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A framework for
**community health
nursing education**



**World Health
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Regional Office for South-East Asia

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Acknowledgement

Revitalization of primary health care calls for an urgent need to review and strengthen the education and training of the health workforce, especially at the community level. This ensures that the workforce understands the current health challenges and health systems of the country, is competent to work with the people and community in delivering public health interventions based on primary health care, and effectively responds to the needs and demands of the people.

The community health nurse or public health nurse is one category of the health workforce in the community. In all pre-service nursing or nursing and midwifery curricula, there are one or two courses in community health nursing, which provide basic information on community health and the role of nurses in the community. In response to the primary health care movement, a framework of community health nursing education has been developed for use in countries of South-East Asia. This framework may be adapted according to the country context.

We are grateful to Dr Khanitta Nuntaboot for developing this framework. Dr Khanitta is an associate professor in community health nursing, Faculty of Nursing, Khon Kaen University, Thailand, a chairperson of the Nurse for the Community by the Community Project, and the President of Nurse Practitioner Association in Community Nursing, Thailand. This document was developed based on her extensive research studies in the community and teaching experience.

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Preface



The Member States of the WHO South-East Asia Region constitute one fourth of the world's population and bear the second highest disease burden. They are faced with many issues and challenges. Among others, these are the epidemiological changes in diseases and conditions, population structure and illness pattern; the occurrence of new and emerging diseases, emergencies and disasters; the impact of socio-political and economic factors and environment on health; weak health systems; and inequity in accessing health-care services especially among the poor and vulnerable population in rural

areas. One of the solutions for these challenges is to strengthen health systems based on primary health care.

An adequate and competent health workforce is important for a health system to function effectively. However the workforce in most countries in the Region is critically inadequate and inequitable, and is lacking in competence. Educational institutions can play an important role in producing a larger and quality workforce and building its capacity in implementing vertical and horizontal health programmes, and in producing innovation, knowledge and evidence-based practice. Keeping in view the above challenges and in the context of revitalization of primary health care, health care reforms and the Millennium Development Goals, the roles and functions of the health workforce have to be modified and strengthened. Education and training of health workers need to be reviewed and revised.

We have nurses/nurse-midwives working in the community. Some are called community health nurses or public health nurses. Their client is the community, and not any individual person. A community comprises people of various ages, health conditions, social status and cultures. The community health nurses are expected to focus their work on disease prevention and health promotion, including promotion of self-care. At the same time, there are many players in the community in the area of health. These include individual persons, family, community people, community leaders, local government, the health

workforce and people from sectors outside health or from nongovernmental organizations. Community health nurses need to coordinate and collaborate with these people.

The framework for nursing education on community health is aimed to provide guidance to nurse educators on the key contents to be included in the community nursing teaching course for the pre-service nursing and midwifery curriculum. It includes the key role functions, and the work of community health nurses; the population targeted, core competencies, and the teaching and learning process. Capacity building of nursing educational institutions to promote teaching of community health should also be included in the curriculum.

It is hoped that the country will use or adapt this framework in designing the community health nursing course and in preparing the capacity of nursing educational institutions for teaching community health nursing. In the long term, nurses working in the community will have the basic knowledge on community health services, community resources and the ability to deliver community health nursing interventions to meet the needs of people more effectively and efficiently.



Dr Samlee Plianbangchang
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Introduction

Rapid social and economic growth in countries of the world has resulted in an increase both in the number of elderly people who are prone to degenerative and chronic diseases, and new patterns of illnesses that are brought on by social and economic factors such as occupational hazards, accidents, and environmental poisonings caused by air pollution, noise and contaminated water. Communities are struggling with a large number of people across the lifespan, who receive minimal or no health care because they cannot afford or access services. Moreover, public concerns regarding quality, cost, access and fragmentation of health care have contributed to a shift in care from the more traditional acute care settings to the community. This has led to changes in nursing practice.

Nurses have always cared for individuals, families and communities in their practice. Recently, there has been an increase in the number of nurses working outside the hospital, primarily in community-based settings that focus on individuals and families. There is also increasing emphasis on community-focused nursing care with the community as the client.

The population of ageing and chronically ill patients is increasing, and, coupled with the complex social conditions of today, has led to ill-health, which increases hospital care expenses. Professional health services are not capable of meeting the ever-increasing demands of health care in this changing health culture. Evidence suggests that increasing attention to healthy lifestyles and healthy behaviours prevents health problems and reduces health risk and threats. Strengthening the community health-care system based on primary health care is thus the focus of health-care reform. Practically and preferably, professional nursing services focusing on providing health care and services to the entire community is an ideal solution to meeting the demands of community health care.

Confronted with changing health-care systems and needs, nursing educators must now visualize nursing and nursing education from a different perspective. Students must be prepared to meet the needs of populations rather than institutions. They must form new partnerships in the community if they are to be prepared for health care in the next century, giving health back to

the home and community. In many nursing programmes, educators have tried to adjust to this change by increasing the amount of time that nursing students have to spend in the community. Some nursing programmes have modified the course design of community health nursing education in the baccalaureate curriculum. The focus of teaching of such diverse course designs ranges from individuals, to families, to groups and populations.

As we move forward toward to ensure that knowledgeable and capable nurses work in the community health-care system, we must make efforts to strive for solutions to many tough questions in advancing nursing education. What are the functions and areas of work of community health nursing in our community health-care system? How do educators best illustrate community health nursing functions and areas of work as learning phenomena for students? How can students be effectively educated to perform community health nursing functions competently? What are the settings in which good practices/best practices in community health nursing are implemented? How do workers develop such good practices/ best practices? What will be the mainstream knowledge that forms the basis of practice in community health nursing? How do educators develop such essential knowledge to ground education in community health nursing?

This document illustrates three issues that underlie the development of a framework of community health nursing education: (1) core concepts underlying community health nursing practice, (2) a framework of community nursing education, and (3) capacity building of nursing education institutions to promote community health nursing education, especially in a baccalaureate degree programme or pre-service education.

1

Core concepts underlying community health nursing practice

1.1 Trends in health-care delivery: the move towards the community

Changing demographics, changing disease patterns, an increase in chronic illnesses resulting in underestimated health-care expenditure, a reform in the health financing system, and a renewed focus on health promotion open up new opportunities for providing community-based care in community settings. Health care in the context of the community represents an alternative mode of health-care delivery. Emphasis is placed on promoting health and access to care by addressing the health-care needs of people where they live and work. Moreover, local community needs, resources and preferences of the people drive community health services. In any country, the health services/family health/disease prevention and health promotion provided to the community are delivered through the available community health service system.

Recent developments have taken place in community health care. Various types of providers have been used to increase access to care and healing services to meet the needs of the people. Since the health-care demands of the community and people are diverse, non-professional care and services may be needed to complement professional care and fulfil demands. Some of their practices mimic professional services. A number of actions help in meeting the health-care demands of patients. Thus, capacity building for non-professional caregivers and service providers is crucial. Health-care professionals including nurses play major roles in guiding the functions of such non-professional providers. For this reason, non-professional care providers must be in the community health-care team. Therefore, professional roles and functions, which can be differentiated from non-professional ones, must be highlighted and strengthened during the education programme.

1.2 Care demands leading to the development of cost-effective, high-quality and innovative systems of community health care that are accessible to all citizens (Nuntaboot 2006)

The health-care demands of the community could be defined through analysing four major contributing factors: (1) health problems and risks, (2) lifestyle in terms of health behaviour and care, (3) environment as a threat to health, and (4) available and accessible health services and care. To assess health-care demands, emphasis must be placed on exploring and collecting relevant information on these contributing factors.

Community health-care demands underpin health services and care activities, which could also be categorized into four interrelated groups: (1) clinical care, (2) health care, (3) support for healthy activities and (4) welfare and other support; comprehensive community health care to cover all the bases for health problems and risks. Most of the services and care activities carried out must also be in consonance with the resources and preferences of the community. Details of each category of community health-care demands are discussed.

- (1) **Clinical care** is confined to diseases and symptomatic therapeutics, which involve medical remedies and treatments. As these days patients are discharged home earlier in the course of recovery, the need for continuing clinical/medical care has escalated. Most people who are homebound under a physician's plan of treatment, and have an unstable acute or chronic illness require care and services that respond to their clinical care demands. A philosophy that guides the practice of health professionals in meeting clinical care demands is community-based health care. Clinical care demands in community health may include:
 - delegated medical treatment and observation
 - symptom management
 - wound care
 - surveillance and referrals/follow up for acute and critical illnesses
 - tube feeding, etc.

(2) **Health care** represents diverse direct health services and care provided to individuals, families and groups, by the community health centre or similar facility. Examples of health-care demands include the following:

- day-to-day basic medical care for common ailments
- health assessment and outreach/case finding
- screening and surveillance for both communicable diseases such as tuberculosis (TB), HIV, dengue haemorrhagic fever (DHF), influenza; and non-communicable diseases such as hypertension, diabetes mellitus, cardiovascular diseases, etc.
- immunization for vaccine-preventable diseases for all age groups including pregnant women and children
- medication management for persons with chronic and stable illnesses
- disease investigations
- chronic disease management
- health education
- health counseling/family counseling
- interventions for family planning and birth spacing, etc.

(3) **Support for healthy activity** is designed to promote healthy lifestyles and reduce health threats and risks in the community. This category of services and care activities is focused on public health and covers a wide range of programmes and interventions provided collaboratively to the residents by community allies including the health centre and other facilities. Support for healthy activity may range from:

- health teaching and health information dissemination
- capacity building to informal caregivers of those persons living with chronic illnesses, disabilities, and those who are housebound or bedridden in the family and community
- promoting health behaviour including food and nutrition, physical exercise, self-care, etc.
- empowering and capacity building of community agencies/ organizations, groups and networks to encourage collaborative community initiatives on healthy physical environment and sanitation, food safety, healthy workplaces, road safety, and nurturing social relations and activities among people in the community.

- (4) **Welfare and other support** is usually provided to the needy such as the disabled, those who are housebound and bedridden, and the aged. Community allies, such as the local administrative government; community organizations, for example community health funds, community funds, and cremation funds; social welfare office; and others should provide equipment, tools, and community and housing arrangements to facilitate daily activities. The community health-care worker guarantees that such welfare and support is workable for a particular patient. Welfare and other support may include:
- aids and tools for day-to-day activities of the disabled
 - compensation for caregivers of persons who are bedridden
 - living allowance for the needy (the aged, the disabled, which may include those persons living with a mental illness)
 - establishment of a system of family and community caregivers, helpers, or home assistants or volunteers to care for and assist those in need (the aged, the disabled which may include those living with mental illness)

1.3 Key actors in the community health-care system

The dynamic atmosphere of community health-care reform challenges health professionals and community allies to participate actively in developing a culturally appropriate and comprehensive community health-care delivery system. In most developing countries, the community health-care system represents at least five layers of care that respond to the comprehensive health-care demands of its people. The five layers include:

- (1) individual self-care,
- (2) family care,
- (3) care and support among neighbours and groups in the community,
- (4) care and support given by health-care providers and healers, and
- (5) welfare and support provided by community allies such as the local administrative government; community organizations such as community health funds, community funds, and cremation fund; social welfare office; etc.

Through assessing all layers of care, key actors in community health care can be identified. These key actors work to their capacity in a community health-care team, according to their roles and functions. The key actor could be an able contributor to the learning of students.

1.4 Community health nursing and practical implications

All community health services and care activities carried out respond to the needs, health problems and health risks, cultural way of living, resources, and preferences of the community. In a health-care system in transition, where currently the quality of service is emphasized, community health nursing represents a profession that responds to all categories of demands of the people. The roles and responsibilities of the community health nurse thus vary and differ according to the context of the health-care delivery system. The dynamic, complex and emerging environment of health care presents complex health-care demands of the community that require different capabilities in today's community health nurses and health-care professionals.

Community health nursing is a population-focused, community-oriented approach aimed at health promotion of an entire population, and prevention of disease, disability and premature death in a population. Unique to community health nursing is the opportunity for nurses to learn and develop partnership skills with all stakeholders and key actors in their communities. The experience of community health nurses heightens communication and leadership skills and allows for creativity in solving community health problems. In cooperation with other disciplines, community nurses are expected to have greater professional autonomy to provide ethical and legal nursing care services in different community settings, such as schools, homes and health centres. Although the number of roles and responsibilities of community health nurses are many, these are far fewer than what the community expects them to fulfill.

1.5 Definitions that guide the practice of community health nursing

Nurses who work for the community must be knowledgeable and aware of community concepts. Hence, community health nursing practice synthesizes nursing theory and public health science, and places priority on prevention, protection and promotion of health. Specifically, in dealing with the needs of

the population, nurses must be sensitive to the community culture, competent in utilizing the social capital and resources of the community, and capable of collaborative practice among community allies. Negotiation with mainstream health-care institutes and government services that are relevant to improving the quality of life of the people may be carried out for continuity of care. Community health nurses work to meet the health-care demands of the people and form new partnerships to promote the health-care potential in the community. There are at least two definitions that need to be addressed when discussing nursing in community settings: community health nursing and community-based nursing.

The term **community health nursing** is synonymous with public health nursing in this paper. Community health nursing relies heavily on the systematic process of designing and delivering health services and nursing care to improve the health of the entire community. Community health nursing is a specialty in nursing. According to the American Nursing Association (ANA), public health nursing is the practice of promoting and protecting the health of populations using knowledge from nursing, social and public health sciences (Waldorf, 1999). The primary goal of community health nursing is to help a community protect and preserve the health of its members, while the secondary goal is to promote self-care among individuals and families. In the health-care reform environment, the community health nurse will probably continue to care for individuals and families, particularly high-risk clients and those with communicable diseases. Community health nursing involves the identification of high-risk aggregates in the community, and the development of appropriate and workable policies and interventions to ensure accessible services for all groups of the population.

Community-based nursing covers nursing care provided to individuals, families and groups wherever they live, work, play or go to school. Community-based nursing is a philosophy of care that is characterized by collaboration, continuity of care, client and family responsibility for self-care, and preventive health care (Hunt, 2005). Community-based nursing focuses on an individual and is family-centred in orientation. Partnerships with clients are developed and awareness created on the influences of the community on the health and care of individuals and families. Community-based nursing applies to all nurses who practise outside the hospital. Major activities include case management, patient education, individual and family advocacy, and an interdisciplinary approach (Zotti, Brown, Stotts, 1996). According to this definition, community-based nursing is not a specialty in nursing but a philosophy that guides care, design and delivery of all nursing specialties.

The **roles and responsibilities of the community health nurse** in a country are usually defined through the functions of the service settings in the health service delivery system. Whatever the practice setting, community health nurses should perform the roles of clinician, advocator, collaborator, consultant, counselor, educator, researcher and case manager. Importantly, the community health nurse meets the health-care demands of the entire community, where those of individuals and families are integrated. Thus, practically and ideally, community health nursing includes clinical care to individuals when needed. Family-centred care is directed towards self-care, healthy living conditions and healthy lifestyle choices. Individual and family-centred care are carried out to reach the goal of care of the entire community. Hospital nurses, on the other hand, provide individual care with an awareness of the influences of the community and the family on the health and recovery of the patient.

1.6 Key to the success of the community health-care system

Six tenets of community health nursing have been developed to guide the success of practice in the context of Thailand (Nuntaboot et al., 2006).

- (1) Community health nursing practice **incorporates social capital and resources** in the community and collaboratively works towards solutions for health conditions, risks and problems.
- (2) The health of the people is most effectively promoted and protected through **collaboration with members of other professions and organizations**. Collaborators from community organizations, agencies and groups, such as stakeholders and key actors in community health, interactively work together towards the greater good of the population as a whole. Participation of such stakeholders and key actors in collaborative work occurs to varying degrees. Stakeholders take turns at leading a particular collaborative action, which is based on the major functions of their respective organizations.
- (3) The community health nursing practice of **promoting and protecting the health of the entire community** utilizes knowledge from two sectors: (1) the academic sector, which relies on nursing, social and public health sciences; and (2) the community's experiential knowledge of solutions for their own health. Community health nursing interventions and programmes must respond to the health conditions, risks, problems and resources in the community. The interventions and programmes must be sensitive to the community culture and rely heavily on acceptance by the people.

- (4) The dominant concern and obligation is the **best use of information** related to community health, gathered by community organizations, agencies, groups and authorities ,which needs to be shared among all.
- (5) As community health nursing is **oriented to outcomes**, population health outcomes and indicators must be identified by consensus-building among all stakeholders.
- (6) Community health nurses must be **well equipped with up-to-date community health nursing knowledge and skills**, especially in developing **partnerships with representatives of the people**, members of various professions, organizations and groups in the community that are stakeholders of community health.

1.7 Systematic process used in community health nursing practice

Community health nursing interventions have traditionally been recognized by the service delivery setting, such as schools, home visits and immunization clinics. To move from a service-setting orientation to a population health-outcome orientation, direct and indirect service interventions that improve people's health must be designed and described. Three core functions of public health have been proposed as a means of describing the work and functions of public health workers. These include: (1) assessment (the regular collection, analysis and sharing of information on health conditions, risks and resources in the community); (2) policy development (the use of information gathered during the assessment to develop local and state health policies); and (3) assurance (availability of necessary health services throughout the community) (Institute of Medicine cited in Fahrenwald & Maurer, 2000).

In this document, four underlying core functions that guide the practice of community health nursing are discussed as components of a systematic process of designing and delivering health services and nursing care to improve the health of the entire community (Nuntaboot, 2007).

The four core functions of community health nursing practice are:

- (1) community social capital, including community culture, and identification of resources as key actors in the community health-care system
- (2) assessment of community health conditions, health risks and problems to identify the health-care demands of the people
- (3) design and implementation of comprehensive community health interventions, care, services and programmes, and
- (4) health policies/agreements developed at the local community level to drive policies/agreements at the state and national levels for collaborative endeavours and actions.

Each work or intervention of community health nursing has components of all four core functions to varying degrees. The success of one function lays a strong foundation for another function. For example, in-depth information about health conditions, health risks and problems during the assessment process could back up three other functions – community social capital and resource identification; design and implementation of comprehensive community health interventions, care, services and programmes; and development of health policies/agreements.

In practice, operations of function, that is, (1) community social capital and resource identification and (2) community health assessment, are crucial for empowering the community to act upon functions, that is, (3) community health interventions, care, services, and design and implementation of interventions, and (4) development of health policies/agreements. On the other hand, actions of function, that is, (3) and (4), may give clues for redesigning stronger evidence from functions (1) and (2). The principles and methods used for implementing the four core functions of comprehensive community health nursing are discussed below.

(1) ***Community social capital and resource identification***

Social capital affects community health in various ways (Kritsotakis & Gamarnikow, 2004; Stone, 1086; Kawachi & Berkman, 2000), including the identification of key actors for community health actions and care solutions.

The characteristics of community social capital are:

- (1) focusing on human capacity in finding solutions for community health, which depends upon an individual's own missions, roles and functions
- (2) participation of stakeholders including the community to strengthen social ties and encourage appreciation of the value of human capacity building for community self-reliance
- (3) being sensitive to the existence and use of community networks, volunteers, groups engaged in community actions
- (4) being aware of people who are involved in finding community solutions
- (5) identifying social relationships among the community especially in health care, which creates mutual benefits
- (6) appearing trusting of, as opposed to fearing, others in the community
- (7) requiring timeless communication, on a day-to-day basis, with people in the social network.

The methods used for identification of community social capital and resources include **human mapping, resource mapping, rapid ethnographic community assessment**, etc. Human mapping relies on qualitative research methods such as in-depth interviews, observations and deep listening. This process, employed for community social capital and resource identification, leads to other functions and usually ends at the design and implementation of comprehensive community health interventions, services, care and programmes that are mostly focused on capacity building of the key actors, whether or not policies are developed and formulated.

(2) ***Assessment of community health conditions, health risks and problems***

The health-care demands of the people are identified by critically analyzing information related to health conditions, risks and problems of people in the community. To do this, at least four major factors that contribute to health are used: (1) health problems and risks, (2) lifestyle in terms of health behaviour and care, (3) environment, such as health threats, and (4) available and accessible health services and care.

Characteristics of the assessment process:

- (1) a participatory process among stakeholders to encourage information sharing and increase awareness on health risks and problems in the community
- (2) community health-care team building comprising representatives from the community or members of stakeholder organizations
- (3) conducting the assessment process concurrently with other functions throughout the course of the community health-care interventions and programmes
- (4) identifying community people's health-care demands (individuals, families, groups in the community), which lays a strong foundation for other functions
- (5) collecting up-to-date information, representing both the people's perspective/experiences and academic perspective.

The regular collection, analysis and sharing of information employs methods that reveal current community health conditions, risks and problems in the cultural context. Examples of such methods are: community health nursing assessment process, participatory rural appraisal (PRA), participatory action research (PAR), epidemiological study, qualitative research, ethnographic study, etc.

(3) ***Comprehensive community health interventions, care, services, and programme design and implementation***

This function targets the design and implementation of interventions, care, services and programmes that respond to the health-care demands of the people in the community in a culturally sensitive manner. This function ensures that necessary health care and services are available and accessible to all, especially underserved and vulnerable groups. It should

- be participatory in nature, especially with stakeholders who are involved in the provision of interventions, care, services and programmes;
- represent the interactive learning through action process of stakeholders in designing and implementing the interventions, care, services and programmes;
- require two essential sets of knowledge: (1) the health-care demands evidently supported by four contributory factors; and

- (2) solutions which may be practice guidelines, care models, practice modalities, services reform, effective programmes and interventions, etc. from the literature, best practice experiences, and research and development projects;
- critically select interventions, care, services and programmes through consensus building of stakeholders to fit well with their roles and missions for community health care;
 - be oriented towards the health outcomes of the entire community rather than service oriented.

Examples of ways of designing and implementing community health interventions, care, services and programmes are care and service model development, regular design and implementation of intervention, care, services and programmes, health-care initiatives, etc.

(4) ***Development of health policies/agreements***

This function relies on critical analysis of the information and evidence gathered during the community health assessment. Development of local health policies or agreements requires at least three essentials. These are: (1) shared understanding of the nature of apparent health-care demands of the people, (2) identifying social capital and resources for possible solutions to meet the demands in health care, and (3) knowledge about the roles and functions of each stakeholder to fulfill the missions and scope of work.

Methods to carry out this function mostly use platforms to encourage conversation and communication among stakeholders. These include forums, conferences, seminars, and the like. Indicators of success are workable agreements or policies on community health care, especially at the local level.

The following are key to the development of workable agreements and policies. (1) Sufficient information, especially on health-care demands, possible solutions, and required supports/mechanisms to implement solutions; (2) a cycle of interactive learning through actions to help verify the potential agreements/policies; (3) accepted platforms of communication among members of the working team; and (4) opportunities for stakeholders to present information and evidence relevant to the development of particular agreements or policies.

Among all the four core functions, there are shared characteristics, which are crucial for capacity building of community health nurses and other professionals who work in the community health-care system.

Shared characteristics:

- (1) belief in human capacity
- (2) participation of all stakeholders as team members, taking turns at being leaders
- (3) using area-based evidence and information to guide the process and actions
- (4) using actual activities and processes as the centre of functions
- (5) putting emphasis on outcome-oriented rather than service-oriented programmes, and welcoming all possible means and solutions to achieve desirable outcomes.

1.8 Community health nursing education: challenging health-care reform

The current trend in nursing education is to put more emphasis on practice in the community. Pre-service nursing education has included community health nursing as part of the curriculum for several decades. Recently, there has been a renewed interest in how to best prepare students to practise in the community setting. Most programmes focus on caring for individuals and families in the community, while others emphasize the community as a client (McKnight & Van Dover, 1994). Experts suggest that nursing students working for the Bachelor of Science degree should work with a group of people with different health issues such as the elderly, those with disability, etc. (Baumann & Schmelzer, 1994; Caretto & McCormick, 1991), based on the belief that by improving the health of the community, the health of individuals and families is improved. Some experts have suggested that care should be given to the entire community as a client not merely to special groups (Flick, Reese, & Harris, 1996; McKnight & Van Dover, 1994). The World Health Organization (WHO) recommends that basic nursing education for community health practice should prepare nurses to identify, assess, plan, implement, and evaluate the population at risk (WHO, 1985).

According to the proposed four core functions, most basic nursing education programmes have selected clinical contents and learning experiences related to community health assessment and community health interventions, care, services, and the design and implementation of interventions, care and service to varying degrees. Two of the other functions have appeared less frequently in most recommendations for basic nursing education and have not been included in advanced nursing practice, although research highly recommends them.

It is crucial for a nursing education programme to be responsive to the country's health-care system. The competency requirements of nurses working in community health care must be tailored to meet the country's expectations, although common features must be maintained. The key in attaining the challenges of the new paradigm of community health care is a focus on preparing new nurse graduates to be generalists with strengths in community health nursing interventions, not as specialists in community health care. Thus, the proposed four core functions must be applied in the context of the health-care system and the functions must be conceptualized in ways that are workable in the particular community health-care context. Educators must be well aware that they are educating future nurses for the future community health-care system.

2

A framework for community health nursing education

This framework for community health nursing education is developed after conceptualization of the findings from research and development projects relevant to community health-care systems in Thailand (Nuntaboot et al., 2000, 2001, 2002, 2003, 2004a, 2004b, 2006; Nuntaboot, 2007, 2006).

Five essential components constitute the framework. Each component is identified and critically analyzed, as it guides the design and implementation of the teaching and learning process in community health nursing courses. They are as follows:

- (1) Core functions, roles and areas of work of community health nurses in the health-care system
- (2) Classification of the population that is the target of the services and its health-care demands
- (3) Competencies of nurses working in community health care as expected outcomes of education
- (4) Knowledge and skills required for baccalaureate graduates working in community health nursing
- (5) A participatory teaching and learning process: interactive learning through action.

2.1 Core functions, roles and areas of work of community health nurses in the health-care system

The core functions of community health care are critically examined to identify appropriate functions to be carried out by baccalaureate graduates or advanced community health nurses. It is crucial for nurse educators to realize the impact of all four core functions on the community health-care system and carefully select the basic means and methods that are suitable for students to learn. Research

indicates a set of roles and responsibilities for nurses working in community health care, although they must respond to the functions of community health nursing in the country's health-care system. Examples include advocacy, case management, coalition building, consultation, counseling, educating and capacity building. Similarly, the delegated areas of work in community health care lay the foundation for setting goals and outcomes of the practice, which are central to community health nursing.

In the community health-care system in Thailand, six areas of work have been proposed (Wasi, 2006):

- (1) To ensure essential and accessible health care to the underserved/underprivileged identified by the local community
- (2) To provide comprehensive disease/illness management especially for chronic illnesses
- (3) To ensure that comprehensive health care and welfare are provided to the aged in accordance with their health-care demands
- (4) To manage all common ailments that require basic medical care and treatment and observation that is delegated to this category of health-care provider
- (5) To ensure surveillance and control of all local diseases, both communicable and non-communicable (lifestyle diseases)
- (6) To encourage community allies to develop community initiatives and programmes that enhance and promote people's health through healthy behaviour, healthy living conditions, healthy workplace, etc.

2.2 Classification of the population that is the target of the services and its health-care demands

There are two types of people in the community with whom nurses work. First, the key actors in community health care are identified during mapping of social (human) capital. Second, the people who are the targets of community health care are categorized using critical analysis of health conditions, health problems and health risks; for example, people who are at risk for diseases and health problems, people who are ill, people living with certain diseases or

illnesses, and people who require welfare and other support. Classification of the target population requires a systematic assessment process to identify health-care demands. These are used as the basis for designing and implementing community health interventions, services, care and programmes.

Specifically, types of community health interventions, services, care and programmes include: (1) direct services and care for the needy, and (2) capacity building for self-care, self-management and self-reliance of the community and stakeholders who are key actors in a particular health problem or issue. Community health nursing courses must be designed to cover two aspects: characteristics and types of interventions, services, care and programmes provided to each category of the target population, and the means to identify all categories of the target population. In practice settings, student placements must be diverse and according to the categories of the people nurses work with.

2.3 Competencies of nurses working in the community health-care as expected outcomes of education

At least two sets of competencies – core competencies and the complementary competencies – are required to practice community health nursing. There are two core competencies; the core competencies for clinical care, and the core competencies for implementing the four functions of community health care. Competencies for clinical care range from health assessment, disease management, case finding, case management, observation and treatment according to delegated responsibility, etc. Competencies for the four functions rely heavily on the means and methods employed to implement each function. Complementary competencies may include cultural sensitivity, participatory research, leadership, development of tools and guidelines for data collection and analysis, and experiential learning through action. Competency mapping is crucial for designing both the theory and practice aspects of community health nursing courses.

2.4 Knowledge and skills required

Knowledge and many diverse skills are required for community health nurses to function effectively. These are primarily related to each of the two core competencies. Clinical content incorporates knowledge from the nursing sciences and public health science, while practical knowledge relies on work

experiences in the actual practice of community health nursing. Furthermore, knowledge from other community health allies is required. To gain all the knowledge required, contents and resources for learning, both as texts and from experts, must be mapped out to lay down the architecture of the courses.

Example of an 80-hour course design for community health nursing (theoretical) (Nuntaboot, et al., 2000, 2001)

Sets of knowledge	Selected concepts and principles	Selected means/methods/approaches
Community as a client	<ul style="list-style-type: none"> • Concepts of the community and community functions • Social capital and resources of the community as they impact on the health of the people • Cultural influences on the health of the community 	<ul style="list-style-type: none"> • Identification of social capital and community resources for health care using a human mapping process
Community health	<ul style="list-style-type: none"> • Common health problems, threats and issues in Thailand's context • People in the community and their health status • Quality of life • Self-reliance • Community health-care system 	<ul style="list-style-type: none"> • Community health assessment process using rapid ethnographic methods, regular methods of data collection and analysis, and participatory rural appraisal • Approaches to community health and illness such as epidemiology, demography, risk approach, etc. • Synthesis of health-care demands of the community using information and evidence from the assessment

Sets of knowledge	Selected concepts and principles	Selected means/methods/approaches
Community health nursing	<ul style="list-style-type: none"> • Definitions and functions of community health nursing • Changes in functions of community health nurses in an era of health-care reform • Areas of work of community health nurses • Core competencies of nurses working for community health • Positioning community health nursing in the health-care system • Standards of nursing practice in the community health-care system • Roles and responsibilities of nurses working in the community health-care system • Types of community health nursing interventions, care, services and programmes 	<ul style="list-style-type: none"> • Means and methods to implement the four core functions of community health nursing • Underlying concepts and principles of types of services and care in community health nursing – direct care, capacity building, behavioral modification, etc. • Techniques to carry out the four core functions of community health care such as team building for data collection and analysis; relationship building; partnerships with stakeholders and key actors; forums for developing policies/agreements; consensus building among key stakeholders in designing and implementing community health interventions, care, services and programmes • Knowledge and information searching
Factors influencing community health	<ul style="list-style-type: none"> • Four major contributing factors include: (1) health problems and risks, (2) lifestyle in terms of health behaviour and care, (3) environment as a threat to health, and (4) available and accessible health services and care 	<ul style="list-style-type: none"> • Frameworks for analysis and synthesis of the health-care demands of people in the community

Skills listed in community health nursing courses (Nuntaboot et al., 2000, 2001)

Competencies	Skills
Core competencies Clinical care competencies	<ul style="list-style-type: none"> • health assessment • disease investigation and management • case finding • case management • delegated medical treatment and observations • basic medical care • nursing therapeutics such as symptom management, wound care, counseling, • therapeutic communication, etc.
Competencies for implementing the four functions of community health care	<ul style="list-style-type: none"> • building a trusting relationship and establishing partnerships • community health assessment using at least one method • community health interventions, care, service, designing and implementing programmes • community mobilization and community participation • collaborative practice • outcome-oriented management to ensure available and accessible community health interventions, care, service, and programmes for all people in the community • health promotion and risk reduction • management of forums for development of policies/agreements on community health care, etc.
Complementary competencies	<ul style="list-style-type: none"> • critical thinking • participatory research in the community health-care system • cultural sensitivity • group process • leadership • negotiation • consultation • development of tools and guidelines for data collection and analysis • experiential learning through action, etc.

2.5 A participatory teaching and learning process: interactive learning through action

There are four essential components of the process of interactive learning through action; (1) actual community health-care work and activities, (2) learning about the other parties and their roles and functions, (3) learning activities, and (4) interactive teaching and learning context.

A nursing education programme requires diverse community clinical placements for students, to expose them to experts who carry out the four core functions and areas of work in real-life community health care. Services settings such as health-care centres of the mainstream health service system and other healing systems, the workplace, school and clinics could be selected as practice settings for students. The community, community health-care institutes or agencies, and community allies are identified, based on the functions they carry out for the community. Students should be actively involved in actual activities of community clinical work during their practice. The involvement of students varies, depending on the activities carried out, which range from observations to hands-on experience.

The entire process of learning must include partnerships with stakeholders and key actors in the course of performing the actual community health-care functions and work. Such participation enhances the interactive learning atmosphere of the community health nursing course. There are at least four parties involved in interactive learning through action in community health nursing:

- (1) community health nurses, other health personnel and community allies,
- (2) people in the community who have experience in both illness and care,
- (3) nurse educators, and
- (4) nurse students.

Each party pursues its own role and function to support active learning in community health.

Significant contributions to community health nursing education are emerging outcomes of the experiential learning process in an evidence-based community setting. The experiential learning process, through interaction in community health situations among stakeholders, students, educators, agency staff and community members facilitates partnerships in community health

nursing practice and education, and health development for the population. Learning activities are a part of community health-care functions and work in the placement setting. Conceptualization of community health nursing, which is considered an important part of conceptual outcomes of the interactive learning through action process, must be developed throughout the process of experience sharing and reflection during the course of actual community health-care activities. Initiatives and development of work models guided by the four functions are needed the most for students to learn.

Most nursing programmes design learning activities that are reflective and allow all parties to learn and share experiences. Reviews of work or activities carried out help in identifying lessons learnt. Student placements for practice in community health nursing include (1) the community in both urban and rural settings where the context of health care is different and a variety of community allies work with the people, and (2) the community health-care unit or centre. Students are divided into several groups and placed in different community settings where lessons learnt can be shared.

The “interactive learning through action” process has been implemented in area-based community health-care management (Nuntaboot et al., 2006). The implementation could be an example that best illustrates how this process works for community health-care development.

The “interactive learning through action” process involves four key components. *First*, strategies implemented in the process utilize (1) community data and information, (2) case studies in the selected communities, (3) situations of health and illness care, and community welfare, and (4) experiences shared with experts in community health development. *Second*, learning activities and access to learning are made possible through: (1) studies of community health and illness and their management and care, (2) studies of family health and care, (3) situational studies on the context of local administrative organizations (LAOs) and their management structure for health care, and (4) situational studies on the community’s funds and its welfare system. *Third*, develop learning from the roles and functions of LAOs in community health-care management and welfare, through ways of thinking and believing, methods of work and tools. Finally, outcomes from the interactive learning process could be categorized into two groups: concrete outcomes and conceptual outcomes.

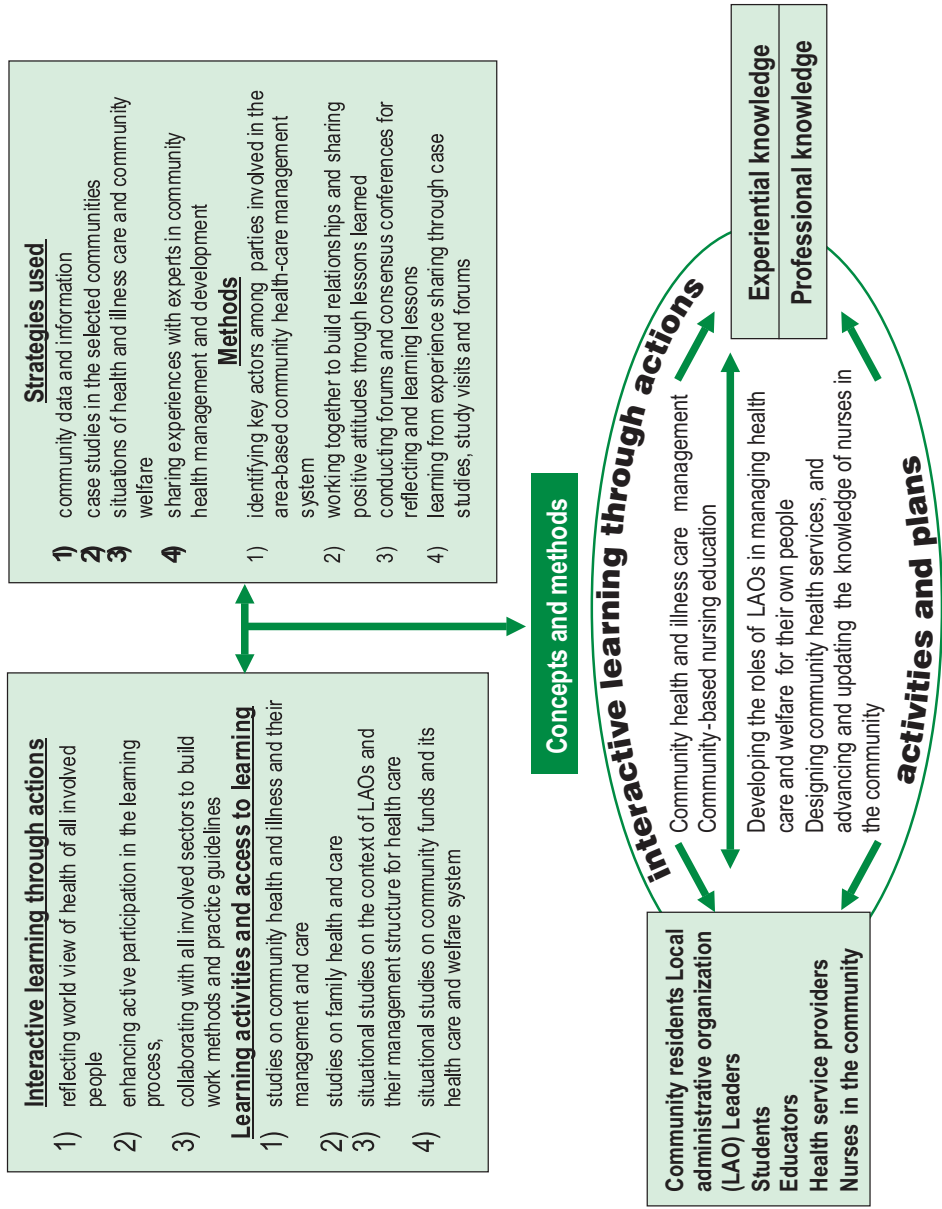
Examples of *concrete outcomes* include: (1) area-based community health-care management activities carried out; (2) community data – identifying the health status of the people, factors that influence health, and management of community health-care and welfare; (3) community members receiving

the health services provided; (4) practical community-designed health-care policies and plans; (5) designing community-based health services and projects; (6) practical models of hiring nurses to work at LAOs; (7) actual model of the community-based teaching and learning system in nursing education; (8) “interactive learning through action” units for area-based community health-care management; (9) tools for studies on community-based health services and care management, and community-based nursing education; (10) learning networks.

Conceptual outcomes include: (1) positive attitudes towards the “interactive learning through action” process in area-based community health-care management; (2) concepts underlying the work done to promote community health and solutions for community health problems among all involved people; (3) being knowledgeable in their own community’s health problems, and a capacity to manage such problems among local people, LAOs, students and nurses in the community; (4) development of the process of designing community-based health services among LAOs, local health-care providers, students, educators and nurses in the community; (5) capacity-building in community health-care management among LAO administrators; (6) development of cultural competency among students, educators, nurses in the community, and health-care providers in the area.

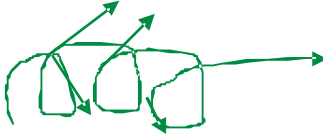
The “interactive learning through action” in area-based community health-care management is best illustrated in Figures 1 and 2.

Figure 1: An interactive learning through action process in area-based community health-care management
(Nuntaboot, 2006)



- Conceptual outcomes**
- 1) positive attitudes toward interactive learning through action
 - 2) concepts underlying work done to promote community health and solutions for community health problems among all involved people
 - 3) being knowledgeable in own community health problems and capacity to manage such problems among local dwellers, LAOs, students
 - 4) development of a process of designing community-based health services among LAOs, local health-care providers, students, educators
 - 5) capacity building in community health-care management among administrators of LAOs
 - 6) developing cultural competency among students, educators and health-care providers in the area; and nurses in the community

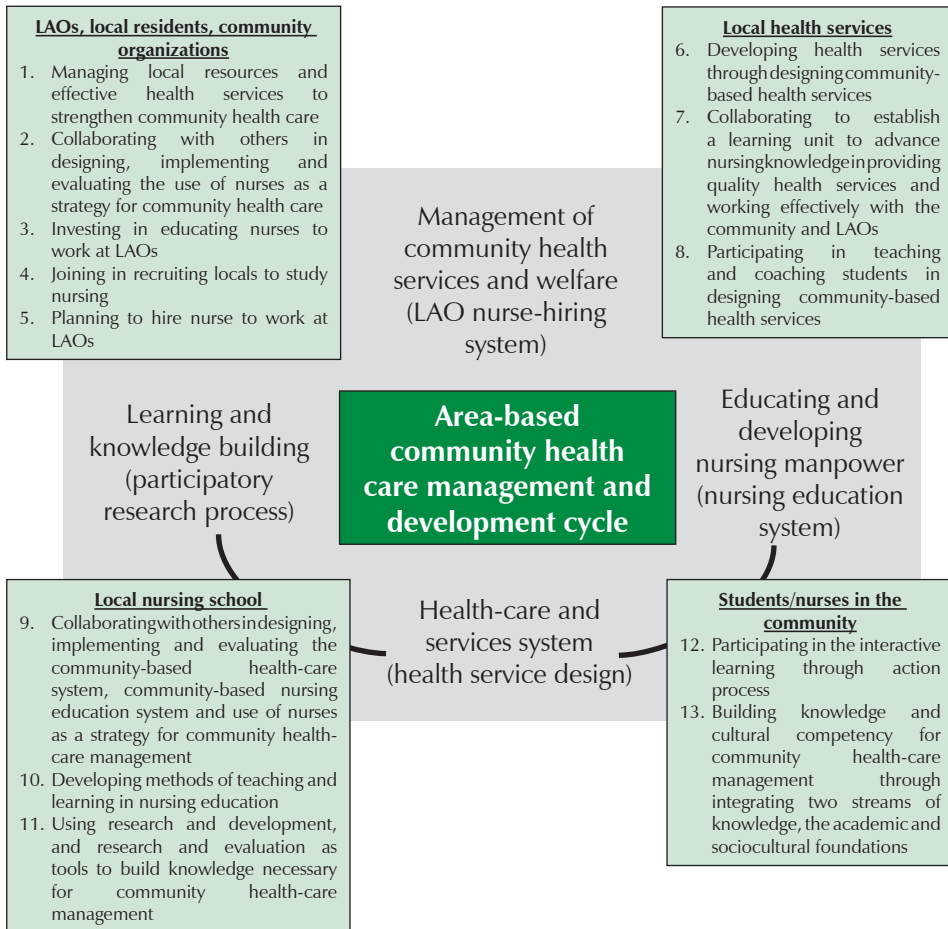
Outcomes



Strategies for development of appropriate and area-based community health care management

- Concrete outcomes**
- 1) projects and activities carried out in the community
 - 2) community data – identifying the health status of people, factors that influence health, and management of community health care and welfare
 - 3) community receives health services provided through the system monitoring and assessment
 - 4) actual community-designed health-care policies and plans
 - 5) practical design of community-based health services and projects
 - 6) practical models of hiring nurses working at LAOs
 - 7) practical model of community-based teaching and learning system in nursing
 - 8) interactive learning through action units representing area-based community health-care management
 - 9) tools for studies of community-based health care and welfare, and community-based nursing education
 - 10) learning networks, etc.

Figure 2: Roles and functions of the four main sectors involved in the interactive learning through action process in area-based community health-care management (Nuntaboot, 2006)



An example of a course design for 256 hours (32 days) of practice in community health nursing (Nuntaboot et al., 2001)

Day	Community health-care activities	Learning activities
1	Identification of key stakeholders in the community	Course design and learning expectations of students
2–10	Community health assessment <ul style="list-style-type: none"> • Data collection • Mapping community and human resources 	Active participation in the conduct of activities Using five stages of the interactive learning through action process
11–15	<ul style="list-style-type: none"> • Data analysis and synthesis of health care demands of the community people 	Stage 1: Practical experience (initial); more at individual level Stage 2: Sharing of knowledge and experiences in core clinical and functions
16–21	Community health interventions, care, services, and design and implementation of programmes <ul style="list-style-type: none"> • Forums among stakeholders for consensus building and developing policies/ agreements 	Stage 3; Reflection in a group of those involved on the benefits and limitations encountered Stage 4: Discussion based on the outcome of reflection. New learning is planned and developed. Stage 5: Evaluation of learning and planning to apply the learning to future actions
22–28	Implementation of community health interventions, care, services and programmes	Participation in activities according to the competencies developed Reflection and conceptualization of concepts, principles, methods underlying nursing care to the community through presentations and sharing of lessons learnt
29–32	Wrap up and evaluation forums among stakeholders	Reflection and conceptualization of community health nursing functions and areas of work in community health care

Some considerations are given priority for implementing the proposed framework for community health nursing education.

- Community health is dynamic and rapidly changing. Community health nursing requires a systematic process for designing and implementing interventions, care, services and programmes to meet the health needs of people in the community. Development of initiatives and models are a feature of health-care changes. Nursing education must realize these facts and make essential updates in the teaching and learning curriculum.
- Since community health nursing education constitutes research and development, it requires a continuous cycle of development.
- The nature of teaching in health care provides opportunities to educators to design interactive methods embedded in particular community health-care situations. Strong, trusting relationships must be built with the community, community allies and nursing education institutes.
- Among all competencies, critical thinking in nursing decision-making is highly required since it contributes greatly to the development of shared philosophy and paradigms in community health nursing education. Interactive teaching strategies and methods, with strong foundations in collaborative efforts between the education and health services, are crucial for the development of critical thinking ability in students.
- To encourage experience sharing for implementing the interactive learning through action process in community health nursing education, collaborative efforts among different nursing programmes are strongly recommended. Collaborative activities should be initiated and modified according to shared commitments and positive attitudes among nurse educators, which leads to quality improvement in both nursing education and services.
- Strong commitments in advancing nursing education and positive attitudes towards academic collaboration are essential components of the reform in nursing education. Educators and school administrators should be well aware of the fact that teaching and learning requires innovative methods and processes.

3

Capacity building of nursing education institutions to promote community nursing education

Recommendations for capacity building of nursing education institutions to promote community nursing education constitutes three strategies: research and knowledge development, effective and continuous communication among all key stakeholders to encourage potential actions, and networking or developing nodal institutions for sharing experiences and consensus building towards core functions of community health nursing and community health nursing education models.

3.1 Research and knowledge development

Community health nursing education is research and development oriented. It requires a continuous cycle of knowledge development, both from research and from work experiences, especially for pursuing all four functions of community health nursing. Educators must be well equipped with research, and knowledge conceptualization and development skills. For educators, a hallmark of continuing competence in teaching should include updated knowledge that has a sustained relevance to the development of diverse professional services and research. Creative methods should be initiated for capacity building of educators, such as:

- area-based research and development of care models integrated with teaching
- research and development of a process of community assessment with diverse degrees of participation from community representatives and community allies in different practice settings of students
- collaborative mechanisms for continuous care and services for the aged and the disabled, as one of the teaching strategies.

Policies and programmes on strengthening educators' capacity in research and development should be developed. Strong and continuous support from school administrators is needed since the activities of improving the teaching and learning system require understanding derived from knowledge and experience sharing as well as actual practice. Actual implementation leads to modification of the practice, following the in-depth analysis of such practice and reflection from others. On the other hand, such practical knowledge is best taken up in education, which builds a strong links/relationships between education, research and practice.. Community health nursing education welcomes and encourages routine and research endeavours in both education and practice. Administrators have to formulate policies to support such research and development activities in the actual teaching and learning system.

3.2 Communication

Effective and continuous communication among all key stakeholders of community health nursing education encourages potential actions for community health care that facilitates student learning. Crucial to timeless communication is knowledge and evidence on community health nursing practice and education. Moreover, academic service, which is one of the major roles of educational institutes, disseminates health information and health-care knowledge to the society. Public awareness of the health and well-being of the population could then be increased through knowledge dissemination. Thus, knowledge generated from the interactive learning through community health-care actions of key actors and students must be managed in practical ways and be usable by the public.

Platforms for communication range from regular venues such as newsletters, websites and journals to academic and policy forums and seminars. An educational institute also communicates and makes necessary linkages with other institutes for sharing of guidelines and solutions in community health nursing education.

3.3 Networking and development of nodes

The practices of stakeholders contribute greatly to sharpening skills in teaching community health nursing. Establishment of models of collaboration among the community health service institute, community health care allies and the nursing educational institute is highly recommended. Collaboration encourages stakeholders to initiate solutions for good practice. They are considered as

centers of learning and examples of initiatives and good practice in community health care and education. Moreover, to enhance knowledge of community health-care conditions, long-term and trusting relationships with the people in the community that forms the practice setting of students should be built and maintained. Networking guarantees that students can be exposed to learning good practices and best practices in community health nursing, which lays a strong foundation for a positive attitude in the professional practice of students. Means to encourage networking rely heavily on four essentials: mutual benefits, trusting relationships, leadership skills, and working in one's own roles and functions to complement others.

3.4 Concluding remarks

Constant changes are predicted in health care in the foreseeable future. It is imperative that nursing education programmes act as agents of change. It is challenging for educational institutes to prepare nurses to be well equipped with competencies in caring for people in the community. Within the context of the dynamic atmosphere of health-care reform, a nursing programme must guarantee a minimum level of basic and essential knowledge and skills. It is the responsibility of nursing educators, in collaboration with practice settings and community health care allies, to shape practice and health care, and not merely respond to changes in the practice environment.

Nursing education must prepare qualified nurses to respond to changes in the health-care goal of the nation's population. The philosophy underlying community health nursing puts an emphasis on people being at the centre of care in every setting, including the community. Such a philosophy is crucial for modifying community health nursing education in the new era.

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