World Health Organization

ENHANCING THE ROLE OF COMMUNITY HEALTH NURSING FOR UNIVERSAL HEALTH COVERAGE

Human Resources for Health Observer Series No. 18

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Acknowledgements

Executive summary

Universal health coverage (UHC) is a concept that refers to the ability of all individuals and communities to access quality health care without suffering undue financial hardships. For UHC to be successful in countries, an effective and well-functioning primary health care (PHC) system is essential. The goal of achieving UHC will be undermined if concrete steps are not taken to protect, motivate, increase and retain adequate numbers of skilled, well-educated and trained health workers in countries. The health care workforce is a major building block of health systems. The focus of this paper is on community health nursing (CHN) and community health nurses' (CHNs) contribution to UHC.

Community health nurses have the potential to make significant contributions to meet the health care needs of various population groups in a variety of community settings. In order to assess the extent to which CHNs are achieving this potential, WHO conducted a study between 2010 and 2014 that examined the status of community health nursing in 22 countries, 13 of which were experiencing a critical shortage of health care workers. The study revealed that the countries surveyed had the basic and operational framework for optimizing CHN in their health systems as evidenced by the availability of PHC structures to guide interventions. However, challenges were identified related to the education, practice and management of CHNs in these countries. The major challenges identified were: Limited availability of career opportunities; poor worker retention; low recognition for CHNs; inadequate and unsupportive working conditions and environments; absence of educational standards; varying educational entry-level requirements for CHN programmes; and a lack of consensus on the scope of practice for CHNs. These challenges were derived from the five key areas of the study focus.

- National strategies for the practice of nursing and the nursing profession.

- Educational preparation of nurses and CHNs.

- Regulation of CHN practice.

- CHN practice elements.

- Advocacy and support for CHNs.

The study data were obtained from nursing faculties, nurses in practice settings, representatives of nurses in ministries of health, and representatives of nurses professional associations. Primary data generated from the WHO study was complemented by secondary data

from literature reviews. Based on the findings, it is imperative that steps are taken by policy-makers to build the local capacity of health systems to address these highlighted issues pertaining to CHN. Some of the policy options described to address challenges and gaps include:

- establishing a clear framework for the practice of community health nursing;

- enhancing the education of CHNs related to practice in primary health care and community settings;

- fostering collaboration between key stakeholders in PHC systems;

- developing comprehensive advocacy plans for increasing awareness and understanding of CHN in countries.

These policy options, if properly implemented in the context of both PHC and UHC, and aligned with local health systems policies and settings, can help policy-makers to address challenges that are hampering the practice of CHN as well as optimize the contribution of CHNs to health systems.

1
Introduction

The World Health Organization (WHO) has a long history of supporting the nursing and midwifery workforce through the provision of technical assistance, as well as through establishing related norms and standards. As a follow-up to the 2011 World Health Assembly resolution (WHA64.7) on strengthening nursing and midwifery, WHO was compelled: *"…to provide technical support and evidence for the development and implementation of policies, strategies and programmes on interprofessional education and collaborative practice, and on community health nursing services…"* The mandate created by this resolution was since supplemented by the vision and key policy directions articulated in two other key WHO strategy documents: *Global strategy on human resources for health: Workforce 2030 (1)* and the Global strategic directions for strengthening nursing and midwifery 2016–2020 *(2)*.

WHO and its partners have scaled up their efforts to address health workforce shortages since the publication of the *World health report 2006: Working together for health (3)*. The report described the critical shortage of health workers in 57 countries, and the potential of this deficiency to undermine health development in affected countries. Today, it is estimated that of the existing 43.5 million health workers globally, 20.7 million are nurses or midwives. Nurses and midwives also represent more than 50% of the estimated current (2013) health worksforce shortfall: 9 million out of 17.4 million. Strengthening the capacity of nurses and midwives (the largest cadre of the health workforce in many countries) can improve their ability to reach more people with quality health services.

This document utilizes evidence obtained from a 2010–2014 WHO study of community health nursing (CHN) as a key component of primary health care (PHC). The study was conducted in 22 countries affected by a critical shortage of health workers *(4)*. It aims to contribute to the achievement of universal health coverage (UHC) by highlighting the key contribution of community health nurses (CHNs), as well as some of the challenges CHN faces. A summary of the study findings and corresponding policy options are presented in this document. The findings and policy options can be used by policy-makers in ministries of health and other relevant agencies or departments in Member States, including educational and research institutions, regulatory bodies, professional associations and practicing nurses, in order to review and develop relevant policies for CHN in specific settings and contexts.The final study analysis examined data from 13 countries that were most affected by critical shortage of health care workers: Bangladesh, Belize, Bhutan, Cameroon, Guyana, India, Indonesia, Malawi, Nepal, Senegal, Swaziland, Trinidad and Tobago, and Uganda.

1.1   Essential components of community health nursing

Nurses providing community health services play key roles in disease and injury prevention, disability alleviation and health promotion, as well as managing and providing care and follow-up across a broad range of settings. These roles are clearly articulated in the various definitions that describe CHN as a discipline. In this document, the terms 'public health nursing' and 'community health nursing' are used interchangeably. WHO defines CHN as follows: *"A special field of nursing that combines the skills of nursing, public health and some phases of social assistance and functions as part of the total public health programme for the promotion of health, the improvement of the conditions in the social and physical environment, rehabilitation of illness and disability" (5)*. Community health nursing promotes and protects the health of populations through a combination of knowledge derived from nursing, social and public health sciences *(6)*. CHNs perform this role through several key elements of practice:

- Assessment of entire population needs – the health and health care needs of a population are assessed using systematic approaches aimed at identifying sub-populations, families and individuals who might benefit from health promotion programmes, or who are at risk of illness, injury, disability or premature death.

- Identification and articulation of the multiple determinants of health in communities

- CHNs often work to provide solutions that address biological, physical, social and environmental causes of illness. Through the planning of programmes and promotion of policy changes, interventions are developed in collaboration with the community, helping to meet locally identified needs, take into account available resources and consider other related activities that might contribute to better health outcomes.

- Effective and equitable implementation of public health plans and policies.

- Conduct of evaluations to determine the extent to which CHN programmes impact the health status of individuals and populations.

- Use of evaluation results to inform further research, influence and direct the delivery of care services, deployment of health resources, and development of local, national and regional health policies to promote health and prevent disease.

Communities are varied and dynamic. To be effective, CHNs must adapt to changing contexts to enable the provision of quality, and needs-based care. Accordingly, they must have excellent clinical skills as well as the ability to think critically, analyse complex situations, and advocate for patient-centred care and wellness goals *(7).*

Figure 1 illustrates a summary of CHN activities in a typical PHC system as elaborated by the respective definitions and concepts laid out by WHO *(5)* and the American Public Health Association *(6).*

Figure 1. Summary of community health nursing interventions in PHC systems

1.2   Background and importance of community health nursing

The value of community health nursing

Community health nurses provide care in many settings, including community health clinics, faith-based settings, homeless shelters and schools. They are primarily concerned with meeting the public/CHN needs of populations. CHNs work with diverse partners and health care providers in communities and can effectively contribute towards UHC, if properly educated, managed and supported.

Countries are often confronted with diverse health challenges that together influence the overall health of communities. Diseases such as tuberculosis (TB), human immunodeficiency virus (HIV), noncommunicable diseases (NCDs), as well as other illness-causing phenomena—including environmental toxins, violence, accidents and injuries, manmade and natural disasters—require that policy-makers put in place health service delivery structures to ensure a comprehensive approach. Failure to address common preventable risk factors underlining both communicable and noncommunicable diseases continue to result in increased burden of disease (8). Emerging health threats of global significance, such as Ebola virus disease and Middle East Respiratory Syndrome (MERS), have put the lives of many (including attendant health care workers) at risk. For example, a recent report by WHO (9) showed that over 50% of health worker Ebola infections that occurred from January 2014 to March 2015 in the Republics of Guinea, Liberia and Sierra Leone were among nurses, nurse assistants and nurse aides. In addition to increasing disease burdens and emerging health threats, changing demographic patterns are also contributing to increased need for community health workers (10). These complex and dynamic interactions illustrate how current trends in global health status are increasing the need for more systematic health promotion and disease prevention interventions in communities. CHNs can make significant contributions in meeting these global health challenges (11), but only if governments ensure that quality educational programmes and policies to provide appropriate support for the practice of CHN are in place.

Community health nursing and universal health coverage

As a broad and overarching concept to ensure strong and responsive health systems, Member States have embraced UHC as a means to provide wide-reaching access to health care for their citizens, while also protecting them from financial ruin. UHC calls for equitable, efficient and well-run health systems to meet priority health needs through people-centred, integrated care. It requires health systems to educate and encourage people to stay healthy, detect health conditions early, treat diseases and provide rehabilitation services. The significance of UHC as vital for sustainable development and the continuous improvement of health was summarized by the health-related targets of the Sustainable Development Goals (SDGs) (12). An essential requirement for the achievement of sustainable UHC is the availability of adequate quantity and quality of health care workers (13). Recognizing the importance of the nursing and midwifery health workforce for effective delivery of PHC and provision of UHC, more than 700 nurses, midwives, physicians and other health professionals met in February of 2008 in Chiang Mai, Thailand to discuss the role of nursing and other professions (14). The contributions of nurses and midwives (including CHNs) to UHC and to the SDGs are also incorporated into the *Global strategy on human resources for health: Workforce 2030 (1)*, and the *Global strategic directions for strengthening nursing and midwifery 2016–2020 (2)*.

The link between community health nursing and primary health care

The spectrum of PHC includes health promotion, disease prevention, treatment and rehabilitation. These core concepts of PHC intersect with fundamental elements of CHN and UHC. CHN practice is relevant for PHC and UHC in both developed and developing countries, and has also progressively evolved in other areas such as emergency and disaster management. A recent WHO document on expanding the role of nursing and midwifery to address the prevention and control of NCDs describes evidence- and community-based nursing interventions that have improved population health by addressing four major NCDs (15). Other WHO publications have also described how nurses and midwives perform key public health roles by addressing harmful use of alcohol and other psychoactive substances (16). Findings from other studies have demonstrated that CHNs are cost-effective in the provision of health care in remote or isolated communities (17, 18). It is also noteworthy that midwifery is included in the education and training of nurses in several countries and, in such contexts, nurses may provide midwifery services as an integral part of providing community health services. These examples demonstrate the significant contribution of nurses and midwives, including CHNs, on multidisciplinary public health teams. It is therefore crucial for governments and policy-makers to continue to support the development of CHN.

1.3 Interprofessional and multidisciplinary approaches to harness the potential of community health nursing

In order to meet the diverse range of family and individual needs depicted in Figure 2, CHNs collaborate with communites and with members of interprofessional health teams, to make essential referrals, and provide clinical care as and when needed. To ensure productive and efficient cooperation within and between various disciplines, improved communication and collaboration skills are needed by all health workers.

Effective delivery of CHN services relies largely on collaborative work and dialogue among diverse partners and health providers in order to address complex challenges for individuals of all ages in various settings, including schools, workplaces, and homes. In addition to health promotion and disease prevention CHNs also provide comprehensive care for people with a variety of health problems, including HIV, NCDs, and other chronic health problems *(19–21)*. Figure 2 illustrates some diverse situations that CHNs may address during a typical home visit.

Figure 2. An example of home visit scenarios

Source: Adapted from *(22).*

2
Key challenges in enhancing community health nursing

2.1   Summary of findings from the WHO study on community health nursing

To improve understanding of the challenges faced by CHNs, WHO conducted a study between 2010 and 2014 in 22 Member States distributed among the African Region, the Region for the Americas and the South-East Asia Region.

Table 1. Participants by country and WHO Region

		NUMBER OF RESPONDENTS				
REGION	COUNTRY	Government Office for Nursing	Nursing Council	Nursing Schools	Nurses' Associations	CHNs
AFR	Senegal	2		5	1	5
	Cameroon			5	2	
	Malawi	1	1	1	1	13
	Swaziland	1	1	1	1	
	Uganda	1	2	7		41
AMR	Belize	1	1	1		27
	Guyana	1	1		1	1
	Trinidad & Tobago	1		3	1	10
SEAR	Indonesia	1	1	6	1	30
	India	1	1	6	1	212
	Bangladesh	1	1	6	1	23
	Bhutan	1	1	1		29
	Nepal	1	1	6	1	36
Total	**13**	**13**	**11**	**48**	**11**	**427**

AFR: African Region; AMR: Region of the Americas; SEAR: South-East Asia Region; WPRO: Western Pacific Region.

The study was carried out in response to the World health report 2006: *Working together for health*, which raised the alarm on the critical shortage of health care workers in 57 countries worldwide. Ethical permission was obtained from the WHO Research Ethics Review Committee. Questionnaires were prepared electronically by WHO and sent to respondents with feedback made anonymous to ensure privacy. The overall sample size for nurses participating in the survey was about 36 per country (assuming that each randomly selected health facility across a country each had about five to six nurses. The samples in each country were randomly drawn from two rural, two peri-urban and two urban PHC centres).

There were a total of 427 responses from CHNs (in 11 countries). In addition, four other groups of participants (representatives of nursing and midwifery regulatory bodies, government officers responsible for nursing, nursing academic institutions and nursing and midwifery associations) were selected to take part in the study.

The questionnaire used for the study focused on five major areas impacting the practice of CHN:

- National strategies for the practice of the nursing profession.

- Educational preparation of nurses and CHNs.

- Regulation of CHN practice.

- CHN practice elements.

- Advocacy and support for community health nurses.

A major finding from the study was that most countries had the basic and operational framework for optimizing CHN, as evidenced by the availability of existing PHC structures. Nevertheless, major gaps were identified that undermined the contribution of CHNs to improving PHC in these countries. The study largely attributed such gaps to the general lack of commitment and a reduced capacity of policy-makers to implement existing global and regional policy tools on CHN. Table 2 outlines some of the multiple factors that were suggested by respondents as influential to CHN practice.

Table 2. Selected factors affecting community health nursing practice

CHN ISSUES	SELECTED FACTORS MENTIONED BY RESPONDENTS	FREQUENCY (%)
Career advancement (n=440)	Need for further training	165 (38%)
	Need for CHNs to specialize	70 (16%)
	Need for promotion/career progression	55 (13%)
	Limited opportunities for CHN career advancement	42 (10%)
	Need to improve/update/advance CHNs	23 (5%)
	Need for recognition from other health sectors	17 (4%)
Working conditions (n=617)	Need for resources/basic services	96 (16%)
	Good working conditions	80 (13%)
	Need for better working/environmental conditions	82 (13%)
	Insufficient infrastructure	57 (9%)
	Insufficient personnel	57 (9%)
	Need for education and professional support/ development	51 (8%)
Scope of practice (n=395)	CHNs need independence in nursing/professional practice	99 (25%)
	CHN involves health promotion, preventive, curative and rehabilitative services	86 (22%)
	CHNs perform non-CHN activities	27 (7%)
	Need for knowledge enhancement and professional development	26 (7%)
	CHN includes health programmes at health centres, schools and rural areas	21 (5%)
	Need to broaden the scope of practice	18 (5%)
	Need to broaden the scope of practice	18 (5%)

Table 2 shows only the suggested influencing factors with the highest observed frequencies (rounded to the nearest whole). The need for provision of further training of CHNs was noted as important by 38% of the responding nurses. This represents an opportunity that can be met by strengthening existing in-country CHN educational programmes through measures such as building capacity of faculty members and developing evidence-based curricula according to local needs and settings.

The study also revealed marked variations and inconsistencies between countries with regard to the required level of qualification needed to become a CHN practitioner. About three quarters of responding nurses indicated that they had a minimum of a certificate, diploma, bachelor or PhD degree–having received formal training to qualify as nurses. Pre-registration education standards clearly vary considerably, and could affect the competency level required for the safe practice of CHN. This finding may be attributed to a reduced capacity of accreditation and regulatory systems to set proper standards for the enhanced scope of CHN education across all levels of learning.

Figure 3. Role and functions of nurses and midwives practising community health nursing (n=403)

Counselling and advocacy (2%)

Health promotion, disease prevention and rehabilitative care (6%)

Others (6%)

Education/training/research (9%)

Nursing and health care provision (49%)

Administration, coordination and management (28%)

Only 6% of CHNs were performing roles in health promotion, disease prevention and rehabilitative care—areas that should be major domains of CHN practice. Roles in counselling and advocacy were reported by only 2% of respondents, compared to 49% for nursing and health care provision. The findings imply that CHNs spend more time at health facilitites e.g. PHC centres rather than being engaged in field-based activities. This reveals a significant misalignment between the roles and responsibilities for which CHNs are generally trained and what they actually do in practice. In order to maximize the potential of CHN, there is a need for clearer role definitions through the careful alignment of competencies and public health nursing needs.

In addition to the above-mentioned gaps, other constraints to the roles of CHNs were identified from the analysis of survey responses. They include:

- Poor enforcement of CHN policies and absence of standards.

- Lack of consensus on the scope of CHN practice.

- Poor workforce alignment and harmonization of multidisciplinary practice.

- Few CHN career opportunities and poor worker retention.

- Low recognition of CHN.

- Escalation of CHN service demand – intensified by the increasing commitments of governments to PHC and UHC, despite a concomitant shortage of health care workers in many countries.

- Too much emphasis still placed on facility-based clinical care.

3
Key policy options to strengthen community health nursing for universal health coverage

The policy options outlined below can be used to support policy-makers in countries in building the capacity of CHNs. They are based on evidence from relevant literature and interpretation of the analysed data from the WHO study. Table 4 highlights the linkages between specific policy options, CHN interventions and their relevance to improving PHC and UHC.

Table 4. Key policy options to enhance community health nursing

POLICY OPTIONS	RELEVANCE FOR PHC AND UHC
Establishing a clear framework for CHN practice	Provides coherence for the implementation of policy initiatives and clearly outlines CHNs' roles in multidisciplinary public health teams working in PHC systems.
Enhancing the education and training of CHNs to practice in PHC and community settings	Contributes to improved competence of CHNs and the quality of health services provided in PHC settings, leading to better health outcomes.
Fostering collaboration between key stakeholders in PHC systems	Helps to maximize the utility of CHNs' public health skill mix, to help facilitate people-centred collaboration in multidisciplinary public health teams and improved health service delivery. Also helps to minimize role confusion within the health team.
Developing comprehensive advocacy plans for CHN in countries	Increases community knowledge and acceptance of CHNs.

3.1   Establishing a clear framework for the practice of community health nursing

A national health workforce strategy should be an integral part of a country's national health plan. It helps to set out the essential quantity and skill mix of health workers to meet and future needs. It should include policies and strategies to scale up, retain and motivate the health workforce *(23)*, as well as take into consideration the budgetary implications of implementing all the required actions. Ensuring that CHNs are clearly integrated across PHC and national health plans encourages policy coherence and improves the quality of CHN services. There is also a need for countries to develop policies that ensure employment and roles of CHNs are aligned with their areas of training and expertise. To be successful, good workforce planning needs to be backed up by strong political will and negotiation skills, and complemented by the availability of quality information and data. One example of a country-level strategy to promote contributions of CHNs to achieve UHC was the development of a generic model for CHN in Scotland (see Box 1) *(24).*

Box 1. Developing a generic model for community health nursing

In 2006, Scotland's review of nursing in the community identified a new generic model as a way forward. It recommended that the disciplines of district nursing, health visiting, school nursing and family health nursing be absorbed into a new, single role: the community health nursing discipline. This new service module was also designed to utilise the core principles of CHN by adopting a strong partnership approach with individuals, carers, families and communities; work as part of nursing and multidisciplinary, multi-agency teams; and focus on providing services that meet local needs and reflect government priorities *(24)*.

3.2   Enhancing the education and training of community health nurses to practice in primary health care and community settings

Education and training

Scaling up educational programmes to produce multidisciplinary public health service delivery teams is urgent and essential. The increased availability of a well-educated health workforce, including CHNs–with the right skill balance to match needs–is an asset to any health care system. In 2013, WHO published a set of education guidelines on *Transforming and scaling up health professionals' education and training (25)*, to support Member States with the necessary policy tools to rapidly increase the quantity and quality of health care workers with the optimal skill mix. Contained in the guidelines are recommendations that provide evidence-based policy and technical guidance in the area of pre-service education, particularly for countries experiencing shortages of doctors, nurses and midwives, including CHNs and other health professionals. The report also provides recommendations to policy- makers on how to integrate continuing professional development (CPD) in medical, nursing, midwifery and other health professionals' education. As with other health professions, five key areas of focus ought to be considered when applying the guideline recommendations to scale up education for CHN. These are:

- education and training institutions;

- accreditation, regulation;

- financing and sustainability;

- monitoring and evaluation; and

- governance and planning.

Competency in community health nursing

Quality education and training is vital to equip CHNs with the core and complementary competencies they require to serve effectively. The WHO *Framework for community health nursing education (26)* outlines two sets of competencies required for CHNs to practice effectively: clinical care and complementary competencies. The clinical care competencies include health assessment, disease management, case finding, case management, observation and treatment according to delegated responsibility etc. Complementary competencies 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 CHN courses. When drawing up educational policies to build competencies for CHN, it is important to holistically consider the five areas of focus described earlier. Optimal education outcomes rely on efficiently harnessing the interlinkages between respective areas.

Approaches to foster community health nursing practice

A variety of teaching strategies may be used to impart theoretical and practical knowledge to CHNs. Where feasible, computer-based or eLearning methods may also be applied *(27)*. Boxes 2 and 3 describe programmes initiated in China and Thailand respectively to develop comprehensive community-based approaches for training CHNs to meet local health needs.

Box 2. Using multiple approaches to foster community health nursing development

In 2008, Zhejiang province of China doubled its community primary health care service centres and service stations within four years to 1200 and 6789 respectively. This huge progress was achieved by the introduction of practical guidelines for CHN management, community nurse education programme and a community nurse management model. As of 2010, there were 27 000 community nurses and an equivalent number of family doctors working in community health care service centres and stations as a direct result of a multi-pronged approach to revamp the status of CHN in Zhejiang and improve people's health *(31)*.

Interprofessional education

The concepts of interprofessional education (IPE) and continuous professional development (CPD) are also important for the education of CHNs *(28,29)*. IPE provides learners with the training they need to become part of the collaborative, practice-ready health workforce. CPD is beneficial to all health workers in the community, as it helps to maintain competencies and gain additional skills needed to improve the quality of care. These concepts need to be increasingly embedded into coherent policy plans in order to address education of CHNs in countries. Educating CHNs will also require that policy-makers put in place motivation and retention strategies to attract and retain competent educators in faculty programmes. Versatility and 'closeness-to-community' should also be considered as important factors for employment of educators, as familiarity with local health problems can enable the teaching of local needs-based skills.

3.3   Fostering collaboration between key stakeholders in primary health care systems

Community health nursing is critical for health care systems to develop people-centred service delivery mechanisms for PHC. Achieving large-scale positive health outcomes for people in communities will be made more difficult without effective collaboration between all players in the health workforce including CHNs. To ensure better collaboration and effectiveness, clear mechanisms of planning and implementation must be established jointly by leaders and managers of multidisciplinary health workforce teams–not just in education and training but also in practice and partnerships. To this end, WHO has identified key enablers for interprofessional education (IPE) and collaborative practice in nursing and midwifery *(30)* and these can be adapted and applied to CHN as follows:

- Presence of CHN leaders and champions.

- Provision of administrative, institutional and work culture support for members of collaborative teams through policy frameworks and sound management.

- Availability of interprofessional collaborative mentorship and learning to new CHNs.

- Availability of a shared vision/mission in respective public health teams.

- Encouraging supportive physical environments and space designs that foster teamwork.

Policy-makers and health leaders in countries need to assess their health care systems by identifying bottlenecks in IPE and collaborative practices. Full implementation of IPE and collaborative practice with CHNs will also require the assistance and cooperation of accreditation and regulatory bodies to ensure that IPE is part and parcel of national CHN education curricula. Other essential factors such as adequate funding and infrastructure for programmes need to be put in place to complement policy initiatives, as well as ensure sustainability and better outcomes.

Box 3. Training nurses to work in their own communities

In Thailand, a project named "nurses of the community" generates nurses who are trained through participatory processes with key stakeholders (i.e. the local administrative organizations, the local community hospitals and the local schools of nursing). The project was initiated in 2002 at the Faculty of Nursing, Khon Kaen University, with the support of WHO, 10 community hospitals and 12 local administrative organizations. In 2006–2007, the Thai Health Foundation provided funding to involve four more nursing education institutions. By 2008, two main funding agencies had supported the participation of 33 nursing education institutions, more than 300 local administrative organizations and nearly 60 community hospitals. After graduation the nurses typically return to their home communities to work. The nurses are able to provide essential services to the target population, especially mothers and children, older and disabled people, and those with chronic diseases. They also work to empower groups such as youth, elderly and self-help groups, as well as voluntary organizations in the community. They focus on healthy activities, disease surveillance and control and welfare, and some of the nurses are also involved in local policy development to improve quality of life *(32,33).*

The Thailand case study is an illustration of the relevance of CHN to better health outcomes in the community. If empowered and motivated through effective planning and management, CHNs can bridge gaps in the delivery of community health services and help achieve UHC.

3.4   Developing comprehensive advocacy plans for community health nursing in countries

WHO defines advocacy for health as: "…a combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or programme" *(34)*. Policy advocacy by CHNs and other stakeholders–using evidence-based knowledge and health promotion through patient education and representation–is crucial to appropriately inform and convince policy makers, politicians, community health practitioners, civil society groups and patients about the importance of CHN to ensuring good health outcomes. Figure 4 illustrates a framework for CHN advocacy.

For advocacy to be effective in influencing decision-makers, a good understanding of the issues affecting CHN and how they relate to the health of people in communities is essential. Although advocacy is taught as part of the curriculum in many nursing schools, it still needs to be further emphasized in training and practice, particularly in many developing country contexts. To strengthen advocacy campaigns and promote good health, increased public awareness and support ought to be sought through the ethical and responsible use of mass media (news outlets, social media and other communication channels, depending on context and most appropriate options). Dissemination of strategies for advocacy campaigns should be backed by systematic and comprehensive approaches that match the vision and mission statements of CHN and PHC systems in respective contexts. Practitioners, institutions and individuals engaged in advocacy for CHN are encouraged to build alliances that strengthen ties and maximize political and technical leverage and influence, in order to achieve greater impact. Policy-makers in health authorities of Member States are encouraged to involve CHNs in advocacy and public health leadership and policy planning, as they are key stakeholders and have the required competencies to support policy development planning and implementation.

Figure 4. A framework for community health nursing advocacy
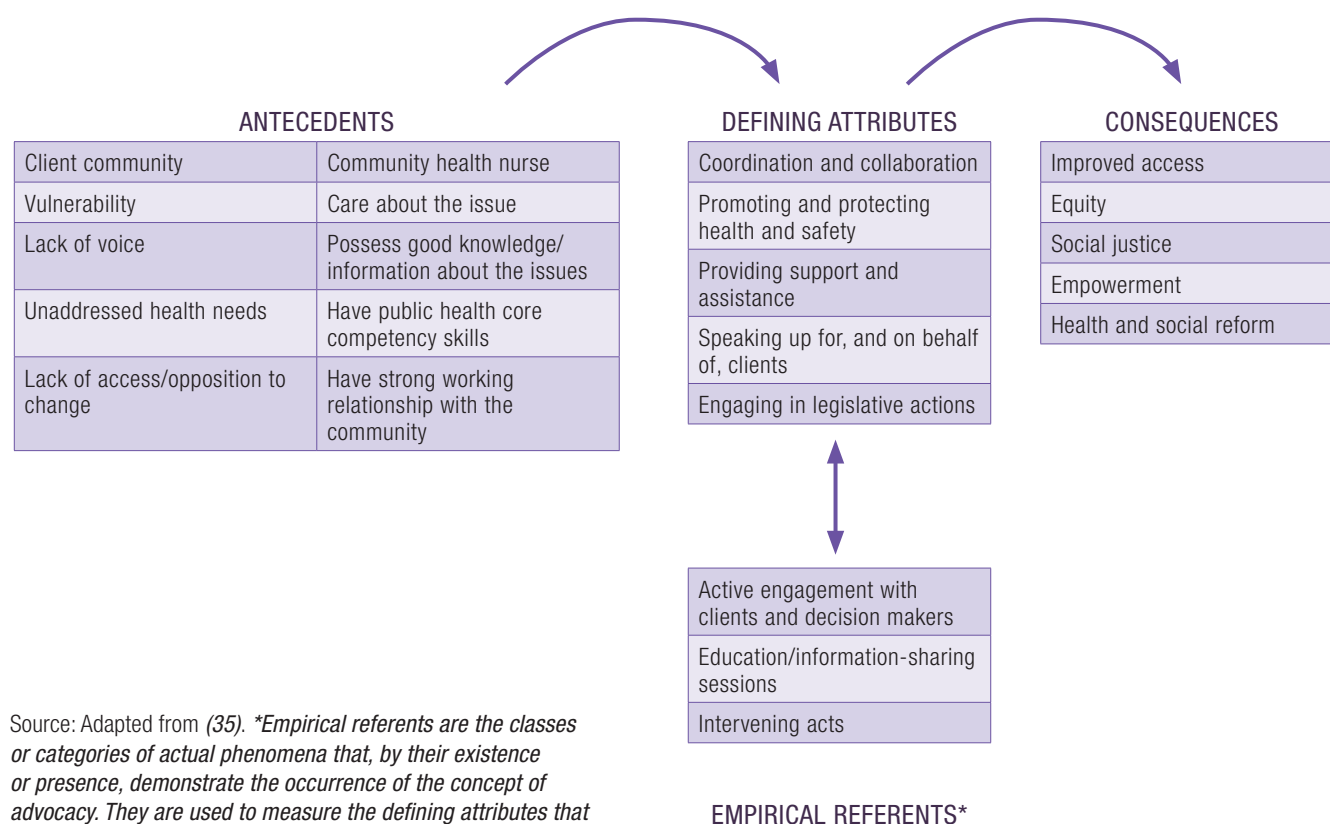
Source: Adapted from *(35)*. *Empirical referents are the classes or categories of actual phenomena that, by their existence or presence, demonstrate the occurrence of the concept of advocacy. They are used to measure the defining attributes that provide nurses with evidence Demonstrating whether or not advocacy is happening in a community.*

Conclusion

Community health nursing services can be effective if appropriate measures are taken to address the challenges identified in this policy brief. This document adds to the growing number of resources and compliments existing WHO tools on nursing and midwifery. It is hoped that policy-makers looking to implement UHC through strengthening the contribution of CHN will take into account the options provided.

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Annex

Community health nursing core competencies

Community health nurses make significant contributions to population health and to the realisation of UHC through their roles in health assessment, surveillance, disease and injury prevention, health promotion, and health protection. The current document proposes a set of core competencies necessary for the practice of CHN. Core competencies refer to "the specific knowledge, skills, judgment and personal attributes required to practice safely and ethically in a designated role and setting"*(38)*. These core competencies can be used to guide educational programmes at all levels, to ensure that nurses are prepared for roles in community health to promote UHC. These core competencies also apply to public health nursing as the term is used interchangeably with CHN throughout this document.

These core competencies are adapted mainly from those developed in the public health sector in Canada (38). Other relevant literature related to community health care provider development, needs, and education and expert input are also reflected in its development *(36–46)*. A set of proposed domains and competencies was identified as outlined in the table below:

Table A1. Competencies' domains

DOMAIN	COMPETENCIES
1. Public health sciences	1. Demonstrate knowledge of the following concepts: Health status of populations; inequities in health; the determinants of health and illness; strategies for health promotion; disease and injury prevention and health protection; as well as the factors that influence the delivery and use of health services. 2. Demonstrate knowledge about the history, structure and interaction of public health and health care services at local, provincial/territorial, national, and international levels. 3. Comply with the requirements of patient confidentiality and human subject protection. 4. Apply the public health sciences to practice. 5. Use evidence and research to inform health policies and programmes. 6. Demonstrate the ability to pursue life-long learning opportunities in the field of public health.
2. Assessment and analysis	1. Identify the determinants of health and illness of individuals and families, using multiple sources of data. 2. Use epidemiologic data and the ecological perspective to identify health risks for a population. 3. Identify individual and family assets and needs, values and beliefs, resources and relevant environmental factors. 4. Identify variables that measure health and public health conditions. 5. Use valid and reliable methods and instruments for collecting qualitative and quantitative data from multiple sources. Develop a data collection plan using appropriate technology to collect data to inform the care of individuals, families, and groups. 6. Identify sources of public health data and information. Collect, interpret and document data in terms that are understandable to all who were involved in the process, including communities. 7. Utilize valid and reliable data sources to make comparisons for assessment.

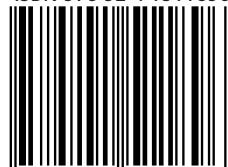| DOMAIN	COMPETENCIES
3. Policy and programme planning, implementation, and evaluation	1. Identify policy issues relevant to the health of individuals, families, and groups. Describe the structure of the public health system and its impacts on individuals, families, and groups within a population. 2. Identify the implications of policy options on public health programmes and the potential impacts on individuals, families, and groups within a population. 3. Identify outcomes of health policy relevant to practice. 4. Plan, implement, monitor and evaluate community programmes and projects. 5. Collect information that will inform policy decisions. 6. Describe the legislative policy development process. 7. Identify outcomes of current health policy relevant to practice.
4. Partnership, collaboration, and advocacy	1. Identify and collaborate with partners in addressing public health issues. 2. Utilize skills such as team building, negotiation, conflict management and group facilitation to build partnerships. 3. Mediate between differing interests in the pursuit of health and well-being, and facilitate the allocation of resources. 4. Support effective community mobilization. 5. Advocate for healthy public policies and services that promote and protect the health and well-being of individuals and communities.
5. Diversity and inclusiveness	1. Recognize how the determinants of health (biological, social, cultural, economic and physical) influence the health and well-being of specific population groups. 2. Address population diversity when planning, implementing, adapting and evaluating public health programmes and policies. 3. Apply culturally relevant and appropriate approaches with people from diverse cultural, socioeconomic and educational backgrounds, and persons of all ages, sexes, health status, sexual orientation and abilities. 4. Use concepts, knowledge and evidence of the social determinants of health in the delivery of services to individuals, families, and groups. 5. Utilize information technology to understand the impact of the social determinants of health on individuals, families, and groups. 6. Adapt public health nursing care to individuals, families, and groups based on culture needs and differences. 7. Apply health education using appropriate and culturally relevant visual aids.
6. Communication	1. Communicate effectively with individuals, families, groups, communities and colleagues. 2. Interpret information for professional, non-professional and community audiences. 3. Mobilize individuals and communities by using appropriate media, community resources and social marketing techniques. 4. Use current technology to communicate effectively, including orally, in writing and through electronic means. 5. Articulate the role of public health nursing to internal and external audiences. 6. Demonstrate presentation of targeted health information to multiple audiences at a local level, including to groups, peer professionals, and agency peers. 7. Document clear, concise reports and relevant information and data.
7. Leadership	1. Describe the mission and priorities of the public health organization where one works, and apply them in practice. 2. Contribute to developing key values and a shared vision in planning and implementing public health programmes and policies in the community. 3. Utilize public health ethics to manage self, others, information and resources. 4. Contribute to team and organizational learning in order to advance public health goals. 5. Contribute to maintaining organizational performance standards. 6. Demonstrate ability to build community capacity by sharing knowledge, tools, expertise and experience. 7. Act as a mentor, coach, or peer advisor/reviewer for public health nursing staff. 8. Maintain personal commitment to life-long learning and professional development. 9. Participate with stakeholders to identify vision, values, and principles for community action.

Source: Adapted from *(38).*

By acquiring these competencies, CHN practitioners will be equipped to practice effectively in communities, health centres, schools and crèches, industries, water works and sewerage management facilities, and in information offices of hospitals and clinics etc. The following are some outcomes that could result from effective use of these competencies:

- Effective community collaboration and partnerships.

- Availability of data on community health needs.

- Functional multidisciplinary health promotion teams.

- Availability of advocacy resource tools.

- Effective management system for community health information.

- Sustainable, well-implemented health promotion programmes and other related community health programmes.