741. The Industrial Revolution created additional problems; among them were epidemics, high infant mortality, occupational diseases and injuries, and increasing mental illness in both Europe and America.

Despite increased numbers of hospital and dispensaries in larger cities, disease was rampant; mortality rates were high; and institutional conditions, especially in prisons, hospitals, and "asylums" for the insane, were deplorable. The sick and afflicted were kept in filthy rooms without adequate food, water, cover, or care for their physical and emotional needs. During all these periods both Catholic and Anglican religious nursing orders were rendering care to the sick, poor in their homes. Women who are nurses are of low status and often the least respected, in 1844 Martin Chuzzlewit,Charles Dickens (1910) portrayed the nurseSairy Gamp as an unschooled and slovenly drunkard, reflecting society's view of nursing at the time. It was in the midst of these deplorable conditions and in response to them that Florence Nightingale began her work.

Her remarkable accomplishments laid the foundation for modern community health nursing practice. She worked with the soldiers during the Crimean War (1854–1856), her determination to serve the needy resulted in major reforms and improved status for nursingand she has been referred to

as a reformer, a reactionary, and a researcher. Her work further demonstrated that capable nursing intervention could prevent illness and improve the health of a population at risk—precursors to modern community health nursing practice.

District nursing (Mid-1800s to 1900): This is the next stage in the development of community health nursing, it was the formal organization of visiting nursing, or district nursing. The aim of the district nurse is to give first-rate nursing to the sick poor at home. In 1859, William Rathbone, an English philanthropist, became convinced of the value of home nursing as a result of private care given to his wife. He employed Mary Robinson, the nurse who had cared for his wife, to visit the sick poor in their homes and teach them proper hygiene to prevent illness. The need was so great that it soon became evident that more nurses were needed. In 1861, with Florence Nightingale's help and advice, Rathbone opened a training school for nurses connected with the Royal Liverpool Infirmary and established a visiting nurse service for the sick poor in Liverpool. Florence Lees, a graduate of the Nightingale School, was appointed first Superintendent-General of the District Nursing System (Mowbray, 1997 [cited in Allender, Rector & Warner 2014, p. 27]).).

As the service grew, visiting nurses were assigned to districts in the city—hence the name, district nursing. Subsequently, other British cities also developed district nursing training and services. An example is the Nurse Training Institution for district nurses, founded in Manchester in 1864. Privately financed, the nurses were trained and then "dispensed food and medicine" to the sick poor in their homes; they were "closely supervised by various middle and upper class women who collected the necessary supplies"(Allender, Rector & Warner 2014). Although Florence Nightingale is best remembered for her professionalization of nursing, she had a full understanding of the need for community health nursing. In 1876 it was documented that Hospitals are but an intermediate stage of civilisation and her ultimate object is to nurse all sick at home (Nightingale, 1876 [cited in Allender, Rector & Warner 2014, p. 28]).

In the United States, the first community health nurse, Frances Root, hired by the Women's Branch of the New York Missionin 1877, pioneered home visits to the poor in New York City. District nursing associations were founded in Buffalo in 1885, and in Boston and Philadelphia in 1886. These district associations served the sick poor exclusively, because patients with enough money had private home nursing care. However, the English model with its standards for visiting nurses' education and practice, established in 1889 under Queen Victoria, was not followed in the United States. Instead,

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visiting nursing organizations sprang up in many cities without common standards or administration. Twenty-one such services existed in the United States in 1890 (Allender, Rector & Warner 2014, p. 33). Although district nurses primarily cared for the sick, they also taught cleanliness and wholesome living to their patients, even during that early period.

For example, the Boston program, founded by the Women's Educational Association, "emphasized the teaching of hygiene and cleanliness, giving impetus to what was called instructive district nursing" (Bullough&Bullough, 1978, [cited in Allender, Rector & Warner 2014, p. 33]). This early emphasis on prevention and "health" nursing became one of the distinguishing features of district nursing and, later, of public health nursing as a specialty. The work of district nurses in the United States focused mostly on the care of individuals. District nurses recorded temperatures and pulse rates and gave simple treatments to the sick poor under the immediate direction of a physician. They also instructed family members in personal hygiene, diet and healthful living habits, and the care of the sick. There are problems associated to early home care patients in the United States among which are: Thousands of European and eastern European immigrants filled tenement housing in the poorest and most crowded slums of the large coastal cities during the late 1800s.

Inadequate sanitation, unsafe and unhealthy working conditions, and language and cultural barriers added to poverty and disease. Nursing educational programs at that time did not prepare district nurses to cope with their patients' multiple health and social problems. The sponsorship of district nursing changed over time. Early district nursing services in both England and the United States were founded by religious organizations. Later, sponsorship shifted to private philanthropy. Funding came from contributions and, in a few instances, from fees charged to patients on an ability-to-pay basis. Finally, visiting nursing began to be supported by public money. An early example occurred in Los Angeles where, in 1897, a nurse was hired as a city employee.

Although one form of funding dominated, all three types of financing continued to exist, as they still do. Although the government was beginning to assume more responsibility for the public's health, most district nursing services during this time remained private. In England, the establishment of "health visitors" in poor areas of London began early in the 19th century. These health care providers enhanced the English model of health visitor/district nurse/midwife as the backbone of the primary health care system in the second half of the 1800s. "The impact of early health visiting was clearly shown by the halving of infant mortality in the areas within two

years" and the main focus of the health visitor's work was giving advice to poor mothers and teaching hygiene to prevent infant diarrhoea. (Beine, 1996, p. 59 [cited in Allender, Rector & Warner 2014, p. 34]).

Public Health Nursing (1900 to 1970)

By the beginning of the 20th century, district nursing had broadened its focus to include the health and welfare of the general public, not just the poor. This new emphasis was part of a broader consciousness about public health. Robert Koch's demonstration that tuberculosis was communicable led the Johns Hopkins Hospital to hire a nurse, Reba Thelin, in 1903, to visit the homes of tuberculosis patients. Her job was to ensure that patients followed prescribed regimens of rest, fresh air, and proper diet and to prevent possible infection (Sachs, 1908 [cited in Allender, Rector & Warner 2014, p. 36]). A growing sense of urgency about the interrelatedness of health conditions and the need to improve the health of all people led to an increased number of private health agencies. These agencies supplemented the often-limited work of government health departments. By 1910, new federal laws made states and communities accountable for the health of their citizens.

Jessie Sleet was hired by the Charity Organization Society's (COS) tuberculosis committee as a temporary district nurse in New York City to visit the city's black community, which was ravaged by the disease. Jessie Sleet had nurse's training program for black women she was the first black public health nurse, she was a pioneer in early community health nursing practice.

When specialized programs such as infant welfare, tuberculosis clinics, and venereal disease control were developed, there was an increased demand for nurses to work in these areas. "Although the hospital nursing school movement emphasized the care of the sick, a small but growing number of nurses were finding employment in preventive health care." In 1900, there were an estimated 200 public health nurses. By 1912, that number had grown to 3,000 (Gardner, 1936 [cited in Allender, Rector & Warner 2014, p. 37]). Lillian D. Wald (1867–1940), was a leading figure in this expansion, she first used the term public health nursing to describe this specialty. She and a nurse-friend, Mary Brewster, started the Henry Street Settlement in 1893 to provide nursing and welfare services. Nursing visits conducted through her organization were supervised by nurses, in contrast to earlier models, in which nursing services were administered by lay boards and actual care was supervised by lay persons. In 1906 Miss Elizabeth Tyler, a graduate of the Freedmen's Hospital Training School for Nurses (Washington, DC) became the first black nurse hired at the Henry

Street Settlement; miss Wald work at the Henry Street Settlement showed clearly that nursing could reduce illness-caused employee absenteeism and this success address the issue of childhood illness and school absenteeism (Bullough&Bullough, 1978 [cited in Allender, Rector & Warner 2014, p. 37]). She suggested that placing nurses in the schools would allow for follow-up on recurring cases and home visits during the periods of exclusion. She argued that the nurses could supplement the work done by local physicians, who occasionally examined the children.

Lina Rogers Struthers was the first school nurse, and her presence in the school caused the number of children sent home from the New York City schools to drop dramatically. By September 1903, only 1,000 children needed to be excluded (compared with 10,000 1 year earlier). As a result, the New York Board of Health hired dozens of nurses to work at the schools (Allender, Rector & Warner 2014, p. 38). In 1909, Wald convinced the Metropolitan Life Insurance Company that nurse intervention could reduce death rates (Hamilton, 2007). In collaboration with the Henry Street Settlement, the company organized the Visiting Nurse Department and provided services to policy holders in a section of Manhattan. The success of this program resulted in expansion to other parts of the city and to 12 other eastern cities within 1 year.

By 1912, the company had organized 589 Metropolitan nursing centres. Through her efforts, the New York City Bureau of Child Hygiene was formed in 1908, and the Children's Bureau at the federal level in 1912. Wald's emphasis on illness prevention and health promotion through health teaching and nursing intervention, as well as her use of epidemiologic methodology, established these actions as hallmarks of public health nursing practice. She promoted rural nursing and family-focused nursing and encouraged improved coursework at the Teachers College of Columbia University (New York) to prepare public health nurses for practice. In 1912, she helped to found National Organization for Public Health Nursing (NOPHN) and she was the first president of the organization.

Her exemplary accomplishments truly reflect a concern for populations at risk and she further demonstrated how nursing leadership involvement in policy formation through the use of epidemiology can led to improved health for the public. The multiple problems faced by many families impelled a trend toward nursing care generalized enough to meet diverse needs and provide holistic services. Public health nurses gradually gained more autonomy in such areas as home care and instruction of good health practices to families and community groups. Public health nurses also began keeping better records of their services. Industrial nursing, another

form of public health nursing, also expanded during the early 1900s. The first known industrial nurse, PhilippaFlowerday Reid, was hired in Norwich, England, by J. and J. Colmans in 1878. Her job was to assist the company physician and to visit sick employees and their families in their homes. In the United States, the Vermont Marble Company was first to begin a nursing service in 1895; other companies followed soon after. By 1910, 66 firms in the United States employed nurses. During World War I, the number of industrial nurses greatly increased with the recognition that nursing service reduced worker absenteeism (Bullough&Bullough, 1978 [cited in Allender, Rector & Warner 2014, p. 39]).

Early industrial nursing was the forerunner of modern occupational and environmental health nursing. During this stage, the institutional base for much of public health nursing shifted to the government. By 1955, 72% of the counties in the continental United States had local health departments. Public health nursing constituted the major portion of these local health services and emphasized health promotion, as well as care for the ill at home. Rural public health nursing was organized around 1900 in Great Britain, Germany, and Canada, also expanded in the United States. Initially, starting in 1912, rural nursing was privately financed and largely administered through the Red Cross and the Metropolitan Life Insurance Company, but responsibility had shifted to the government by the 1940s (Allender, Rector & Warner 2014, p. 38). An innovative example of rural nursing was the Frontier Nursing Service, which was started by Mary Breckenridge (1881–1965) in 1925, to serve mountain families in Kentucky.

From six outposts, nurses on horseback visited remote families to deliver babies and provide food and nursing services. Over the years, the service has expanded to provide medical, dental, and nursing care. The Frontier Nursing Service continues today, with its remarkable accomplishments of reducing mortality rates and promoting health among this disadvantaged population, as the parent holding company for the Frontier School of Midwifery and Family Nursing. The public health nursing stage was characterized by service to the public, with the family targeted as a primary unit of care.

Community Health Nursing (1970 to the Present): The emergence of the term community health nursing heralded a new era. By the late 1960s and early 1970s, while public health nurses continued their work, many other nurses who were not necessarily practicing public health were based in the community. Their practice settings included community-based clinics, doctors' offices, work sites, and schools. To provide a label that

encompassed all nurses in the community, the America Nurses Association (ANA) and others called them community health nurses. This term was not universally accepted, however, and many people—including nurses and the general public—had difficulty distinguishing community health nursing from public health nursing. For example, nursing education, recognizing the importance of public health content, require course work in public health for all baccalaureate students. This meant that graduates were expected to incorporate public health principles such as health promotion and disease prevention into nursing practice, regardless of their sphere of service.

Carolyn Williams clearly stated that community health nursing's specialized contribution lay in its focus on populations (Williams, 1977 42 [cited in Allender, Rector & Warner 2014, p. 40]), this concept did not appear to be widely understood or practiced. Confusion also arose regarding the question of whether community health nursing was a generalized or a specialized practice. Graduates from baccalaureate nursing programs were inadequately prepared to practice in public health; their education had emphasized individualized and direct clinical care and provided little understanding of applications to populations and communities. By the mid-1970s, various community health nursing leaders had identified knowledge and skills needed for more effective community health nursing practice (Roberts & Freeman, 1973 [cited in Allender, Rector & Warner 2014, p. 40]).

These leaders valued promoting the health of the community, but both education and practice continued to emphasize direct clinical care to individuals, families, and groups in the community. Reflecting this view, the ANA's Division of Community Health Nursing developed A Conceptual Model of Community Health Nursing in 1980. This document distinguished generalized community health nursing preparation at the baccalaureate level and specialized community health nursing preparation at the masters or postgraduate level. The generalist was described as one who provides nursing service to individuals and groups of clients while keeping "the community perspective in mind" (American Nurses Association, 1980, p. 9 [cited in Allender, Rector & Warner 2014, p. 40]).

To distinguish the domains of community and public health nursing, in 1984, the U.S. Department of Health and Human Services, Bureau of Health Professionals, Division of Nursing, convened a Consensus Conference on the Essentials of Public Health Nursing Practice and Education in Washington, DC (U.S. Department of Health and Human Services [USDHHS], Division of Nursing, 1984). This group concluded

that community health nursing was the broader term, referring to all nurses practicing in the community, regardless of their educational preparation. Public health nursing, viewed as a part of community health nursing, was described as a generalist practice for nurses prepared with basic public health content at the baccalaureate level and a specialized practice for nurses prepared in public health at the master's level or beyond. Public health nursing continues to mean the synthesis of nursing and the public health sciences applied to promoting and protecting the health of populations. Community health nursing, for some, refers more broadly to nursing in the community.

As community health nursing continues to evolve, many signs of positive growth are evident. Community health nurses are carving out new roles for themselves in primary health care. Collaboration and interdisciplinary teamwork are recognized as crucial to effective community nursing. Practitioners work through many kinds of agencies and institutions, such as senior citizen centres, ambulatory services, mental health clinics, and family planning programs. Community needs assessment, documentation of nursing outcomes, program evaluation, quality improvement, public policy formulation, and community nursing research are high priorities. This field of nursing is assuming responsibility as a full professional partner in community health. Internationally, community nursing services are well established in England, Scandinavia, the Netherlands, and Australia Services, however, are relatively underdeveloped in France and Ireland. Furthermore, relatively few professional nurses are working in the community in central and Eastern Europe and in the former Union of Soviet Socialist Republics (USSR). Table 1 show the summary of the most important changes that have occurred during community health nursing's four stages of development in terms of focus, nursing orientation, service emphasis, and institutional base.

Nationally, public health in Nigeria can be traced back to the 19th century when the white settlers arrived in Nigeria. The primary aims of these white settlers were to colonize, trade and as missionaries. However their attention were drew to the poor health condition of natives and their poor hygienic practices. The first medical doctor to come to Nigeria was Dr. Jones Mc.William between 1841and 1854, he made available the first written account about health problems in Nigeria especially the malaria epidemics that claimed the death among the crew. During the time of Lugard as the commander of West Africa frontier force, his headquarter was set up in Lokoja of the present day Kogi State headquarter being a river town. The poor rural area such as bad house, poor food etc posed a lot of health problems for Lugard and his crew which resulted to many death among his

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crew. Ronald Ross discovered that mosquitoe bite result to malaria and not due to decay vegetation matter as they previously thought. Lugard became of the discovery and informed his crew to protect themselves with mosquitoe nets, take 300mg of quinine daily and boil their water and milk. As a follow up measured Lugard established small military hospital in Lokoja, Jabba, Zungeru and Zaria in 1900 and 1910 at this period the impact of medical men were not felt because of their few numbers and the gravity of the problems.

Stages	Focus	Nursing Orientation	Service Emphasis	Institutional Base (Agencies)
Early home care (Before mid-1800s)	Sick poor	Individuals	Curative	Lay and religious orders
District nursing (1860–1900)	Sick poor	Individuals	Curative; beginning of preventive	Voluntary; some government
Public health nursing (1900–1970)	Needy public	Families	Curative; preventive	Government; some voluntary
Emergence of community health nursing (1970–present)	Total community	Populations	Health promotion; illness prevention	Many kinds; some independent practice

Table 1 Development of community health nursing adopted from Community and Public Health Nursing: Promoting the Public's Health. 8th edition, by **Allender, Rector & Warner 2014 p. 43**

As medical sanitation reforms evolved, by 1877 the appointment of the first inspector of nuisance was gazetted. In 1897 Lagos had a medical and sanitary directorate which was headed by Dr. Strachan as the chief medical officer, assisted Mr. W.M Mackinson (the sanitary engineer) and Mr M. Lumpkin (the inspector of nuisance). These three men were assisted by thirteen colonial surgeons, three of who were Nigerians. In all they are team of sixteen government officials, they worked relentlessly to reform Lagos. The team drew ordinances and rules for housing and sanitation, meet houses and markets, hospitals etc. the ordinances stipulated that building plans and sites should be approved by medical officer. From literature searched, all through the early history of public health in Nigeria to 1959 when there were three regions in the country, it has been the doctors and Public Health Attendants (known as Sanitary Inspectors) that handled the public health affair of the nation. However Public health attendants have been completely eliminated but report showed that some states are contemplating reinstituting them (Scott-Emuakpor A, 2010). In many of the most populated regions of the world—such as China, Africa, and India—

volunteers, lay providers, and paraprofessionals provide the bulk of community health services (Allender, Rector & Warner 2014, p. 44).

In Nigeria the benefits of community health nursing practice has not being maximally optimized as means of ensuring better health, health care access and health promotion and to achieve the goals of primary health care. There are many certified public health nurses in the hospitals and only few are actually into community practice. While other community health workers currently function at the community level, their capacity is also subject to their background and what they can do are also limited. At an higher level, there are increasing number of Advanced Community Health Nurse Practitioners with Masters and Doctoral degrees that need to give leadership to community health nursing practice in Nigeria but this also will require appropriate policy review and implementation.

The concepts of health promotion and health education are not well understood, with the vast majority of health care provided at the tertiary level. It is concerning that modernization in many countries has not included expansion of public health services in community health nursing more specifically. In 1978, a joint World Health Organization (WHO) and the United Nations Children's Fund International Conference in Alma-Ata, in the Soviet Union, adopted a declaration on primary health care as the key to attaining the goal of health for all by the year 2000. At this conference, delegations from 134 governments agreed to incorporate the concepts and principles of primary health care in their health care systems to reach this goal (WHO, 1978; 1998[cited in Allender, Rector & Warner 2014, p. 43]). This was adopted by the World Health Assembly and endorsed by the United Nations General Assembly in 1981. On paper, everyone acknowledged the crucial need for nurses to be involved in reaching this goal but in practice, support has not been forthcoming in many countries. Policy makers and the public still need to be educated to realize that nursing's most effective contributions to the overall health of the population are based in the community.

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4.0 CONCLUSION

This unit enables you to have an understanding of concept of community and public health nursing practice. It also expand your horizon on this two concepts and their history both internationally and nationally.

5.0 SUMMARY

The practice of public nursing practice is a speciality that is population focus while that of community focus on family as a primary care unit and community. According to history internationally public health nursing evolves to become today community health nursing. However, their works are interrelated but they are differ and that is why some authors used them interchangeably.

6.0 TUTOR-ASSIGNMENT EXERCISE

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1. In Nigeria are populations and communities the target of public health and community health nursing practice?
2. Are the nurses in Nigeria prepared in public health and community health nursing, engaged in public health practice?

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MODULE 2 THE ARTS, THE SCIENCE AND THE PRACTICE OF PUBLIC/COMMUNITY HEALTH NURSING

Unit 1 Community Health Nursing Process
Unit 2 Theories and Models in Community Health Nursing Practice
Unit 3 Basic Elements of Community Health Nursing
Unit 4 Major Settings for Community Health Nursing Practice
Unit 5 Professional Roles of Public/ Community Health Nurse

CONTENTS

1.0 INTRODUCTION

As you might have learnt in other courses, the nursing process, the professional tool in nursing practice is a systematic way of determining a client's health status, isolating health concern and problems, developing the plans to remediate them, initiating actions to implement the plan, and finally evaluating the adequacy of the plan in promoting wellness and problem resolution. The nursing process defines interactions and interventions with the client system, whether that system is an individual, a family, or a community.

2.0 OBJECTIVE

Community health nursing process takes its conception from this orientation and commonly consists of six phases:

- Community assessment
- Community diagnosis
- Outcome identification
- Planning
- Implementation
- Evaluation.

It is employed to respond and address the health needs of the community when the community is the client. The community as a client refers to the broader concept of wide community as people in focus for nursing services..

3.0 MAIN CONTENTS

3.1 Community as a Client

For community health nurses, working with communities has four important missions:

1. Helping the community to understand and take positive steps and actions to meet the needs that directly influence the health of the individuals, families, groups, and populations who may be a part of it to meet such needs.
2. Working with community members to take responsibility for health promotion, disease prevention, surveillance and engage in appropriate health care seeking behavior as necessary
3. Provision of health services at the community level
4. Tracking and documenting the health, disease patterns and impact of interventions and programme

Let us look at the community as a client.

Dimensions of the Community as Client
A community has three features:

- Location
- A population

- A social system

It is useful to think of these dimensions of every community as a rough map to follow for assessing needs or planning for service provision.

3.2 Location

Every physical community carries out daily existence in a specific geographic location. The health of a community is affected by this location including the placement of health services, the geographic features, plants, animals and animals and the human made environment.

Six Location Variables

- Community boundaries
  To talk about community in any sense, one must first describe its boundaries. It serves as basis for measuring incidence of wellness and illness and for determining spread of a disease.
- Location of health services
  When assessing a community, the community health nurse will want to identify the major health centers and know they are located. Use of health services depends on availability and accessibility.
- Geographic features
  Communities have been constructed in every suitable physical environment and that environment certainly can affect the health of a community. Injury, death, and destruction may be caused by floods, cyclones, earthquakes volcanoes…etc. recreational activities at lakes, seashores, mountains promote health and wellness.
- Climate
  Climate has a direct effect on health of a community e.g., extreme heat and cold.
- Flora and Fauna
  Poisonous plants and disease carrying animals can affect community health.
- Human made environment
  All human influences on environment (housing, dams, farming, types of industry, chemical wastes, air pollution…etc.) can influence levels of community wellness.

We may also look at aggregates of people in a community because a community may have diverse small aggregates of people bonded by some things.

3.3 Population

Population consists not only of a specialized aggregate, but also of all the diverse people, who live within the boundaries of the community. The health of any community is greatly influenced by the population that lives in it. Different features of the population suggest the health needs and provide bases for health planning.

Population variables: these are some characteristics of the people that constitute the aggregate. These include
Size:the size of a population influences the number and size of health care institutions. Knowing community size provides important information for planning.

Density:increased population density may increase stress. Similarly when people are spread out health care provision may become difficult.

Composition: composition of the population often determines types of health needs. A health community is one that takes full account of and provides for differences in age, sex, educational level, and occupation of its members, all of which may affect health concerns. Determining a community composition is an important early step in determining its level of health.

Rate of growth or decline: rapidly growing communities may place extensive demands on health services. Marked decline in population may signal of poorly functioning community.

Cultural difference: health needs may vary among sub-cultural and ethnic populations. Cultural difference can create conflicting or competing demands for resources and services or create inter-group hostility.

Social class and educational levels: social class refers to the ranking of groups within society by income, education, occupation, prestige or a combination of these factors. Educational level is a powerful determinant of health related behavior. Health promotion and preventive health services are most needed for people with low income and educational levels.

Mobility:mobility of the population affects continuity of care and availability of services. Mobility has a direct effect on the health of a community.

3.4 Social System

In addition to location and population, every community has a third dimension, a social system. The various parts of community that interact and influence the system are called social system variables. These variables include the health, family, economic, educational, religious, welfare, legal, communication, recreational, and the political systems. Although community health nurses must examine all the systems in the community and how they interact, the health system is of particular importance to promote the health of the community.

3.5 Phases of Nursing Process in the Community

SELF ASSESSMENT EXERCISE

Assessment is the first step of the nursing process, which means to collect and evaluate data/information about a community's health status to discover existing or potential needs, concerns and problems as bases for planning.

Community Assessment
This is the process of searching for and validating relevant community based data according to specified methods, to learn about the interaction among the people, resources and environment.

Community assessment includes:

- Collecting pertinent community data
- Analyzing and interpreting the collected data.

Community need assessment:- is the process of determining the real or perceived needs of a defined community of people. In some situation; an extensive community study becomes first priority. In others, all that is needed is a study of one system (e.g., health system, educational system …etc.) or organization (e.g., women association, youth, men association …etc).

3.6 Major Aspects of Community Assessment

A. Physical Environment

Just as physical examination is important to individual patients, so is examination of the community physical environment. Five senses are used in physical assessment: inspection, auscultation, vital signs, system review, and laboratory studies.

Inspection: inspection uses all sense organs and is done by walking survey in the community, or micro-assessment of housing, open spaces, boundaries, transportation service centers, markets places, meeting street people, signs of decay, ethnicity, religion, health and morbidity, political media.

Auscultation: is listening to the community residents about the physical environment.

Vital signs: observe the climate, terrain, natural boundaries such as rivers and hills. Community resources: look for signs of life such as notices, posters, new housing and buildings.

System review: hosing age, architecture, building materials used, signs of disrepair, running water, plumbing, sanitation, windows (glasses)..etc. Also business facilities and churches.

Laboratory studies: census data or planning studies for community mapping.

B. Health and Social System

Differentiate between facilities located within the community and those located outside. Hospital: number of beds, staffing, budget, health center, clinics, or health posts, public health
services, private clinics, pharmacies, dental and other services. Signs of drugs or substance abuse, alcoholism. Social services include counseling and support, clothing, food, shelter and special needs as well as markets and shops.

C. Economics

Financial characteristics median household income, percentage of households living in poverty, Labor force characteristics, employment status of the general population greater than 18 years of age. Occupational categories and percentage of persons employed by government, farmers, skilled, unskilled, professional, types of business/industry.

D. Safety and Transportation

Police, sanitation (water source, solid waste disposal, sewage and air quality) and fire services. Primary means of transportation; walking, mule, taxi, bus, train, private car, and air services. Frequency and affordability of public/private transport, and standard of roads.

E. Politics and Government

Peasant association, business alliances, religious groups, youth and women's associations, professional associations, ethical associations, political activism…etc. describe the associations' objectives and activities.

F. Communication

Bulletin boards, posters, oral messages, radio, television, newspapers, postal services, telephone. telephone wires, magazines, and satellite dishes.

G. Education

Types of schools, colleges and universities. Note languages used, grades, courses offered, percentage of attendants (male, female), adequacy, accessibility, and acceptability of education. Average number of years completed by people at school.

H. Recreation

Note facilities such as stadium, recreational areas, volleyball court, playground, picnic areas, museum, music/dancing, theatre/cinema. Who is going out about during the evening and in the morning? Teenagers, mothers and children, the homeless?

Community Assessment Tools

Different kinds of tools are usually needed to collect relevant information that are needed to give relative ideas about the issues, concerns, health challenges of members of a community. Some of the tools are useful to collect subjective and objective information either from individuals, groups depending on what one is looking for. Some of the tools are here presented.

1. Survey Questionnaire

This is one of the best known and most popular methods of assessing community's strength and weaknesses. An effective community survey can reveal a wealth of useful and easily quantifiable information and is a good option for many projects. The following areas are of nursing concerns when making community assessment that helps to reach a community nursing diagnosis. The point under each sub-heading may be modified to meet the need of individual practice. The questions are modified under the following sub-headings.

Location perspectives

- Where is the community located?
- What is the boundary?
- Where is the major health institutions located?
- What major landforms are in or near the community?
- What geographic features offer opportunities for healthful activities?
- What are the average temperature and precipitation?
- What climatic features affect health and fitness (extreme temperatures)?
- What plants and animals pose possible threats to health?
- What are the major industries?
- How have air, land, and water been affected by humans?
- What is the quality of housing?
- Do highways allow access to health institutions?

Population perspectives

- What is the population of the communities (urban, rural)?
- What is the density of the population per square kilometer?
- What is the age and composition of the community?
- What is the marital status of the community?
- What occupations are presented in the community? In what percent?
- How has the population size changed over the past two decades?
- What are the health implications of the changes?
- What are the ethnic compositions of the community?
- What percentage of the population falls into each social class?
- What is the average income per family member?
- Are there any specific population such as migrant workers that are highly mobile ?
- Is the community organized to meet the health needs of the mobile group?

Social system perspectives

- What are the functions of each major system?
- What are the major organizations in each sub-system?

- Is there adequate communications among the major systems?
- Does the education system offer equal eduacational opportunities to all children in thecommunity?
- What is the level of health promotion in the community?
- Are there mechanisms for resolving conflicts?
- Does any part of the total system dominate the others?
- What community needs is not being met?
- What recreational facilities are available?
- What types of health services are available?
- What health services and resources are available?

Community core

The definition of core is "that which is essential, basic, and enduring." The core of a community is its people- their history, characteristics, values and beliefs. The first stage of assessing a community, then, is to about its people. Major components of community core:

1. History- history of that society
2. Demography- age, sex, ethnicity, marital status
3. Vital statistics- birth, death
4. Values beliefs, and religious practice of the people

All these can be collected using survey tools such as questionnaire.

2. Focus Group Discussion

A focus group is a carefully planned discussion used to determine a community's preferences and opinions on a particular issue or idea. Conducting a focus group requires careful planning and someone skilled at facilitating discussion. Most focus groups consists of 5-10 diverse stakeholders. Participants are asked a series of carefully warded questions that focus on different issues in the community.

3. Panel Discussion

A panel discussion is a guided exchange involving several experts on a specific subjects. Panel discussion are carefully structured and typically involve a facilitator who asks panelists specific questions about the community or a particular issue. Often, city governments, hospitals, universities pay experts to collect and interpret detailed information about communities and the issues they face. Drawing on this expertise is an

excellent way to learn about a community without having to invest a lot of time or money in a new community assessment.

4. Community Café

Community café create the atmosphere of a restaurant or a café in which small groups of people from the community discuss issues raised by facilitators.

5. Community Mapping

This is used to reveal peoples different perspectives about a community. It requires few resources and a little time and can be adapted for participants of virtually any age or educational background.

6. Daily Activities Schedule

Finding about the work habits of community members is an excellent way to learn about a community division of labour and perception of work based on gender and age.

7. Saesonal Calendar

This activity reveals changes in seasonal labour supply an demand, household income patterns, food availability and demands on public resources, such as schools, mass transit systems and recreational facilities.

8. Asset Inventory

An asset inventory is a technique for collecting information about a community through observation. It is similar to a shopkeeper taking stock of merchandise. It works best when conducted at a community meeting or gathering.

3.7 Community Analysis and Nursing Diagnosis

Community Analysis

Analysis is the study and examination of data. Analysis is necessary to determine community health needs and strength as well as to identify patterns of health responses and trends in health care use.

Community analysis, like so many procedures we carry out, may be viewed as a process with multiple steps. The phases of analysis include:

- **Data categorization** (demographic, geographic, socioeconomic, health resource and services…etc)
- **Data summarization** (rates, charts graphs…etc.)
- **Comparing data** (with similar data, identification of data gaps, incongruence…etc)
- **Draw inferences** (draw logical conclusions from the evidence) that lead to community diagnosis.

Community nursing diagnosis
This is a statement that defines the health strength, health problems or health risks of the community. Nursing diagnosis is a real clinical judgment or conclusions about human response to actual or potential problems. A community diagnosis forms the basis for community based intervention.
A nursing diagnosis has three parts:

- Description of the problem (specific target or groups)
- Identification of factors/etiology related to the problem
- The sign and symptoms (the manifestations) that characteristics of the problem.

Examples;
Inadequate ANC related to inadequate health information or service accessibility as evidenced by 70% of female delivering at hospital with no antenatal care.
Poor nutritional status of under five children in thecommunity related to knowledge deficit regarding weaning diet as evidenced by growth monitoring chart.
High infant mortality related to inadequate ANC, maternal nutrition, and unhygienic delivery practice as evidenced by IMR 75 /1000 live births.

3.7.1 Outcome Identification

This the step where the community health nurse and the community as a client identify the goals of client (community) care which are client centred and time-bound. This step will help guide the community health nurse in working with the community to select appropriate interventions that are beneficial, cost-effective and risk-free for the community.

3.7.2 Planning

This is a logical, decision making process of designing an orderly, detailed programs of action to accomplish specific goals and objectives base d on assessment of the community and the nursing diagnosis formulated.

Activities in planning: these include

- Setting priorities involves:

Assigning rank/importance to client's needs. Determining the order in which the goal should be addressed. The goal can be immediate, intermediate or long range goal.

- Establishing goal and objectives

Goal is a broad statement of desired end results. Objectives are specific statement of the desired outcomes. They objectives must be ***SMART.***
Characteristics of good objectives:

- Specific- target specific population
- Measurable- when the results are stated
- Achievable- within the capacity of the available resources.
- Relevant- fits with the general identified needs.
- Time bound- that is achieved within specified timeframe.

Planed actions are specific activities or methods of accomplishing theobjectives or expected outcomes.

- Outcome measurements is judging of the effectiveness of goal attainment.
- Howand when was each objective met, why not?
- Recording the plan

3.7.3 Implementation

Implementation is putting the plan into actions and actually carrying out the activities delineated in the plan, either by nurse or other professionals. It is the action phase of the nursing process. Community interventions are the

therapeutic actions designed to promote and protect the community health, treat and remediate community health problems and support the community as it changes over time.

Key areas of nursing intervention in the community are:

- link the community members with the available resources
- pulls together information and resources to assist community in addressing its health concern andproblems
- Harmonize its strength through facilitation, education, organization, consultation and direct care.

3.7.4 Evaluation

It is systematic, continuous process of comparing the community's response with the outcome as defined by the plan of care. The ultimate purpose of evaluating interventions in community health nursing is to determine whether planned actions met client needs, if so how well they were met, and if not why not.
Evaluation requires a stated purpose, specific standards and criteria by which to judge and judgment skills.

UNIT 2 THEORIES AND MODELS IN COMMUNITY HEALTH NURSING PRACTICE

The commonly used theories, models, and concepts in community health nursing are:

1. Nightingale's theory of environment
2. Orem's Self-care model
3. Neuman's health care system model
4. Roger's model of the science and unitary man
5. Pender's health promotion model
6. Roy's adaptation model
7. Milio's Framework of prevention
8. Salmon White's Construct for Public health nursing
9. Block and Josten's Ethical Theory of population focused nursing
10. Canadian Model

Florence Nightingale Theory of Environment

Florence Nightingale's theory focused on manipulating a patient's environment to facilitate healing of the body. This theory can be modeled into practice by assessing a patient's environment for factors that can hinder or promote health, then creating an environment that will contribute to more positive health outcomes for the patient. Some of these factors may be nutrition, hygiene or socialization.

Dorothea Orem Self Care Model

The goal of Dorothy Orem's theory is to help the patient regain the ability to care for herself. Using this theory as a model for nursing care requires finding out what self-care needs the client is unable to fulfill herself and why she can't do those things, then providing the assistance necessary to help the client perform those activities with the intention of increasing the client's abilities to do them herself later.

Sister Calista Roy

Sister Callista Roy's adaptation theory focuses on helping the client adapt to changes in his body functioning, emotional states and roles in his family, society or elsewhere, and achieving a balance between being dependent and independent. The nurse applying this model first finds out what conditions are causing problems for the client and assesses how the client is adapting

to them. Then she designs interventions aimed at helping the client adapt better.

Nola J Pender's Health Promotion Model

Health Promotion Model has given health care a new direction. According to her, Health Promotion and Disease Prevention should be the primary focus in health care, and when health promotion and prevention fail to prevent problems, and then care in illness becomes the next priority. She defined 2 concepts: health promotion & health protection. Health promotion is defined as behavior motivated by the desire to increase well-being and actualize human health potential. It is an approach to wellness. On the other hand, health protection or illness prevention is described as behavior motivated desire to actively avoid illness, detect it early, or maintain functioning within the constraints of illness.

Betty Neuman Health System Model

Neuman's model includes intrapersonal, interpersonal and extrapersonalstressors.Nursing is concerned with the whole person. Nursing actions (Primary, Secondary, and Tertiary levels of prevention) focuses on the variables affecting the client's response to stressors.

Martha E. Rogers Science Of Unitary Human Being

Person and environment are energy fields that evolve negentropically Nursing is a basic scientific discipline. Nursing is using knowledge for human betterment. The unique focus of nursing is on the unitary or irreducible human being and the environment (both are energy fields) rather than health and illness

Milio's Frame Work of Prevention

Nancy Milio a nurse and leader in public health policy and public health education developed a framework for prevention that includes concepts of community-oriented, population focused care.(1976,1981). The basic treatise is that behavioral patterns of populations and individuals who make up populations are a result of habitual selection from limited choices. She challenged the common notion that a main determinant for unhealthfulbehavioral choice is lack of knowledge. Governmental and institutional policies, she said set the range of options for personal choice making. It neglected the role of community health nursing, examining the determinants of community health and attempting to influence those determinants through public policy.

Salmon White's Construct for Public Health Nursing

Mark Salmon White (1982) describes a public health as an organized societal effort to protect, promote and restore the health of people and public health nursing as focused on achieving and maintaining public health. He gave 3 practice priorities i.e.; prevention of disease and poor health, protection against disease and external agents and promotion of health. For these 3 general categories of nursing intervention have also been put forward, they are: education directed toward voluntary change in the attitude and behaviour of the subjects.

Scope of prevention spans individual, family, community and global care.

Intervention target is in 4 categories:

1. Human/Biological
2. Environmental
3. Medical/technological/organizational
4. Social

Block And Josten's Ethical Theory Of Po PulationFocuse Nursing

Derryl Block and LavohnJosten, public health educators proposed this based on intersecting fields of public health and nursing. They have given 3 essential elements of population focused nursing that stem from these 2 fields:

1. an obligation to population
2. the primacy of prevention
3. centrality of relationship- based care

The first two are from public health and the third element from nursing. Hence it implies to nursing that relation-based care is very important in population focused care.

Canadian Model for Community

The community health nurse works with individuals, families, groups, communities, populations, systems and/or society, but at all times the health of the person or community is the focus and motivation from which nursing actions flow. The standards of practice are applied to practice in all settings where people live, work, learn, worship and play. The philosophical base and foundational values and beliefs that characterize community health nursing - caring, the principles of primary health care, multiple ways of knowing, individual/community partnerships and empowerment - are embedded in the standards and are reflected in the development and application of the community health nursing process. The community health nursing process involves the traditional nursing process components of assessment, planning, intervention and evaluation but is enhanced by community health nurses in three dimensions:

1. Individual/community participation in each component; multiple ways of knowing, each of which is necessary to understand the complexity and diversity of nursing in the community; knowledge and utilization of all these ways of knowing forms evidence-based practice consistent with these standards, and

2. The inherent influence of the broader environment on the individual/community that is the focus of care (e.g. the community will be affected by provincial/territorial policies, its own economic status and by the actions of its individual citizens). The standards of practice are founded on the values and beliefs of community health nurses, and utilization of the community health nursing process.

3. The model illustrates the dynamic nature of community health nursing practice, embracing the present and projecting into the future. The values and beliefs (green or shaded) ground practice in the present yet guide the evolution of community health nursing practice over time. The community health nursing process provides the vehicle through which community health nurses work with people, and supports practice that exemplifies the standards of community health nursing. The standards of practice revolve around both the values and beliefs and the nursing process with the energies of community health nursing always being focused on improving the health of people in the community and facilitating change in systems or society in support of health. Community health nursing practice does not occur in isolation but rather within an environmental

context, such as policies within their workplace and the legislative framework applicable to their work

UNIT 3 BASIC ELEMENTS OF COMMUNITY HEALTH NURSING

Basic elements of nursing practice incorporated in community health programs and services are:

Advocacy

Advocacy is an element used in community health nursing practice to help individuals, families, and groups become aware of issues that may impact on their health; the focus may be on those who are disadvantaged due to socioeconomic status, age, isolation, culture, lack of knowledge, etc.

- Works to develop clients' capacity to speak for themselves.
- Uses advertising and media in skilful ways, for advocacy.
- Promotes resource development that will lead to equal access to health and health-relatedservices.
- Uses collaborative approaches and acts as an advocate for change.
- Shows a strong commitment to equity and social justice and speaks out for equity in health
  through legislation and policy-making activities.
- Acts as spokesperson, when asked, to represent the views of individuals and groups seeking to promote their health.

Building Capacity

- Encourages and supports the community to be active in stating and taking ownership of health issues that need to be resolved; this may include working with the community to develop skills in how to access resources, how to develop social networks, and how to learn from the efforts of others.
- Acts as a catalyst to help resolve issues and concerns.
- Educates community members about the political process as it relates to community health issues and about how they can become active in decisions about health issues.
  Helps the community (and its members) better understand that their own abilities may be their best health resource.
- Uses group process and leadership skills.

Building Coalitions and Networks

- Sees the need for and identifies opportunities to build coalitions and networks to promote health or prevent illness.

- Identifies the type of coalition that best fits the mission or purpose.
- Facilitates skill development (capacity building) of community members and supports community engagement.
- Makes clear how leadership and guidance will work and supports development of agreed-upon roles, rules, and procedures.
- Helps to create links between the broader community and the coalition/network.
- Provides support as requested by the coalition or network. Care/Counseling
- Establishes a therapeutic relationship based on trust, respect, caring, and listening.
- Uses clinical skills to assess the client's ability to participate in joint planning, implementation, and evaluation of nursing interventions.
- Uses health promotion, illness, and injury prevention techniques that are client centred, client-driven, and strengths-based.
- Helps clients to accept their share of responsibility for health.
- Sets and maintains boundaries, monitors the counselling relationship, and effectively plans and manages the process until the relationship ends.
- Remains sensitive to how each client is unique and to the client's vulnerabilities, while placing the focus on enhancing the client's strengths.
- Promotes client self-care and/or avoidance of harm to self and others.

Case Management

- Actively engages with individuals, groups, and communities; this may involve case-finding, a process of identifying individuals and/or families who may be at risk and who meet the agency's criteria for case management.
- Assesses the resources and services that will be needed to build on the client's strengths and skills and thus help the client to attain and/or maintain a desired health status or set of healthy behaviours for improved quality of life.
- Builds trusting relationships and works with clients to identify and resolve health issues.
- Develops, implements, and evaluates an agreed-upon plan with the client; the plan respects the client's (and sometimes a family's) control over their health and decisions; it prepares the client for an end to the professional relationship (except when child protection or other welfare concerns apply).

- Supports individuals and families to build on their strengths and skills so they can find and access available resources and services and thus attain or maintain a desired health status.
- Links individuals and/or families with needed services and resources.
- Uses an inter-disciplinary approach and cooperates with other organizations as needed, basedon how complex the circumstances are.
- Coordinates services and applies plans in a logical sequence together with individuals and/or families.
- Helps to resolve potential or actual barriers in the way services are provided.
- Evaluates progress with individuals and/or families and revises service plan(s) as needed.

Communication

Uses oral and written skills, along with visual, print, and other media to:

- build trusting, helping relationships, convey health information, including details on risk.
- assess knowledge, attitudes, beliefs, etc.,
- help clients find options for making choices that will meet their health needsand/or allow them to speak up for themselves.
- Negotiates or contracts with health care, social services, or resource agencies, and all segments
- of the community, to ensure clients have access to services.
- Uses effective communication with team members.
- Effectively addresses and manages conflict.
- Contributes to and plays an active role in health promotion and social marketing that support attitudes and/or beliefs to reduce health inequalities and improve health outcomes.
- Works to achieve inter-agency and inter-governmental cooperation.
- Uses effective risk communication approaches.
- Acts as a spokesperson, as needed, on public health issues.
- Uses appropriate technology to manage, mitigate, and communicate about public health events; this includes good record keeping.

Community Development

- Applies knowledge of community assessment and community development models to support public participation in identifying and resolving health issues.
- Uses a strengths-based approach that supports capacity development and empowerment in the community.
- Works with the community to make decisions about, and claim ownership of, changes needed to enhance community health.
- Recognizes the value of community wisdom and supports community-generated plans for economic development, environmental improvement, or other community-based plans.
- Assists in the development of health services and programs based upon community assessments, in order to meet the health needs of the community.
- Fosters and supports inter-agency links and working relationships.
- In developing programs, uses awareness of factors which impact on or affect health such as social, cultural, and economic issues, as well as environmental hazards.

Consultation

- Uses knowledge and expertise in public health, especially in health promotion, disease and injury prevention, epidemiology, and emergency preparedness to inform clients, lay helpers, nursing students, colleagues, other professionals, professional associations, non-profit agencies, organizations, institutions, the public, and all levels of government.
- Acts as a resource person to communities, groups, and individuals.
- Uses knowledge of a community to link those needing services to the correct community resources.
- Uses discussion with the client to clearly outline what will happen during a consultation.
- Collaborates with the client and adapts the consultation to meet the client's needs; helps the client find ways and options for change and improvement.

Facilitation

Works with groups or individuals to use effective processes to:

- Bring people together and create a setting where ideas and points of view may be shared openly;
- Clarify issues or processes;

- Ensure that meetings are run well and achieve a high degree of agreement on the meeting's stated goals and objectives.
- support building of community, group, and individual capacity.

Health Education

- Assesses the knowledge, attitudes, values, beliefs, behaviours, practices, stage of change, and skills of the learner.
- Considers contexts that may impact the person's ability to learn, such as environment, readiness, and other factors; involves the learner in setting health education needs.
- Supports knowledge development, generation, and translation.
- Selects and adapts the teaching methods that are most likely to meet the needs of the learner and considers the learner's cultural preferences and stage of change.
- Uses content expertise on a topic to offer formal presentations and educational programs, as well as informal teaching to communities, groups, families, and individuals.
- Emphasizes health promotion, disease and injury prevention, and the determinants of health.
- Includes knowledge of behavioural sciences in teaching and applies the correct
  - learning principles, pedagogy, and educational theories to educational activities.
- Evaluates effectiveness of health education interventions.
- Uses novel health promotion strategies in service delivery.
- Uses marketing techniques to promote both community health programs and healthy living.

Health Threat Response

- Supports early identification of a health threat by gathering data from many sources at the same time (to understand the cause, natural course, and expected outcomes of the disease or health threat).
- Follows established criteria for responding to population-level threats (such as fire or flood) as well as criteria for case investigation including: the collection and analysis of data from multiple valid sources; identification of factors likely to cause the problem or risk; offering options for prevention (at the primary, secondary, or tertiary levels); providing options for preventive care as required; and referral and follow-up for those who need treatment.
- Uses effective risk communication techniques to inform individuals and the public, as well as colleagues and other health professionals.

- Evaluates the impact of the public health response and identifies implications for future practice.

Leadership

- Applies current knowledge of professional, community, and political issues to develop a proactive approach to health and environmental issues.
- Initiates and participates effectively in intersectoral efforts.
- Initiates action and encourages individuals, the community, and people in positions of power to take action.
- Acts as an interim leader until the community can take the needed action. Outreach
- Uses community assessment data to determine population health needs and designs activities to address the unique features of the population of interest.
- Uses strategies to engage with people where they live, work, learn, or play.
- Builds trusting relationships and engages the client in identifying and resolving health issues.
- Uses a holistic approach which includes finding solutions to service access barriers.
- Seeks to get involved in, change, and provide services in environments where risk is higher (engages in harm reduction activities).
- Uses proven methods, such as early involvement of key stakeholders when developing outreach plans.

Policy Development and Implementation

- Identifies areas in need of policy and program development.
- Participates in implementing and evaluating policy.
- Helps to set clear philosophies, policies, standards of practice, and program objectives with measurable outcomes for nurses and other health care providers.
- Uses the political process to promote health.
- As a delegated act, may enforce policy by requiring others to comply with laws,
  - rules, regulations, and policies.

- Uses excellent communication skills to foster relationship-building collaboration, negotiation, and conflict resolution when differing points of view on policy enforcement occur.

Referral and Follow-Up

- Supports the client's control of referrals and follow-up; this includes the client's right to refuse a referral.
- Supports the referral process by using a number of ways to ensure, where possible, that a link to service has occurred.
- Uses links with other providers, organizations, and networks to make needed resources and services available to populations at risk.
- Carries out intervention strategies that fall within the employer/agency's mission and goals.
- Helps to evaluate referral and follow-up processes and strategies.

Research and Evaluation

- Identifies and supports investigation into key issues and approaches relevant to community health and wellness; where possible, uses the right methodology, such as participatory research methods, to involve community members in planning or carrying out research.
- Shares research and program evaluation information with colleagues, educators, nursing students, other professionals, and the public.
- Participates in research projects.
- Uses structure, process, and outcome-oriented research as a guide to practice and evidence-informed decisions.
- Uses research findings to assign human and financial resources and to evaluate interventions.
- Identifies program areas which need to change; works with other colleagues to alter programs.

Resource Management, Planning, Coordination

- Uses evidence-informed and best practices in planning to support responsible and accountable resource management.
- Applies concepts of social justice in assigning time and other resources to promote health equity.
- Acts as agent to marshal and advocate for human, financial, and physical resources.

- Involves communities, families, and individuals in health services planning and priority setting.
- Shares information about community resources.

Screening

- Conducts evidence-based screening.
- Ensures the client understands the reason for screening and the procedure; ensures that follow-up is available.
- Monitors and evaluates screening activities and documents both the process and the results.
- Seeks input from those to be screened and collaboratively designs culturally sensitive interventions with other professionals.
- Uses screening activities as an opportunity to provide health education and counselling.

Surveillance

- Uses resources and the correct technology to get the information that is needed about a problem, its natural course, and its aftermath.
- Actively participates in informal surveillance and shares findings with those who may be able to use it.
- Follows established protocols for surveillance, such as maintaining the confidentiality of data/information, and collecting enough data from a number of reliable sources.
- Uses and applies surveillance information to practice.
- Interprets and shares surveillance data in a way that decision-makers, the community, and the public can understand.
- Understands the implications of surveillance data.

Team Building and Collaboration

- Uses techniques that foster team building, mutual respect, and joint decisionmakingin all interactions with colleagues, educators, nursing students, other professionals, and the public.
- Uses mediation skills to facilitate inter-agency and inter-governmental cooperation.
- Commits to a capacity-building approach that uses collaboration (with two or more people or organizations) to promote and protect health.

UNIT 4 MAJOR SETTINGS FOR COMMUNITY HEALTH NURSING PRACTICE

Settings for community health nursing can be grouped into six categories:

(1) Homes
(2) Ambulatory care settings
(3) Schools
(4) Occupational health settings
(5) Residential institutions, and
(6) The community at large.
(7) Correctional Homes

Community health nursing practice is not limited to a specific area, but can be practiced anywhere.

UNIT 5 PROFESSIONAL ROLES OF PUBLIC/ COMMUNITY HEALTH NURSE

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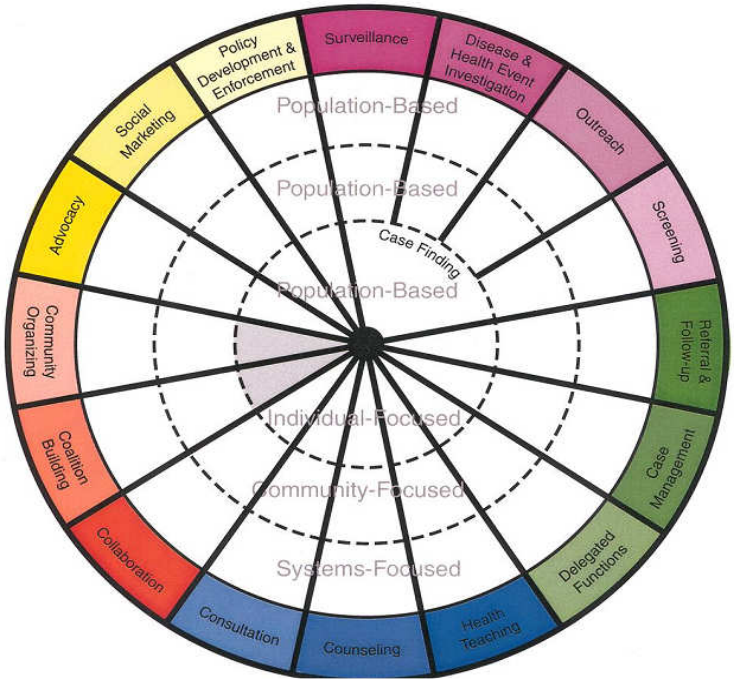

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- Provider of PHC
- Care provider to the sick unhospitalized person
- Advocate
- Educator
- Sensitized observer
- Change agent
- Organizer/manager
- Researcher

To function in their roles, public health/community health nurses must use advanced decision-making strategies such as the nursing process, which combines judgment, action, responsibility, and accountability. Public health/community health nurses must take the time to inform themselves about current community health issues and new technologies, so they can properly apply public health science and epidemiological principles to their work. The roles includes;

I. Role in Health Promotion

- Encourages the adoption of health beliefs, attitudes, and behaviours that contribute to the overall health of the population through public policy, community-based action, public participation, and advocacy or action on environmental and socio-economic determinants of health, as well as health inequities.
- Supports public policy changes to modify physical and social environments that contribute to risk.
- Assists communities, families, and individuals to take responsibility for establishing, maintaining, and/or improving their health by adding to their knowledge or control over (and ability to influence) health determinants.

- Works with others and leads processes to enhance community, group, or individual plans that will help society to plan for, cope with, and manage change.
- Encourages skill building by communities, families, and individuals so they can learn to balance choices with social responsibility and, in turn, create a healthier future for all.
- Initiates and participates in health promotion activities in partnership with others such as the community and colleagues in other sectors.

II. Role in Disease and Injury Prevention

- Reduces the risk of infectious disease outbreaks; this includes early identification, investigation, contact tracing, preventive measures, and activities to promote safe behaviours.
- Applies epidemiological principles and knowledge of the disease process so as to manage and control communicable diseases using prevention techniques, infection control, behaviour change counseling, outbreak management, surveillance, immunization, episodic care, health education, and case management.
- Uses appropriate technology for reporting and follow-up.
- Uses effective strategies to reduce risk factors that may contribute to chronic disease and disability; this may include changes to social and economic environments and inequities that increase the risk of disease.
- Helps individuals and families to adopt health behaviours that reduce the likelihood of disease, injury, and/or disability.
- Encourages behaviour changes to improve health outcomes.

III. Role in Health Protection

- Acts in partnership with public health colleagues, government, and other agencies to:
  – ensure safe water, air, and food,
  – control infectious diseases, and
  – provide protection from environmental threats (including delegating orcarrying out delegated regulatory functions).
- Takes the lead in identifying issues that may need attention and offers public health advice to groups such as municipal governments or regional districts about the public health impact of policies and regulations.
- Works with individuals, families, and communities to create or maintain a safe environment where people may live, work, and play.

IV. Role in Health Surveillance

- Is aware of health surveillance data and trends; applies this knowledge to day-to-day work.
- Integrates eco-social surveillance that focuses on broad, multi-level conditions that contribute to health inequalities.
- Mobilizes formal and/or informal networks to systematically and routinely collect and report health data for tracking and forecasting health events or health determinants.
- Collects and stores data within confidential data systems; integrates, analyzes, and interprets this data.
- Provides expertise to those who develop and/or contribute to surveillancesystems, including risk surveillance.

V. Role in Population Health Assessment

- Uses health surveillance data to launch new services or revise those that exist.
- Contributes to population health assessments and includes community viewpoints.
- Plays a key role in producing and using knowledge about the health of communities (or certain populations or aggregates) and the factors that support good health or pose potential risks (determinants of health), to produce better policies and services.

VI. Role in Emergency Preparedness and Response

- Contributes to and is aware of public health's role in responding to a public health emergency.
- Plans for, is part of, and evaluates the response to both natural disasters (such as floods, earthquakes, fires, or infectious disease outbreaks) and man-made disasters (such as those involving explosives, chemicals, radioactive substances, or biological threats) to minimize serious illness, death, and social disruption.
- Communicates details of risk to population subgroups at higher risk and intervenes on their behalf during public health emergencies using a variety of communication channels and engagement techniques.

Other roles of a professional community health nurse includes; care provider, educator, advocate, manager, collaborator, leader, and researcher.

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MODULE 3 ART, SCIENCE AND PRACTICE OF COMMUNITY HEALTH NURSING PROCESS

UNIT 1 COMMUNITY NURSING PROCESS

1.0 INTRODUCTION

Community health nurses practice autonomously and independently in a variety of settings, they need evidence to inform their practice decisions. This evidence can be achieved through knowledge of art and science of nursing process. The science of nursing process provides the bases for predicting, prescribing, determining and explaining nursing care in the community. The art of nursing process encompasses the skills, basic components, settings of practice and the roles of community health nurses. Therefore for you to effectively practice community health nursing utilizing nursing process, the knowledge of science and art is of utmost importance.

Community health nurses take care of the clients and their families in the community. For this care to be qualitative, it should be provided in a

systematic manner. This can be achieved through the use of the nursing process. As a community health nurse the nursing process is a scientific method that describes your interactions with the client either as an individual, a family, or a community. The community health nursing process provides the vehicle through which community health nurses work with people, and supports practice that exemplifies the standards of community health nursing. This unit will enlighten you on the utilization of nursing process in your community health practice.

Fig. 3.0 Community model

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- utilizecritical thinking to synthesize knowledge derived from art and science of nursing process in the practice of community health nursing.
- apply relevant theories and models in providing community health nursing care
- practice roles of the community health nursing competently
- apply the knowledge of the basic components of community health nursing in practice.
- describe the community as a client.
- explain the phases of community health nursing process.
- apply the nursing process in providing community health nursing care

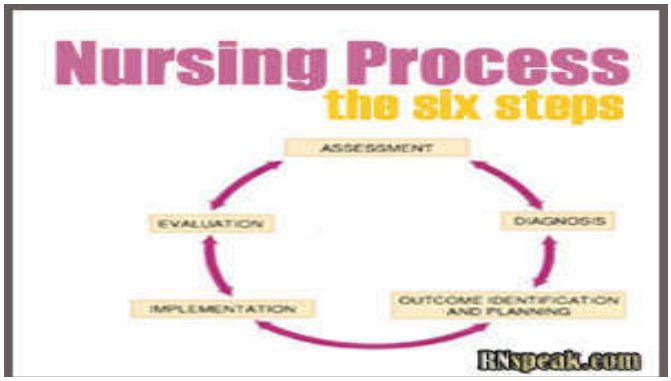

Fig. 3.1 Six step Nursing Process

3.0 MAIN CONTENT

3.1 Community as a Client

When you provide health care service at the community level, you are expected to consider every aspect of the community. Treating a community as a client is taking into cognizance the physical structure of the community and relationship between these structures and the health of the people living in that community. For you to conduct any form of intervention in the community, it is necessary for you to assess the community first. The community as a client refers to the broader concept of wide community as people for the nursing services in focus. It is important for as community health nurses, to note that working with communities has two important missions:

1. The community directly influences the health of the individuals; families, groups, and populations who may be a part of it.
2. Provision of the most important health services at the community level.

Fig. 3.2.Model of community as a client

Dimensions of the Community as Client
A community has three features

a. Location
b. A population
c. A social system

It is useful for you to think of these dimensions of every community as a rough map to follow for assessing needs or planning for service provision.

a. Location
Every physical community carries out daily existence in a specific geographic location. The health of a community is affected by this location including the placement of health services, the geographic features, plants, animals and animals and the human made environment.

Six Location Variables

- **Community boundaries**: To talk about community in any sense, one must first describe its boundaries. It serves as basis for measuring incidence of wellness and illness and for determining spread of a disease.
- **Location of health services**: When assessing a community, the community health nurse will want to identify the major health centers and know they are located. Use of health services depends on availability and accessibility.
- **Geographic features**: Communities have been constructed in every suitable physical environment and that environment certainly can affect the health of a community. Injury, death, and destruction may be caused by floods, cyclones, earthquakes volcanoes…etc. recreational activities at lakes, seashores, mountains promote health and wellness.
- **Climate**: Climate has a direct effect on health of a community e.g., extreme heat and cold.
- **Flora and Fauna**: Poisonous plants and disease carrying animals can affect community health.
- **Human made environment**: All human influences on environment (housing, dams, farming, types of industry, chemical wastes, air pollution…etc.) can influence levels of community wellness.

b. Population

Population consists not only of a specialized aggregate, but also of all the diverse people, who live within the boundaries of the community. The health of any community is greatly influenced by the population that lives in it. Different features of the population suggest the health needs and provide bases for health planning.

Population variables

- **Size:**the size of a population influences the number and size of health care institutions. Knowing community size provides important information for planning.
- **Density:**increased population density may increase stress. Similarly when people are spread out health care provision may become difficult.
- **Composition**: composition of the population often determines types of health needs. A health community is one that takes full account of and provides for differences in age, sex, educational level, and occupation of its members, all of which may affect health concerns. Determining a community composition is an important early step in determining its level of health.
- **Rate of growth or decline**: rapidly growing communities may place extensive demands on health services. Marked decline in population may signal of poorly functioning community.
- **Cultural difference**: health needs may vary among sub-cultural and ethnic populations. Cultural difference can create conflicting or competing demands for resources and services or create inter-group hostility.
- **Social class and educational levels**: social class refers to the ranking of groups within society by income, education, occupation, prestige or a combination of these factors. Educational level is a powerful determinant of health related behavior. Health promotion and preventive health services are most needed for people with low income and educational levels.
- **Mobility:**mobility of the population affects continuity of care and availability of services. Mobility has a direct effect on the health of a community.

c. Social system

In addition to location and population, every community has a third dimension, a social system. The various parts of community that interact and influence the system are called social system variables. These variables include; the **health, family, economic, educational, religious, welfare, legal, communication, recreational, and the political systems**. Although as community health nurses, we must examine all the systems in the community and how they interact, the health system is of particular importance to promote the health of the community.

Phases of community health nursing process.

The nursing process is a systematic way of determining a client health status, isolating health concern and problems, developing the plans to remediate them, initiating actions to implement the plan, and finally evaluating the adequacy of the plan in promoting wellness and problem resolution .Just as the standard nursing process, the community health nursing process comprise of the following stages;

- Community assessment
- Community analysis and diagnosis
- Outcome identification
- Planning
- Implementation
- Evaluation.

3.2 Community Assessment

Assessment is the first step of the nursing process, which means to collect and evaluate data/information about a community's health status to discover existing or potential needs as a basis for planning. It is a process of searching for and validating relevant community based data according to a specified method, to learn about the interaction among the people, resources and environment. Community assessment includes;

- Collecting pertinent community data
- Analyzing and interpreting the collected data.

Major Aspects of Community Assessment

- **Physical Environment:** Just as physical examination is important to individual patients, so is examination of the community physical environment. Five senses are used in physical assessment: inspection, auscultation, vital signs, system review, and laboratory studies.
- **Inspection**: inspection uses all sense organs and is done by walking survey in the community, or micro-assessment of housing, open spaces, boundaries, transportation service centers, markets places, meeting street people, signs of decay, ethnicity, religion, health and morbidity, political media.
- **Auscultation**: is listening to the community residents about the physical environment.
- **Vital signs**: observe the climate, terrain, natural boundaries such as rivers and hills. Community resources: look for signs of life such as notices, posters, new housing and buildings.
- **System review**: housing age, architecture, building materials used, signs of disrepair, running water, plumbing, sanitation, windows (glasses).etc. Also business facilities and churches.
- **Laboratory studies**: census data or planning studies for community mapping.
- **Health and Social System:** Differentiate between facilities located within the community and those located outside. Hospital number of beds, staffing, budget, health center, clinics, or health posts, public health services, private clinics, pharmacies, dental and other services. Signs of drugs or substance abuse, alcoholism. Social services include counseling and support, clothing, food, shelter and special needs as well as markets and shops.

i. **Economics:** Financial characteristics; median household income, percentage of households living in poverty, Labor force characteristics, employment status of the general population greater than 18 years of age. Occupational categories and percentage of persons employed by government, farmers, skilled, unskilled, professional, types of business/industry.

ii. **Safety and Transportation:** Police, sanitation (water source, solid waste disposal, sewage and air quality) and fire services. Primary means of transportation; walking, mule, taxi, bus, train, private car, and air services. Frequency and affordability of public/private transport, and standard of roads.

iii. **Politics and Government:** Peasant association, business alliances, religious groups, youth and women's associations, professional associations, ethical associations, political activism…etc. describe the associations' objectives and activities.

iv. **Communication:** Bulletin boards, posters, oral messages, radio, television, newspapers, postal services, telephone. telephone wires, magazines, and satellite dishes.

v. **Education:** Types of schools, colleges and universities. Note languages used, grades, courses offered, percentage of attendants (male, female), adequacy, accessibility, and acceptability of education. Average number of years completed by people at school.

vi. **Recreation:** Note facilities such as stadium, recreational areas, volleyball court, playground, picnic areas, museum, music/dancing, theatre/cinema. Who is going out about during the evening and in the morning? Teenagers, mothers and children, the homeless?

3.3 Community Assessment Tools

Assessment as the first phase of nursing process requires tools which includes;

i. **Survey Questionnaire**: One of the major tools for assessing community's strength and weaknesses. An effective community survey can reveal a wealth of useful and easily quantifiable information and is a good option for many projects. To conduct survey in the community, questions covering important areas of the community are asked. Such areas includes;

a) Location perspectives
b) Population perspectives
c) Social system perspectives
d) Community core

Fig. 3.3. Community health nurse conducting survey

a. Location perspectives

- Where is the community located
- What is the boundary?
- Where is the major health institution located?
- What major landforms are in or near the community?
- What geographic features offer opportunities for healthful activities?
- What are the average temperature and precipitation?
- What climatic features affect health and fitness (extreme temperatures)?
- What plants and animals pose possible threats to health?
- What are the major industries?
- How have air, land, and water been affected by humans?
- What is the quality of housing?
- Do highways allow access to health institutions?

b. Population perspectives

- What is the population of the communities (urban, rural)?
- What is the density of the population per square kilometer?
- What is the age and composition of the community?
- What is the marital status of the community?
- What occupations are presented in the community? In what percent?
- How has the population size changed over the past two decades?
- What are the health implications of the changes?
- What are the ethnic compositions of the community?
- What percentage of the population falls into each social class?
- What is the average income per family member?
- Are there any specific population such as migrant workers that are highly mobile ?
- Is the community organized to meet the health needs of the mobile group?

c. Social system perspectives

- What are the functions of each major system?
- What are the major organizations in each sub-system?
- Is there adequate communications among the major systems?
- Does the education system offer equal educational opportunities to all children in the Community?
- What is the level of health promotion in the community?

- Are there mechanisms for resolving conflicts?
- Does any part of the total system dominate the others?
- What community needs is not being met?
- What recreational facilities are available?
- What types of health services are available?
- What health services and resources are available?

d. Community core

The core of a community is its people- their history, characteristics, values and beliefs. The first stage of assessing a community, then, is to know about its people. Major components of community core;

1. History- history of that society
2. Demography- age, sex, ethnicity, marital status
3. Vital statistics- birth, death
4. Values beliefs, and religious practice of the people

ii. Focus Group Discussion

A focus group is a carefully planned discussion used to determine a community's preferences and opinions on a particular issue or idea. Conducting a focus group requires careful planning and someone skilled at facilitating discussion. Focus groups should consist of 6-12 participants. 10 is okay but 8 is ideal. Focus group discussion session should be between 45-90 minutes. Participants are asked a series of carefully warded questions that focus on different issues in the community.

Fig. 3.4. A focus group discussion session

iii. Panel discussion

A panel discussion is a guided exchange involving several experts on specific subjects. Panel discussion is carefully structured and typically

involves a facilitator who asks panelists specific questions about the community or a particular issue. Often, city governments, hospitals, universities pay experts to collect and interpret detailed information about communities and the issues they face. Drawing on this expertise is an excellent way to learn about a community without having to invest a lot of time or money in a new community assessment.

iv. Community cafe

Community cafe creates the atmosphere of a restaurant or a cafe in which small groups of people from the community discuss issues raised by facilitators.

v. Community mapping

This is used to reveal peoples different perspectives about a community. It requires few resources and a little time and can be adapted for participants of virtually any age or educational background.

vi. Daily activities schedule:

Finding about the work habits of community members is an excellent way to learn about a community division of labour and perception of work based on gender and age.

vii. Seasonal calendar

This activity reveals changes in seasonal labour supply and demand, household income patterns, food availability and demands on public resources, such as schools, mass transit systems and recreational facilities.

viii. Asset inventory

An asset inventory is a technique for collecting information about a community through observation. It is similar to a shopkeeper taking stock of merchandise. It works best when conducted at a community meeting or gathering.

3.4 Community Analysis and Nursing Diagnoses Community Analysis

Analysis is the study and examination of data. Analysis is necessary to determine community health needs and strength as well as to identify patterns of health responses and trends in health care use. Community analysis, like so many procedures we carry out, may be viewed as a process with multiple steps. The phases of analysis include:

- **Data categorization**
- **Data summarization**
- **Comparing data**
- **Draw inferences**

Community nursing diagnosis

This is a statement that defines the health strength, health problems or health risks of the community. Nursing diagnosis is a real clinical judgment or conclusions about human response to actual or potential problems. A community diagnosis forms the basis for community based intervention. A nursing diagnosis has three parts

- Description of the problem (specific target or groups)
- Identification of factors/etiology related to the problem
- The sign and symptoms (the manifestations) that characteristics of the problem.

Examples of nursing diagnosis:

- High infant mortality related to inadequate antenatal care, maternal nutrition, and unhygienic delivery practice evidenced by infant mortality rate 80 /1000 live births.
- Inadequate antenatal carerelated to inadequate health information or service accessibility evidenced by 80% of female delivering at hospital with no antenatal care.
- Inadequate nutritional status of under-five children in thecommunity related to knowledge deficit regarding weaning diet as evidenced by growth monitoring chart.

3.5 Outcome identification

Outcome identification is a new concept in the process that involves a setting a predetermined goal to be achieved at the end of the interaction between the community health nurse and the community. This the step where the community health nurse and the community as a client identify the goals of client (community) care which are client centred and time-bound. This step will help guide the community health nurse in the selection of nursing interventions that are beneficial, cost-effective and risk-free for the community. The community health nurse develops outcomes for the patient to achieve showing an optimum or improved level of functioning in the problem areas identified in the nursing diagnoses. It is developed to make the nursing care both individualized for the patient and realistic for the community, hospital or home care setting.

3.6 Planning

It is a logical, decision making process of design an orderly, detailed programs of action to accomplish specific goals and objectives based on assessment of the community and the nursing diagnosis formulated. A care plan is usually designed at this stage. The care plan consists of 5 columns which are; nursing diagnosis, nursing objective, nursing intervention, scientific rationale and evaluation. The nursing diagnosis is derived from the second phase of nursing process.

Activities in planning:
Setting priorities involves:

- assigning rank/importance to client's needs.
- determining the order in which the goal should beaddressed. The goal can be immediate, intermediate or long range goal.
- establishing goal and objectives

Goal is a broad statement of desired end results. Objectives are specific statement of the desired outcomes. Characteristics of good objectives include;

- **Specific**- target specific population
- **Measurable**- when the results are stated
- **Achievable**- within the capacity of the available resources.
- **Relevant**- fits with the general policies
- **Time bound**- that is achieved within specified timeframe.

Planed actions are specific activities or methods of accomplishing the objectives or expected outcomes. An outcome measurement is judging of the effectiveness of goal attainment. How and when was each objective met, why not?

3.7 Implementation

Implementation is putting the plan into actions and actually carrying out the activities delineated in the plan, either by nurse or other professionals. It is the action phase of the nursing process. Community interventions are the therapeutic actions designed to promote and protect the community health, treat and remediate community health problems and support the community as it changes over time.

Key areas of nursing intervention in the community are:

- link the community members with the available resources
- pulls together information and resources to assist community in addressing its health concern andproblems
- harmonize its strength through facilitation, education, organization, consultation and directcare.

3.8 Evaluation

It is systematic, continuous process of comparing the community's response with the outcome as defined by the plan of care. The ultimate purpose of evaluating interventions in community health nursing is to determine whether planned actions met client needs, if so how well they were met, and if not why not. Evaluation requires a stated purpose, specific standards and criteria by which to judge and judgment skills.

4.0 CONCLUSION

When you provide health care service at the community level, you are expected to consider every aspect of the community. Treating a community as a client is taking into cognizance the physical structure of the community and relationship between these structures and the health of the people living in that community.

5.0 SUMMARY

Considering the community as a client is necessary if you are to assess needs and plan for care in the community. Every community is made up of

3 major dimensions which are; location, people and social system. Interaction among these dimensions affects the health of the people living in that community. Community health nursing process consists of six phases which if applied to practice will enhance client care.

6.0 TUTOR-MARKED ASSIGNMENT

Using the community in which you work, conduct an assessment using at least two convenient tools and identify two nursing diagnoses for that community. Discuss your findings with your colleagues in the discussion forum.

SELF-ASSESSMENT EXERCISE

You have learnt the various aspects of community as a client and nursing process in the community. Can you assess your understanding of the above subject matter with the following questions:

1. What do you understandby the term‘community as a client’?
2. explain the phases of community nursing process ?
3. how can you apply the nursing process in providing community health nursing care?

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UNIT 2 THEORIES AND MODELS FOR COMMUNITY HEALTH NURSING

CONTENTS

1.0 INTRODUCTION

In your daily practice of community health nursing you encounter a variety of situations and cases, there is need to have evidence and rationales that guides, predicts, prescribes, explains, describes and shapes your practice. Major sources of evidence for your practice are theories related to community health nursing practice. Commonly used theories, models, and concepts in community health nursing discussed in this unit.

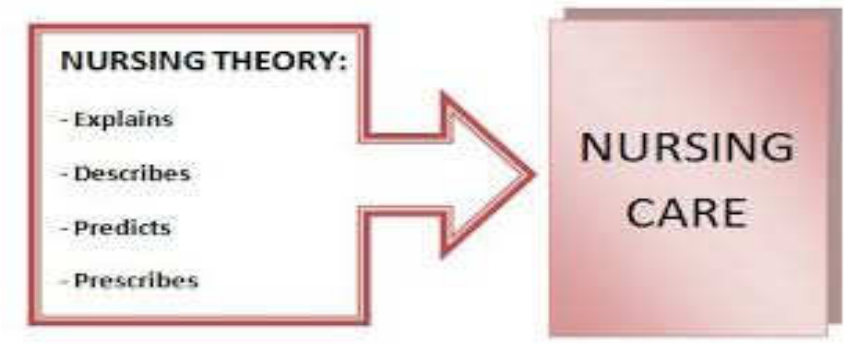

Fig 3.2.1 Functions of nursing theories

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- explain theories and models related to community nursing health practice
- apply related theories and models in providing community health nursing care services.

3.0 MAIN COPNTENT

3.1 Florence Nightingale Theory of Environment

Fig. 3.2.2. Florence Nightingale

According to Florence Nightingale, restoration of health status of clients is an inseparable component of delivery of health care. Her theory focused on manipulating a patient's environment to facilitate healing of the body. This

theory can be modeled into practice by assessing a patient's environment for factors that can hinder or promote health, then creating an environment that will contribute to more positive health outcomes for the patient. Some of these factors may be nutrition, hygiene or socialization.

3.2 Martha E. Rogers science of unitary human being

Rogerian or Roger's model of the science and unitary man provides the way of viewing the unitary human being. According to it human beings are integral part of the universe. The two form a single entity. Person and environment are energy fields that evolve synergistically. Nursing is a basic scientific discipline. Nursing is using knowledge for human betterment. The unique focus of nursing is on the unitary or irreducible human being and the environment (both are energy fields) rather than health and illness.

3.3 Block Andjosten's Ethical Theory of Population Focused Nursing

Derryl Block and Lavohn Josten, public health educators proposed this based on intersecting fields of public health and nursing. They have given 3 essential elements of population focused nursing that stem from these 2 fields:

- an obligation to population
- the primacy of prevention
- centrality of relationship- based care

The first two are from public health and the third element from nursing. Hence it implies to nursing that relation-based care is very important in population focused care.

3.4 Nola J Pender's Health Promotion Model

Health Promotion Model has given health care a new direction. According to her, Health Promotion and Disease Prevention should be the primary focus in health care, and when health promotion and prevention fail to prevent problems, and then care in illness becomes the next priority. She defined 2 concepts: health promotion & health protection. Health promotion is defined as behaviour motivated by the desire to increase well-being and actualize human health potential. It is an approach to wellness. On the other hand, health protection or illness prevention is described as

behaviour motivated desire to actively avoid illness, detect it early, or maintain functioning within the constraints of illness.

3.5 Betty NeumanHealth Care System Model

Neuman's model includes intrapersonal, interpersonal and extra personal stressors. Nursing is concerned with the whole person. Nursing actions (Primary, Secondary, and Tertiary levels of prevention) focuses on the variables affecting the client's response to stressors.
According to this model, the nurse should remember that the patient is greater than the sum of the sum of the body parts or sum of the systems he is made off. Therefore in her dealings with them she should adopt the holistic approach.

3.6 Dorothea Orem self-care model

Also known as 'self-care' model of nursing, the goal of Dorothy Orem's theory is to help the patients regain the ability to care for their self. Using this theory as a model for nursing care requires finding out what self-care needs the client is unable to fulfill herself and why she can't do those things, then providing the assistance necessary to help the client perform those activities with the intention of increasing the client's abilities to do them herself later.

3.7 Milio's frame work of prevention

Nancy Milio a nurse and leader in public health policy and public health education developed a framework for prevention that includes concepts of community-oriented, population focused care.(1976,1981). The basic treatise is that behavioral patterns of populations and individuals who make up populations are a result of habitual selection from limited choices. She challenged the common notion that a main determinant for unhealthful behavioral choice is lack of knowledge.

3.8 Salmon white's construct for public health nursing

Mark Salmon White (1982) describes public health as an organized societal effort to protect, promote and restore the health of people and public health nursing as focused on achieving and maintaining public health. He gave 3 practice priorities i.e.; prevention of disease and poor health, protection against disease and external agents and promotion of health. For these 3 general categories of nursing intervention have also been put forward, they are: education directed toward voluntary change in the attitude and

behaviour of the subjects. Scope of prevention spans individual, family, community and global care. Intervention target is in 4 categories: Human, environmental, medical/technological/organizational and social

3.9 Roy's adaptation model

Adaptation is a process of responding positively to the unending changes in the environment and stimuli affecting people. Sister Callista Roy's adaptation theory focuses on helping the client adapt to changes in his body functioning, emotional states and roles in his family, society or elsewhere, and achieving a balance between being dependent and independent. The nurse applying this model first finds out what conditions are causing problems for the client and assesses how the client is adapting to them. Then she designs interventions aimed at helping the client adapt better.

3.10 Canadian model for community

The community health nurse works with individuals, families, groups, communities, populations, systems and/or society, but at all times the health of the person or community is the focus and motivation from which nursing actions flow. The standards of practice are applied to practice in all settings where people live, work, learn, worship and play. The philosophical base and foundational values and beliefs that characterize community health nursing - caring, the principles of primary health care, multiple ways of knowing, individual/community partnerships and empowerment - are embedded in the standards and are reflected in the development and application of the community health nursing process. The community health nursing process involves the traditional nursing process components of assessment, planning, intervention and evaluation but is enhanced by community health nurses in three dimensions:

- Individual/community participation in each component;
- The inherent influence of the broader environment on the individual/community that is the focus of care (e.g. the community will be affected by provincial/territorial policies, its own economic status and by the actions of its individual citizens).
- The model illustrates the dynamic nature of community health nursing practice, embracingthe present and projecting into the future. The values and beliefs (green or shaded) ground practice in the present yet guide the evolution of community health nursing practice over time.

4.0 CONCLUSION

Nursing is using knowledge for human betterment. The unique focus of nursing is on the unitary or irreducible human being and the environment (both are energy fields) rather than health and illness.

5.0 SUMMARY

This unit discussed nursing theories that are related to practice of community health nursing. These theories give the rationale and evidence that supports and shapes community health nursing practice.

6.0 TUTOR-MARKED ASSIGNMENT

Pick a community health nursing theory of your choice, read extensively on it and apply it to plan community health nursing care using an identified community health diagnosis from your previous unit activity. Discuss your work with your colleagues in the in the discussion forum.

SELF ASSESSMENT EXERCISE

After going through this unit you can assess yourself by attempting the following questions.

i. State the nursing theories and models related to community nursing health practice?
ii. How can you relate the theories and models you have learntto practice of community health nursing?

7.0 REFERENCES/FURTHER READING

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UNIT 3 BASIC COMPONENTS/ELEMENTS OF COMMUNITY HEALTH NURSING

CONTENTS

1.0 INTRODUCTION

Community health nursing practice does not occur in isolation but rather within an environmental context, such as policies within their workplace and the legislative framework applicable to their practice. The standards of practice revolve around both the values and beliefs and the nursing process with the energies of community health nursing always being focused on improving the health of people in the community. There are basic concepts that must be followed if you are to practice efficiently in the community. This unit will take you through basic components/elements of nursing practice incorporated in community health programs.

Fig. 3.1.1 A community health nurse on duty

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- describe the basic components of community health nursing practice
- apply the basic components of community health nursing practice in utilizing the nursing process.

3.0 MAIN CONTENT

3.1 Advocacy

Advocacy helps individuals, families, and groups become aware of issues that may impact on their health; the focus may be on those who are disadvantaged due to socioeconomic status, age, isolation, culture, lack of knowledge, etc. It involves working to develop clients' capacity to speak for themselves, Using advertising and media in skilful ways, for advocacy.

Promoting resource development that will lead to equal access to health and health-related services. Using collaborative approaches and acts as an advocate for change, and showing a strong commitment to equity and social justice and speaks out for equity in health through legislation and policy-making activities. The community health nurse should always act as spokesperson, when asked, to represent the views of individuals and groups seeking to promote their health.

3.2 Building capacity

Community health nurses should encourage and support the community to be active in stating and taking ownership of health issues that need to be resolved; this may include working with the community to develop skills in how to access resources, how to develop social networks, and how to learn from the efforts of others. They act as a catalyst to help resolve issues and concerns. They educate the community members about the political process as it relates to community health issues and about how they can become active in decisions about health issues. They Help the community better understand that their own abilities may be their best health resource and uses group process and leadership skills while practicing.

3.3 Building coalitions and networks

A community health nurse should see the need for and identify opportunities to build coalitions and networks to promote health or prevent illness. She Facilitates skill development (capacity building) of community members and supports community engagement. This Makes clear how leadership and guidance will work and supports development of agreed-upon roles, rules, and procedures. It will also help to create links between the broader community and the coalition/network. Building coalition networks Provides support as requested by the coalition or network, counselling, establishes a therapeutic relationship based on trust, respect, caring, and listening, uses clinical skills to assess the client's ability to participate in joint planning, implementation, and evaluation of nursing interventions.

3.4 Case management

Case management as a component of community health nursing practice requires the nurse to;

i. Actively engages with individuals, groups, and communities; this may involve case-finding, a process of identifying individuals and/or families who may be at risk and who meet the agency's criteria for case management.
ii. Assesses the resources and services that will be needed to build on the client's strengths and skills and thus help the client to attain and/or maintain a desired health status or set of healthy behaviours for improved quality of life.
iii. Builds trusting relationships and works with clients to identify and resolve health issues.

iv. Develops, implements, and evaluates an agreed-upon plan with the client; the plan respects the client's (and sometimes a family's) control over their health and decisions; it prepares the client for an end to the professional relationship (except when child protection or other welfare concerns apply).
v. Supports individuals and families to build on their strengths and skills so they can find and access available resources and services and thus attain or maintain a desired health status.
vi. Links individuals and/or families with needed services and resources.
vii. Uses an inter-disciplinary approach and cooperates with other organizations as needed, basedon how complex the circumstances are.
viii. Coordinates services and applies plans in a logical sequence together with individuals and/or families.
ix. Helps to resolve potential or actual barriers in the way services are provided
x. Evaluates progress with individuals and/or families and revises service plan(s) as needed.

Fig. 3.3.2. Community health nurse on duty

3.5 Communication

This is the use of oral and written skills, along with visual, print, and other media outlets to:

i. build trusting, helping relationships and convey health information, including details on risk.
ii. assess knowledge, attitudes, beliefs, etc.,
iii. help clients find options for making choices that will meet their health needsand/or allow them to speak up for themselves.

iv. Negotiate or contract with health care, social services, or resource agencies, and all segmentsof the community, to ensure clients have access to services.
v. Use effective communication with team members.
vi. Effectively address and manage conflict.
vii. Contribute to and play an active role in health promotion and social marketing that support attitudes and/or beliefs to reduce health inequalities and improve health outcomes.
viii. Work to achieve inter-agency and inter-governmental cooperation.
ix. Use effective risk communication approach.
x. Act as a spokesperson, as needed, on public health issues.
xi. Use appropriate technology to manage, mitigates, and communicates about public health events; this includes good record keeping.

3.6 Community development

This is the application of knowledge of community assessment and community development models to support public participation in identifying and resolving health issues. It uses a strengths-based approach that supports capacity development and empowerment in the community. Works with the community to make decisions about, and claim ownership of, changes needed to enhance community health. It also recognizes the value of community wisdom and supports community-generated plans for economic development, environmental improvement, or other community-based plans. Community development assists in the development of health services and programs based upon community assessments, in order to meet the health needs of the community. It fosters and supports inter-agency links and working relationships. In developing programs, it uses awareness of factors which impact on or affect health such as social, cultural, and economic issues, as well as environmental hazards.

3.7 Consultation

i. Uses knowledge and expertise in public health, especially in health promotion, disease and injury prevention, epidemiology, and emergency preparedness to inform clients, lay helpers, nursing students, colleagues, other professionals, professional associations, non-profit agencies, organizations, institutions, the public, and all levels of government.
ii. Acts as a resource person to communities, groups, and individuals.
iii. Uses knowledge of a community to link those needing services to the correct community resources.

iv. Uses discussion with the client to clearly outline what will happen during a consultation.
v. Collaborates with the client and adapts the consultation to meet the client's needs; helps the client find ways and options for change and improvement.

3.8 Facilitation

Works with groups or individuals to use effective processes to:

- Bring people together and create a setting where ideas and points of view may be shared openly;
- Clarify issues or processes;
- Ensure that meetings are run well and achieve a high degree of agreement onthe meeting's stated goals and objectives.
- support building of community, group, and individual capacity.

3.9 Health education: Here the community health nurse;

i. Assesses the knowledge, attitudes, values, beliefs, behaviours, practices, stage of change, and skills of the learner.
ii. Considers contexts that may impact the person's ability to learn, such as environment, readiness, and other factors; involves the learner in setting health education needs.
iii. Supports knowledge development, generation, and translation.
iv. Selects and adapts the teaching methods that are most likely to meet the needs of the learner and considers the learner's cultural preferences and stage of change.
v. Uses content expertise on a topic to offer formal presentations and educational programs, as well as informal teaching to communities, groups, families, and individuals.
vi. Emphasizes health promotion, disease and injury prevention, and the determinants of health.
vii. Includes knowledge of behavioural sciences in teaching and applies the correctlearning principles, pedagogy, and educational theories to educational activities.

3.10 Health threat response

i. Supports early identification of a health threat by gathering data from many sources at the same time (to understand the cause, natural course, and expected outcomes of the disease or health threat).

ii. Follows established criteria for responding to population-level threats (such as fire or flood) as well as criteria for case investigation including: the collection and analysis of data from multiple valid sources; identification of factors likely to cause the problem or risk; offering options for prevention (at the primary, secondary, or tertiary levels); providing options for preventive care as required; and referral and follow-up for those who need treatment.
iii. Uses effective risk communication techniques to inform individuals and the public, as well as colleagues and other health professionals.
iv. Evaluates the impact of the public health response and identifies implications for future practice.

Leadership

The community health nurse as a leader;

i. Applies current knowledge of professional, community, and political issues to develop a proactive approach to health and environmental issues.
ii. Initiates and participates effectively in intersectoral efforts.
iii. Initiates action and encourages individuals, the community, and people in positions of power to take action.
iv. Acts as an interim leader until the community can take the needed action. Outreach
v. Uses community assessment data to determine population health needs and designs activities to address the unique features of the population of interest.
vi. Uses strategies to engage with people where they live, work, learn, or play.
vii. Builds trusting relationships and engages the client in identifying and resolving health issues.
viii. Uses a holistic approach which includes finding solutions to service access barriers.
ix. Seeks to get involved in, change, and provide services in environments where risk is higher (engages in harm reduction activities).
x. Uses proven methods, such as early involvement of key stakeholders when developing outreach plans.

Policy development and implementation

The community health nurse;

i. Identifies areas in need of policy and program development.
ii. Participates in implementing and evaluating policy.
iii. Helps to set clear philosophies, policies, standards of practice, and program objectives with measurable outcomes for nurses and other health care providers.
iv. Uses the political process to promote health.
v. As a delegated act, may enforce policy by requiring others to comply with laws,rules, regulations, and policies.

Referral and follow-up

To ensure referral and follow-up, the community health nurse;

i. Supports the client's control of referrals and follow-up; this includes the client's right to refuse a referral.
ii. Supports the referral process by using a number of ways to ensure, where possible, that a link to service has occurred.
iii. Uses links with other providers, organizations, and networks to make needed resources and services available to populations at risk.
iv. Carries out intervention strategies that fall within the employer/agency's mission and goals.
v. Helps to evaluate referral and follow-up processes and strategies.

Research and Evaluation

The community health nurse as a researcher;

i. Identifies and supports investigation into key issues and approaches relevant to community health and wellness; where possible, uses the right methodology, such as participatory research methods, to involve community members in planning or carrying out research.
ii. Shares research and program evaluation information with colleagues, educators, nursing students, other professionals, and the public.
iii. Participates in research projects.
iv. Uses structure, process, and outcome-oriented research as a guide to practice and evidence-informed decisions.
v. Uses research findings to assign human and financial resources and to evaluate interventions.
vi. Identifies program areas which need to change; works with other colleagues to alter programs.

Resource Management, Planning, Coordination

This requires that the community health nurse;

i. Uses evidence-informed and best practices in planning to support responsible and accountable resource management.
ii. Applies concepts of social justice in assigning time and other resources to promote health equity.
iii. Acts as agent to marshal and advocate for human, financial, and physical resources.
iv. Involves communities, families, and individuals in health services planning and priority setting.
v. Shares information about community resources.

Screening

Screening entails that the community health nurse;

i. Conducts evidence-based screening.
ii. Ensures the client understands the reason for screening and the procedure; ensures that follow-up is available.
iii. Monitors and evaluates screening activities and documents both the process and the results.
iv. Seeks input from those to be screened and collaboratively designs culturally sensitive interventions with other professionals.
v. Uses screening activities as an opportunity to provide health education and counselling.

Surveillance

i. Uses resources and the correct technology to get the information that is needed about a problem, its natural course, and its aftermath.
ii. Actively participates in informal surveillance and shares findings with those whomay be able to use it.
iii. Follows established protocols for surveillance, such as maintaining the confidentiality of data/information, and collecting enough data from a number of reliable sources.
iv. Uses and applies surveillance information to practice.
v. Interprets and shares surveillance data in a way that decision-makers, the community, and the public can understand.

vi. Understands the implications of surveillance data.

2.3.17. Team Building and Collaboration

The community health nurse in order to ensure collaboration;

i. Uses techniques that foster team building, mutual respect, and joint decisionmakingin all interactions with colleagues, educators, nursing students, otherprofessionals, and the public.
ii. Uses mediation skills to facilitate inter-agency and inter-governmentalcooperation.
iii. Commits to a capacity-building approach that uses collaboration (with two ormore people or organizations) to promote and protect health.

Fig. 3.3.3. Community health nurse fostering collaboration with community members

Major Setting S for Community Health Nursing Practice

Community health nursing practice is not limited to a specific area, but can be practiced anywhere. Settings for community health nursing can be grouped into six categories:

1. Homes
2. Ambulatory care settings
3. Schools
4. Occupational health settings

5. Residential institutions, and
6. The community at large.

Fig 3.3.4. A market community setting

5.0 SUMMARY

This unit discussed the basic components/ elements of community health nursing practice, they include Advocacy, building capacity, building coalitions and networks, case management, communication, community development, consultation, facilitation, health education, health threat response, leadership, policy development and implementation, referral and follow-up, research and evaluation, resource management, planning, coordination, screening, surveillance, team building and collaboration. This unit also discussed the major settings in which community health nurses practice.

6.0 TUTOR-MARKED ASSIGNMENT

Based on the major components of community health nursing practice discussed in this unit, identify two other settings in your community that was not stated in this unit in which community health nurses can practice.

SELF ASSESSMENT EXERCISE

You have learnt the basic components of community health nursing practice, can you attempt the following question to assess your understanding of the unit.

i. What are the basic components of community health nursing practice?
ii. How can you apply the basic components of community health nursing practice in utilizing the nursing process?

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UNIT 4 PROFESSIONAL ROLES OF PUBLIC/ COMMUNITY HEALTH NURSE

CONTENTS

1.0 INTRODUCTION

For you to function effectively in your roles as acommunity health nurses, you must use advanced decision-making strategies such as the nursing process, which combines judgment, action, responsibility, and accountability. Public health/community health nurses must take the time to inform themselves about current community health issues and new technologies, so you can properly apply public health science and epidemiological principles to your work. The roles includes;Health Promotion, disease and injury prevention, health protection, health surveillance, population health assessment and emergency preparedness and response.

Fig 3.4.1. Roles of a community health nurse

2.0 OBJECTIVES

At the end of this unit, you shouldbe able to:

- to describe the roles of community health care nurses.
- explain specific duties performed by nurses in each role.

3.0 MAIN CONTENTS

3.1 Role in Health Promotion

Community health nurses encourages the adoption of health beliefs, attitudes, and behaviours that contribute to the overall health of the population through public policy, community-based action, public participation, and advocacy or action on environmental and socio-economic determinants of health, as well as health inequities.

They support public policy changes to modify physical and social environments that contribute to risk. They also assist communities, families, and individuals to take responsibility for establishing, maintaining, and/or improving their health by adding to their knowledge or control over (and ability to influence) health determinants.Encourages skill building by communities, families, and individuals so they can learn to balance choices with social responsibility and, in turn, create a healthier future for all. Works with others and leads processes to enhance community, group, or individual plans that will help society to plan for, cope with, and manage change. Initiates and participates in health

promotion activities in partnership with others such as the community and colleagues in other sectors.

3.2 Role in Disease and Injury Prevention

Community health nurses work to reduce the risk of infectious disease outbreaks; this includes early identification, investigation, contact tracing, preventive measures, and activities to promote safe behaviours. Applies epidemiological principles and knowledge of the disease process so as to manage and control communicable diseases using prevention techniques, infection control, behaviour change counseling, outbreak management, surveillance, immunization, episodic care, health education, and case management. Uses appropriate technology for reporting and follow-up. Uses effective strategies to reduce risk factors that may contribute to chronic disease and disability; this may include changes to social and economic environments and inequities that increase the risk of disease.Helps individuals and families to adopt health behaviours that reduce the likelihood of disease, injury, and/or disability.Encourages behaviouralchanges to improve health outcomes.

Fig 3.4.2. Community health performing her role of disease prevention

3.3 Role in Health Protection

The community health nurse acts in partnership with public health colleagues, government, and other agencies to:

i. ensure safe water, air, and food,
ii. control infectious diseases, and
iii. Provide protection from environmental threats (including delegating orcarrying out delegated regulatory functions).

They take the lead in identifying issues that may need attention and offers public health advice to groups such as municipal governments or regional districts about the public health impact of policies and regulations. They also work with individuals, families, and communities to create or maintain a safe environment where people may live, work, and play.

3.4 Role in Health Surveillance

The community health nurse should be aware of health surveillance data and trends; applies this knowledge to day-to-day work. Other health surveillance roles of the community health nurse include;

i. Integrating eco-social surveillance that focuses on broad, multi-level conditions that contribute to health inequalities.
ii. Mobilizing formal and/or informal networks to systematically and routinely collect and report health data for tracking and forecasting health events or health determinants.
iii. Collecting and storing data within confidential data systems; integrating, analyzing, and interpreting the data.
iv. Providing expertise to those who develop and/or contribute to surveillancesystems, including risk surveillance.

3.5 Role in Population Health Assessment

Population health assessment as a role of the community health nurses entails using health surveillance data to launch new services or revise those that exist and contributing to population health assessments and includes community viewpoints. They also play a key role in producing and using knowledge about the health of communities (or certain populations or aggregates) and the factors that support good health or pose potential risks (determinants of health), to produce better policies and services.

3.6 Role in Emergency Preparedness and Response

Community health nurses as part of their roles in emergency preparedness and response performs the following roles;

i. Contributes to and is aware of public health's role in responding to a public health emergency.
ii. Plans for, is part of, and evaluates the response to both natural disasters (such as floods, earthquakes, fires, or infectious disease outbreaks) and man-made disasters (such as those involving

explosives, chemicals, radioactive substances, or biological threats) to minimize serious illness, death, and social disruption.

iii. Communicates details of risk to population subgroups at higher risk and intervenes on their behalf during public health emergencies using a variety of communication channels and engagement techniques.

Other roles of a professional community health nurse includes; care provider, educator, advocate, manager, collaborator, leader, and researcher.

4.0 CONCLUSION

Community health nurses encourages the adoption of health beliefs, attitudes, and behaviours that contribute to the overall health of the population through public policy, community-based action, public participation, and advocacy or action on environmental and socio-economic determinants of health, as well as health inequities.

5.0 SUMMARY

This unit discusses the roles of community health nurses in the community. The roles includes; care provider, educator, advocate, manager, collaborator, leader, and researcher, Health Promotion, disease and injury prevention, health protection, health surveillance, population health assessment and emergency preparedness and response.

6.0 TUTOR-MARKED ASSIGNMENT

Study your community and identify 5 other roles a community health nurse can perform. Discuss your findings with your colleagues in the discussion forum.

SELF-ASSESSMENT EXERCISE

Can you attempt the following question in order assess your understanding of the roles of community health nurses.

i. What are the roles of community health care nurses?

ii. Explain specific duties performed by community health nurses during emergencies?.

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MODULE 4 THE FAMILY – THE UNIT OF CARE AT THE COMMUNITY LEVEL

CONTENTS

1.0 INTRODUCTION

The importance of family and family considerations become vividly important for a nurse while practicing in community health setting. Family usually involves a residence in which family .members, friends, relatives interact with each other, that is, how human beings are influenced by each other, the phenomenon that is strong within the family setting. The common meaning, all over the world about family, is that family is a nuclear family unit which is structurally composed of a man and a woman who is married and have children. Different people have defined family in different ways and the definition reflects some thinking about the concept of family.

In this unit you will learn the concept, definition and functions of family and how family is considered as a unit of community health service. You will also gain an understanding of objectives of family health care and its advantages and principles. At the end you will also learn about health tasks family members perform, and plan family nursing care while working with the family in community health nursing field.

2.0 OBJECTIVES

In this unit you will learn about concepts and principles of Family and Family Health Care in community set up. After going through this unit, you should be able to:

- Define family as a unit of health service in community health List
- And describe the functions of the family
- Describe the family as a natural and fundamental unit of communityhealth nursing Services
- Explain how family.isconsidered as patient in community health
- nursing practice
- List the factors that affect the family and its functioning
- Describe the health tasks each family is performing
- List and describe the objectives and principles of family health care
- Explain how as a community health nurse you should work with thefamilies in providing family health care.

3.0 MAIN CONTENT

Concept, Definition and Functions of the Family

3.1 Concept and Definition of Family

The interest in, and concern for, the health of the family as a unit in societyhas come about with the growth of understanding that the health of eachindividual is affected by and affects the health of the individuals with whom he is in relationship. Each person's most intimate relationships from birth are with the members of the family in which he or she is born and later as a member of the new family he or she helps to found for the rearing of another generation. Thus relationships in families are important for health. A 'family', as the word is commonly used, is a group of individuals who live together as a social unit usually, but not always, related by blood or social or legal contracts (parents, children, relatives; servants, visitors, etc.). They live as a household usually under the headship of one senior member and share the same food and environment. Throughout history, although differing in form from place to place and time to time, there has always been this type of a social unit, and it has played a key role as a basic biological institution. It changes and adjusts but remains central for reproduction, the rearing of children; the socialization of individuals and the organization of roles.

This description is not a definition. A definition may vary with the purpose to which it is related. Thus the United Nations' definition of a family is `those members of a household who are related to a specific degree through blood, adoption and marriage. However, for health purposes it is the 'household' which is usually more important (e.g., epidemiologically).

This social unit, family or household, has a life of its own, as a group has roles in which the individual members play their parts.

3.2 Functions of the, Family

The family is an active social unit always changing and always related toother families within the society of which it is a part. Its functions arecomplex and far-reaching, but specific areas can be described.

Areas of Family Functioning-(WHO)

Biological	Psychological	Socio-cultural	Economic	Educational'
Reproduction and child-bearing	Emotional security of members	The transfer of values relating to behaviour, tradition, language and 'mores'	Acquisition of resources to fulfil other functions	Inculcation of skills, attitudes and knowledge relating to other functions
Rearing of children	Sense of identity for members		Distribution of resources expenditure, savings	
Nutrition of family members				Preparation for adult life
Protection of health of family members at all ages	Maturation of person-ality	Socialization of children		Fulfilment of adult role
	Psychological protection	The formulation of norms of behaviour for all stages in development and adult life	Economic buffering of members of family	
Recreation for family and its members	Ability to make relation-ships outside the family			

One possible grouping of these is into biological, psychological, socio-cultural, economic and educational (Table 1.1), and under each heading further analysis is possible. This table must, however, be recognized as a

simplification for the purposes of description for each area, and each item within that area are related to and affected by all the others; all, affect family well-being, and many affect and are affected by the health of individuals.

All these items can be treated as variables affecting family health, and it can also be seen that the effects of different variables will vary through the chronological duration of a family.

3.3 Family as a Unit of Community Health Service

We spoke about the concepts, definitions and functions of family. Now we shall talk about family as a Unit of Service.

Family as a Unit of Service
In community health nursing practice family is considered as a unit of service because of the following reasons:

i) Family is a natural and fundamental unit of society. Every individualin the community is the member of the family. Families throughoutthe world virtually comprise a community. Intimacy of contacts, social and legal obligations are because of family membership; structure and role of family members. The degree to which family can move as a unit to deal with their own problems can maximize the potential of each of its members. This will also influence the capability of the family for dealing with their own health matters.
That is why quality of the functioning of the family is of central concern for the community health nurse.

ii) The family as a group generates, prevents, tolerates or corrects health problems within its membership. Health problems may be causedbecause of family behaviour or relationship. For example diseasesmay be transmitted because of lack of. knowledge or the style of family living. Improvement in the health behaviour may contribute in treatment and prevention of further spread of disease. Similarly diseases or defect may be transmitted in the family because of emotional imbalance and correction in this imbalance may facilitate treatment and prevent illness.

iii) The health problems of family are interlocking. The health of any family member may affect health of others. For example, the toddlerchild who is sick in the family may have its effect on mother's healthor the person who is caring for the child because of extra effort involved or disease transmission.

iv) The family provides crucial environmental force, each member of family constantly interacts with other members and the environment..
The individual responds in its own ways and affects family environment by his own presence. Each person in the family serves toreinforce, to preserve or to modify the existing physical environmentwhich finally strengthens or weakens the cohesiveness of family as aunit and functioning of the family in its environment.

v) The family is the most frequent locus of health decision and action in personal care. The health decisions are most often taken by members of the family. It depends who is directing in the family, influences the decisions for health actions. For example, the father may influence mother's decision to receiver proper immunization of child or grandmother may influence child rearing practices or encourage home remedies. The family is also a frequent provider of health care. Care of person with minor ailments, long-term illness, pre and post hospital care for acute illness are generally provided at home by the family members. Hence, the ability of the family to provide nursing care for its members is an important factor in health care.

vi) The family is an effective and easily available channel for most of thecommunity health nursing effect. The family becomes the means of extending a nurse's influence to those members whom she cannot personally see. Through family approach she is able to reach all the members of the family.

So the community health nurse may consider family asa unit of service justas a clinical nurse in the hospital setting may consider an individual patient as a unit of service.

3.4 Family as a Unit of Community Health Nursing Practices

Community health nursing services will depend upon the type of the family and its membership or the needs reflected bythe family. These will depend upon how family presents as a unit of community health nursing service. Let us discuss further.

The family is a product of time and place:-Family is a universal phenomenon. The type of family and how family is organized will vary with time and place, increasing technology and urbanization encourages both parents as wage earners. The economic function of family may besubordinated to its social function whereas in agricultural village of developing country the family may be organized as an extended group with

clearly defined roles. Family size is also affected by social conditions. It increases in good times such as rise of economic level, and falls in poor times such as war or death of the wage-earner.

The family develops its own life style:-Each family develops its own set of values, its own pattern of behavior and its own style of life. Families develop their own power systems for decision making which may be balanced. Inbalanced power system of family, the father, mother and children have theirown areas of decision and control. Sometimes it may be biased and one of the members gain dominance over the others. These may reflect their role in. the family.

The family operates as a group:-The family develops its own ways of operating and dealing with common problems. Some families discuss theproblems, whereas other do not. Some families may give up when troublestrikes and wait helplessly for something to happen or someone to care and help them.

The family accommodates the needs of individual:-Each individual is aunique human being. Sometimes individual and group needs and familyneeds find a natural balance. In some families, members accommodate each other's needs. In some families, members do not easily accommodate, then conflict, results.

The family relates to the community:- The family utilizes the communityinstitution &f and contributes whatever it can for community's betterment.
Some families may feel more responsible than others to the community.

The family has its growth cycle:-Families have their own growth cycle.When a couple gets married, generally children are born, and new parentaltasks arise. They provide guidance and enable their children to live independently. After children have grown and moved away, the couplereadjusts to difficult period. They face retirement and try to cope with special problems of ageing.

To sum up the family is the unit to which community health nursing ismost-often addressed. Family is the group in which action of any familymember may set off a whole series of reactions within a group. Thesereactions may be supportive factors toward members who are sick or in need of health care.

3.5 Factors Influencing Family Health

The state of health or well-being of a family at any given time or a family's capacity to reach a state of family health is determined by the interaction of many factors both outside and inside the family which have beneficial or adverse effects. The total effect at any given time can be considered as the algebraic sum of these positive and negative forces.

These factors which together make up the families' total environment may be set out as follows:

a) Environmental factors
i) Climate, water supply, air, terrain.
ii) The biological environment, animals and all living things.
iii) Man-made physical environment-character of buildings, noise, space, sewage disposal, etc.

b) Family factors influencing physical or mental health

i) Family structure and type, number, age, relationship, family type.
ii) Biological characteristics and each member's genetic, prenatal, nutritional, physical and mental health.
iii) Cultural patterns, family dynamics and roles, coping and behaviour patterns.
iv) social class or status, value systems; religious belief; occupation of wage earners, skills, social habits.
v) Economic status.

c) Ethnic and geographic factors, migration, racial minorities, etc.
This total environmental system forms the framework within whichthe needs of families and therefore the support systems are determined for; both the nuclear and the extended family.
Knowledge of these factors can help you to identify the health illnessfactors that affect family health. Insensitivity to these factors may create a situation in which misunderstanding may lead to a breakdownin communication between the nurse and the family. For example, if awoman is anaemic during pregnancy knowledge about dietary.

3.6 Health Tasks of the Family

The health tasks that the family performs are of primary concern for your as a community health nurse. The tasks of the family include the following:

- Recognizing interruptions of health development:The family monitors illness or failure to thrive and this recognition will facilitatehealthful development.
- Making decisions for seeking health care: Usually the family is the first to recognize any deviation from normal health and when necessary family members must take decision about utilizing healthcare system.
- Dealing with health crisis:Crisis are inevitable in any family. Severe illness, death, child bearing and hospitalization are crisissituations and affect the heath of the family.
- Providing nursing care to sick or dependent members of thefamily:Care of sick in the hospital or at home is done by the familymembers with the help of the health team.
- Maintaining healthy home environment:Home should be clean,safe from hazards like fire, accidents, falls, etc. The place for playand recreational activities should provide emotional and socialenvironment conducive to development.

The family health tasks are of great importance and you as a communityhealth nurse must be deeply concerned with increasing the capability of each family to be responsible for their own health. This is what we call self-care approach.

3.7 Family Health Care

For providing comprehensive nursing care to family, you as a nurse should understand the objectives of care, principles of care and its advantages.
These are discussed in the following subsections.

3.8 Objectives of Family Health Care

For providing comprehensive nursing care to family, the objectives whichshould be kept in mind are the following:

i) To discover and appraise health problems through combiningcommunity health, nursing efforts with those of other professionalworkers serving the family and the community.
ii) To ensure family's understanding and acceptance of the problems. Thefamily should recognize what are their health problems and should bemade to accept these problems.
iii) To provide nursing services that the family needs and that it cannot provide for itself.

iv) Todevelop the competence of each individual member of the family to think through and cope with his or her own problems.
v) To contribute to personal and social development of the family members.
vi) to promote full and intelligent use of available facilities and servicesfor medical care, health promotion, illness prevention and for related social and educational facilities.
vii) to bring to the family an understanding of non-nursing health serviceswithin or outside the agency in which the community health nurse isworking and to provide the families with the necessary information and education to use resources wisely and fully.

3.9 Principles of Family Health Care

Community health nurse should keep the following principles in mind while planning and implementing family health care:

- Establish professional relationship with the family in which the roleof the nurse and the role of each member of the family in health development is clear, unambiguous and accepted by everyone.
- Help the family to help themselves and provide guidance to the family to identify their health needs in making plans to meet their needs.
- Collect information about the size, occupation, education, religion,custom and tradition etc. of the family
- Identify the health problems of the family and set priorities.
- Provide need based support to the family to improve their healthstatus instead of routine services.
- Each member of the family must be given health care irrespective of sex, age, earning capacity and being head of the family or otherwise. This is a very important factor affecting health of the mother andchildren. Who are often not earning members of the family and havelower health status as compared to men (father and boys).
- Care to the family provided by different health agencies (government, non-government, and different voluntary agencies) need to be coordinated and overlapping of services need to be avoided. This is in order to save time, energy, manpower and financial resources.
- Provide services which are preventive in nature so that the familymembers are maintaining good health and this would help tominimize the need for curative services.
- In every contact with the family, communicate the health messagesthat are important for them to know and practice.

3.10 Advantages of Family-based Care

The community health nurse who provides comprehensive health care to thecommunity should provide family based services. It is advantageous to planfamily based care because of the following reasons:

- Knowledge of the family background makes it easy to understandhealth care needs of each member of the family.
- All family members can assist in preparing a plan to provide healthcare to a member who requires special health care services.
- Family based care provides the opportunity to give health care to anindividual member as per pre-determined schedule.
- It is economical as it saves time, man, money, material and resourcesof health services.
- Overlapping of services and deficient services can be avoided.
- It helps the family to be self-reliant in meeting the needs of itsmembers, and in improving health, welfare and nutrition of thefamily.

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MODULE 5 HEALTH PROMOTION - THE CONCEPT AND DETERMINANTS OF HEALTH

CONTENTS

1.0 INTRODUCTION

Health Promotion People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. That is, securing foundation in a supportive environment, having access to information and opportunities for making healthy choices. Health promotion then focuses on achieving equity in health.

Essential to the understanding of health promotion is the concept of ***health*** which has multiple definitions and meanings. In 1948 the World Health Organization (WHO) defined health as *"a state of complete physical, social, and mental well-being, and not merely the absence of disease or infirmity"* (WHO, 1998). However, this definition of health is limited to the individual and does not take into consideration the environment in which the individual lives.

Some nursing theorists such as Florence Nightingale, Virginia Henderson, Dorothea Orem, and Margaret Newman defined health in relation to the individual and the absence of disease or performance limitations without considering an individual's environment (Tomey & Alligood, 1998). While other nursing theorists like, Sister Callista Roy, Martha Rogers, Imogene King and Nola Pender recognized the environment as a factor when defining health (Tomey & Alligood, 1998; Pender, Murdaugh & Parsons, 2006).

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- Define and explain health promotion
- Discuss the various principles, theories, approaches, strategies, and components of health promotion
- Describe the framework for actions for health promotion
- Discuss the levels of prevention
- Apply theories in programme development for health promotion

3.0 MAIN CONTENTS

3.1 Definitions of Health Promotion

- WHO (1986) as "the process of enabling people to increase control over and to improve their health".
- Green and Kreuter (1991) as "the combination of educational and environmental supports for actions and conditions of living conducive to health".
- Nutbeam (1997) defined health promotion as "a process of enabling people and communities to increase control over the determinants of health and thereby improve their health".
- DeLaune and Ladner (1998) as " a process undertaken to increase the levels of wellness in individuals, families, and communities…a goal to be embraced by everyone"
- Ignnatavicius and Workman (2006) as "activities that are directed toward developing a person's resources to maintain or enhance well-being as a protection against illness"
- O'Donnell (2009) as "science and art of helping people change their lifestyle to move toward a state of optimal health, which is a balance of physical, emotional, social, spiritual, and intellectual health. Lifestyle change can be facilitated through a combination of learning experience that enhances awareness, increase motivation and build skills and most importantly through creating supportive environments that provide opportunities for positive health practices".

Goal of Health Promotion

The overall goal of health promotion is to enhance positive health and prevent ill health. In addition, it has a role in well-established preventive health measures such as screening and immunization (O'Donnell, 2009).

The Concept of Health Promotion

Historically, the concept of health promotion started in the United States of American in the 1920s. At first, the focused was on providing information to individuals and allowing them to make changes in their health behaviors until the 1970s when environmental issues, which support good health practices were, included (Minkler, 1999). Health promotion is therefore, the process of enabling people to increase control over, and to improve, their health. Health is, therefore, seen as a resource for everyday life and a positive concept emphasizing social and personal resources, as well as physical capacities.

In 1986, the First International Conference on Health Promotion was held as a result of the need for a new worldwide public health movement. At that conference, participants identified health as "a resource for social, economic and personal development, and an important dimension of quality of life" and defined health promotion as the process of enabling people to improve health. (WHO, Ottawa, 1986).

Gaining momentum on health promotion, the Second International Conference for Health Promotion occurred in 1998, and identified that "healthy public policy establishes the environment" for health promotion to occur (WHO, Adelaide, 1998). The healthy public policy's main focus is to create environments that enable individuals to lead healthier lives.

The first and second international conferences further identified health promotion actions areas as the means by which health can occur. These actions includes:

1. Building healthy public policy
2. Creating supportive environments
3. Developing personal skills
4. Strengthening community action
5. Reorienting health services

1. Building healthy public policy: - Healthy public policy is characterized by an explicit concern for health and equity in all areas of policy. The main aim of healthy public policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes health choices possible or easier for citizens. A commitment to healthy public policy means that governments must measure and report the health

impact of their policies in language that all groups in society readily understand. The Conference emphasizes the need to evaluate the impact of the policy. Health information systems that support this process need to be developed. This will encourage informed decision-making over the future allocation of resources for the implementation of the policy. In other words, it puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

2. Creating supportive environments: - Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable. Systematic assessment of the health impact of a rapidly changing environment - particularly in areas of technology, work, energy production and urbanization - is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.

3. Development of personal skills: - Health promotion supports personal and social development through provision of information, education for health, and enhancing life skills. This increases the options available to people to exercise more control over their own health and environments, and to make choices conducive to their health. However, this has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies.

4. Strengthening community actions: -Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation in and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

5. Re-orient Health Services: - The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health. The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing

clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services which refocuses on the total needs of the individual as a whole person.

3.2 Principles and Theories of Health Promotion

Principles of health promotion

According to WHO (2009), a discussion document on the concept and principles of health promotion, Copenhagen, 9-13 July 1984 presented the following principles of health promotion:

1. **Health promotion involves the population as a whole in the context of their everyday life, rather than focusing on people at risk for specific diseases:** It enables people to take control over, and responsibility for, their health as an important component of everyday life - both as spontaneous and organized action for health. This requires full and continuing access to information about health and how it might be sought for by allthe population, using all dissemination methods available.

2. **Health promotion is directed towards action on the determinants or causes of health**:Health promotion requires a close cooperation of sectors beyond health services, reflecting the diversity of conditions which influence health. Government, at all levels of healthcare, has a unique responsibility to act appropriately and timely way to ensure that the "total" environment, which is beyond the control of individuals and groups, is conductive to health.

3. **Health promotion combines diverse, but complementary, methods or approaches:** Theseinclude; communication, education, legislation, fiscal measures, organizational change, community development and spontaneous local activities against health hazards.

4. **Health promotion aims particularly at effective and concrete public participation:**This focus requires the further development of problem-defining and decision-making life skills both individually and collectively.

5. **Health professionals - particularly in primary health care - have an important role in nurturing and enabling health**

promotion: While health promotion is basically an activity in the health and social fields, and not a medical service, health professionals should work towards developing their special contributions in education and health advocacy.

In another development, the World Health Organization (cited in Rootman, 2001) identified seven key principles of health promotion as follows:

1. **Empowerment –** Health promotion initiatives should enable individuals and communities to assume more power over the personal, socio-economic and environmental factors that affect their health.
2. **Participative –** Health promotion initiatives should involve those concerned in all stages of planning, implementation and evaluation.
3. **Holistic –** Health promotion initiatives should foster physical, mental, social and spiritual health.
4. **Inter-sectoral –** Health promotion initiatives should involve the collaboration of agencies from relevant sectors.
5. **Equitable –** Health promotion initiatives should be guided by a concern for equity and social justice.
6. **Sustainable -** Health promotion initiatives should bring about changes that individuals and communities can maintain once initial funding has ended.
7. **Multi-strategy –** Health promotion initiatives should use a variety of approaches in combination with one another, including policy development, organizational change, community development, legislation, advocacy, education and communication.

Health Promotion Theories

There are different theories and models that are used to explain health promotion and many of these theories are behavioral. However, there are other theories that are also applicable. The several theories include the following:

a. Behavioral theories

i. The Health Belief Model (1966)
ii. The Social Cognitive/Learning Theory (1989)
iii. Theory of Reasoned Action (1975)
iv. Theory of Planned Behavior (1985)
v. Self-Determination Theory (1991)
vi. The Transtheoretical Model or Stage of Change Model (1997)

b. Intervention-Based models

The Tannahill Model (1980)

c. Ecological theories

Social Ecological Model (1979)

d. Planning models

A Stage Planning Program Model for Health Education/Health Promotion Activity (2001)

e. Evaluation models

The RE – AIM Framework (1999)

f. Communication theories

Weick's Health Communication Theory (1979)

g. Nursing theories

Health Promotion Model (1987)

Behavioral Theories

i. The Health Belief Model [HBM] (1966) –The theory was developed by Irwin Rosenstock in 1966. It is identified as one of the earliest and most influential models in health promotion. The theory states that individuals must have a desire to avoid an illness (value) and believe that participating in a certain behavior will prevent the illness from happening (expectancy). Hence the model is often referred to as a "value expectancy theory". Initially, the theory relies on the concepts of perceived susceptibility, perceived severity, perceived benefits, and perceived barriers.

- Perceived susceptibility pertains to an individual's belief regarding the chance of contracting a medical disease or illness.
- The construct of perceived severity relates to an individual's feelings of the seriousness of contracting the disease or illness, medically and socially.
- Perceived benefits relates to an individual's belief about how effective the plan is at reducing the disease threat. The concept of perceived benefits also considers non health-related benefits, such as financial concerns and pleasing family members.
- Perceived barriers include cost, pain, danger of the treatment, and time constraints.

(Hochbaum, 1958 and Rosenstock, 1966)

However, in the 1970s and 1980s, Becker and colleagues modified the HBM to include people's responses to symptoms and illness and

compliance with medical directives. This is the construct of cues to action which involves triggers that motivate the individual to take action to instigate preventive health such as information sought/provided; personal experiences. They expanded the model to include illness behaviors, preventive health, health screening, health motivation, perceived control, perceived threat and self-efficacy (ability to adopt the desired behavior). (Becker & Maiman, 1975).

ii. The Social Cognitive/Learning Theory [SCT] (1989) – The Social Cognitive Theory is an example of an intrapersonal theory that was developed by Albert Bandura. According to the theory, behavior change is determined by environment, social, personal, and behavioral elements. Each of the elements influences the other. The theory described learning as the constant reciprocal interaction of environmental events, personal factors, and behavior. The Social Cognitive Theory uses constructs of symbolizing capability, forethought capability, vicarious capability, self regulatory capability, self-regulatory, and self- efficacy to describe the learning process.

- **Symbolizing capability** describes the process and transformation of an experience into internal model, which will serve as a guide for future action. It is the symbol that gives meaning to the experience. This symbolization allows individuals to cognitively solve a problem prior to actually performing the action. Symbolization also allows for communication to occur among individuals.
- **Forethought capability** explains the notion that individuals do not merely react to the environment, but instead use past experiences to perform a behavior that is purposeful and thoughtful. (It is forethought that motivates individuals into performing actions to achieve goals).
- **Vicarious capability** concept explains that individuals do not learn by trial and error, but instead learn through watching others. This observational learning allows the individual to watch a role model, perform the behavior and witness the consequences of it. Modeling also speeds up the acquisition of the new behavior by an individual.
- **The self-regulatory** concept explains that individuals do not perform a specific behavior to please others, but instead that most behaviors are regulated by internal mechanisms of control. Individuals monitor their own behavior through the use of internal standards and self-evaluation.
- **Self-reflective capability** is the ability for individuals to reflect on not only the behavior, but also their own thought process. This

allows individuals to gain understanding of their actions and their thoughts.

- **Self-efficacy** is the judgment of one's ability to carry out a task. Bandura believes that self-efficacy is the most important predictor of behavior change because it gives value to a given task. The more confidence an individual has in performing a behavior, the greater the effort to try the behavior.
  (Bandura, 1989).

According to Hubley and Copeman (2008) the theory also stated that, human activity has four special characteristics that allow an individual to;

- symbolize one's own experiences
- learn from others
- regulate one's own actions
- reflect on the situation

iii. Theory Of Reasoned Action [TRA] (1975) – The Theory of Reasoned Action was developed by Martin Fishbein and Icek Ajzen in 1975. It was developed to understand the relationship between attitudes and behavior and to allow for consideration of factors outside of an individual's control.

The theory considers the individual and the influences of those around him/her. It takes into consideration the person's own beliefs about the consequences of his/her action(s) along the belief about how others within the same social network would approve, or disapprove, of the action.
There are however three constructs considered in the theory.

a. ***Behavioral intention***– this is a function of the person's attitude about the behavior.
b. ***Attitude*** – in this construct, voluntary behavior is predicted by one's attitude toward the behavior and what important people would think if the behavior was not performed.
c. ***Subjective norms*** – these are the perceived expectations of key individuals such as significant others, family members, experts and co-workers.
   (Fishbein & Azjen, 1975).

iv. Theory Of Planned Behavior [TPB] (1985) – Ajzen (1985) extended the theory of Reasoned Action and developed the TPB by adding a perceived behavioral control predictor (from Bandura's work with self-efficacy). Ajzen's work emphasized the role of intention and suggested that

the likelihood of behavior change is dependent on the amount of control a person has over a given behavior and the strength of their intent to change.

According to TPB, three factors influence intent: (a) The person's attitude toward the behavior (b) The person's evaluation of how important significant others like co-workers, partner consider the behavior to be (subjective norms) and (c) The degree of perceived behavioral control or the perceived ease/difficulty associated with the behavioral change.

v. Self-Determination Theory [SDT] (1991) – It was developed by Deci, E. and Ryan, R. in 1991. The theory focuses on the intrinsic motivation behind choices that individuals make. According to SDT, there are three ways people orient themselves to the environment and regulate their behavior.

a. Orientation are autonomous (result from satisfaction of basic needs)
b. Controlled orientations (result from satisfaction of competence and relatedness needs)
c. Impersonal orientations (result from a lack of fulfilling the three needs)
Poor functioning and ill-health result when a person has/experiences an impersonal orientation.

In addition, there are three important elements of SDT:
1. Humans desire to master their drives and emotions
2. Humans have an inherent tendency towards growth, development and integrated functioning.
3. Optimal development actions are inherent but do not happen automatically.

Hence people need nurturing from their social environment including health care professionals to actualize their potentials.
(Deci & Ryan, 1991).

vi. The Transtheoretical Model or Stage of Change Model (1997) – The Transtheoretical Model was developed by James Prochaska and Carlo DiClemente in 1997. They posited that, willingness or intention to change behavior varies among individuals and within individuals over time. They described a person's motivation and readiness to change a health-related behavior. Hence their theory focuses more on health-related interventions than on individuals. The model has the construct of the stages of change which represent the thought process individuals must go through in order for change to occur.

The stages of change include:

a. **Precontemplation** – During this stage, the individual is unaware of a problem and has no intention of making a change within the next six months.
b. **Contemplation** – The individual moves into the contemplation stage when he/she becomes aware of the problem and intend to take action within the next six months.
c. **Preparation** – This stage occurs when an individual makes some behavioral steps towards a change within the next thirty days.
d. **Action** – This is when the individual has made the behavioral change and continued it for less than six months.
e. **Maintenance** – This is the final stage, when the behavior change persists for longer than six months.
(Prochaska & Velicer 1997).

Intervention-Based Models

i. The Tannahill Model (1980) – It was developed by Andrew Tannahill in 1980. The model consists of three overlapping spheres of activity: health education; disease prevention and health protection.

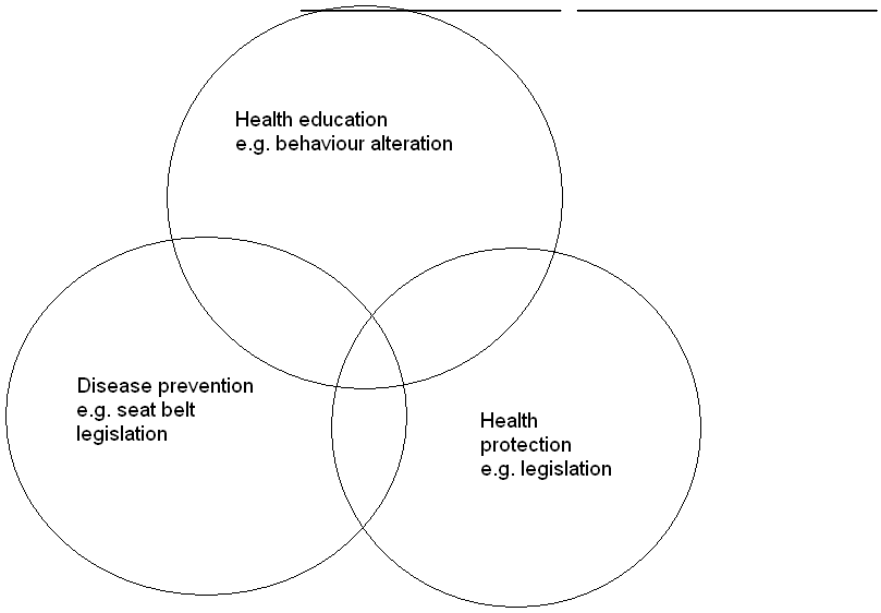


Fig. 1: Tannahill Model, (2009).

1. **Health education** designed to change the knowledge, beliefs, attitudes and behavior in a way that facilitates health.

2. **Disease prevention** designed to reduce risk factors and minimize the consequences of disease (at the Primordial, primary, secondary and tertiary levels).
3. **Health protection** which focuses on fiscal or legal controls and policies aimed at preventing ill-health and enhancing well-being. (Tannahill, 2009).

Ecological Theories

i. Social Ecological Model [SEM] (1979) – The SEM was developed by Bronfenbrenner, U. in 1979. The model consists of person-focused and environment-focused interventions designed to promote health (focuses on how the environment and people influence one another).

According to SEM, human behavior is shaped by recurring patterns of activities that take place in structured environments such as residential, educational, occupational, recreational, healthcare environment etc. these environments have a cumulative and combined influence on well-being.
In SEM, the primary influences are intercultural, community-level, organizational-level and interpersonal/individual-level. In this theory, the individual, organization, community and culture are nested spheres like "Russian dolls". Actions in one sphere can influence what happens in another sphere. There are micro and macro spheres of influence.

One interpersonal microsystem consists of the roles a person plays within his/her social context. For example, mother, father, brother, sister, child, friend, employee, peer, student etc. these Microsystems influence can be learned but are also inframed based on gender, ethnicity and culture.
Mesosystems are organizational or institutional factors that shape and structure one's environment. For instance, policies, acceptable etiquette and norms that shape individual behavior.

Exosystems are community-level influences that include norms, standards, social networks and the media. An individual must not have to be an active member before s/he can be influenced. For example, Western culture influencing a Nigerian.

Macrosystems are cultural influences such as Christianity, Islam etc.
Benefit of the ecosystem theories is that, large number of people benefit from them not just an individual.
(Bronfenbrenner, 1979).

Planning Models

These are models designed for community-based settings, not for use with individual clients. They are useful in guiding community needs through assessment, planning, implementation and evaluation.

i. **A Stage Planning Program Model for Health Education/Health Promotion Activity (2001) –** It was developed by Whitehead, D. a nurse. The theory follows the sequence below:

- It begins with identifying a target group or community and then having the nurse reconciles his/her own health beliefs with those of the community s/he is working.
- Identifying needs of the community with input from community members.
- Collaborating with other disciplines to locate needed resources
- Empowering clients
- Involving them in needed social, environmental and political changes.
- Finally, participation of community members in evaluation activities.
  (Whitehead, 2001a).

Evaluation Models

i. The RE – AIM Framework (1999) – The idea that a health programme should be efficacious (create a substantial amount of change and reach a large number of people) led to the development of the RE-AIM framework by Glasgow, R.E; Vogt, T.M; and Boles, S.M. in 1999.

RE-AIM stands for

R – Reach
E – Efficacy or Effectiveness
A – Adoption
I – Implementation
M – Maintenance

- **Reach** – is a measure of how many people can be influenced by the health promotion programme
- **Efficacious/Effectiveness** – how effective programmes produce positive outcomes along with few unintended consequences

- **Adoption** – focuses on the participation rate (number of people who engage in the health promotion behavior) and whether for example, multiple health educators presented content in different ways, making the outcome hard to evalualate.
- **Maintenance** – focuses on long-term utilization of the given health behavior. It also refers to whether a health promotion programme is sustainable even if there is a change in available resources.

The goal is not to have a health promotion programme that is equally effective on all five dimensions (RE-AIM); rather these dimensions help to evaluate a programme before it is adopted so that the characteristics that are most important in the given setting can be selected.
(Glanz & Rimer 2005).

Communication Theories

i. Weick's Health Communication Theory (1979) – This health communication theory was developed by Weick, E.K. in 1979. The theory focuses on communication between healthcare providers within organization/facilities and their clients. There are three phases

a. Enactment – focuses on health-related challenges
b. Selection – decisions are made about ways of increasing the understandability of communication
c. Retention – processes are used to preserve what was learned by creating a repertoire of experience about what worked and what did not.
Rules and cycles are used to help individuals manage equivocal information. Health pamphlets, prints are examples of rule-governed strategies, while communication cycles include establishing a procedure for referring a client to a specialist having a nurse explaining information to a client in the client's primary language.
(Weick, 1979).

Nursing Theories

i. Health Promotion Model [HPM] (1987) – The health promotion model (HPM) was proposed by Nola J. Pender in 1982 and was revised in 1996. The model is an approach oriented model. It does not depend on fear or threat to motivate an individual to perform a behavior.

The Health Promotion Model uses constructs from expectancy-values theories and social cognitive theory in addition to a holistic nursing

perspective to explain the multidimensional nature of an individual interacting with his interpersonal and physical environments. Biological, psychological, socio cultural, and prior experience make up the individual characteristic and experiences that affect subsequent actions.

The model uses activity-related affect construct is to identify the subjective feelings the individual has before, during, and after an activity. The feelings experienced throughout the activity affect the probability of the individual performing the activity again.

The Health Promotion Model also recognizes that interpersonal influences affect an individual's behavior. Interpersonal influences, which include expectations of significant others, the social support received, and observational learning, come from family, peers, and health care providers.

(Pender, Murdaugh, & Parsons, 2006).

Approaches and Strategies for Health Promotion

Health promotion which is the process of enabling people to increase control over, and to their improve health, is not directed against any particular disease, but is intended to strengthen the host through a variety of approaches or interventions and strategies.
Some of these approaches or interventions and strategies presented by Park (2009) include:

- Health education
- Environmental modifications
- Nutritional interventions
- Lifestyle and behavioural changes.

(i)**Health Education:** This is one of the most cost effective approaches/interventions. A large number of diseases could be prevented with little or no medical intervention if people were adequately informed about them and if they were encouraged to take necessary precautions in time. The targets for educational efforts may include the general public, patients, priority groups, health providers, community leaders and decision makers.

(ii)**Environmental Modifications:** A comprehensive approach to health education requires environmental modifications, such as provision of safe water; installation of sanitary latrines; control of insects and rodents; improvement of housing, etc.

The history of medicine has shown that many infectious diseases have been effectively controlled in western countries, through environmental modification even prior to the development of specific vaccines or chemotherapeutic drugs. Environmental interventions are non clinical and do not involve the physician.

(iii)**Nutritional Interventions:** This comprises food distribution and nutritional improvement of vulnerable groups; child feeding programmes; food fortification; nutrition education etc.

(iv) **Lifestyle and Behavioural Changes:** The action of prevention in this case, is one of individual and community responsibility for health, the physician and in fact each health worker acting as an educator than a therapist, health education is a basic element of all health activity, it is of paramount importance in changing the views, behaviours and habits of people.

Examples of approaches to health promotion

Aim	**Appropriate Method**	**Example - Smoking**
1. Health awareness goal Raising awareness, or consciousness, of health issues	talks group work mass media displays and exhibitions campaigns	Encourage people to seek early detection and treatment of smoking-related disorders
2. Changing attitudes and behaviour Changing the lifestyles of individuals	group work skills training self help groups one-to-one instruction group or individual therapy written material advice	Persuasive education to prevent non-smokers from starting and persuade smokers to stop
3. Improving knowledge Providing information	one-to-one teaching displays and exhibitions written materials mass media campaigns group teaching	Giving information to clients about the effects of smoking. Helping them to explore their own values and attitudes and come to a decision. Helping them to learn how to stop smoking if they want to

4.**Self empowering** Improving self-awareness, self-esteem, decision-making	group work practising decision-making values clarification social skills training stimulation, gaming and role play assertiveness training counselling	Clients identify what, if anything, they want to know about it
5. **Societal/environmental change** Changing the physical or social environment	positive action for under-served groups lobbying pressure groups community development community-based work advocacy schemes environmental measures planning and policy making organisational change enforcement of laws and regulations	No smoking policy in public places. Cigarette sales less accessible, especially to children; promotion of non-smoking as social norm. Banning tobacco advertising and sports sponsorship

Example of Strategies and Activities
Program Goal:
All Adolescents have healthy sexual attitudes and behaviours.
Key overall strategy:

Education of youth
What literature says about education of youth:

- youth learn best in small groups
- youth trust peers to give good information
- youth learn from multimedia education campaigns
- youth need easy access to condoms and contraceptives

Suggested Activities:
- Establish youth groups in schools and community settings
- Develop peer networks
- Develop a multimedia sexual health media campaign
- Increase number of sites where youth can access condoms and contraceptives
- Collaborate with community partners to provide a forum for youth

Continuum of Health Promotion Practice

The continuum of health promotion practice generally contains a range of approaches within five areas for action, comprising both individual and population approaches. The areas of action are designed to complement one another as they target the determinants of health and different factors at various stages of health across the life course. Health promotion practice is most effective when a combination of approaches is implemented. The continuum of health promotion practice has been developed to be consistent with and reflective of the five action areas of health promotion in the Ottawa Charter. Consistency with and reflection of the Ottawa Charter, as the overarching global framework guiding health promotion, is important.

The five areas of action across the Continuum of Health Promotion Practice are:

a. Settings and Supportive Environments
b. Community Action
c. Health Information and Social Marketing
d. Health Education and Skills Development
e. Screening, Individual Risk Assessment and Immunization

Table 1: Summary of continuum of health promotion practice, adapted from the Integrated Health Promotion Kit, Victoria, 2008.

Settings and Supportive Environments	**Community Action**	**Health Information and Social Marketing**	**Health Education and Skills Development**	**Screening, Individual Risk Assessment, Immunization**
AIMS				
To develop healthier physical, social and cultural environments where people live, learn, work and relax. This can be established through: • **Organizational development**	To increase community control over the determinants of health through collective efforts, community participation, empowerment, capacity building and increasing healthy	To influence individual behavior change through the provision of health information and development of personal skills. To advocate for broader social and	To improve knowledge, attitudes, confidence and individual capacity to change psychosocial and behavioral risk factors. To improve health literacy of individuals, communities	To enable early detection and management of diseases to improve physiological risk factors.

• **Economic and Regulatory activities.**	literacy.	environment change agendas.	and organizations.	
ACTIVITIES				
Organizational development Integration of health promotion principles in organizational policies, structures, systems, service directions, priorities and practices to create a supportive environment for health promotion activities within an organization. Usually divided into 3 domains: • **Service** (Recognition and reward systems, information systems, monitoring and evaluation, quality improvements, integration of health literacy focus **)** • **Policy and strategic plans** • **Management** (structures, support and commitment). *__Economic, regulatory__	This must involve: • **Community engagement** in priority setting, decision making, planning, implementation and evaluation of strategies It can also involve: • **Advocacy** work to gain political commitment, structural changes or systems support for a particular issue.	**Health information** Presentation of information to a general or targeted audience using a variety of forms in diverse settings and languages, such as spoken word (including telephone information services), written materials and internet and web based information. **Social marketing** Application of commercial marketing techniques to the analysis, planning, execution and evaluation of programs that are designed to influence behaviour. This activity is usually targeted to a specific population	**Health education** Health education is any combination of learning experiences designed to facilitate voluntary actions conducive to health. It can involve individuals and/or groups **Skills development** Building the skills required to empower individuals or communities to have greater control over their lives.	**Screening** Systematic use of a testing tool to detect individuals at risk of developing a specific disease. **Individual risk assessment** Detecting the overall risk of disease(s) through identification of biological, psychological and behavioral risk factors. **Immunization** Inoculation of vaccine to reduce the spread of vaccine-preventable diseases.

activities and legislation Application of financial and legislative incentives or disincentives that affect a range of parameters (eg standards, pricing, availability, promotion of a product and restrictions to use).		group.		

Components of Health Promotion

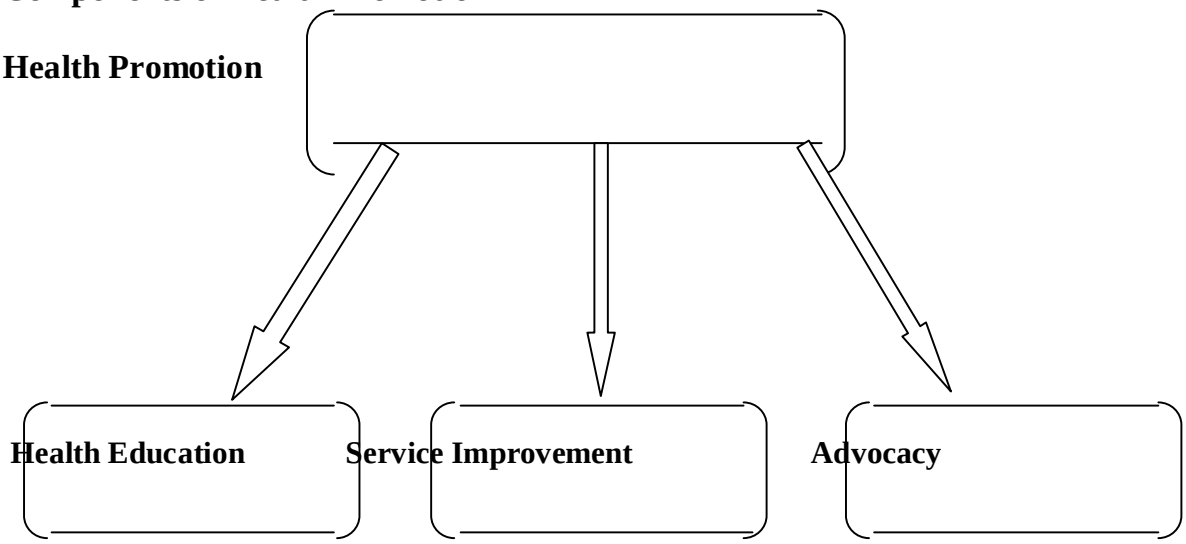


Fig. 2: Components of health promotion

1. **Health Education** – Communication directed at individuals, families and communities to influence:
2.

- awareness/knowledge
- decision-making
- beliefs/attitudes

- empowerment
- individual and community action/behaviour change
- community participation

3. **Service Improvement** – improvements in quality and quantity of services:

- accessibility
- case management
- counseling
- patient education
- social marketing

4. **Advocacy** – agenda setting and advocacy for healthy public policy:

- policies for health
- income generation
- removal of obstacles, discrimination and inequalities
- gender barriers

Framework for Actions for Health Promotion

Health Promotion Strategic Framework (HPSF) is informed by the best available international and national evidence of health promotion effectiveness. The framework outlines a model of health promotion that addresses health inequalities, the broad determinants of health as well as the health promotion outcomes through health services, community and education settings (Health Service Executive [HSE], 2010).

Health promotion will be achieved in the different settings through partnership and capacity building approaches to deliver the expected health promotion outcomes.

Health Inequalities

Health inequalities are not simply a matter of chance but are strongly influenced by the actions of governments, organizations, communities and individuals. And actions to reduce health inequalities means tackling those factors which impact unequally on the health of the population in a way which is avoidable and can be dealt with through public policy.(Commission of the European Communities, 2009).

According to Dahlgren and Whitehead (2006) addressing health inequalities has been an important feature of health promotion. They noted that health inequalities are:

- ❖ **Systematic** - they are not random but follow a consistent pattern
- ❖ **Socially produced** - that means that they can be changed and widely perceived to be unfair or inequitable.

While poverty is the key underlying cause of poor health outcomes, examples of health inequalities also exist independently within specific subgroups in societies. Health and wellbeing is affected by the level of health and social care services provided and also by the degree of access to them.

The Marmot Review (2010) reported that, the way in which health services are provided influences health outcomes, and it is important to recognize that the root causes of health inequalities are social, economic, cultural and political. Therefore, these determinants must be tackled in order to address the social-class gradient differences in health outcomes effectively.

Determinants of Health

The determinants of health are a range of interacting factors that shape health and wellbeing and are underpinned by social and economic inequalities (Marmot Review, 2010). These determinants include: material circumstances, the social environment, psychosocial factors, behaviors and biological factors. These factors are however influenced by education, occupation, income, gender, early childhood development, social position, ethnicity and race.

Expected outcomes from a 'determinants of health' approach

In order to be effective, a 'determinants of health' approach requires long-term vision and investment that will result in a reduction in health inequalities by reducing social inequalities. The Marmot Review (2010) identified the health and economic benefits of using this approach which can actively influence and facilitate:

- A focus on health equity in all national policies
- Opportunities for every child to be given the best start in life
- The development of sustainable and healthy communities
- The prevention of ill health and strengthening of mechanisms for early intervention
- Enhanced opportunities for education and training for all in order to maximize their skills and capabilities

- Self fulfillment
- A good quality of life.

Settings for Health Promotion

1. **Health promotion priorities in the health service setting –** In the health service setting, the framework outlines an approach that focuses on creating an appropriate balance between the promotion of health and the prevention and treatment of disease. The main objective for the health setting is the development of a Health Promoting Health Service (HPHS). Through implementation of this objective, the health service itself becomes health promoting, and not just a place in which health promotion activity takes place. This means that the environment, the health personnel-patient relationship, and the services, are designed to improve and sustain health and wellbeing.

2. **Health promotion priorities in the community setting –** Within the community setting, the priority objective is to develop and implement a model for health promoting communities that will enable and empower communities and individuals to have greater influence over factors that affect their health. A strong focus on inter-sectoral collaboration is essential to achieve this objective.

3. **Health promotion priorities in the education setting –** Within the education setting, the priority objective is to implement a nationally agreed model for promoting health in preschool, primary, post-primary, third level and out-of-school settings based on existing Health Promoting School (HPS) approaches.
(Health Service Executive, 2010).

Partnership and Capacity Building Approaches

Partnership working underpins almost all health promotion practice, for example, from a shared approach to patient education to the joint formulation of national policy. Building the capacity of others, whether in a lead or support role, is also a significant part of health promotion practice (HSE, 2010).

The principal theory that underpins partnerships for health is that the partners can achieve more by working together than each could achieve on their own; this is known as *'synergy'*. Child and Faulkner (1998) note that *'the idea of synergy is that the whole is greater than the sum of the parts'*. Synergy is therefore the degree to which the partnership combines the

strengths, perspectives, resources and skills of all the partners in the search for better solutions.

Capacity building can be developed with individuals, organizations and communities (Ontario, 2002). Capacity building occurs within systems and programmes, and is heavily dependent on collaboration and partnership working. According to Hawe, King, Noort, Jorden and Lloyd (1997), it has three distinct dimensions which are:

a. **Health infrastructure or service development –** capacity to deliver particular programme responses to particular health problems.
b. **Programme maintenance and sustainability –** capacity to continue to deliver a particular programme through a network ofagencies.
c. **Problem solving capability of organizations and communities –** capacity to identify health issues and developappropriate mechanisms to address them, either building on the experience with aparticular programme or as an activity in its own right.

The partnership and capacity building approaches deal with the following different areas:

- Training and education
- Policies and frameworks
- Social marketing and advocacy
- Research and evaluation
- Programme development and implementation

1. Training and Education: A key priority for health promotion is to build the capacity of health care personnel and others to promote health. This can be achieved through training and education programmes. Training and education are delivered as part of a suite of interventions which address individual, group and population-based approaches for promoting health (HSE, 2010).

2. Policies and Frameworks: The development of health-related policy happens at a number of different levels: National/state/local government level with the development of government policies; and Organizational level or within specific settings. A key role for the national health promotion function is to lead on the inter-sectoral partnerships with key government departments and agencies (HSE, 2010).

One of the valuable outcomes of this inter-sectoral approach is the development of health-related policy which can, in turn, influence the

development of strategies, frameworks and programme interventions that make real changes to the determinants of health. A policy approach to health promotion has been shown to be one of the most effective ways of achieving change. With regard to reducing health inequalities, there is good evidence to suggest that change is best effected by altering the policies andenvironments which have greatest impact on the lives of poor and marginalized people (HSE, 2010).

3. Social Marketing and Advocacy: Health advocacy is often confused with social marketing, particularly in the area of media advocacy, however, the two approaches are significantly different. While social marketing is generally used to influence individual lifestyle choices and behaviors, media advocacy is a political tool strategically used to promote healthy public policy (HSE, 2010).

Social marketing is a process that applies marketing principles and techniques to create, communicate and deliver value in order to influence target audience behaviors that benefit society (public health, safety, the environment and communities) as well as the target audience (National Social Marketing Centre, 2010). Social marketing incorporates approaches used throughout the health and social care system including the Stages of Change Model (Prochaska & DiClemente, 1983), the Health Belief Model (Rosenstock, 1966), Social Cognitive Theory (Bandura, 1986), Health promotion incorporates the social marketing approach to influence and improve health and wellbeing. It also acknowledges that social marketing is more than an attempt to raise awareness, provide information or change behavior.

Advocacy on the other hand is the pursuit of influencing outcomes, including public policy and resource allocation decisions within political, economic, and social systems and institutions - that directly affect people's current lives (The Advocacy Institute, cited in Public Health Alliance, 2007). Political, economic, social, cultural, environmental, behavioral and biological factors are all determinants of health. Health determinants are, for the most part, created through the decisions and actions taken by governments, organizations and individuals. It is important, therefore, that health practitioners who want to promote health, should find ways to influence these decisions across a range of sectors, either directly 'at the table', or indirectly through advocacy. Effective health advocacy must be planned, focused, people-centered, engage decision-making systems and translate protest into demands for specific change. In this regard, health practitioners must draw on different methods of advocacy which include lobbying, grass roots organizing, strategy development, partnership

building, development of clear position statements and submissions as well as media advocacy (HSE, 2010).

4. Research and Evaluation: Health promotion research is predominantly based on theories of organizational behavior, sociology, social psychology, anthropology, education, economics and political science (Dean, 1996). In research, evidence is obtained to support, reject or modify theories, to explain patterns of behavior, and to develop appropriate interventions. The ultimate aim of all health research is to understand and then improve the health of individuals and communities. Research is, therefore, central to the discipline of health promotion and should be designed and undertaken in ways which are, themselves, health promoting (HSE, 2010).

While evaluation within the health arena, comes from a wide range of stakeholders for a variety of different reasons; managers require accountability, funders require evidence of effectiveness, project managers require feedback on the successes and challenges and evidence to promote their projects (HSE, 2010).

5. Programme Development and Implementation: Programme development and implementation has been, and continues to be, an integral part of health promotion strategies and policies at national, state and local levels. Programme development provides a means for translating strategy and policy into action through the key settings of health services, communities and education. The development of health promotion programmes involves:

- Identifying and prioritizing health issues and needs
- Agreeing to appropriate interventions to address these health issues and needs
- Committing support and resources for health promotion action. (HSE, 2010).

Health Promotion Outcomes

The HPSF identifies six key outcome areas for health promotion as follows:

1. Re-orientate health and other public services
2. Create supportive environments for health
3. Reduce health inequalities
4. Improve health
5. Prevent and reduce disease

6. Reduce costs to the healthcare system.

Examples of the outcomes in each of these areas include the following:

1. Re-orientate health and other public services: The development and effectiveness of primary care will be strengthened by improved capacities in community needs. Re-orientate health and other public services outcomes include:

- Needs assessments
- Community participation and mobilization
- Provision of socially inclusive services.

2. Create supportive environments for health: The role of supportive environments is essential to achieving health gain. Supportive environments include the built and social aspects of where we live, work and play. Actions to create environments that support health have four main dimensions: physical, social, economic and political. A supportive environment for health includes the following outcomes:

- A planning process that is needs-based and incorporates evaluation and coordination between health care providers
- Full engagement in collaborative partnerships which are adequately resourced and are regularly reviewed in terms of structure, function and effectiveness
- The use of multi-strand approaches to promote and enhance health and include a combination of medical, lifestyle, behavioral and social-environmental approaches
- The allocation of adequate resources to effectively address the broader determinants of health and social inequities
- The development of evidence-based programmes and interventions, which include monitoring and evaluation measures.

3. Reduce health inequalities: Addressing health inequalities is critical if improvements in health and wellbeing are to be achieved across society. Outcomes that can be expected are:

- Improved inter-agency cooperation to address the social determinants of health and health inequalities
- Development of partnerships for health which will result in integrated planning in areas such as housing, public spaces, transport, etc.

- Increased involvement and participation of individuals and communities in identifying and addressing health needs and health inequalities
- The effective use of community development approaches to addressing lifestyle risk factors
- Increased capacity of health and social care agencies to promote health and address health inequalities, and in particular, to support the development of primary care teams
- Development and utilization of specific information, data systems, tools and key performance indicators which provide reliable evidence to support more effective decision-making
- Monitoring and dissemination of evidence to support economic investment in health and the reduction of health inequalities

4. **Improve health:** The concept of health improvement is based on the premise that health is something that can be created, and need to be improved. While disease prevention primarily addresses risk factors that cause people to become ill, health improvement seeks to promote wellbeing or health gain. Health improvement places greater value on Quality of Life (QoL), rather than avoiding illness. Outcomes of improved health include the following areas:

- Increased awareness of the determinants of health and effective approaches used to address the determinants of health
- Increased environments to support healthy choices in the priority settings of health services, communities and education
- Increased capacity of individuals and groups to take action to improve health, for example, through the development of personal skills to address health issues and the determinants of health
- Mechanisms to support improved health behavior and practices among individual population groups identified through particular settings, for example, children, adults, older people, special interest groups, etc.

5. Prevent and reduce disease: Health promotion plays a critical role, not only in improving health, but also in maintaining and protecting health. An important element of this role is disease prevention.
Traditionally, disease prevention is classified as:

a. Primordial prevention is a new conceptthat deals with the prevention of the emergence or development of risk factors in population groups in which they have not yet appeared

b. **Primary prevention** where efforts are made to prevent the occurrence of any disease. This ranges from the prevention of an acute illness, for example, by inoculation or vaccination, to the prevention of chronic conditions such as heart disease, cancers, sexual or mental illnesses.

c. **Secondary prevention** where efforts are made to ameliorate and stop progression of disease. This includes the use of therapies, surgical procedures and an array of other interventions such as smoking cessation, diet and physical activity programmes as well as one-to-one support.

d. **Tertiary prevention** where all efforts are made to minimize the impact of disease on the affected individual and/or rehabilitate them.

(Park, 2009).

Outcomes of prevent and reduce disease include the following areas:

- Modifications in risk-taking behaviors and addressing risk factors for diseases like heart diseases, cancers, etc
- Reduction in factors that contribute to mental ill-health through creating supportive environments for health, reducing stressful circumstances and developing supportive personal relationships and social networks
- A significant reduction in sexually transmitted infections and negative outcomes in relation to unplanned and unwanted pregnancies
- Contribution to a reduction in unintentional injuries in the home environment at work and on the road.

6. Reduce costs to the healthcare system.: Effective health promotion programmes, properly funded over sustained periods, can produce significant economic and health gains for individuals, the health service, the government and the society. For instance, in the United Kingdom, according to the National Social Marketing Centre (2010) four out of five deaths of people under 75 years could have been prevented. The economic analysis estimates suggest that for every 1% improvement in health outcomes from health promotion and prevention, public expenditure could be reduced by £190million, saving families £700m and reducing employer costs by £110m as well as reducing the level of premature death and disability.

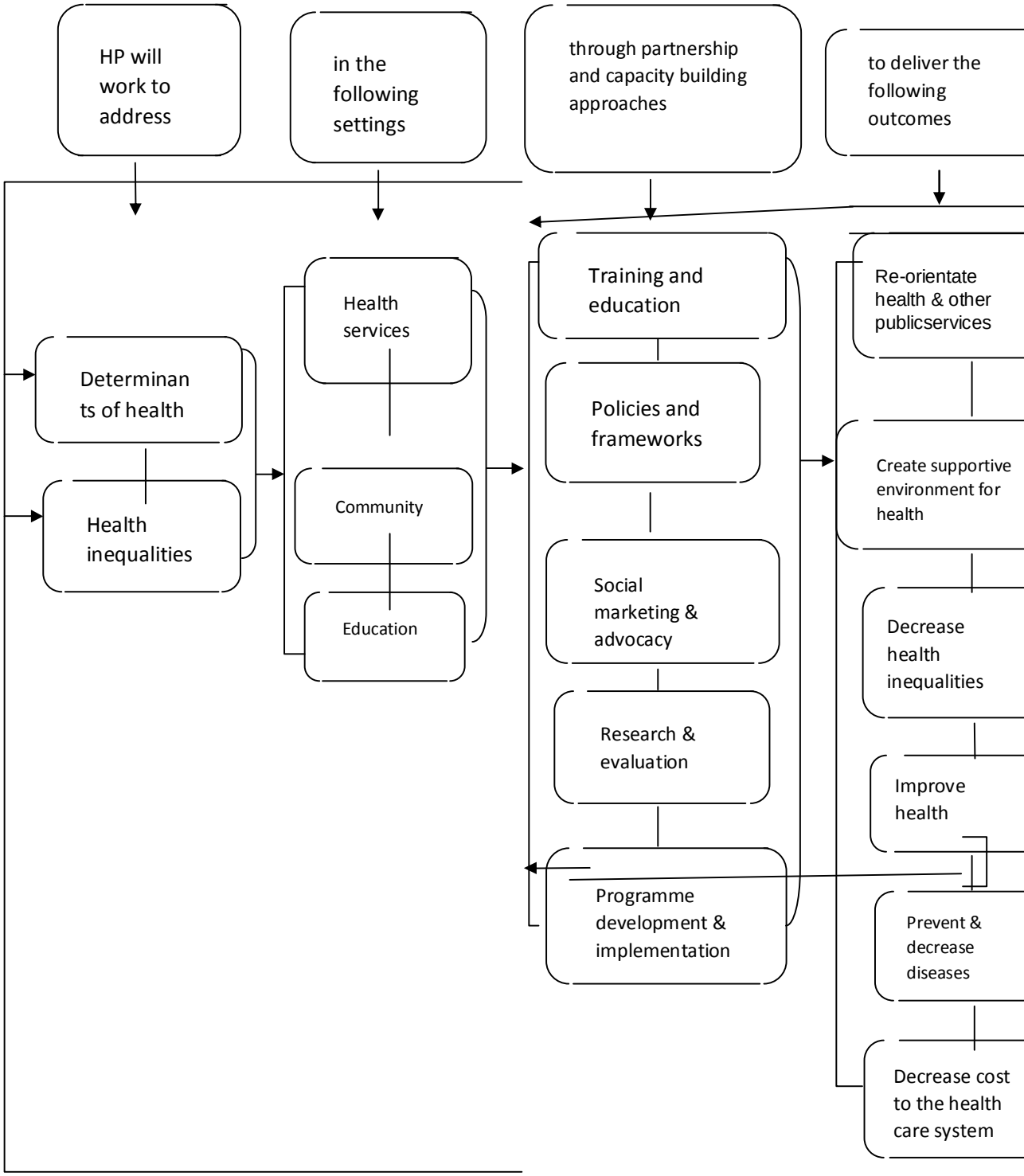
Outcomes for reduce costs to the healthcare system include the following areas:

- For older people, regular physical activity reduces the risk of falls and resulting injuries.
- Systematic reviews of workplace programmes have found cost benefit from such programmes
  (HSE, 2010).

The Health Promotion Strategic Framework (HPSF) Model

According to HSE (2010), the HPSF introduces a model that illustrates the main structural elements of health promotion. The model presents five particular approaches that are adopted through the health services, community and education settings.

Fig. 3: Health Promotion Strategic Framework Model



3.3 Levels of Prevention

Prevention of illnesses/diseases is one of the essential elements of modern public health. And public health can be defined as '... the science and art of preventing disease, prolonging life, and promoting physical health and efficiency, through organized community efforts, for the sanitation of the environment, the control of community infections...'(Park, 2009).

The concept of prevention was initially narrowed to protective measures like vaccination and improved nutrition with focus on only the healthy individuals with the intent of preventing the onset of diseases. Today, the concept has been expanded to cover the early diagnosis and treatment of sick individuals with the aim of preventing complications that could lead to advanced diseases and in communicable diseases, prevention of spread of diseases within the community. In other words, successful prevention depends upon a knowledge of causation, dynamics of transmission, identification of risk factors and risk groups, availability of prophylactic or early detection and treatment measures, an organization for applying these measures to appropriate persons or groups and continuous evaluation of and development of procedures applied (Park, 2009)
There are four levels of disease prevention which include:

1. Primordial level
2. Primary Level
3. Secondary Level
4. Tertiary Level

Within the four levels above, there are five stages of prevention.

Table 2: Levels and Stages of Prevention

Levels of Prevention	Stages of Prevention
1. Primordial – This is a new conceptthat deals with the prevention of the emergence or development of risk factors in population groups in which they have not yet appeared **Target population:** The target population is usually the entire population with special attention to the healthy individuals • **Objective:** To prevent the emergence or development of risk factors in population groups in which they have not yet appeared	a. **General Health Promotion** - **Target population:** The entire population especially the healthy individuals - **Objective:** To prevent onset of illness - **Methods:** Individual and mass education, environmental modification, life style changes etc

• **Methods/interventions:** Individual and mass education, nutrition, environmental modification	
2. Primary **Target population:** The target population is usually the entire population with special attention to the healthy individuals **Objective:** The main objective is the prevention of onset of illness **Methods:** Individual and mass education, immunization, environment sanitation, food hygiene among other methods of prevention could be used	b. **Specific Prophylaxis** - **Target population:** The entire population - **Objective:** To prevent the onset of specific diseases - **Methods:** Individual and mass education, immunization, chemoprophylaxis like against malaria, nutritional supplements like Vitamin A
3. SECONDARY **Target population:** Sick individuals **Objectives:** Early diagnosis and treatment to prevent further damage to the individual and in cases of infectious diseases, spread to the community **Methods:** Screening of high risk groups e.g. Pap smears, sputum examination for TB, monitoring of vulnerable groups – children, pregnant women	c. **Early diagnosis and treatment** **Target population:** Sick individuals - **Objectives:** Early diagnosis and treatment to prevent further damage to the individual and in cases of infectious diseases, spread to the community - **Methods:** Screening of high risk groups e.g. Pap smears, sputum examination for TB, blood test for HIV, monitoring of vulnerable groups – children, pregnant women
4. TERTIARY **Target population:** Sick patients **Objectives:** Reduce damage from disease and restore function **Methods:** Clinical care and rehabilitation	d. **Limiting damage** - **Target population:** Sick patients - **Objectives:** To limit damage from disease - **Methods:** Skilled clinical care and social support to limit physical and social damage from the disease e. **Rehabilitation** - **Target population:** Convalescent patients - **Objectives:** To restore function and capability - **Methods:** Physical and social rehabilitation

Programming for Health Promotion

According to the HSE (2010) document, programme development and implementation has been, and continues to be, an integral part of health promotion strategies and policies at national, state and local levels. Programme development provides a means for translating strategy and policy into action through the key settings of health services, communities and education. It is also one of the areas covered in partnership and capacity building.

The development of health promotion programmes involves:

- Identifying and prioritizing health issues and needs
- Agreeing to appropriate interventions to address these health issues and needs
- Committing support and resources for health promotion action.

Common Program Elements

Effective worksite health promotion programs begin with benchmarking and incorporate an evaluation system that measures process and outcome variables. Additional program elements include:

1. **Health education –** Programs that focus on skill development and lifestyle behavior change.
2. **Supportive environments** in which organizational values, norms, policies, and initiatives reinforce and support a healthy work culture.
3. **Integration –** Health promotion programs that are embedded effectively within the organizational structure.
4. **Linkage –** Linking health promotion cross-functionally to other employee support services (e.g., benefits, Employee Assistance Program [EAP], work/life) to optimize reach and effectiveness.
5. **Health screening –** Programs that help employees assess health risks. These programs are ideally linked to the health benefit plan to provide appropriate medical follow-up and treatment.

Use of Theories in Programme Development for Health Promotion

Theory gives planners tools for moving beyond intuition to design and evaluate health behavior and health promotion interventions are based on understanding of behavior. Using theory as a foundation for program planning and development is consistent with the current emphasis on using evidence-based interventions in public health, behavioral medicine, and

medicine. Theory provides a road map for studying problems, developing appropriate interventions, and evaluating their successes. It can inform the planner's thinking during all of these stages, offering insights that translate into stronger programmes. Theory can also help to explain the dynamics of health behaviors, including processes for changing them, and the influences of the many forces that affect health behaviors, including social and physical environments. Theory can also help planners identify the most suitable target audiences, methods for fostering change, and outcomes for evaluation. Theory also helps to identify which indicators should be monitored and measured during programme evaluation. For these reasons, program planning, implementation, and monitoring processes based in theory are more likely to succeed than those developed without the benefit of a theoretical perspective.

Choosing a theory that will bring a useful perspective to the problem at hand does not begin with a theory, instead, the process starts with a thorough assessment of the situation: the units of analysis or change, the topic, and the type of behavior to be addressed. Because different theoretical frameworks are appropriate and practical for different situations, selecting a theory that "fits" should be a careful, deliberate process.

A useful theory makes assumptions about a behavior, health problem, target population, or environment that are:

- Logical
- Consistent with everyday observations
- Similar to those used in previous successful programs
- Supported by past research in the same area or related ideas.

Most health behavior theories can be applied to diverse cultural and ethnic groups, but health practitioners must understand the characteristics of target populations (e.g., ethnicity, socioeconomic status, gender, age, and geographical location) to use these theories correctly.

There are several reasons why culture and ethnicity are critical to consider when applying theory to a health problem. First, morbidity and mortality rates for different diseases vary by race and ethnicity; second, there are differences in the prevalence of risk behaviors among these groups; and third, the determinants of health behaviors vary across racial and ethnic groups.
(U.S. Department of Health and Human Services, 1999).

Application of Theoretical Explanations of Three Levels of Influence

Theories and their applications at the individual (intrapersonal), interpersonal, and community levels of the ecological perspective. At the individual and interpersonal levels, contemporary theories of health behavior can be broadly categorized as "Cognitive-Behavioral." Three key concepts cut across these theories:

1. Behavior is mediated by cognitions; that is, what people know and think affects how they act.
2. Knowledge is necessary for, but not sufficient to produce, most behavior changes.
3. Perceptions, motivations, skills, and the social environment are key influences on behavior.

Community-level models offer frameworks for implementing multi-dimensional approaches to promote healthy behaviors. They supplement educational approaches with efforts to change the social and physical environment to support positive behavior change.
(U.S. Department of Health and Human Services, 1999).

Table 3: Summary of Theories, Focus and Key Concepts at the Three Levels of Influence

Level	**Theory**	**Focus**	***Key Concepts***
Individual Level	**Health belief model**	Individuals' perceptions of the threat posed by a health problem, the benefits of avoiding the threat, and factors influencing the decision to act	Perceived susceptibility, Perceived severity, Perceived benefits, Perceived barriers, Cues to action, Self-efficacy
	Stages of change model	Individuals' motivation and readiness to change a problem behavior	Precontemplation, Contemplation, Decision, Action, Maintenance
	Theory of Planned Behavior	Individuals' attitudes toward a behavior, perceptions of norms, and beliefs	Behavioral intention, Attitude, Subjective norm, Perceived behavioral control

		about the ease or difficulty of changing	
Interpersonal Level	**Social Cognitive Theory**	Personal factors, environmental factors, and human behavior exert influence on each other	Reciprocal determinism, Behavioral capability, Expectations, Self-efficacy, Observational learning, Reinforcements
Community Level	**Communication Theory**	How different types of communication affect health behavior	Example: *Agenda Setting,* Media agenda setting, Public agenda setting, Policy agenda setting, Problem identification, definition

Application of Theories in Programme Development and Practice

Theoretical frameworks offer flexible guidance for applying the abstract concepts of theory to a vast array of real circumstances. By becoming familiar with behavior change theories and planning systems, practitioners gain access to tools that allow them to generate creative solutions to unique situations. They are able to go beyond acting on instinct or repeating earlier interventions to adopt a systematic, scientific approach to their work. Theory helps practitioners to ask the right questions and develop effective programmes. Other key elements of effective programmes include matching programmes to the audience, making information accessible and practical, involving participants in active learning, and including elements that build skills and reinforce behavior change.

Several theories can be used to design and solve a particular problem. For instance, designing a programme to reduce tobacco use among adolescents will involve several theories to inform the design. Applying each of these theories might look like this:

- ***Stages of Change model:*** Learn more about readiness to change among adolescents who smoke in order to plan appropriate and effective cessation messages and strategies.
- ***Social Cognitive Theory****:* Examine how social environment, including peer attitudes, influences adolescents' tobacco use. What are the expectations of teens who experiment with tobacco, or who

use it regularly? How do observational learning and reinforcement contribute to the reasons why they smoke? Could these constructs help identify someone who can successfully help them to quit?

- ***Community Organization:*** Consider how to involve teen smokers in developing and carrying out the programme. One idea might be to organize a coalition of concerned parents, teachers, and teens to help explore why teens smoke, and identify potential solutions.

  These examples above offer a basic illustration of how multiple theories might be combined to address a single problem. The resulting program would be a multifaceted and multilevel effort. (Green & Kreuter, 1999).

Implication of Health Promotion for Nursing

Health professionals have the responsibility to promote health at the individual, group, and community levels. Nurses are the most visible professionals of the health care industry and usually at the forefront. And as the largest group of health professionals within the healthcare industry, trained and certified nurses have the potential to contribute substantially in the area of health promotion.

The logical approach to promoting healthy behavior change is to promote individual responsibility. This has influenced the professional practice of nurses as many nurses view themselves as providing health promotion by presenting health education to individuals, families and groups. Health education is a component of health promotion; however health education differs from health promotion as it is specifically geared towards individual learning.

Health education "comprises 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" (WHO, Health Promotion Glossary, 1998).

4.0 SUMMARY/CONCLUSION

Since health promotion comprises a broad spectrum of activities, a well conceived health promotion programme would first attempt to identify the "target groups" or at risk individuals in a population and then direct more appropriate message to them. Goals must be defined. Means and alternative means of accomplishing them must be explored. It involves "organizational, political, social and economic intervention designed to

facilitate environmental and behavioural adaptation that will improve or protect health.

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MODULE 6 TOOLS IN PUBLIC/COMMUNITY HEALTH NURSING

UNIT 1 TOOLS IN PUBLIC/COMMUNITY HEALTH NURSING

1.0 INTRODUCTION

Working effectively as a community health nurse requires appropriate, adequate and current knowledge on the tools that are used in this field of Nursing practice.

2.0 OBJECTIVES

- To find out students'entry behaviour on the above listed sub-topics.
- Students will be able to explain what each of the sub-topic means to a community health nurse practitioner.
- Students will be able to identify and perform acceptable procedures associated with the aforementioned sub-topics.
- Students will demonstrate competence in their practice of commnuity health nursing.

Teacher's Activities: Explanation of the tools in community health nursing
Discussion on the sub-topics
Write out on the board all that is necessary
Students'Activities: Provide answers to questions
Write down notes
Do their assignments and submit as at when due.

Assignment:The pros and cons of each community assessment tool will not be given to students in class, rather they will have it as their assignments.
Also, students will be required to write out the chain/ pathway of infection of a particular disease (e.g Malarioa) and submit within a week.
Evaluation: At the end of the semester/ session, the students will be assessed as seem necessary by the lecturer.

3.0 MAIN CONTENTS

Epidemiology
Types of Community needs; Types of Community needs assessment**;**
Community assessment process; Community assessment tools
Quality Assurance
Health Education and Counselling in P/CHN
Reference Materials: Online textbooks, articles and journals
Instructional Materials: Projector, Laptop, Marker, Print material,
Power point presentation.

3.1 Epidemiology

Concepts of Epidemiology
Epidemiology is defined from the combination of the three Greek words **Epi** which means "upon" "among" or even " befall"; **Demos** meaning "people" or "human population" and **Logos** meaning "the study of." Epidemiology can then be litrarily defined as the study of that which befalls people.
"Epidemiology is the **study** of the **distribution** and **determinants of health-relatedstates or events** in **specified populations**, and the **application** of this study to the controlof health problems." This definition ofincludes several terms which reflect some of the importantprinciples of the discipline.

Definition of Terms
Study: Epidemiology is a scientific discipline, sometimes called "the basic science of publichealth." It has, at its foundation, sound methods of scientific inquiry.

Distribution: Epidemiology is concerned with the **frequency** and **pattern** of health events in apopulation. Frequency includes not only the number of such events in a population, but also therate or risk of disease in the population. The rate (number of events divided by size of thepopulation) is critical to epidemiologists because it allows valid comparisons across differentpopulations.Pattern refers to the occurrence of health-related events by time, place, and personalcharacteristics.

- Time characteristics include annual occurrence, seasonal occurrence, and daily or evenhourly occurrence during an epidemic.
- Place characteristics include geographic variation, urban-rural differences, and locationof worksites or schools.

- Personal characteristics include demographic factors such as age, race, sex, maritalstatus, and socioeconomic status, as well as behaviors and environmental exposures.

Determinants: Epidemiology is also used to search for causes and other factors thatinfluence the occurrence of health-related events.

Health-related states or events: Epidemiology is concerned with epidemics of communicable diseases, endemic communicable diseases, noncommunicable infectious diseases; chronic diseases, injuries, birth defects, maternal-child health, occupational health, and environmental health. Now, even behaviors related to health and well-being (amount of exercise,seat-belt use, etc.) are recognized as valid subjects for applying epidemiologic methods.

Specified populations: Epidemiologist focuses on the exposure (action or source that causes an illness), the number of other persons who mayhave been similarly exposed, the potential for further spread in the community, and interventionsto prevent additional cases or recurrences.

Application: Epidemiology is more than "the study of." As a discipline within public health,epidemiology provides data for directing public health action. Epidemiologist uses the scientific methods of descriptive and analytic epidemiologyin "diagnosing" the health of a community.
Today, public health workers throughout the world accept and use epidemiology routinely.

Epidemiology is often practiced or used to characterize the health ofcommunities and to solve day-to-day problems.

Case definition:is a set of standard criteria for deciding whether a person has a particulardisease or other health-related condition. By using a standard case definition we ensure thatevery case is diagnosed in the same way, regardless of when or where it occurred, or whoidentified it.

Types of Epidemiology
Analytic epidemiology: Attempts to provide the *Why* and *How* of such events by comparing groups with different rates of disease occurrence and with differences in demographic characteristics, genetic or immunologic make-up, behaviour, environmental exposures, and other so-called potential risk factors.

Descriptive epidemiology: Provides the *What*, *Who*, *When*, and *Where* of health-related events. In descriptive epidemiology, data are organised and summarised according to time, place, and person. These three characteristics are sometimes called the **epidemiologic variables**.

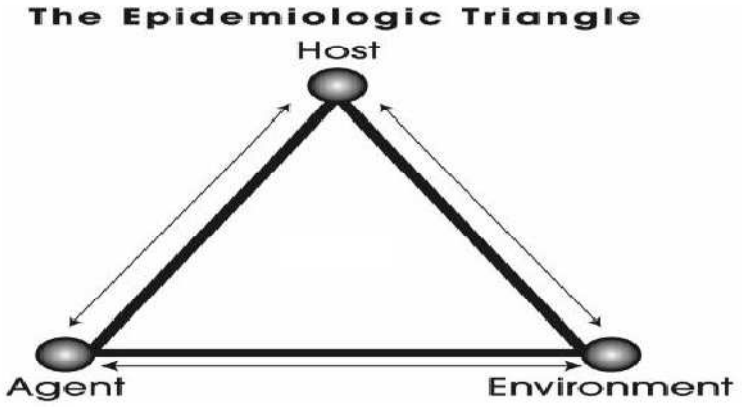
Uses

- **Population or community health assessment**
  To set policy and plan programs, publichealth officials must assess the health of the population or community they serve and mustdetermine whether health services are available, accessible, effective, and efficient.
- **Search for causes**
  Much of epidemiologic research is devoted to a search for causes, factorswhich influence one's risk of diseaseso that appropriate public health action might be taken.
- Quantifies the relationship between an exposure and a health outcome
- **Individual decisions:**People may not realize that they use epidemiologic information intheir daily decisions. When they decide to stop smoking or choose one method of contraceptioninstead of another, they may be influenced, consciously or unconsciously, by epidemiologists'assessment of risk.
- **Completing the clinical picture**: Epidemiologists contribute to physicians' understanding of the clinical picture andnatural history of disease. For example, in late 1989 three patients in New Mexico were diagnosed as having myalgias (severe muscle pains in chest or abdomen) and unexplainedeosinophilia (an increase in the number of one type of white blood cell). Their physician couldnot identify the cause of their symptoms, or put a name to the disorder. Epidemiologists beganlooking for other cases with similar symptoms, and within weeks had found enough additionalcases of eosinophilia-myalgia syndrome to describe the illness, its complications, and its rate ofmortality.

The Epidemiologic Triad:

The **epidemiologic triangle** or **triad** is the traditional model of infectious disease causation.It has three components: **an external agent, a susceptible host, and an environment** that brings thehost and agent together. In this model, the environment influences the agent, the host, and

theroute of transmission of the agent from a source to the host.



Agent factors

Agent refers to infectious microorganism—virus, bacterium, parasite, orother microbe. May also be chemical and physical causes of disease. These includechemical contaminantsand physical forces, such as repetitive mechanical forces associated withcarpal tunnel syndrome.

Generally, these agents must be present for disease to occur. That is, they arenecessary but not always sufficient to cause disease.

Host factors

Host factors are intrinsic factors that influence an individual's exposure, susceptibility, orresponse to a causative agent. Age, genetic composition, race, sex, socioeconomic status, and behaviour (smoking, drug abuse, lifestyle, sexual practices and contraception, eating habits) are some of thehost factors which affect a person's likelihood of exposure

Environmental factors

Environmental factors are extrinsic factors which affect the agent and the opportunity forexposure. Generally, environmental factors include physical factors such as geology, climate,and physical surroundings (e.g., a nursing home, hospital); biologic factors such as insects thattransmit the agent; and socioeconomic factors such as crowding, sanitation, and the availabilityof health services.

Chain/ pathway of infection

Transmission occurs when the **agent** leaves its **reservoir** or host through a **portal of exit**, and isconveyed by some **mode of transmission**, and enters through an appropriate **portal of entry** toinfect a susceptible **host**.

Reservoir

The **reservoir** of an agent is the habitat in which an infectious agent normally lives, grows,and multiplies. Reservoirs include humans, animals, and the environment. The reservoir may ormay not be the source from which an agent is transferred to a host. For example, the reservoir of *Clostridium botulinum*is soil, but the source of most botulism infections is improperly cannedfood containing *C. botulinum*spores.

Human reservoirs. Many of the common infectious diseases have human reservoirs.

Two types of human reservoirexist:

- persons with symptomatic illness
- carriers

A **carrier** is a person without apparent disease who is nonetheless capable of transmitting theagent to others. Carriers may be **asymptomatic carriers**, who never show symptoms during thetime they are infected, or may be **incubatory** or **convalescent carriers**, who are capable oftransmission before or after they are clinically ill. A **chronic carrier** is one who continues to harbor an agent (such as hepatitis B virus or *Salmonella typhi*—the agent of typhoid fever) for anextended time (months or years) following the initial infection.

Animal reservoirs. These diseases are transmitted from animal to animal, with humans as incidental hosts. Such diseases includebrucellosis (cows and pigs), anthrax (sheep), plague (rodents), trichinosis (swine), and rabies(bats, raccoons, dogs, and other mammals).

Another group of diseases with animal reservoirs are those caused by viruses transmitted byinsects and caused by parasites that have complex life cycles, with different reservoirs atdifferent stages of development. Such diseases include St. Louis encephalitis and malaria (both requiring mosquito) and schistosomiasis (requiring fresh water snails).

Environmental reservoirs. Plants, soil, and water in the environment are also reservoirs forsome infectious agents. Many fungal agents, such as those causing histoplasmosis, live and multiply in the soil. The primary reservoir of Legionnaires' bacillus appears to be pools of water,including those produced by cooling towers and evaporative condensers.

Portal of exit

Portal of exit is the path by which an agent leaves the source host. The portal of exit usuallycorresponds to the site at which the agent is localized. Thus, tubercle bacilli and influenzaviruses exit the respiratory tract.

Modes of transmission

After an agent exits its natural reservoir, it may be transmitted to a susceptible host innumerous ways. These modes of transmission are classified as:

Direct

- Direct contact
- Droplet spread

Indirect

- Airborne
- Vehicleborne
- Vectorborne
- Mechanical
- Biologic

Vertical transmission(inter-generation): The transmission of disease-causing agents from mother directly to baby

- Just before or just after birth
- Via placenta or breast milk

Portal of entry

An agent enters a susceptible host through a portal of entry. The portal of entry must provideaccess to tissues in which the agent can multiply or a toxin can act. Often, organisms use thesame portal to enter a new host that they use to exit the source host. For example, influenza virusmust exit the respiratory tract of the source host and enter the respiratory tract of the new host.

Host

The final link in the chain of infection is a susceptible host.

Dynamics of Disease Transmission

- Interaction of agents and environmental factors with human hosts
- Distribution of severity of disease
- Modes of disease transmission
- Level of disease in a community when transmission stops

A. Research in P/CHN

Research and research methodology on public or community health nursing is similar to research in other fields ofnursing and other health/social sciences field.

Definition of research and Importance of research in Community health

Research is a planned and systematic application of the scientific method to the study ofproblems. In community health, the problems could be in the area of patient care, prevention of diseases, health promotion or evn rehabilitation.

Importance of research in community health

- Research in Community Health is essential for continued improvement in patient'scarethrough development of new products,procedures and methods of care.
- Community Health practitioners are being increasingly required to utilize research-based practice(evidence -based practice) to make decisions and take actions in respect of patient's care.
- Communityhealth workers are accepting the need to base their community health actions and decisions on evidence toshow that the actions are clinically appropriate, cost effective, and so more acceptable to the patients.
- Research findings will help community health workers eliminate actions that do not achieve the desiredresults, and help them to identify those practices that can change outcomes.Practice orientedresearch is a great avenue for improving professional practice in nursing.
- Research could promote better administrative methods in community health, and moreeffective use for staff of all cadres.
- Community health administrators find research useful particularly in the aspect of skill mixand staffing levels.
- As in all other fields, research could form the basis for extension of knowledge in nursing,and provision of scientific knowledge that could enhance the professional status.
- Research also contributes to better teaching methods, better curriculum, and enhancescommunity health education.
- Research encourages scientific accountability in community health practice, and enablescommunity health workers to evaluate the efficacy of their care, and modify/abandon thosepractices shown to have no effect on the health status of the patients.

B. Community Assessment

In order to effectively serve a community, it is important to understand the community. This understanding can be achieved through a community assessment. The findings from an assessment will define the extent of the needs that exist in a community and the depth of the assets available within the community to address those needs. This understanding of needs and assets can be used to strategically plan and deliver relevant, successful, and timely services.

A goal of a community assessment is to develop an informed understanding of the gaps or needs that exist within a community and their impacts upon the community's members.

Community Assets

Community asset assessment is a process of critically examining the characteristics and resources that currently exist in the community that can be used to help meet community needsin collaboration with that community, in order to develop strategies to improve the health and quality of life of the community.

Community assets are defined as those things that can be used to improve the quality of life. These include organizations, people, partnerships, facilities, funding, policies, regulations, and a community's collective experience. Any positive aspect of the community is an asset that can be leveraged to develop effective solutions.Resources may be natural, man-made and human.

Community Needs

Community needs assessment is a process of critically examining the characteristics, resources, assets and needs of a community in collaboration with that community, in order to develop strategies to improve the health and quality of life of the community.
Need is anything one cannot do without. In other words, the concept of needs describes the situation or circumstances in which something is lacking, or necessary or requiring some course of action to provide satisfaction.Need determination is primary to community assessment

Types of Needs

- **Felt Needs:**These are what people "feel" or their wants. They are only but the feelings of the individual people or wants shared by groups or majority of people in the community. Felt needs may be expressed informally within the community.

- **Express Needs**:These are needs that have been moved from the level of being "felt" to that of being brought to the attention of authorities at various levels (expressed) by requests, complaints, petitions etc. These needs have been spoken out or expressed in writing.
- **Agency / Organisation Determined/ Normative Needs**: These are products of decisions emanating from external Organisations to the Community. Organisational determined needs are what external organisations such as the Ministry of Health, Department of Community Development, etc. have decided the community needs and may not necessarily reflect the felt needs of the people. These are determined from outside the community. It is the type of need most often regarded as objective and unbiased
- **Comparative Need:** Described as need determined by comparing the resources or services of one group or area with those of another similar group or area.Problem with this type of need is based on the assumption that similarity exist between the areas & that the response to the need in the area of comparison was the most appropriate response to the problem which may not be true.

Community assessment opens the eyes of community members to their own needs, it enables them to identify resources and empower them to solve identified problems.

Community Assessment Tools/ Instruments

- **Key Informants Interview**

Key informants of the community are people who hold socially responsible positions (such as educators, public officials, clergy and business representatives), or are active in community events (Opinion leaders). Key informants, by virtue of their positions in the community, have wide contact with people in the community; typically community members turn to key informants for help in answering their questions.

Key informants interviewis qualitative, in-depth interview of 15 to 35 people selected for their first-hand knowledge about a topic of interest. The information is then analyzed and reported tothe community.By interviewing key informants, one can get a better understanding of their impressions of the needs of the community.

Advantages

1. One of the easiest and least expensive ways tosystematically assess needs.

2. Opportunity to establish rapport and trust andthus obtain the insiders' view.
3. Depth of information concerning causes ofreasons.
4. Permits continual clarification of ideas andinformation.
5. Can be combined effectively with othertechniques.
6. Permits input from many individuals withdifferent perspectives on the needs of thecommunity.
7. Can be implemented by community volunteers,thereby building citizen involvement andawareness.
8. Does not involve the high cost of printing anddata analysis.
9. May help initiate (or strengthen) the lines ofcommunication on among service organizations,agencies, and associations.
10. Discussion of the findings with the key informantspromotes insights for all concerned.
11. The data collection instruments are usually easierto construct than those associated with theSurveyApproach.

Disadvantages

1. The information derived from this technique mayrepresent a "biased perspective":
2. The information derived from key informantsoften represents the perspectives (and biases) ofthe organization, agencies, and associations withwhich these informants are associated.
3. A group meeting held to "feed back" the findings of the study to the key informants may only workto rigidify a "provider" bias in terms of clarifyingwhat the real needs are.
4. Personal relationships between researchers andinformants may influence type of data obtained.
5. Jealousies and resentment on the part of othercommunity members whose opinions are notsolicited may develop.
6. Should be combined with other methods, becauserepresentativeness of total community is difficultto achieve.
7. Few people can sense all the needs and concernsof all people in a community—the perspectives ofthose who are less visible may be overlooked.

An Optional Approach

The "expanded key informant approach" isdesigned to capture some of those individuals whomay be omitted using the traditional approach butwho occupy positions of leadership in the community.One method that can be used to identify thesepeople is to select five individuals who hold officialpositions in the community (e.g., city manager, business leader).

Askeach of these persons the following concerning the issue(s) which is (are) being considered:

Please name five to ten individuals who you feelare knowledgeable about this (these) issue(s) inthis community.
Compile the list of persons mentioned. Take themost frequently mentioned persons on the list and askthem to complete the same questionnaire or interviewthat the key informants (who hold formal positions ofauthority) have been asked to complete.

- **Community/ Public Forum**

A public meeting(s) is/ are held during which the participants discuss what some of the needs facing the community are, what some of the priority needs are, and what can be done about these priority needs. All members of the community are encouraged to attend and express their concerns pertaining to their well-being and perceived needs.

Advantages

1. Offers a good way to elicit opinions from a widerange of the citizenry.
2. Provides an opportunity for citizens to activelyparticipate in the assessment process.
3. Participants in the forums may offer ableassistance to decision makers after the process is completed.
4. Often contributes to enhancing the lines ofcommunication between the "providers" and"consumers" of services and programs.
5. Can provide an intensive picture ofcommunity concerns.
6. Gives community issues broad visibility.
8. Useful to identify problems, assess needs, or tosuggest questions requiring further study.
9. Design is flexible—a variety of techniques can beincorporated.

Disadvantages

1. The burden will be squarely on the sponsoringorganizations, agencies, or associations toencourage participation.
2. Require good leadership and advanceorganization.
3. Opinions obtained are limited to those whoattend—all viewpoints may not be heard.
4. Participants in the forums may actually representa variety of "vested interest" groups.
5. Poor advance planning and advertising may resultin limited participation.

6. Participants in forums may use the sessions as avehicle to publicize their grievances ("gripes")about local organizations or agencies.
7. If not well-facilitated, only the vocal minoritieswill be heard.
8. May generate more questions than answers.
9. The forums may bring about unrealisticterms of what "providers" can do to help meetneeds.

- **Public Records/ Existing Data**

A more objective method of data collection is to use public records (such as the national Census) to find out the social indicators or demographics of your community related to age, gender, education level, income level, etc.

- **Focus groups**

A focus group, led by a trained facilitator, is a particular type of "group interview" that consists of groups of people whose opinions are very valuable. Focus groups are perhaps the most flexible tool for gathering information because you can focus in on getting the opinions of a group of people while asking open-ended questions that the whole group is free to answer and discuss. This often sparks debate and conversation, yielding lots of great information about the group's opinion.During the focus group, the facilitator is also able to observe the nonverbal communication of the participants. Although the sample size is generally smaller than some other forms of information gathering (6-10), the free exchange of opinions brought on by the group interaction is very useful.

Advantages

1. If well-organized in advance, a heterogeneousgroup can move toward definite conclusions.
2. Can be used to expand the data obtained fromsurveys or existing documents, or can be used togenerate a more specific survey.
3. Motivates all participants to get involved becausethey sense they are personally affected.
4. Generates many ideas in a short period of time;allows for a full range of individuals' thoughts andconcerns.
5. A good way to obtain input from people ofdifferent backgrounds and experiences.
6. Gives all participants an equal opportunity toexpress opinions and ideas in a non-threateningsetting.
7. Stimulates creative thinking and effectivedialogue.
8. Allow for clarification of ideas.

Disadvantages

1. Process may appear rigid if group leader does notshow flexibility—encourage agenda building, andshow respect for all ideas and concerns.
2. "Knowledgeable" individuals selected toparticipate may not represent all communitysubgroups.
3. Assertive personalities may dominate unlessleadership skills are exercised.
4. May not be a sufficient source of data in itself;may require follow-up survey, observations ordocumentary analysis.

- **The Delphi Technique**

The Delphi technique is more structured than the focused group; uses a series ofquestionnaires and summarized feedback reports frompreceding responses.

This approach is useful for many of the samethings as the focused group process: generating andclarifying ideas, reaching consensus, prioritizing, andmaking decisions on alternative actions but does not require face- to-face interraction. Since face -to-face interaction is not a requirement, the Delphitechnique could be used with groups that would notordinarily meet together.

How to Implement the Delphi Technique

Many variations of the Delphi technique can bedesigned. The following steps outline a generalapproach for using the Delphi technique:

1. Develop a questionnaire focusing on identifiedissues: problems, causes, solutions, actions. Theintent is for each respondent to list ideasregarding the specified issue.
2. Distribute the questionnaire to an appropriategroup of respondents.
3. Each respondent independently generates ideas inanswering the questions and returns thequestionnaires.
4. Summarize the questionnaires into a feedbackreport and develop a second questionnaire for thesame respondent group. The secondquestionnaire should ask respondents toprioritized or rank input from the first round.
5. Distribute feedback summary and secondquestionnaire.
6. Respondents review feedback report, independently rate priority ideas in secondquestionnaire, and return response.

7. This process is repeated until general agreementis reached on problems, causes, solutions, andactions.
8. A final summary and feedback report is preparedand distributed to respondents. The feedbackreports throughout this process allow for theexchange of opinions and priorities, and oftenresults in individual changes in opinions andpriorities after respondents evaluate the generalgroups perspectives.

Advantages

1. Allows participants to remain anonymous.
2. Inexpensive.
3. Free of social pressure, personality influence, andindividual dominance.
4. Allows sharing of information and reasoningamong participants.
5. Conducive to independent thinking and gradualformulation.
6. A well-selected respondent panel—a mix of localofficials, knowledgeable individuals, citizens of thecommunity, regional official, academic socialscientists, etc.—can provide a broad analyticalperspective on local problems and concerns.
7. Can be used to reach consensus among groupshostile to each other.

Disadvantages

1. Judgments are those of a selected group ofpeople and may not be representative.
2. Tendency to eliminate extreme positions andforce a middle-of-the-road consensus.
3. More time-consuming than the focused groupprocess.
4. Should not be viewed as a total solution.
5. Requires skill in written communication.
6. Requires adequate time and participantcommitment.

- **Asset Inventory**

An asset inventory is a technique for collecting informationabout a community through observation. It's similar to ashopkeeper taking stock of merchandise, but instead of cataloguingproducts in a store, community memberscatalogueassets in their community. It works best when conducted at acommunity meeting or gathering.

To conduct the inventory, small teams of participants walkaround their community identifying people, places, andthings they think are valuable. Team members then discusstheir choices, create a list for the team, and share it withthelarger group.

- **Community Mapping**

Community mapping is used to reveal people's different perspectivesabout a community. In this facilitated activity, individuals or groups of participantsdraw a map of their community, marking certainpoints of importance and noting how often they visit theseplaces. A facilitator leads a discussion about the maps, whileanother facilitator records the discussion. Community mappingcan be conducted at both informal communitygatheringsand at meetings to which community stakeholders areinvited.

- **Daily Activities Schedule**

Finding out about the work habits of community members is an excellent way to learn about a community's division of labor and perceptions of work, based on gender and age. Itcan also help identify areas where new vocational techniquesor tools might be used to improve a community's workefficiency. Participants are separated into groups of men and women and asked to develop an averagedaily schedule, based on their daily activities. A facilitatorleads participants in a discussion of the different activities ofcommunity members, while another facilitator records themain points of the discussion.This type of assessment reveals a great deal about perceptionsof gender that might limit the effectiveness of a service projectby affecting the participation of some community stakeholders.It can also provide important information aboutwhen different groups of people are available to participateincertain types of activities.

- **Seasonal Calendar**

This activity reveals changes in seasonal labour supply and demand, household income patterns, food availability, anddemands on public resources, such as schools, mass transitsystems, and recreational facilities. A group of community members isdivided into smaller groups based on age, gender, or profession.A facilitator asks each group to identify different tasksmembers must do at different times of the year (related topaid and unpaid work, social events, educational activities,family health, and environmental changes) and plot them ona timeline, which they then share with the other groups. Thefacilitator leads a discussion in which participants examinethe differences.

These results can be used to determine the best times of theyear to begin certain projects and to consider how projectswill affect different groups of people.

- **Community Cafe**

A community cafe creates the atmosphere of a restaurant orcafe in which small groups of people from the communitydiscuss issues raised by facilitators. It can be a both entertainingevent and a unique way to learn aboutcommunity by engaging stakeholders in a direct dialogue.Each table has a "host," or facilitator, who guides discussions ona particular topic. Participants move from table to table after acertain amount of time. As each issue is discussed, major ideasare recorded by the hosts, who report the most common ideasfrom their discussions to the cafe "maitred'," or head facilitator.

Procedures

1. Before participants arrive, make sure your food, tables,and hosts are in place.
2. Greet participants as they arrive, encourage them toget food and drink, and seat them at discussion tables.
3. Once everyone has arrived, introduce yourself andexplain the purpose of your assessment and the proceduresfor the discussions.
4. Have the table hosts start their discussions, takingnotes and facilitating the discussion.
5. Every 20 minutes, have participants switch tables todiscuss a different issue or topic. Before the discussionbegins, have each table host summarize the mainpoints from the previous group's discussion. Continuethe process until everyone has discussed each topic.
6. Ask each host to share with the entire group a summaryof the major ideas discussed at his or her table.
7. Thank participants for attending.
8. Meet briefly with all the hosts to discuss what theylearned and observed. Collect the notes from eachtable and summarize the major themes.
9. Send your summary report to participants after theevent.

- **Panel Discussion**

A panel discussion is a guided exchange involving severalexperts on a specific subject. Panel discussions are carefullystructured and typically involve a facilitator who asks panellists specific questions about the community or a particularissue. Often, city governments, non profit or nongovernmental organizations, hospitals, and universities pay experts tocollect and interpret detailed information about communitiesand the issues they face. Drawing on this expertise is anexcellent way to learn

about a community without having toinvest a lot of time or money in a new communityassessment.

Before conducting a panel discussion, identify communitymembers who are qualified to talk about particular issuesand resources. Panels generally have four to six experts ona particular issue (for example, a discussion on communityhealth might include a nurse from a local hospital, a healthofficial from a government health office, a professor from alocal university who researches community health issues, anda community health care specialist from a local non-profit ornongovernmental organization). To get a broader view of thecommunity, consider facilitating a series of panel discussionson different issues.Panel discussions are a powerful tool to raise the awareness ofclub members and to quickly learn about service opportunitiesfrom experts.

- **The Survey Approach**

A survey is a way of collecting information that represents the views of the whole community or group in which you are interested.This approach is used to collect information from a wide range ofcommunity residents concerning issues andcommunity needs via their responses to specificquestions included in an interview schedule orquestionnaire.

Information (data) is gathered through a carefullydeveloped instrument administered to individualsidentified via a sampling procedure.

Some Types of Surveys

* Personal (face-to-face) interviews
* Personal distribution and collection
* Self administered questionnaires completed by respondents in groups
* Telephone interviews
* Mailed questionnaires

Advantages

1. Perhaps the best approach for eliciting theattitudes of a *broad range* of individuals.
2. The data obtained are usually valid and reliable.
3. Techniques—mail survey, telephone survey,personal interview, drop-off and pick-up survey—may be selected in relation to desired cost orresponse rate.

4. Can be used to survey an entire population andprovide an opportunity for many persons to feelinvolved in the decision-making process.
5. Secures information from individuals who may bethe recipients of services initiated as a result ofthe findings, thereby eliciting data fromindividuals who are usually in a good position ofcritique present services.
6. Can be used to record behaviors as well as opinions, attitudes, knowledge, and beliefs.
7. An excellent technique to use in conjunction withother systematic needs assessmenttechniques.

Disadvantages

1. This approach is often the most costly.
2. To ensure statistical meaning, samples must becarefully selected.
3. Results may not be valid if survey is not designedcorrectly.
4. May require time and expertise to develop thesurvey, train interviewers, conduct interviews, and analyze results.
5. Is subject to misinterpretation depending on howthe questions and response categories aredesigned.
6. Tendency for scope of data to be limited—omission of underlying reasons, and actual behavioral patterns.
7. Individuals sometimes hesitant to answerquestions. Individuals who do answer questionssometimes answer them in the most desirable way(i.e., perhaps their answers represent what theythink the authors want to hear, not necessarilyhow the respondents really feel. This is aproblem particularly with interviews.)
8. Surveys are often "one shot" affairs. For example,persons responding to a needs survey may not beresurveyed again in the future.
9. Individuals' attitudes can change rapidly.Attitudes can change due to a variety of"intervening factors."

Community Assessment Process

1. Establish a working committee to solicit individual and community involvement and develop a plan of action.
2. List important issues to be addressed.
3. Identify the population to be surveyed.

4. Determine the information that is needed -- it may be existing information which must be collected, or it may be information gathered using a survey.
5. Determine the tool appropriate to gather the needed information.
6. Select a random sample of persons to survey.
7. Collect information.
8. Analyze the data.
9. Report the results.

Quality Assurance

Quality is defined as the degree to whichhealth services for the individuals and populationsincrease thelikelihood of the desired health outcomes and are consistent withcurrent professional knowledge.Quality of aservice is defined as the totality of features and characteristics ofa service that bears on it, ability to satisfy the stated and impliedneeds of the patients.

Quality Assurance is anon-going, systematic, comprehensive evaluation of health careservices and the impact of those services on health care services. It is also the monitoring of theactivities of client care to determine the degree of excellenceattained to the implementation of the activities. In Nursing, quality assurance is the defining of nursing practice throughwell written nursing standards and the use of those standards as abasis for evaluation on improvement of client care . Quality assurance is to provide a higher quality of care. It is necessary that nurses develop standards of patient care and appropriate evaluation tools, so that professional aspects of nursing involving intellectual and interpersonal activities will be cattered for as quality will be ensured and attention will be given to the individual needsand responses to patients.The standards must be written, regularly reviewed and well-knownby the nursing staff.

Approaches for quality assurance

There are 2 major categories of approaches; theyare

1. General
2. Specific

General Approaches:It involves large governing of official body'sevaluation of a person’s or agency's ability to meet establishedcriteria or standards at a given time.

A. Credentialing: It is generally defined as the formal recognitionof professional or technical competence and attainment ofminimum standards by a person or agency. Credentialing process has four functional components which include; to produce a quality product, to confer a unique identity, toprotect provider and public and to control the profession.

B. Licensure: Individual licensure is a contract between theprofession and the state, in which the profession is granted controlover entry into and exists from the profession and over quality ofprofessional practice.The licensing process requires that regulations be written todefine the scopes and limits of the professional's practice.

C. Accreditation: It is the standards for inspecting nursingeducation's programs. In the part the accreditation processprimarily evaluated on

agency's physical structure, organizationalstructure and personel qualification.

D. Certification:Certification is usually a voluntary processwith- in the profession. A person's educational achievements,experience and performance on examination are used to determinethe person's qualifications for functioning in an identified specialtyarea.

Specific approaches:

A. **Peer review:**To maintain high standards, peer review hasbeen initiated to carefully review the quality of practicedemonstrated by members of a professional group. Peer review isdivided into two types. One centres on the recipients of healthservices by means of auditing the quality of services rendered. Theother centres on the health professional by evaluating the qualityof individual performance.

B. **Standard as a device for quality assurance**:Standard is apre-determined baselinecondition or level of excellence thatcomprises a model to be followed and practiced.

C. **Audit:**Nursing audit may bedefined as a detailed review and evaluation of selected clinicalrecords in order to evaluate the quality of nursing care andperformance by comparing it with accepted standards. To be effective, nursing audit must be based on establishedcriteria and feedback mechanism that provide information toproviders on the quality of care delivered.

Quality assurance model in nursing

Quality assurancemodel in nursing is the set of elements that are related to eachother and comprise of planning for quality development ofobjectives setting and actively communicating standardsdeveloping indicators, setting thresholds, collecting data tomonitor compliance with set standards for nursing practice andapply solutions to improve care.

Purpose of quality assurance model

To ensure qualitynursing care provided by nurses in order to meet the expectationsof the receiver, management and regulatory body. It also intends toincrease the commitment of the provider and the management

Goals of quality assurance model

Develop confidenceof the receiver that quality care is being rendered as per assurance

Develop commitment of the management towards quality care.
Increase commitment of providers to adhere to set standards for nursing practice and strive for excellence

Models of quality assurance

A. System Model for Quality assurance

The basic components of the system are

i. Input: - Can be compared to the present state of the system.
ii. Through put: - The through put to the developmental process.
iii. Output: - To the finished product.
iv. Feed Back: - It is the essential component of the system because it maintains and nourish growth.

B. America Nurses Association (ANA) Quality Assurance Model

i. Identify Value
ii. Identify structure, process and outcome standards and criteria
iii. Select measurement to determine degree of attainment of criteria and standards

Make interpretations

i. Identify Course of Action
ii. Choose action
iii. Take Action
iv. Re-evaluate

Careful interpretation is essential to determine whether the course of action has improve the deficiency, positive reinforcement is offered to those who participated and the decision is made about when to again evaluate that aspect of care.

C. Joint Commission on the Acctreditation of Healthcare Organisations Quality Assurance Model

D. ISO Quality Assurance Model: Series of standards developed and published by the International Organisation for Standardisation (ISO) that define, establish and maintain an effective quality assurance system for manufacturind and service industries.

Quality assurance process

1. Establishment of standards or criteria
2. Identify the information relevant to criteria
3. Determine ways to collect information
4. Collect and analyze the information

5. Compare collected information with established criteria.
6. Make a judgment about quality.
7. Provide information and if necessary, take corrective action regarding findings of appropriate sources.
8. Determine ways to collect the information.

Factors affecting quality assurance in nursing care

Lack of Resources: Insufficient resources, infrastructures, equipment, consumables, money for recurring expenses and staff make it possible for output of a certain quality to be turned out under the prevailing circumstances.

Personnel problems: Lack of trained, skilled and motivated employees, staff indiscipline affects the quality of care.

Improper maintenance: Buildings and equipments require proper maintenance for efficient use. If not maintained properly the equipments cannot be used in giving nursing care. To minimize equipment down time it is necessary to ensure adequate after sale service and service manuals.

Unreasonable Patients and Attendants: Illness, anxiety, absence of immediate response to treatment, unreasonable and un-cooperative attitude that in turn affects the quality of care in nursing.

Absence of well informed population: To improve quality of nursing care, it is necessary that the people become knowledgeable and assert their rights to quality care. This can be achieved through continuous educational program.

Absence of accreditation laws: There is no organization empowered by legislation to lay down standards in nursing and medical care so as to regulate the quality of care. It requires a legislation that provides for setting of a stationary accreditation /vigilance authority to inspect hospitals and ensures that basic requirements are; enquire into major incidence of negligence and take actions against health professionals involved in malpractice.

Lack of incident review procedures: During patients hospitalisations; incidents may occur which have a bearing on the treatment and the patients final recovery.Example may include; delayed attendance by nurses, surgeon, physician or even incorrect medication.

Lack of good hospital information system: A good management information system is essential for the appraisal of quality of care.

Absence of patient satisfaction surveys: Ascertainment of patient satisfaction at fixed points on an ongoing basis. Such surveys carried out through questionnaires, interviews help to document patient's satisfaction.

Lack of nursing care records: Nursing care records are perhaps the most useful source of information on quality of care rendered. The record: Detail the patient condition, Document all significant interaction between patient and the nursing personnel; Contain information regarding response to treatment and Have the dates in an easily accessible form.

Health Education and Counselling in P/CHN

Health education and counselling are closely linked though they have their uniqueness and their differences, both activities may take place at the same time.

In health education, the aim is to make the patient better informed, so that he/she can make an informed choice of behaviour and practices. Health education is the provision of accurate and truthful information so that a person can become knowledgeable about the subject and make an informed choice. Health education happens when health-care providers share their knowledge with the aim of increasing a client's awareness and understanding and in health education, the same facts are given to everyone.

Counselling relates more to issues of anxiety and coping with health issues or its consequences, biomedical as well as social. It is a two-way interaction between a client and a provider. It is an interpersonal, dynamic communication process that involves a kind of contractual agreement between a client and a counsellor who is trained to an acceptable standard and who is bound by a code of ethics and practice. It requires empathy, genuineness and the absence of any moral or personal judgment.

Counselling aims to encourage healthy living and requires the client to explore important personal issues and to identify ways of living with the prevailing situation, whether it is an infection or bereavement. It is not about providing advice or guidance.

A good counsellor is compassionate and non-judgmental, is aware of verbal and non-verbal communication skills, is knowledgeable concerning issues, and is respectful of the needs and rights of the clients.

Method of counselling

Although the GATHER method of counselling may appear simplistic, it is complete and thorough:

Greet users

Ask users about themselves
Tell users about the service(s) available
Help users choose the service(s) they wish to use
Explain how to use the service(s)
Return for follow-up

Principles of effective counselling

1. Avoid giving advice only and do not impose your personal values.
   - Listen to the client
   - Help the client evaluate his or her situation and behaviour
   - Work with client to identify possible solutions to the problem(s)
   - Be client centered.

2. Respect your clients and encourage their abilities to help themselves,trust in themselves, and take responsibility for their actions and decisions.
3. Treat your clients as individual.
   - Emphasize their good qualities and potential.
   - Respect their rights as people.
   - Promote the exercise of their capacity to think and make decisions.
4. Maintain confidentiality and privacy, talk where no one can see or hear you.

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MODULE 7 TOOLS IN PUBLIC/COMMUNITY HEALTH NURSING

UNIT 1 EPIDEMIOLOGY

CONTENTS

1.0 INTRODUCTION

You all have taken ill at one point or the other or have had to nurse some sick individuals though you may not have fully understand why and how these diseases occur. This unit is designed to help you understand why and how diseases occur. It will also help you to understand the pattern and trends of diseases as well as their determinants.

You have definitely achieved a set goal in your life; right? I am sure you used different tools in achieveing the set goals. Likewise, to be an efficient community health nurse, certain tools must be employed to assess the population that makes up the community and the community at large as well as ensure appropriate actions are taken to maintain population health.

2.0 OBJECTIVE

At the end of this unit, you should be able to:

- discuss theappropriate and relevanttools used in community health nursing.
- define epidemiology
- define relevant terms to epidemiology
- explain different types of epidemiology
- explain the importance of epidemiology to the practice of Community Health Nursing and
- discuss the pathway of infectious diseases.

3.0 MAIN CONTENT

3.1 Definition of Terms

What is epidemiology?
Epidemiology is defined from the combination of the three Greek words Epi which means “upon” “among” or even “ befall”; Demos meaning “people” or “human population” and Logos meaning “the study of.” Epidemiology can then be litrarily defined as the study of that which befalls people.

“Epidemiology is the study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to the control of health problems.” This definition of includes several terms which reflect some of the important principles of the discipline. The concept could be better explained by looking at the key terms.

Study: Epidemiology is a scientific discipline, sometimes called “the basic science of public health.” It has, at its foundation, sound methods of scientific inquiry.

Distribution: Epidemiology is concerned with the frequency and pattern of health events in a population. Frequency includes not only the number of such events in a population, but also the rate or risk of disease in the population. The rate (number of events divided by size of the population) is critical to epidemiologists because it allows valid comparisons across different populations. Pattern refers to the occurrence of health-related events by time, place, and personal characteristics.

- Time characteristics include annual occurrence, seasonal occurrence, and daily or even hourly occurrence during an epidemic.
- Place characteristics include geographic variation, urban-rural differences, and location of worksites or schools.
- Personal characteristics include demographic factors such as age, race, sex, marital status, and socioeconomic status, as well as behaviors and environmental exposures

Determinants: Epidemiology is also used to search for causes and other factors that influence the occurrence of health-related events.

Health-related states or events: Epidemiology is concerned with epidemics of communicable diseases, endemic communicable diseases, noncommunicable infectious diseases; chronic diseases, injuries, birth defects, maternal-child health, occupational health, and environmental health. Now, even behaviors related to health and well-being (amount of exercise, seat-belt use, etc.) are recognized as valid subjects for applying epidemiologic methods.

Specified populations: Epidemiologists focuses on the exposure (action or source that causes an illness), the number of other persons who may have been similarly exposed, the potential for further spread in the community, and interventions to prevent additional cases or recurrences.

Application: Epidemiology is more than "the study of." As a discipline within public health, for you as a Nurse, epidemiology provides data for directing public health action. You will be able to use the scientific methods of descriptive and analytic epidemiology in "diagnosing" the health of a community. Today, public health workers throughout the world accept and use epidemiology routinely.

Epidemiology is often practiced or used to characterise the health of communities and to solve day-to-day problems.

Case definition:is a set of standard criteria for deciding whether a person has a particular disease or other health-related condition. By using a standard case definition we ensure that every case is diagnosed in the same way, regardless of when or where it occurred, or who identified it.

3.2 Types of Epidemiology

Analytic epidemiology: This type will let you know the *Why* and *How* of events by comparing groups with different rates of disease occurrence and with differences in demographic characteristics, genetic or

immunologic make-up, behaviour, environmental exposures, and other so-called potential risk factors.

Descriptive epidemiology: Provides the *What*, *Who*, *When*, and *Where* of health-related events. In descriptive epidemiology, data are organised and summarised according to time, place, and person. These three characteristics are sometimes called the **epidemiologic variables**.

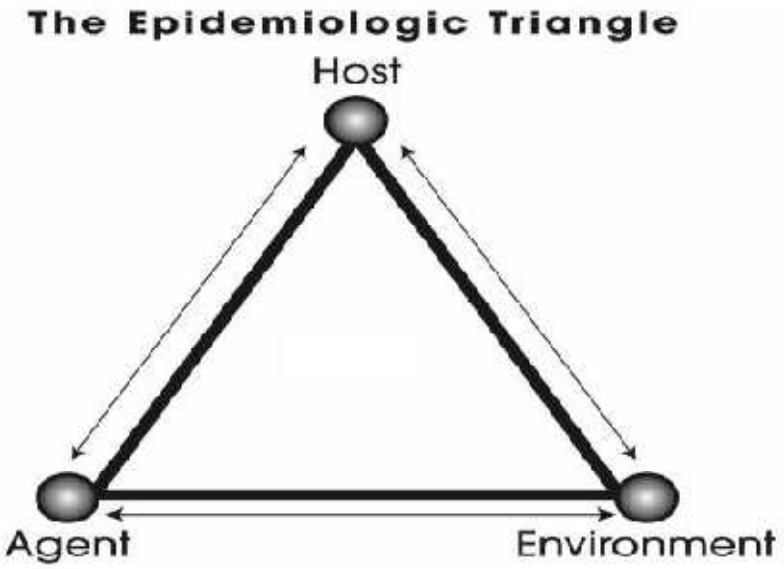
3.3 Uses/ Importance

- **Population or community health assessment:** To set policy and plan programs, you as a Nurse must assess the health of the population or community you serve and must determine whether health services are available, accessible, effective, and efficient.
- **Search for causes:** Much of epidemiologic research is devoted to a search for causes, factors which influence one's risk of disease so that appropriate public health action might be taken.
- Quantifies the relationship between an exposure and a health outcome
- **Individual decisions:**People may not realise that they use epidemiologic information in their daily decisions. When they decide to stop smoking or choose one method of contraceptioninstead of another, they may be influenced, consciously or unconsciously, by epidemiologists'assessment of risk.
- **Completing the clinical picture**: Epidemiologists contribute to physicians' understanding of the clinical picture and natural history of disease. For example, in late 1989 three patients in New Mexico were diagnosed as having myalgias (severe muscle pains in chest or abdomen) and unexplained eosinophilia (an increase in the number of one type of white blood cell). Their physician could not identify the cause of their symptoms, or put a name to the disorder. Epidemiologists began looking for other cases with similar symptoms, and within weeks had found enough additional cases of eosinophilia-myalgia syndrome to describe the illness, its complications, and its rate of mortality.

3.4 The Epidemiologic Triad

The epidemiologic triangle or triad is the traditional model of infectious disease causation. It has three components: an external agent, a susceptible host, and an environment that brings the host and agent together. In this model, the environment influences the agent,

thehost,and theroute of transmission of the agent from a source to the



host.

Agent factors

Agent refers to infectious microorganism—virus, bacterium, parasite, or other microbe. May also be chemical and physical causes of disease. These include chemical contaminants and physical forces, such as repetitive mechanical forces associated with carpal tunnel syndrome.

Generally, these agents must be present for disease to occur. That is, they are necessary but not always sufficient to cause disease.

Host factors

Host factors are intrinsic factors that influence an individual's exposure, susceptibility, or response to a causative agent. Age, genetic composition, race, sex, socioeconomic status, and behaviour (smoking, drug abuse, lifestyle, sexual practices and contraception, eating habits) are some of the host factors which affect a person's likelihood of exposure.

Environmental factors

Environmental factors are extrinsic factors which affect the agent and the opportunity for exposure. Generally, environmental factors include physical factors such as geology, climate, and physical surroundings (e.g., a nursing home, hospital); biologic factors such as insects that transmit the agent; and socioeconomic factors such as crowding, sanitation, and the availability of health services.

3.5 Chain/ pathway of infection

You may become infected (disease transmission) when the agent leaves its reservoir or host through a portal of exit, and is conveyed by some mode of transmission, and enters through an appropriate portal of entry to infect a susceptible host.

Reservoir

You have a place where you live normally- your residence. The reservoir of an agent is the habitat in which an infectious agent normally lives, grows, and multiplies. Reservoirs include humans, animals, and the environment. The reservoir may or may not be the source from which an agent is transferred to a host. For example, the reservoir of *Clostridium botulinum* is soil, but the source of most botulism infections is improperly canned food containing *C. botulinum* spores.

Human reservoirs. Many of the common infectious diseases have human reservoirs.

Two types of human reservoir exist:

- persons with symptomatic illness
- carriers

You are acarrier when you do not have an apparent disease but you are nonetheless capable of transmitting the agent to others. Carriers may be asymptomatic carriers, who never show symptoms during the time they are infected, or may be incubatory or convalescent carriers, who are capable of transmission before or after they are clinically ill. A chronic carrier is one who continues to harbor an agent (such as hepatitis B virus or *Salmonella typhi*—the agent of typhoid fever) for an extended time (months or years) following the initial infection.

Animal reservoirs. Here, the infectious agent lives in the animal and the diseases are transmitted from animal to animal, with humans as incidental hosts. Such diseases include brucellosis (cows and pigs), anthrax (sheep), plague (rodents), trichinosis (swine), and rabies(bats, raccoons, dogs, and other mammals).

Another group of diseases with animal reservoirs are those caused by viruses transmitted by insects and caused by parasites that have complex life cycles, with different reservoirs at different stages of development. Such diseases include St. Louis encephalitis and malaria (both requiring mosquito) and schistosomiasis (requiring fresh water snails).

Environmental reservoirs. Plants, soil, and water in the environment are also reservoirs for some infectious agents. Many fungal agents, such as those causing histoplasmosis, live and multiply in the soil. The primary reservoir of Legionnaires' bacillus appears to be pools of water, including those produced by cooling towers and evaporative condensers.

Portal of exit
Portal of exit is the path by which an agent leaves the source host. The portal of exit usually corresponds to the site at which the agent is localized. Thus, tubercle bacilli and influenza viruses exit the respiratory tract.

Modes of transmission
After an agent exits its natural reservoir, it may be transmitted to a susceptible host innumerous ways. These modes of transmission are classified as:
Direct
- Direct contact
- Droplet spread

Indirect
- Airborne
- Vehicleborne
- Vectorborne
- Mechanical
- Biologic

Vertical transmission(inter-generation): The transmission of disease-causing agents from mother directly to baby

- Just before or just after birth
- Via placenta or breast milk

Portal of entry
An agent enters a susceptible host through a portal of entry. The portal of entry must provide access to tissues in which the agent can multiply or a toxin can act. Often, organisms use the same portal to enter a new host that they use to exit the source host. For example, influenza virus must exit the respiratory tract of the source host and enter the respiratory tract of the new host.

Host

The final link in the chain of infection is a susceptible host.

3.6 Dynamics of Disease Transmission

- Interaction of agents and environmental factors with human hosts
- Distribution of severity of disease
- Modes of disease transmission
- Level of disease in a community when transmission stops

SELF-ASSESSMENT EXERCISE

Now that you have completed unit 1, you can examine yourself to find out how well you have achieved the learning objectives by answering the following questions. You can cross check your answers with the note to determine how much you can remember. If your performance is poor, go over the unit again carefully.

(a) Define epidemiology and explain why the study of epidemiology is important to nursing students.
(b) Discuss the epidemiologic triad
(c) Describe the dynamics of disease transmission.

4.0 CONCLUSION

"Epidemiology is the study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to the control of health problems." This definition of includes several terms which reflect some of the important principles of the discipline.

5.0 SUMMARY

In this unit, you have learnt that:

- epidemiology is the study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to the controlof health problems.
- there are basically two types of epidemiology.
- the epidemilogical triad is necessary in disease transmission.

6.0 TUTOR-MARKED ASSIGNMENT

Visit a PHC in the Local government where you live, from the statistics, describe the distribution of the common diseases presented. What is the implication of your findings for the CHN working in that local government. Share your findings with your colleagues on the discussion forum for the week.

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UNIT 2 RESEARCH IN PUBLIC/ COMMUNITY HEALTH NURSING

CONTENTS

1.0 INTRODUCTION

You have learnt about research in the basic Nursing programme and research in community health nursing is similar to research in other fields of nursing and other health/social sciences field so am sure this unit is not entirely new to you. I also believe you will find it intresting .

www.anmfsa-cpd.org.au

2.0 OBJECTIVES

At the end of this unit, you will be able to:

- define research
- explain why research is important in community health nursing
- describe the research process.

3.0 MAIN CONTENT

3.1 Definition of research and importance of research in community health

You have been involved in conducting a research at one point or the other, so you should have an idea of what this unit is about. Without looking at the definition in this material; what is research to you?
Research is a planned and systematic application of the scientific method to the study of problems. In community health, the problems could be in the area of patient care, prevention of diseases, health promotion or even rehabilitation.

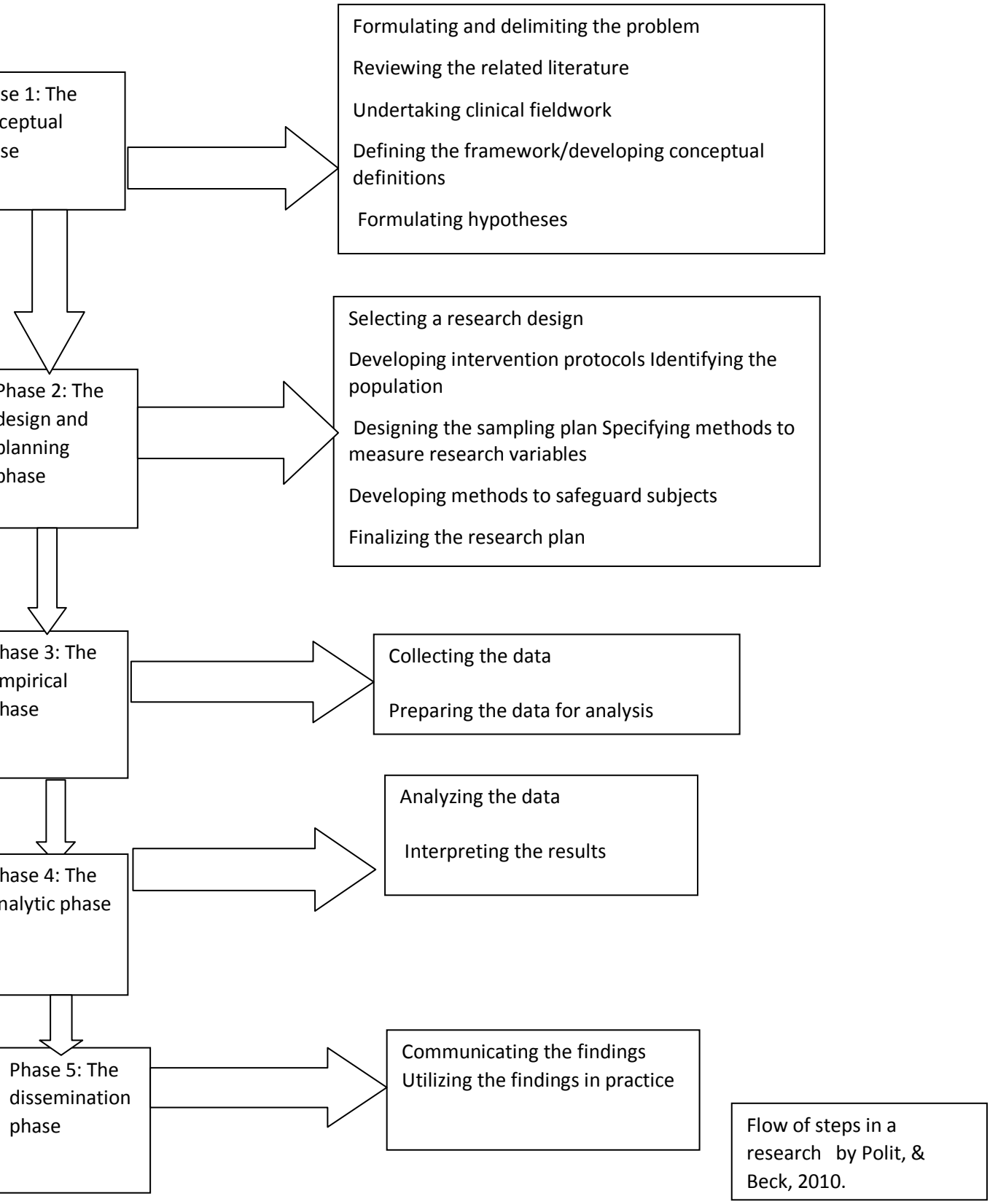
www.mc.vanderbilt.edu

3.2 Importance of research in community health

- Research in Community Health is essential for continued improvement in patient's care through development of new products, procedures and methods of care.
- Community Health practitioners are being increasingly required to utilize research-based practice(evidence -based practice) to make decisions and take actions in respect of patient's care.

- Community health workers are accepting the need to base their community health actions and decisions on evidence to show that the actions are clinically appropriate, cost effective, and so more acceptable to the patients.
- Research findings will help you as a community health Nurse to eliminate actions that do not achieve the desired results, and help you to identify those practices that can change outcomes. Practice oriented research is a great avenue for improving professional practice in nursing.
- Research could promote better administrative methods in community health, and more effective use for staff of all cadres.
- Community health administrators find research useful particularly in the aspect of skill mix and staffing levels.
- As in all other fields, research could form the basis for extension of knowledge in nursing, and provision of scientific knowledge that could enhance the professional status.
- Research also contributes to better teaching methods, better curriculum, and enhances community health education.
- Research encourages scientific accountability in community health practice, and enables community health workers to evaluate the efficacy of their care, and modify/abandon those practices shown to have no effect on the health status of the patients.

The research process/steps in research: It is a cyclical process.



Flow of steps in a research by Polit, & Beck, 2010.

SELF-ASSESSMENT EXERCISE

Now that you have completed the 2nd unit in this Module; you can examine yourself to find out how well you have achieved the learning objectives by answering the following questions. You can cross check your answers with the note to determine how much you can remember. If your performance is poor, go over the unit again carefully.

i. explain five reasons why research is important in community health nursing (LO ii).
ii. describe the research process (LO iii).

4.0 CONCLSUION

Research is a planned and systematic application of the scientific method to the study of problems. In community health, the problems could be in the area of patient care, prevention of diseases, health promotion or even rehabilitation.

5.0 SUMMARY

In this unit, you have learnt:

- that research is necessary for professional growth and development
- the research process occurs in five phases about the research process

6.0 TUTOR-MARKED ASSIGNMENT

You have taken a course in research methodology in year 4, using the knowledge acquired in that course; identify a research problem in your community and discuss with your colleagues on the discussion forum for the week.

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UNIT 3 COMMUNITY ASSESSMENT

CONTENTS

1.0 INTRODUCTION

In order to effectively serve a community, you must understand the community. This understanding can be achieved through a community assessment. The findings from an assessment will define the extent of the needs that exist in a community and the depth of the assets available within the community to address those needs. This understanding of needs and assets can be used to strategically plan and deliver relevant, successful, and timely services.

A goal of a community assessment is to develop an informed understanding of the gaps or needs that exist within a community and their impacts upon the community's members.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- explain the term community assets
- classify community needs
- discuss different community assessment tools
- describe the community assessment process
- conduct a community assessment.

3.0 MAIN CONTENT

3.1 Community Assets/ Community Needs

www.thurstontogether.org

What are your assets and of what importance are they to you? Community assets are defined as those things that can be used to improve the quality of life. These include organizations, people, partnerships, facilities, funding, policies, regulations, and a community's collective experience. Any positive aspect of the community is an asset that can be leveraged to develop effective solutions.Resources may be natural, man-made and human.

Community asset assessment is a process where you critically examine the characteristics and resources that currently exist in a community that can be used to help meet community needs in collaboration with that community, in order to develop strategies to improve the health and quality of life of the community.

Community Needs

Need is anything one cannot do without. In other words, the concept of needs describes the situation or circumstances in which something is lacking, or necessary or requiring some course of action to provide satisfaction. Need determination is primary to community assessment.

Community needs assessment is a process whereby you as a Nurse critically examine the characteristics, resources, assets and needs of a community in collaboration with that community, in order to develop strategies to improve the health and quality of life of the community.

Types of Needs

- **Felt Needs:**There are things you think you need even now but that you have not told anyone about? These things are still at the level of your thought. They are referred to as felt needs. These are what people "feel" or their wants. They are only but the feelings of the individual people or wants shared by groups or majority of people in the community. Felt needs may be expressed informally within the community.
- **Express Needs**: These are needs that have been moved from the level of being "felt" to that of being brought to the attention of authorities at various levels (expressed) by requests, complaints, petitions etc. These needs have been spoken out or expressed in writing.
- **Agency / Organisation Determined/Normative Needs**: These are products of decisions emanating from external Organisations to the Community. Organisational determined needs are what external organisations such as the Ministry of Health, Department of Community Development, etc. have decided the community needs and may not necessarily reflect the felt needs of the people. These are determined from outside the community. It is the type of need most often regarded as objective and unbiased.
- **Comparative Need:** Described as need determined by comparing the resources or services of one group or area with those of another similar group or area. Problem with this type of need is based on the assumption that similarity exist between the areas & that the response to the need in the area of comparison was the most appropriate response to the problem which may not be true.

  Community assessment opens the eyes of community members to their own needs, it enables them to identify resources and empower them to solve identified problems.

3.2 Community Assessment Tools/ Instruments

- **Key Informants Interview**

www.sswm.info

Key informants of the community are people who hold socially responsible positions (such as educators, public officials, clergy and business representatives), or are active in community events (Opinion leaders). Key informants, by virtue of their positions in the community, have wide contact with people in the community; typically community members turn to key informants for help in answering their questions.

Key informants interviewis qualitative, in-depth interview of 15 to 35 people selected for their first-hand knowledge about a topic of interest. The information is then analyzed and reported to the community. By interviewing key informants, one can get a better understanding of their impressions of the needs of the community.

Advantages

1. One of the easiest and least expensive ways to systematically assess needs.
2. Opportunity to establish rapport and trust and thus obtain the insiders' view.
3. Depth of information concerning causes of reasons.
4. Permits continual clarification of ideas and information.
5. Can be combined effectively with other techniques.
6. Permits input from many individuals with different perspectives on the needs of the community.
7. Can be implemented by community volunteers, thereby building citizen involvement and awareness.
8. Does not involve the high cost of printing and data analysis.

9. May help initiate (or strengthen) the lines of communication on among service organizations, agencies, and associations.
10. Discussion of the findings with the key informants promotes insights for all concerned.
11. The data collection instruments are usually easier to construct than those associated with the Survey Approach.

Disadvantages

1. The information derived from this technique may represent a "biased perspective":
2. The information derived from key informants often represents the perspectives (and biases) of the organization, agencies, and associations with which these informants are associated.
3. A group meeting held to "feed back" the findings of the study to the key informants may only work to rigidify a "provider" bias in terms of clarifying what the real needs are.
4. Personal relationships between researchers and informants may influence type of data obtained.
5. Jealousies and resentment on the part of other community members whose opinions are not solicited may develop.
6. Should be combined with other methods, because representativeness of total community is difficult to achieve.
7. Few people can sense all the needs and concerns of all people in a community—the perspectives of those who are less visible may be overlooked.

An Optional Approach

The "expanded key informant approach" is designed to capture some of those individuals who may be omitted using the traditional approach but who occupy positions of leadership in the community. One method that can be used to identify these people is to select five individuals who hold official positions in the community (e.g., city manager, business leader). Ask each of these persons the following concerning the issue(s) which is (are) being considered:

Please name five to ten individuals who you feel are knowledgeable about this (these) issue(s) in this community.

Compile the list of persons mentioned. Take the most frequently mentioned persons on the list and askt hem to complete the same questionnaire or interview that the key informants (who hold formal positions of authority) have been asked to complete.

- **Community/ Public Forum**
  A public meeting(s) is/ are held during which the participants discuss what some of the needs facing the community are, what some of the priority needs are, and what can be done about these priority needs. All members of the community are encouraged to attend and express their concerns pertaining to their well-being and perceived needs.

Advantages

1. Offers a good way to elicit opinions from a wide range of the citizenry.
2. Provides an opportunity for citizens to actively participate in the assessment process.
3. Participants in the forums may offer able assistance to decision makers after the process is completed.
4. Often contributes to enhancing the lines of communication between the "providers" and "consumers" of services and programs.
5. Can provide an intensive picture of community concerns.
6. Gives community issues broad visibility.
8. Useful to identify problems, assess needs, or to suggest questions requiring further study.
9. Design is flexible—a variety of techniques can be incorporated.

Disadvantages

1. The burden will be squarely on the sponsoring organizations, agencies, or associations to encourage participation.
2. Require good leadership and advance organization.
3. Opinions obtained are limited to those who attend—all viewpoints may not be heard.
4. Participants in the forums may actually represent a variety of "vested interest" groups.
5. Poor advance planning and advertising may result in limited participation.
6. Participants in forums may use the sessions as a vehicle to publicize their grievances ("gripes")about local organizations or agencies.
7. If not well-facilitated, only the vocal minorities will be heard.
8. May generate more questions than answers.
9. The forums may bring about unrealistic terms of what "providers" can do to help meet needs.

- **Public Records/ Existing Data**
  A more objective method of data collection is to use public records (such as the national Census) to find out the social indicators or demographics of the community in relation to age, gender, education level, income level, etc.

Focus groups

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A focus group, led by a trained facilitator, is a particular type of "group interview" that consists of groups of people whose opinions are very valuable. Focus groups are perhaps the most flexible tool for gathering information because you can focus in on getting the opinions of a group of people while asking open-ended questions that the whole group is free to answer and discuss. This often sparks debate and conversation, yielding lots of great information about the group's opinion. During the focus group, the facilitator is also able to observe the nonverbal communication of the participants. Although the sample size is generally smaller than some other forms of information gathering (6-10), the free exchange of opinions brought on by the group interaction is very useful.

Advantages

1. If well-organized in advance, a heterogeneous group can move toward definite conclusions.
2. Can be used to expand the data obtained from surveys or existing documents, or can be used to generate a more specific survey.
3. Motivates all participants to get involved because they sense they are personally affected.
4. Generates many ideas in a short period of time; allows for a full range of individuals' thoughts and concerns.
5. A good way to obtain input from people of different backgrounds and experiences.
6. Gives all participants an equal opportunity to express opinions and ideas in a non-threatening setting.

7. Stimulates creative thinking and effective dialogue.
8. Allow for clarification of ideas.

Disadvantages

1. Process may appear rigid if group leader does not show flexibility—encourage agenda building, and show respect for all ideas and concerns.
2. "Knowledgeable" individuals selected to participate may not represent all community subgroups.
3. Assertive personalities may dominate unless leadership skills are exercised.
4. May not be a sufficient source of data in itself; may require follow-up survey, observations or documentary analysis.

- **The Delphi Technique**

  The Delphi technique is more structured than the focused group; uses a series of questionnaires and summarized feedback reports from preceding responses.

  This approach is useful for many of the same things as the focused group process: generating and clarifying ideas, reaching consensus, prioritizing, and making decisions on alternative actions but does not require face- to- face interraction. Since face -to-face interaction is not a requirement, the Delphi technique could be used with groups that would not ordinarily meet together.

How to Implement the Delphi Technique

Many variations of the Delphi technique can be designed. The following steps outline a general approach for using the Delphi technique:

1. Develop a questionnaire focusing on identified issues: problems, causes, solutions, actions. The intent is for each respondent to list ideas regarding the specified issue.
2. Distribute the questionnaire to an appropriate group of respondents.
3. Each respondent independently generates ideas in answering the questions and returns the questionnaires.
4. Summarize the questionnaires into a feedback report and develop a second questionnaire for the same respondent group. The second questionnaire should ask respondents to prioritized or rank input from the first round.
5. Distribute feedback summary and second questionnaire.
6. Respondents review feedback report, independently rate priority ideas in second questionnaire, and return response.
7. This process is repeated until general agreement is reached on problems, causes, solutions, and actions.

8. A final summary and feedback report is prepared and distributed to respondents. The feedback reports throughout this process allow for the exchange of opinions and priorities, and often results in individual changes in opinions and priorities after respondents evaluate the general groups perspectives.

Advantages

1. Allows participants to remain anonymous.
2. Inexpensive.
3. Free of social pressure, personality influence, and individual dominance.
4. Allows sharing of information and reasoning among participants.
5. Conducive to independent thinking and gradual formulation.
6. A well-selected respondent panel—a mix of local officials, knowledgeable individuals, citizens of the community, regional official, academic social scientists, etc.—can provide a broad analytical perspective on local problems and concerns.
7. Can be used to reach consensus among groups hostile to each other.

Disadvantages

1. Judgments are those of a selected group of people and may not be representative.
2. Tendency to eliminate extreme positions and force a middle-of-the-road consensus.
3. More time-consuming than the focused group process.
4. Should not be viewed as a total solution.
5. Requires skill in written communication.
6. Requires adequate time and participant commitment.

- **Asset Inventory**

  An asset inventory is a technique for collecting information about a community through observation. It's similar to a shopkeeper taking stock of merchandise, but instead of cataloguing products in a store, community members catalogue assets in their community. It works best when conducted at a community meeting or gathering.

  To conduct the inventory, small teams of participants walk around their community identifying people, places, and things they think are valuable. Team members then discuss their choices, create a list for the team, and share it with the larger group.

- **Community Mapping**

  Community mapping is used to reveal people's different perspectives about a community. In this facilitated activity, individuals or groups of participants draw a map of their community, marking certain points of importance and noting how often they visit these places. A facilitator leads a discussion about

the maps, while another facilitator records the discussion. Community mapping can be conducted at both informal community gatherings and at meetings to which community stakeholders are invited.

- **Daily Activities Schedule**
  Finding out about the work habits of community members is an excellent way to learn about a community's division of labor and perceptions of work, based on gender and age. It can also help identify areas where new vocational techniques or tools might be used to improve a community's work efficiency. Pparticipants are separated into groups of men and women and asked to develop an average daily schedule, based on their daily activities. A facilitator leads participants in a discussion of the different activities of community members, while another facilitator records the main points of the discussion. This type of assessment reveals a great deal about perceptions of gender that might limit the effectiveness of a service project by affecting the participation of some community stakeholders. It can also provide important information about when different groups of people are available to participate in certain types of activities.
- **Seasonal Calendar**
  This activity reveals changes in seasonal labor supply and dem and, household income patterns, food availability, and demands on public resources, such as schools, mass transit systems, and recreational facilities. A group of community members is divided into smaller groups based on age, gender, or profession. A facilitator asks each group to identify different tasks members must do at different times of the year (related to paid and unpaid work, social events, educational activities, family health, and environmental changes) and plot them on a timeline, which they then share with the other groups. The facilitator leads a discussion in which participants examine the differences.
  These results can be used to determine the best times of the year to begin certain projects and to consider how projects will affect different groups of people.

- **Community Cafe**
  A community cafe creates the atmosphere of a restaurant or cafe in which small groups of people from the community discuss issues raised by facilitators. It can be a unique way to learn about community by engaging stakeholders in a direct dialogue. Each table has a "host," or facilitator, who guides discussions on a particular topic. Participants move from table to table after a certain amount of time. As each issue is discussed, major ideas are recorded by the hosts, who report the most common ideas from their discussions to the cafe "maitred'," or head facilitator.

Procedures

1. Before participants arrive, make sure your food, tables, and hosts are in place.
2. Greet participants as they arrive, encourage them to get food and drink, and seat them at discussion tables.
3. Once everyone has arrived, introduce yourself and explain the purpose of your assessment and the procedures for the discussions.
4. Have the table hosts start their discussions, taking notes and facilitating the discussion.
5. Every 20 minutes, have participants switch tables to discuss a different issue or topic. Before the discussion begins, have each table host summarize the main points from the previous group's discussion. Continue the process until everyone has discussed each topic.
6. Ask each host to share with the entire group a summary of the major ideas discussed at his or her table.
7. Thank participants for attending.
8. Meet briefly with all the hosts to discuss what they learned and observed. Collect the notes from each table and summarize the major themes.
9. Send your summary report to participants after the event.

- **Panel Discussion**

  A panel discussion is a guided exchange involving several experts on a specific subject. Panel discussions are carefully structured and typically involve a facilitator who asks panellists specific questions about the community or a particular issue. Often, city governments, nonprofit or nongovernmental organizations, hospitals, and universities pay experts to collect and interpret detailed information about communities and the issues they face. Drawing on this expertise is an excellent way to learn about a community without having to invest a lot of time or money in a new community assessment.

  Before conducting a panel discussion, identify community members who are qualified to talk about particular issues and resources. Panels generally have four to six experts on a particular issue (for example, a discussion on community health might include a nurse from a local hospital, a health official from a government health office, a professor from a local university who researches community health issues, and a community health care specialist from a local non-profit or nongovernmental organization). To get a broader view of the community, consider facilitating a series of panel discussions on different issues. Panel discussions are a powerful tool to raise the awareness of club

members and to quickly learn about service opportunities from experts.

- **The Survey Approach**
  A survey is a way of collecting information that represents the views of the whole community or group in which you are interested.This approach is used to collect information from a wide range of community residents concerning issues and community needs via their responses to specific questions included in an interview schedule or questionnaire.
  Information (data) is gathered through a carefully developed instrument administered to individuals identified via a sampling procedure.

Some Types of Surveys

* Personal (face-to-face) interviews
* Personal distribution and collection
* Self-administered questionnaires completed by respondents in groups
* Telephone interviews
* Mailed questionnaires

Advantages

1. Perhaps the best approach for eliciting the attitudes of a *broad range* of individuals.
2. The data obtained are usually valid and reliable.
3. Techniques—mail survey, telephone survey, personal interview, drop-off and pick-up survey—may be selected in relation to desired cost or response rate.
4. Can be used to survey an entire population and provide an opportunity for many persons to feel involved in the decision-making process.
5. Secures information from individuals who may be the recipients of services initiated as a result of the findings, thereby eliciting data from individuals who are usually in a good position of critique present services.
6. Can be used to record behaviour as well as opinions, attitudes, knowledge, and beliefs.
7. An excellent technique to use in conjunction with other systematic needs assessment techniques.

Disadvantages

1. This approach is often the most costly.
2. To ensure statistical meaning, samples must be carefully selected.
3. Results may not be valid if survey is not designed correctly.
4. May require time and expertise to develop the survey, train interviewers, conduct interviews, and analyze results.

5. Is subject to misinterpretation depending on how the questions and response categories are designed.
6. Tendency for scope of data to be limited—omission of underlying reasons, and actual behavioural patterns.
7. Individuals sometimes hesitant to answer questions. Individuals who do answer questions sometimes answer them in the most desirable way(i.e., perhaps their answers represent what they think the authors want to hear, not necessarily how the respondents really feel. This is a problem particularly with interviews.)
8. Surveys are often "one shot" affairs. For example, persons responding to a needs survey may not be resurveyed again in the future.
9. Individuals' attitudes can change rapidly. Attitudes can change due to a variety of" intervening factors."

Community Assessment Process

1. Establish a working committee to solicit individual and community involvement and develop a plan of action.
2. List important issues to be addressed.
3. Identify the population to be surveyed.
4. Determine the information that is needed -- it may be existing information which must be collected, or it may be information gathered using a survey.
5. Determine the tool appropriate to gather the needed information.
6. Select a random sample of persons to survey.
7. Collect information.
8. Analyze the data.
9. Report the results.

SELF-ASSESSMENT EXERCISE

Now that you have completed unit 3, you can examine yourself to find out how well you have achieved the learning objectives by answering the following questions. You can cross check your answers with the note to determine how much you can remember. If your performance is poor, go over the unit again carefully.

i. explain the term community assets (LO i)
ii. classify community needs (LO ii)
iii. describe the community process (LO iv)

4.0 CONCLUSION

Community asset assessment is a process where you critically examine the characteristics and resources that currently exist in a community that can be used to help meet community needs in collaboration with that community, in order to develop strategies to improve the health and quality of life of the community.

5.0 SUMMARY

In this unit, you have learnt :

- that community assessment is an important tool for effective community health nursing practice
- about different community assessment tools and their pros and cons
- about community assessment process

6.0 TUTOR-MARKED ASSIGNMENT

Working in your assigned group, assess the community that you have been posted using at least four of the tools learnt and submit your findings to your lecturer for grading.

7.0 REFERENCE/FURTHER READING

UNIT 4 QUALITY ASSURANCE

CONTENTS

1.0 INTRODUCTION

In your purchase of goods or services, you do want to be served the best? In our daily choices of items, quality is an important factor that influences what we go for. The same is true of nursing care and services even at the community level. Quality is defined as the degree to whichhealth services for the individuals and populationsincrease thelikelihood of the desired health outcomes and are consistent withcurrent professional knowledge.Quality of aservice is defined as the totality of features and characteristics ofa service that bears on it, ability to satisfy the stated and impliedneeds of the patients.

Quality Assurance is anon-going, systematic, comprehensive evaluation of health careservices and the impact of those services on health. It is also the monitoring of theactivities of client care to determine the degree of excellenceattained to the implementation of the activities. In Nursing, quality assurance is the defining of nursing practice throughwell written nursing standards and the use of those standards as abasis for evaluation on improvement of client care . Quality assurance is to provide a higher quality of care. It isnecessary that nurses develop standards of patient care andappropriate evaluation tools, so that professional aspects ofnursing involving intellectual and interpersonal activities will be cattered for as qualitywill be ensured and attention will be given to the individual needsand responses to patients.The standards must be written, regularly reviewed and well-knownby the nursing staff.

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2.0 OBJECTIVES

At the end of this unit, you should be able to:

- define quality assurance
- explain the approaches to quality assurance
- describe the models of quality assurance
- apply the models to your practice of community health nursing
- describe the quality assurance process
- explain the factors affecting quality assurance in nursing practice

3.0 MAIN CONTENTS

3.1 Approaches for quality assurance

There are 2 major categories of approaches; theyare

1. General
2. Specific

General Approaches:It involves large governing of official body'sevaluation of a person’s or agency's ability to meet establishedcriteria or standards at a given time.

A. Credentialing: It is generally defined as the formal recognitionof professional or technical competence and attainment ofminimum standards by a person or agency. Credentialing process has four functional components which include; to produce a quality

product, to confer a unique identity, toprotect provider and public and to control the profession.

B. **Licensure:**Individual licensure is a contract between theprofession and the state, in which the profession is granted controlover entry into and exists from the profession and over quality ofprofessional practice.The licensing process requires that regulations be written todefine the scopes and limits of the professional's practice.

C. **Accreditation:** It is the standards for inspecting nursingeducation's programs. In the part the accreditation processprimarily evaluated on agency's physical structure, organizationalstructure and personel qualification.

D. **Certification:**Certification is usually a voluntary processwith- in the profession. A person's educational achievements,experience and performance on examination are used to determinethe person's qualifications for functioning in an identified specialtyarea.

Specific approaches:

A. **Peer review:**To maintain high standards, peer review hasbeen initiated to carefully review the quality of practicedemonstrated by members of a professional group. Peer review isdivided into two types. One centres on the recipients of healthservices by means of auditing the quality of services rendered. Theother centres on the health professional by evaluating the qualityof individual performance.

B. **Standard as a device for quality assurance**:Standard is apre-determined baselinecondition or level of excellence thatcomprises a model to be followed and practiced.

C. **Audit:**Nursing audit may bedefined as a detailed review and evaluation of selected clinicalrecords in order to evaluate the quality of nursing care andperformance by comparing it with accepted standards. To be effective, nursing audit must be based on establishedcriteria and feedback mechanism that provide information toproviders on the quality of care delivered.

3.2 Quality assurance model in nursing

Quality assurancemodel in nursing is the set of elements that are related to eachother and comprise of planning for quality development ofobjectives setting and actively communicating standardsdeveloping indicators, setting thresholds, collecting data tomonitor compliance with set standards for nursing practice andapply solutions to improve care.

Purpose of quality assurance model

www.mstrust.org.uk

To ensure qualitynursing care provided by nurses in order to meet the expectationsof the receiver, management and regulatory body. It also intends toincrease the commitment of the provider and the management

Goals of quality assurance model

1. Develop confidenceof the receiver that quality care is being rendered as per assurance.
2. Develop commitment of the management towards qualitycare.
3. Increase commitment of providers to adhere to set standardsfor nursing practice and strive for excellence

Models of quality assurance

A. System Model for Qualityassurance.

The basic componentsof the system are

- Input: - Can be compared to the present state of thesystem.
- Through put: - The through put to the developmentalprocess.
- Output: - To the finished product.
- Feed Back: - It isthe essential component of the system because it maintains andnourishes growth.

B. America Nurses Association (ANA) Quality Assurance Model

- Identify Value
- Identify structure, process and outcome standards andcriteria
- Select measurementto determine degree ofattainment of criteria andstandards

- Make interpretations
- Identify Course of Action
- Choose action
- Take Action
- Re-evaluate

Careful interpretation is essential to determine whether thecourse of action has improve the deficiency, positivereinforcement is offered to those who participated and thedecision is made about when to again evaluate that aspect ofcare.

C. Joint Commission on the Accreditation of Healthcare Organisations Quality Assurance Model

D. ISO Quality Assurance Model: Series of standards developed and published by the International Organisation for Standardisation (ISO) that define, establish and maintain an effective quality assurance system for manufacturing and service industries.

3.3 Quality assurance process

1. Establishment of standardsor criteria
2. Identify the information relevant to criteria
3. Determine ways to collect information
4. Collect and analyze theinformation
5. Compare collected information with establishedcriteria
6. Make a judgment about quality
7. Provide informationand if necessary, take corrective action regarding findings ofappropriate sources
8. Determine ways to collect the information

3.4 Factors affecting quality assurance in nursingcare

Lack of Resources:Insufficient resources, infrastructures,equipment, consumables, money for recurring expenses and staffmake it possible for output of a certain quality to be turned outunder the prevailing circumstances.

Personnel problems: Lack of trained, skilled and motivatedemployees, staff indiscipline affects the quality of care.

Improper maintenance: Buildings and equipments requireproper maintenance for efficient use. If not maintained properlythe equipments cannot be used in giving nursing care. Tominimize equipment down time it is necessary to ensure adequateafter sale service and service manuals.

Unreasonable Patients and Attendants: Illness, anxiety,absence of immediate response to treatment, unreasonable and un-cooperative attitude that in turn affects the quality of care innursing.

Absence of well informed population: To improve quality ofnursing care, it is necessary that the people becomeknowledgeable and assert their rights to quality care. This can beachieved through continuous educational program.

Absence of accreditation laws: There is no organizationempowered by legislation to lay down standards in nursing andmedical care so as to regulate the quality of care. It requires alegislation that provides for setting of a stationary accreditation /vigilance authority to inspect hospitals and ensures that basic requirements are; enquire into major incidence of negligence and take actionsagainst health professionals involved in malpractice.

Lack of incident review procedures: During patientshospitalisations; incidents may occur which have a bearingon the treatment and the patients final recovery.Example may include; delayed attendance by nurses, surgeon, physician or even incorrect medication.

Lack of good hospital information system: A goodmanagement information system is essential for the appraisal ofquality of care.

Absence of patient satisfaction surveys: Ascertainment ofpatient satisfaction at fixed points on an ongoing basis. Suchsurveys carried out through questionnaires, interviews help to document patient's satisfaction.

Lack of nursing care records: Nursing care records areperhaps the most useful source of information on quality of carerendered. The record: Detail the patient condition, Documentall significant interaction between patient and the nursingpersonnel; Contain information regarding response to treatment and Have the dates in an easily accessible form.

SELF-ASSESSMENT EXERCISE

Haven completed unit 4, it is expedient to examine yourself and find out how well you have achieved the learning objectives by answering the following questions. You can cross check your answers with the note to determine how much you can remember. If your performance is poor, go over the unit again carefully.

i. define quality assurance (LO i)
ii. describe the models of quality assurance (LO iii)

iii. explain the factors affecting quality assurance in nursing practice (LO vi)

4.0 CONCLUSION

5.0 SUMMARY

In this unit, you have learnt :

1. that quality assurance in nursing is the defining of nursing practice through well written nursing standards and the use of those standards as a basis for evaluation on improvement of client care.
2. about the general and specific approaches to quality assurance
3. the quality assurance process

6.0 TUTOR-MARKED ASSIGNMENT

As a group, using any of the quality assurance model, evaluate the qualities of two services being delivered in the facility where you have been posted . Share your findings with your colleagues on the discussion forum for the week, stating the rationale for choosing your preferred model.

7.0 REFERENCES/FURTHER READING

Allender, J.A., Rector, C., & Warner, K.D. (2010*). Community Health Nursing Promoting and Protecting the Public's Health* (7th ed) China: Wolters Kluwer Health | Lippincott Williams & Wilkins. Copyright © 2010

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UNIT 5 HEALTH EDUCATION AND COUNSELING IN PUBLIC/ COMMUNITY HEALTH NURSING

CONTENTS

1.0 INTRODUCTION

To you as a community health nurse, health education/health teaching and health counselling is a foundation of practice. Health education and counselling are closely linked. Though they have their uniqueness and their differences, both activities may take place at the same time.

In health education, your aim is to make the patient better informed, so that he/she can make an informed choice of behaviour and practices. Health education is the provision of accurate and truthful information so that a person can become knowledgeable about the subject and make an informed choice. Health education happens when health-care providers share their knowledge with the aim of increasing a client's awareness and understanding and in health education; the same facts are given to everyone.

For health education to be effective, awareness of the underlying principles of behaviour change is vital. You as a community health nurse should consider what motivates people to adopt new behaviour and what factors may inhibit or prevent that change. By understanding the principles of teaching and behaviour change, you can work toward the ultimate goal of health promotion for individuals, families, groups, and communities.

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Counselling relates more to issues of anxiety and coping with health issues or its consequences, biomedical as well as social. It is a two-way interaction between a client and a provider. It is an interpersonal, dynamic communication process that involves a kind of contractual agreement between a client and a counsellor who is trained to an acceptable standard and who is bound by a code of ethics and practice. It requires empathy, genuineness and the absence of any moral or personal judgment.

Counselling aims to encourage healthy living and requires the client to explore important personal issues and to identify ways of living with the prevailing situation, whether it is an infection or bereavement. It is not about providing advice or guidance.

A good counselor is compassionate and non-judgmental, is aware of verbal and non-verbal communication skills, is knowledgeable concerning issues, and is respectful of the needs and rights of the clients.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- apply all the teaching models
- explain the teaching process
- apply the appropriate method for counseling
- explain the principles of counseling.

3.0 MAIN CONTENT

3.1 Health teaching models

It is scientifically right that your teachings as a community health nurse is structured or guided by a particular model. There are 5 different

models of health teaching for community health nurses and the use of any model will be based on the learner's needs as well as the teacher's choice based on experience and other factors. It is possible for you to combine models in the course of your health teaching. The models are:

- The Cloutterbuck Minimum Data Matrix (CMDM)

The Cloutterbuck Minimum Data Matrix (CMDM) generates a comprehensive base of client information. This information is prerequisite to the in-depth level of critical analysis and synthesis needed to produce quality health care outcomes in the 21st century. It assumes an interdisciplinary perspective and educates the nurse to recognize and incorporate client diversity into care.

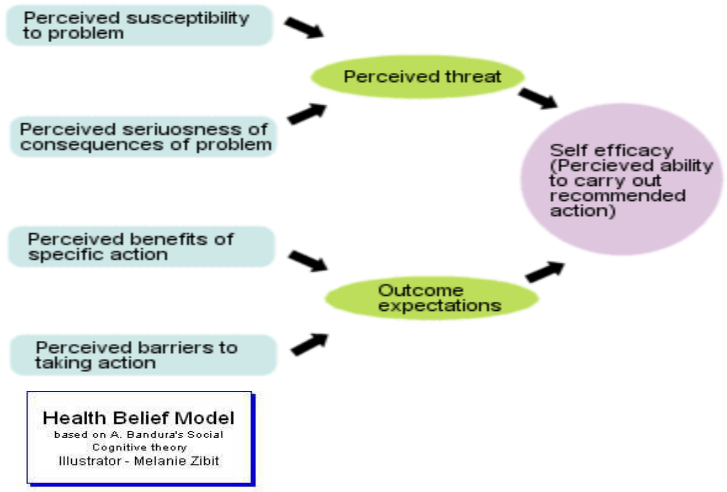
In teaching, it assists the nurse in conceptualizing clients beyond the institutional, individual, and biomedical perspectives. The model helps the nurse to discern the life circumstances or chain of events that have jeopardized a client's health. The model comprises a set of empiric variables that are "known to influence consumer health status, behavior, and outcomes". For example, in the personal variables dimension are items such as age, ethnicity, level of education, and self-care practices. These variables are distributed across three dimensions: personal, situational, and structural. Information generated by the CMDM creates a more comprehensive profile than information gathered in the traditional biomedical health care system. This information, such as client health beliefs and practices and a broad range of personal factors, can be instrumental in helping the nurse design and implement health education programs to promote positive changes in clients' health.

This model has been found to be particularly useful in helping undergraduate nursing students to differentiate between individual- and population-focused practices. The model provides an "opportunity for critical analysis of the multiple variables that affect health and the provision of health care" and can be used in a wide variety of community settings (e.g., elementary schools, homeless shelters, home care settings, home visiting programs for new mothers and their infants, and community senior service centres). An expected student outcome of the use of this particular model is an enhanced awareness of the need for advocating for social change in the communities served. In addition, health promotion and learning needs of the target populations can be more easily identified with this approach.

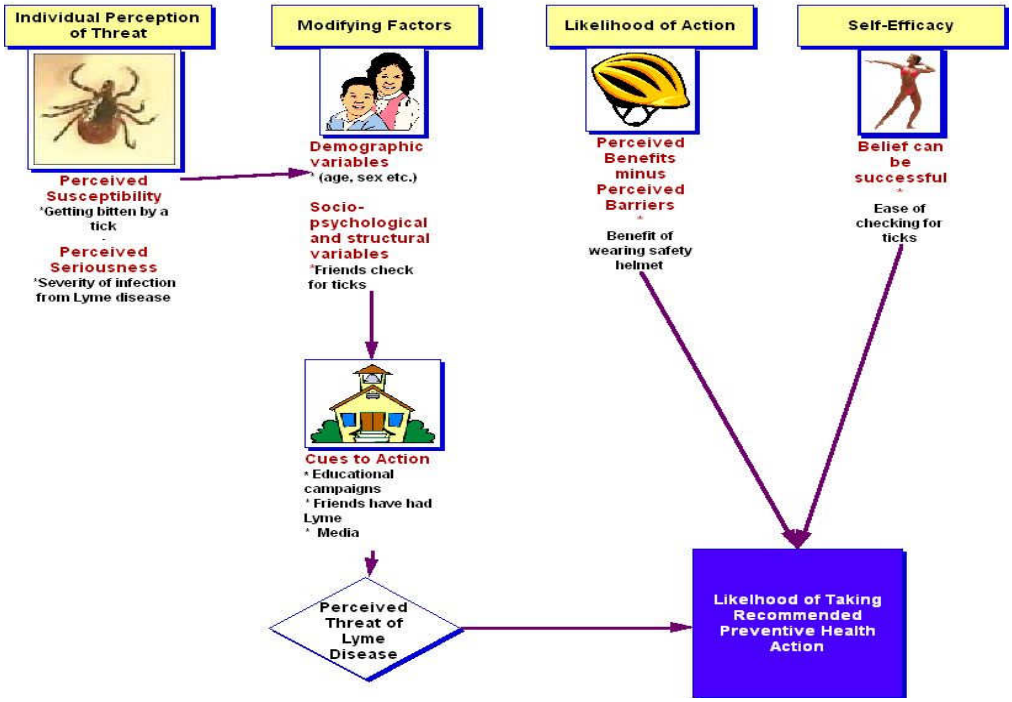
- The Health Belief Model

The HBM is useful for explaining the behaviors and actions taken by people to prevent illness and injury. It postulates that readiness to act on

behalf of a person's own health is predicated on the following (Strecher & Rosenstock, 1997):
Perceived susceptibility to the condition in question
Perceived seriousness of the condition in question
Perceived benefits to taking action
Barriers to taking action
Cues to action, such as knowledge that someone else has the condition or attention from the media and
Self-efficacy—the ability to take action to achieve the desired outcome.

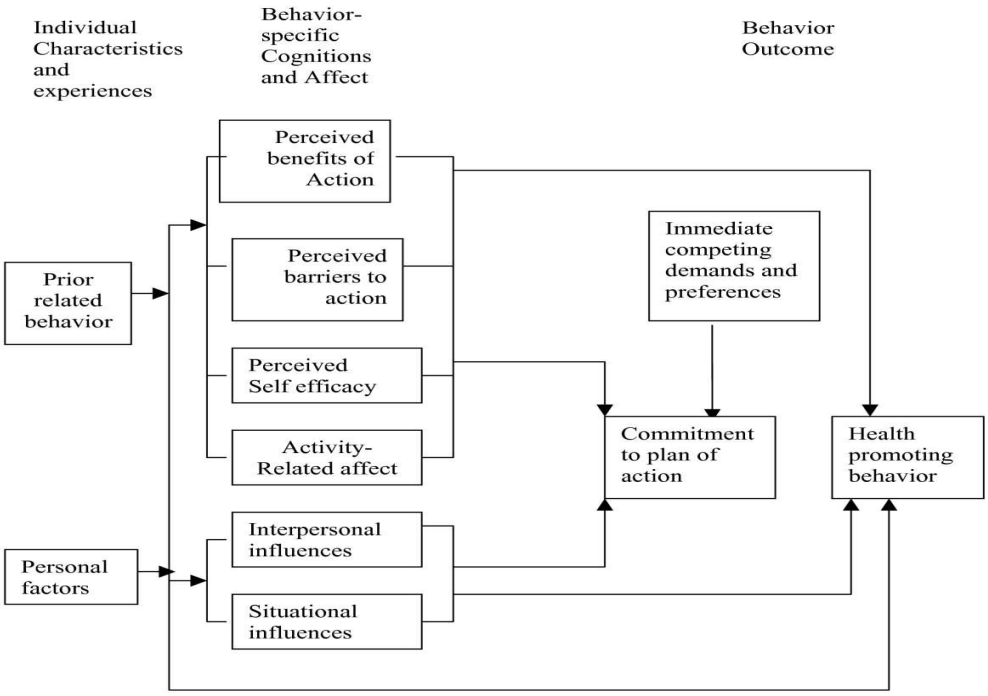


www.ohprs.com



www.bwhpreventlyme.orgHealth-Belief-Model-2-22-2011-BWHTeam

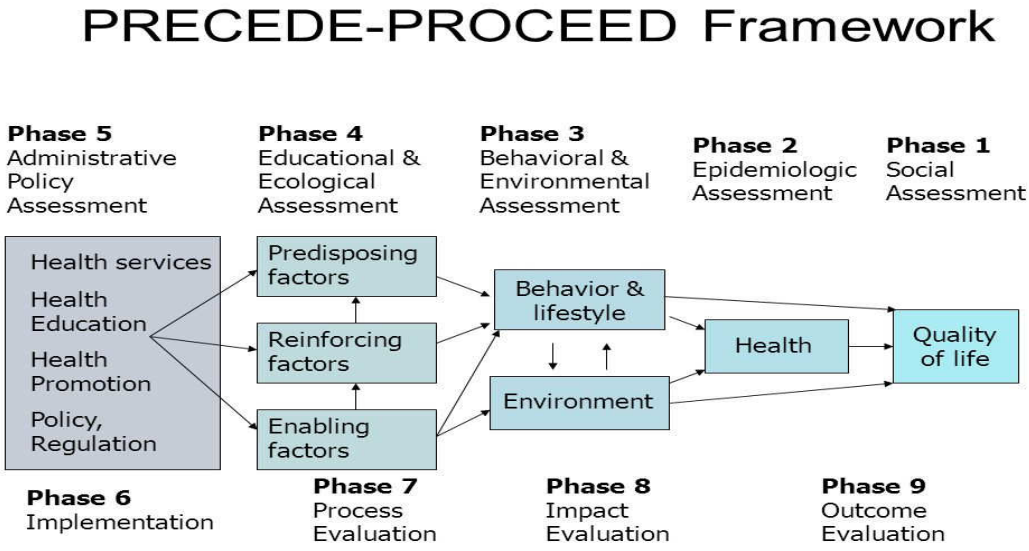
- The Health Promotion Model
  This was envisioned as a framework for exploring health-related behaviour within a nursing and behavioural science context.



www.ijbnpa.org 1479-5868-5-18-1-l health promotion model

Being able to predict health promotion behaviour enhances the community health nurse's ability to work with clients. Awareness of their characteristics, experiences, comprehension of their health-related issues, perceived barriers, self-efficacy, support (or lack of it) from significant others, and commitment provides the nurse with a picture that clarifies the client–nurse role and gives direction for action-taking. "The HPM is a competence- or approach-oriented model [and] does not include 'fear' or 'threat' as a source of motivation for health behaviour"

The PRECEDE and PROCEED models are the last 2 models used in health teaching.



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3.2 Principle of health teaching/education

Seven Principles for Maximizing the Teaching-Learning Process	
Teaching Principles	Learning Principles
1. Adapt teaching to clients' level of readiness.	1. The learning process makes use of clients' experience and is geared to their level of understanding.
2. Determine clients' perceptions about the subject matter before and during teaching.	2. Clients are given the opportunity to provide frequent feedback on their understanding of the material taught.
3. Create an environment that is conducive to learning.	3. The environment for learning is physically comfortable; offers an atmosphere of mutual helpfulness, trust, respect, and acceptance; and allows for free expression of ideas.
4. Involve clients throughout the learning process.	4. Clients actively participate. They assess needs, establish goals, and evaluate their learning progress.
5. Make subject matter relevant to clients' interest and use.	5. Clients feel motivated to interest and learn.
6. Ensure client satisfaction during	6. Clients sense progress toward

the teaching-learning process.	their goals.
7. Provide opportunities for clients to apply material taught.	7. Clients integrate the learning through application.

Adapted from Knowles, M. (1980).

3.3 Teaching Process

The process of teaching in community health nursing follows steps similar to those of the nursing process:

1. Interaction: Establish basic communication patterns between clients and nurse.
2. Assessment and diagnosis: Determine clients' present status and identify clients' need for teaching (keeping in mind that clients should determine their own needs).
3. Setting goals and objectives: Analyze needed changes and prepare objectives that describe the desired learning outcomes.
4. Planning: Design a plan for the learning experience that meets the mutually developed objectives; include content to be covered, sequence of topics, best conditions for learning (place, type of environment), methods, and materials (e.g., visual aids, exercises). A written plan is best; it may be part of the written nursing care plan.
5. Teaching: Implement the learning experience by carrying out the planned activities.
6. Evaluation: Determine whether learning objectives were met and if not, why not. Evaluation measures progress toward goals, effectiveness of chosen teaching methods, or future learning needs.

3.4 Teaching Methods

It is important that if you must get the desired result from your health teaching, the appropriate teaching methods must be used. Four commonly used teaching methods in community health nursing for enhanced learning include;

- Lecture: The community health nurse sometimes presents information to a large group, such as a local parent–teacher association, a women's club, or a county board of commissioners. Under such circumstances, the lecture method, a formal kind of presentation, may be the most efficient way to communicate general health information. However, lecturers tend to create a

passive learning environment for the audience unless strategies are devised to involve the learners. Many individuals are visual rather than auditory learners. To capture their attention, slides, overhead projections, computer generated slide presentations, or videotapes can supplement the lecture. Allowing time for questions and discussion after a lecture also actively involves learners. This method is best used with adults, but even they have a limited attention span and a break at least midway through a presentation of 1 hour or longer will be appreciated. Distributing printed material that highlights and summarizes the content shared, or supplements it, also reinforces important points.

news.harvard.edu

- Discussion: Two-way communication is an important feature of the learning process. Learners need an opportunity to raise questions, make comments, reason out loud, and receive feedback to develop understanding. When discussion is used in conjunction with other teaching methods, such as demonstration, lecture, and role playing, it improves effectiveness.

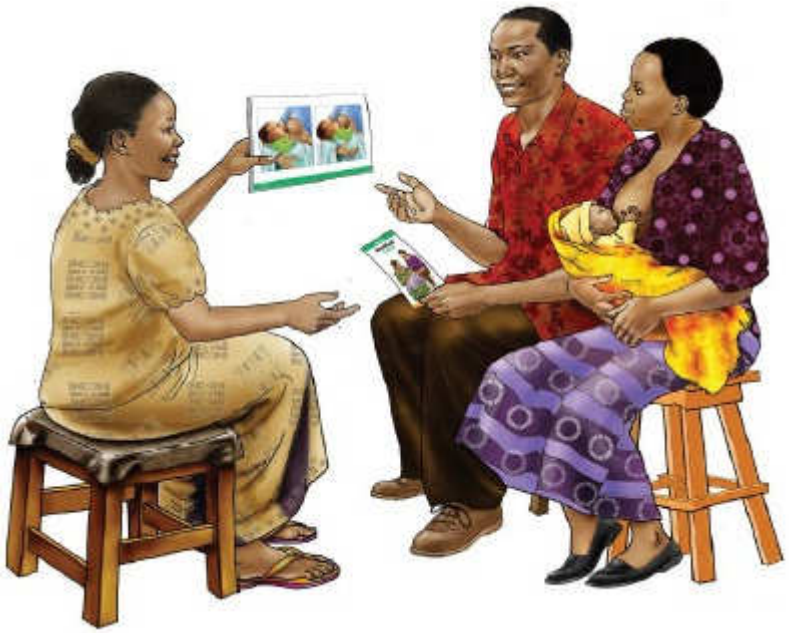
  In group teaching, discussion enables clients to learn from one another as well as from the nurse. The nurse must exercise leadership in controlling and guiding the discussion so that learning opportunities are maximized and objectives are met.
- Demonstration: The demonstration method often is used for teaching psychomotor skills and is best accompanied by explanation and discussion, with time set aside for return demonstration by the client or caregiver. It gives clients a clear sensory image of how to perform the skill. Demonstration should be within easy visual and auditory range of learners, it is therefore best to demonstrate in front of small groups or a single client. Use the same kind of equipment that clients will use, show

exactly how the skill should be performed, and provide learners with ample opportunity to practice until the skill is perfected. This is an ideal method to use in a client's home as well as in groups. The materials and supplies that the client will use when unaided by the nurse should be used in the demonstration.

- Role-playing: At times, having clients assume and act out roles maximizes learning. A parenting group, for example, found it helpful to place themselves in the role of their children; their feelings about various ways to respond became more apparent. Reversing roles can effectively teach spouses in conflict better ways to communicate. To prevent role-playing from becoming a game with little learning, plan the proposed drama with clear objectives in mind.

3.5 Health Counselling

When education alone is not sufficient for empowering the individual to initiate a change or seek assistance, health counselling may be indicated. In the health counselling role, the nurse seeks to understand the individual's perceptions, fears, and barriers that prevent the person from taking action. You may use a five-step health counselling process described as the 5 A's: Ask, Advise, Assess, Assist, and Arrange. Using this process, you as a nurse asks about the person's perceptions related to a specific health concern, advises the person about the health concern and the benefits of taking health promoting actions, assesses the person's readiness to take action, offers assistance and guidance in planning ways to address the health concern, and arranges follow-up support.



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3.6 Method of counselling

Although the GATHER method of counselling may appear simplistic, it is complete and thorough:
Greet users
Ask users about themselves
Tell users about the service(s) available
Help users choose the service(s) they wish to use
Explain how to use the service(s)
Return for follow-up

3.7 Principles of effective counselling

1. Avoid giving advice only and do not impose your personal values.

- Listen to the client
- Help the client evaluate his or her situation and behaviour
- Work with client to identify possible solutions to the problem(s)
- Be client centred
- Respect your clients and encourage their abilities to help themselves,trust in themselves, and take responsibility for their actions and decisions

2. Treat your clients as individual.

- Emphasize their good qualities and potential
- Respect their rights as people
- Promote the exercise of their capacity to think and make decisions

3. Maintain confidentiality and privacy, talk where no one can see or hear you.

SELF-ASSESSMENT EXERCISE

Now that you have completed unit 5, you can examine yourself to find out how well you have achieved the learning objectives by answering the following questions. You can cross check your answers with the note to determine how much you can remember. If your performance is poor, go over the unit again carefully.

- Describe the teaching process
- What are principles of effective counselling

4.0 CONCLUSION

Counselling aims to encourage healthy living and requires the client to explore important personal issues and to identify ways of living with the prevailing situation, whether it is an infection or bereavement. It is not about providing advice or guidance.

5.0 SUMMARY

In this unit, you have learnt:

- the differences between health education and counseling
- the appropriate method of counseling and
- the principles of effective counseling.

6.0 TUTOR-MARKED ASSIGNMENT

Select one of the health-teaching models. Use the model to plan an educational program for a group of teenagers in your community of posting. How did the use of the model enhance your teaching? Share your experience on your discussion forum for the week. (Allender, Rector, & Warner, 2010)

7.0 REFERENCES/FURTHER READING

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