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COMMUNITY HEALTH NURSING

Report of a WHO Expert Committee

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WHO EXPERT COMMITTEE ON COMMUNITY HEALTH NURSING

Geneva, 30 July – 5 August 1974

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COMMUNITY HEALTH NURSING

Report of a WHO Expert Committee

A WHO Expert Committee on Community Health Nursing met in Geneva from 30 July to 5 August 1974. The meeting was opened by Dr W. H. Chang, Assistant Director-General, who welcomed the participants on behalf of the Director-General. The Committee was composed of members representing multiple disciplines in order to have the benefit of varied and broad backgrounds, opinions, and approaches to future health care delivery.

Dr Chang said that the objectives of the meeting were to clarify the contribution of nursing to the improvement of the health of communities, to define the function and tasks of the community health nurse and her role in the health team, to consider the education of personnel in terms of local needs, and to make recommendations that would promote those objectives.

There was an urgent need for peripheral health services, and communities must become involved in developing them. Health workers had to be trained for, and properly utilized at, all levels of the health service. Appropriate safeguards of nursing practice must be instituted and an effort made to develop innovative approaches to the problems involved in establishing and developing community health nursing services. Dr Chang described the community health nurse as a generalist, capable of functioning in a health team, of communicating with and motivating people, and of working effectively with educational, social, and other workers within the community.

1. INTRODUCTION

1.1 Concepts of health care

The Committee considered that the acceptance of health as a basic human right and of health care as an important means of protecting that right are fundamental to the effective delivery of community health care. It follows naturally that health care should be accessible to all the population, the word "accessible" being used in its broadest context to mean available when needed, free of economic barriers, unlimited by social or cultural distinctions, and within reasonably easy reach.

The term "health care" implies a broad spectrum of services including primary health care, the integration of preventive and therapeutic services,

health education, the protection of mothers and children, family planning, and the control of environmental hazards.

A system of health care delivery is essential to the provision of community health care, and that system must reflect certain inherent characteristics of the community. It must, for example, evolve from the community it serves; it should involve the community in all aspects of its organization, such as in the planning, delivery, and evaluation of care; it must be inter-related with other operating social systems within the community; and it must support as well as be supported by the community for which it exists. Moreover, the health system must be flexible in its approaches to health care; those responsible for operating it should be aware that the primary avenue to health may be through education, economic progress, legislation, or other aspects of society rather than through organized health structures.

Given these characteristics, all countries and all communities, even the most rural and impoverished, will find it feasible to develop effective health care. In spite of this, health services have been noted more for their gaps, deficiencies, and poor utilization, especially among rural populations, than for effective and efficient improvement in community health. In order to change this situation, the factors influencing community health must be considered jointly with the modifications required in the health care system.

1.2 Determinants of community health and health care

The health status, disease patterns, and health expectations of the people are the major determinants of community health needs. In addition, the social, economic, and cultural environments influence the health, health behaviour, and health perceptions of groups, both positively and negatively. Thus it is often possible to make major improvements in the health of a population through relatively modest changes in cultural behaviour, economic standards, or social institutions. In countries where malnutrition is prevalent, the identification of a ready source of protein or the introduction of soil fertilization can lead to a considerable reduction in the incidence and severity of communicable diseases. Similarly, clean water supplies and insect control are well-known means of reducing mortality rates. In the more developed countries the steadily increasing prevalence of cardiovascular diseases, cancer, mental illness, and accidents could be reduced by drastic changes in behaviour with regard to the sedentary way of life, excessive eating, alcoholism, smoking, and the generation of mental stresses.

Rapid population growth and urbanization contribute to the health problems in developing countries and constitute additional challenges to community health programmes.

General education, improvements in communications, and technological developments produce changes in people's perception of health, in their definitions of illness, and in their demands on the health care system. They also alter family and community life, changing both the nature of the relationships between individuals and the patterns of social relationships in family and community groups. In some instances these processes are beneficial to health; in others they cause conflicts and stress with detrimental health effects.

Community resources and their allocation to health services (or to services related to health) directly determine the scope and composition of health care delivery systems. *Per capita* income, literacy rate, and educational and occupational opportunities are only a few of the other factors influencing the number and type of health personnel available, the administrative framework of the health system, and the possible strategies for care that may be implemented.

The acceptance of traditional providers of health care enlarges the potential health resources of the community and simultaneously promotes the integration of desired health practices into the accepted social and cultural behaviour of the local population. The importance of this is universally recognized, yet health professionals have been slow in bringing the traditional providers of health care into the health system. The readiness of health planners to acknowledge the influence of birth attendants, healers, and similar people on the health of communities may be an important factor in the eventual success of the health programme. The training and utilization of traditional health workers enables community health services to be provided in the context of accepted norms and encourages traditional culture-bound patterns of health care to become more scientific.

1.3 The community and community health

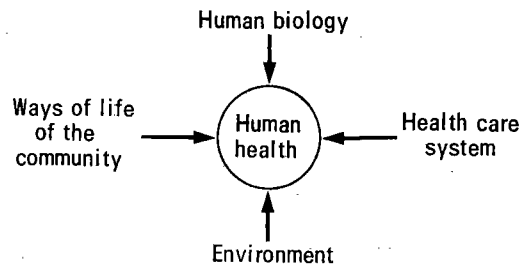
The Committee agreed on the following meanings of the terms used in community health nursing.

Community

A community is a social group determined by geographical boundaries and/or common values and interests. Its members know and interact with each other. It functions within a particular social structure and exhibits and creates certain norms, values, and social institutions. The individual belongs to the broader society through his family and community.

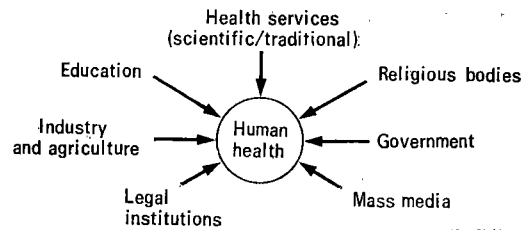
Human health

Individual and group health is determined by human biology, the environment, the ways of life of the community, and the health care system, as shown below.



WHO 40712

The implementation of a health programme leads to a change in individual and group behaviour. This process, as shown below, can be influenced by members of the principal social institutions in the country,



WHO 40713

Community health

Community health refers to the health status of the members of the community, to the problems affecting their health, and to the totality of health care provided for the community.

The assessment of health requires an understanding of the general population to be served. Major categories of information on health are outlined in the following paragraphs.^a

^a These paragraphs are based on: WHO Technical Report Series, No. 481, 1971, pp. 33-36.

- (1) Demographic data
 - present and projected population according to age, sex, location
 - population density
 - migration
 - life expectancy
 - probable birth rates
 - literacy rates
- (2) Environmental characteristics
 - housing conditions
 - working conditions
 - educational opportunities
 - sources of water supply, water quality
 - waste water disposal and water pollution control
 - solid wastes management, including sanitary handling and disposal
 - vector control and the control of alternative hosts of disease
 - environmental pollution
 - climate
 - structural organization and administration of environmental health services
- (3) Economic information
 - occupational characteristics
 - patterns and tendencies regarding personal or family income
 - health sector income and expenditures
 - national income and expenditures
 - costs of providing health services and of maintaining the different categories of health manpower
 - cost/effect information for selected health problems
- (4) Health needs
 - mortality and morbidity data according to major causes, age, sex, geographic distribution
 - the extent to which the principal diagnostic categories result in a demand for health care and in disability

(5) Utilization of health care services by the population

- health services actually utilized (“ met ” demand): number, types, quality, effects
- characteristics of those who use services, including their attitudes and knowledge regarding the use of health services and of the health system that provides them
- “ unmet ” demands or needs for health services
- approximate volume of services desired (or needed) that are not obtained, according to type of service
- characteristics of those who desire (or need) services
- reasons for not obtaining the desired (or needed) services.

1.4 The family and family health

The family is one of the oldest and strongest social institutions. Its members share genetic traits, environment, general attitudes, and life styles. Through their interactions and mutual dependencies, the family functions as a unit; factors impinging on one member affect all other members to some degree.

The state of health of one member and his response to illness influences and is influenced by physical and psychological support mechanisms operating within the family. A child's growth and development reflects the interaction of genetically determined biological factors and the family environment. Poor housing, overcrowding, inadequate food, and inadequate education affect all members of the family, and behaviour patterns, including those governing health care, are shared by the family. It is logical, therefore, to consider the health needs and problems of the family as a whole and to deal with individual health problems within the framework of a comprehensive family health programme.

1.5 Family and community health nursing

The Committee expressed considerable concern that renewed emphasis on the role of nursing in community health might, through misunderstanding, diminish the importance of family health nursing. There was unanimity on the importance of planning, organizing, and evaluating nursing services in terms of the health needs of the whole community, but at the same time the Committee considered it essential to clarify its position on family health nursing. It therefore drew up the following statement, which represents the consensus of the Committee :

Family health nursing is based on the concept of the family as a unit and is directed towards meeting the health needs and concerns of the family by encouraging it to use its own resources, both human and material, and by indicating the best way to use available health services.

Developments taking place in modern life have led to changes in health needs and demands for wider service coverage than has ever been envisaged. Illness, disability, or other events such as unemployment can disturb the equilibrium of the group and affect the mental and physical health of its members.

In many countries, the shortage of health personnel limits the wider use of home visiting services intended to reach all families needing care; such visits often have to be reserved for selected families only. Thus, other methods must be employed to provide family health care. Possible approaches are to work with small groups of families and to organize consultations in a family-centred clinic.

Community nursing includes family health nursing but is also concerned with identifying the community's broad health needs and involving the community in development projects related to health and welfare. It helps communities to identify their own problems, to find solutions, and to take such action as they can before calling on outside assistance.

1.6 Midwifery and community health nursing

Another concern of the Committee related to the place of midwifery in community nursing services. In this instance there was agreement that maternal and child health services, including midwifery, were basic components of family and community health care. For this reason, midwifery is not mentioned specifically in discussions of nursing services but is considered to be implicit throughout.

2. THE SITUATION

The vastness of the world's health problems is difficult to realize, and it is even more difficult to design strategies that will cope with the situation in the foreseeable future.

Hundreds of millions of people have little or no access to essential health services. The seriousness of the problem is indicated in a few vital statistics. In 1970, for example, the infant mortality rates in some countries were officially reported to be as high as 146 per thousand live births.^a Studies and surveys indicate that the infant mortality rate in some populations may be as high as 300 per thousand and in some subgroups even higher. The officially reported life expectancy figures range from 74.5 years in Sweden to 35 years and less in some African countries.^b

^a World Health Organization *World Health Statistics Annual, 1970, Vol. I: Vital statistics and causes of death*, Geneva, 1973, pp. 10-11.

^b United Nations *Compendium of social statistics: 1967*, New York, 1968 (Statistical Papers Series K, No. 3), Table II, p. 158.

The ratio of all nursing and midwifery personnel in various countries illustrates the wide disparity in these services throughout the world. In 1970, Indonesia reported there were 1.7 nurses, midwives, and other nursing personnel per 10 000 population, while Czechoslovakia reported a figure of 54.5 per 10 000.^a These statistics do not, however, show the distribution of nursing personnel within the country, which may be even more disparate when rural and urban areas are compared or when different social, economic, or cultural groups are considered separately.

The major characteristics of rural and semi-rural populations, which comprise 80% of the world's population, are :

- geographical isolation and poor communications
- an unfavourable environment with exposure to communicable diseases and malnutrition
- inadequate health facilities and lack of sanitation
- poor educational opportunities.

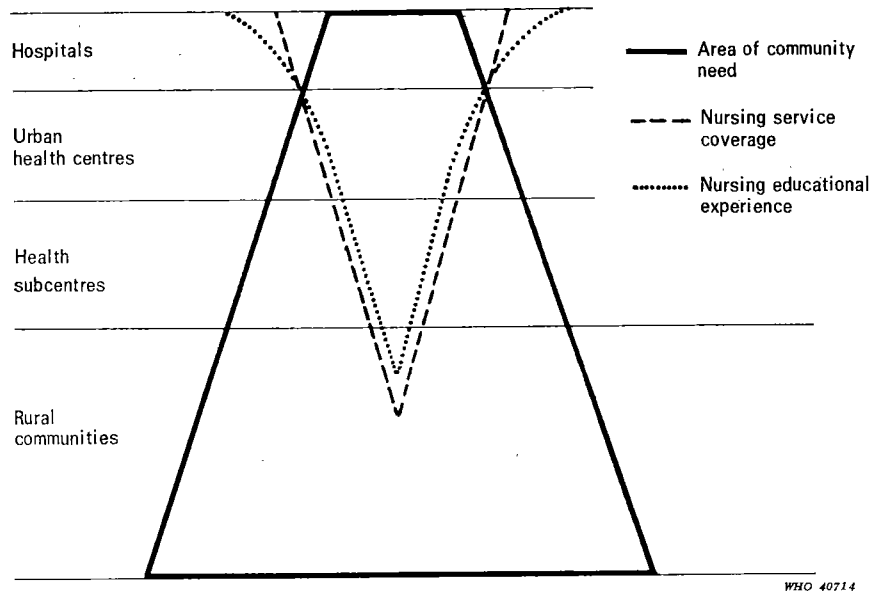
In spite of the above realities, health services and the education of health personnel have been centred on the hospital. Nursing has followed this pattern and most, if not all, basic nursing education prepares the nurse for hospital work rather than for service in the community, where most of the needs for health care and protection occur.

Fig. 1 illustrates the distribution of nursing services in many developing countries. It demonstrates that although the sick in hospitals represent the the smallest proportion of the population needing care, they receive a large proportion of the nursing service available. Populations cared for in urban health centres receive the second highest proportion of nursing care, while those in villages and rural communities have little or no nursing coverage. At these local levels there are vast areas not covered by any organized health service. Birth attendants and other practitioners of traditional folk medicine are frequently the only providers of health care available. It is thus apparent that the "care" pyramid is inverted in relation to the "need" pyramid.

The diagram also shows the discrepancies in nursing education in relation to community needs for service. A preponderance of the educational experience of nursing students is obtained in the care of hospitalized patients with relatively little practice in community nursing. In fact many of the nurses employed in public health have had no community health nursing preparation. This situation is particularly acute in rural peripheral areas of the world, where the provision of care tends to be more challenging and complex and at the same time lacks administrative direction or consultation.

^a World Health Organization *World Health Statistics Annual, 1970, Vol. III: Health personnel and hospital establishments*, Geneva, 1974, p. 57.

FIG. 3. EXISTING NURSING SERVICES RELATED TO COMMUNITY NEED AND EDUCATIONAL EXPERIENCE



The failure to give personnel adequate preparation for service as primary health workers or community health nurses in rural and peripheral areas, consistent with population needs and resources, represents a serious deficiency in health manpower development today. Schools of nursing, like schools of medicine, have focused attention on theory and practice relevant to care of the sick in hospitals, often ignoring the need for disease prevention, health maintenance, and health promotion. Training courses even neglect the care of the sick and disabled who are not institutionalized, in spite of the fact that they far outnumber the hospitalized patients in any community. Personnel trained in hospital-based institutions are often the only staff available for community health services, for which they have little or no preparation. Where postbasic education programmes have been established, the aim has been to prepare administrators of hospital nursing services, public health/hospital supervisors, researchers, and teachers. The preparation of nurses to provide community health care in its full sense, or to feel responsible for meeting the health needs of communities, is lacking in many instances.

There are further constraints that make work at the periphery difficult. In many countries nurses are not accepted as team leaders or coordinators of health care although they are often the personnel most able to assess the

needs and to see that appropriate interventions are carried out. The problem is further aggravated in many societies where nursing personnel are not legally allowed to diagnose and treat patients although they are the only practitioners available. This is especially true in peripheral areas. Not infrequently nursing personnel are instructed to refer patients for diagnosis and treatment to the next echelon in the health structure, but the persons consulted may be even less qualified than the nurse concerned.

Owing to the traditional approaches adopted by nursing and other health education programmes, health personnel tend to provide stereotyped patterns of services instead of trying to adapt the health programme to the community, taking the differing needs of people into consideration. Moreover, inadequate assessment of existing community resources may impose unnecessary limitations on the scope of health services so that they cannot approach major community needs.

Too often health personnel are so preoccupied with establishing a health structure within each community, without questioning its relevance to the existing situation, that their real objectives become clouded. In many instances more rapid progress toward health could be made by developing health services in conjunction with other established programmes, delaying the development of the health organization itself until the community is ready and able to support it. Community developments such as agricultural development, irrigation, transportation, and other health related programmes offer a natural base for health services. The use of these avenues, geared to the expressed needs of the people, provides a solid foundation for the health programme and gives it some chance of success.

Another major constraint needs to be mentioned. In an attempt to close gaps in the health service, workers are often hastily recruited from rural or peripheral communities, narrowly trained, and employed to carry out a varied range of functions. Their job titles and rewards also vary considerably and are often unrelated to their training or actual work. They are frequently assigned to the peripheral health services as primary health workers or for other nursing work in villages. This practice has created conflicts and abuses. The health workers have been expected to carry out tasks for which they have little or no training, the nursing personnel have not been trained to direct or supervise them, and the communities served have been disappointed and critical of the continued gaps in service in spite of the marked increase in the number of personnel.

A well organized nursing system responsible for the education and practice of nursing personnel is needed in every country to cope with these problems. It should be accountable for the nursing services provided and should participate in the planning of the preparation and utilization of all staff recruited for community health.

3. THE CHALLENGE

In considering the magnitude of the problems of effective community nursing practice, the Committee put forward the following list of questions that it felt must be answered by nursing action, functioning alone or in concert with other groups responsible for community health service.

- (1) Can we close the gaps
 - where no service exists ?
 - where personnel exist but are badly distributed ?
 - where service is inefficient ?
 - where service is ineffective ?
- (2) Can we change
 - the medical value system ?
 - the nursing value system ?
 - the disease orientation ?
 - the educational focus ?
 - rigidity in planning health services ?
 - the isolation of health from other sectors ?
 - priorities from individual to community health ?
 - the low status of providers of direct nursing care ?
- (3) Can we provide
 - motivation for community involvement ?
 - new models of nursing education ?
 - personal accountability for practice ?
 - effective coordination of resources for care ?
- (4) Can we remove barriers
 - to effective team leadership and function ?
 - to open communication ?
 - to continuity and cohesiveness within the health system ?
 - to full collaboration of national, international, governmental and nongovernmental agencies for health ?

The Committee was ready to accept these challenges and believed that nursing educators, administrators, and practitioners, once they were aware

of the situation, could, through their concerted efforts, make a dramatic impact on the present indefensible state of community health throughout the world and most particularly in the developing countries.

4. THE PROPOSAL

To provide guidance for those involved in implementing the changes necessary in nursing and the health care system in order to meet the challenges set forth, the Committee proposed the following areas where change is fundamental for sound progress.

4.1 Change in the conceptual framework

The scope and complexity of the health needs of populations and the limited impact of service and educational programmes in meeting these needs point to deficiencies in the underlying concepts of present health care. These concepts must undergo major changes in order to move away from traditional patterns, attitudes, and stereotyped services and to improve the results of nursing practice. The new or revised concepts should be based on :

(1) a health system encompassing the total population rather than focusing on limited groups such as hospitalized patients, self referrals, or other ready utilizers of available services. This broader coverage should be easily identified in all phases of the health programme, i.e., in the planning, provision, and evaluation of services. It would be demonstrated by the proportion of individuals and families served out of the total population (or the appropriate subgroup of the population). Breadth of coverage would not necessarily imply an even distribution of care, since special efforts would be made to protect the vulnerable groups within the total population.

(2) the acceptance of the community itself as the major determinant of health care, its members being stimulated to recognize and express their needs and expectations and to participate actively in the development, implementation, and evaluation of the health service and health educational programmes. The community should be encouraged to mobilize and to use all available resources in the development of health services, which should be so directed as to indicate that they are provided by, rather than for, the community. Thus, community selection of health workers (particularly primary health workers) and of people involved in volunteer services and related activities should be encouraged and respected.

(3) the possibility that community health may be approached other than through an organized health system. The approach should be made through whatever social activity is most significant to the community at its given stage of development. Thus, if health does not have priority, the health worker should first help the community to achieve its other aspirations. The resources generated by such activities and the confidence won by the health worker in participating in them will greatly assist in the creation of a health service. Moreover, other activities frequently have a health component, which the health worker can promote to the maximum extent.

(4) the development of nursing as a system of care rather than as a specialized occupation. Such a system would include the spectrum of health care functions from intuition to expertise. It would comprise members of the community, primary health workers, community health nurses and midwives, teachers, clinical specialists, administrators, and research workers. Between all these people there should be a continuous exchange of views and experience.

(5) the philosophy that people in a community have a potential for continued individual development and are capable of dealing with most of their own problems if they are given health education and encouraged by example. This philosophy is in direct contrast with traditional concepts in which health services are imposed on the community and operate through the medium of health professionals who are not involved in the community, thus creating a feeling of dependency in the people served.

(6) the need to construct nursing educational programmes that embrace all aspects of human life (biological, socioeconomic, and cultural) and that are intimately related to community needs and health practice. Such programmes would compel faculties to train and examine students in a practical setting and would require both teachers and students to cope with the problems of providing health care in a real community. It would also place on them the responsibility for implementing changes in the health and health behaviour of groups.

4.2 Change in nursing education

The implementation of the above concepts will necessitate major changes in nursing education and service. The inferences for nursing education go beyond modifications in technical content or methods of teaching. They call for basic changes in the theory of nursing coupled with the reformulation of curricula, the reshaping of methods and concepts of learning, and the redefinition of the roles of all persons involved according to the functions that they will perform. These changes should be aimed at achieving :

(1) a curriculum that is people-oriented not institution-centred and that emphasizes health rather than disease. Such a curriculum would produce graduates with knowledge of the basic and behavioural sciences, with clinical skill in diagnosing illness and other deviations from health, both physical and emotional, and with the ability to prescribe preventive, curative, and rehabilitative therapy. The graduate nurse would be able to adapt health care to the family and community setting, using medical and other referral services for the greatest benefit to patient and family.

(2) a reversal of traditional nursing education, starting with healthy families in their social and community life, moving to the development of disease, disability and social dysfunction, and so to treatment, cure and rehabilitation.

(3) the participation of students and faculty in community health through the examination of health needs and through working with the community in planning and providing health care, analysing its effects, and studying ways of improving the pattern of care.

(4) opportunities for students to understand community life, its manner of functioning, and the effects of this on health or illness within the population. Given such opportunities, students would learn from a number of experiences of varying complexity among different social and cultural groups in their natural environments. They would also learn to work competently with others, to develop self-reliance in themselves and to encourage this quality in others and in the community.

(5) the imparting to students of a knowledge of life processes, which would enlarge their understanding of human life in general, of value systems, and of society's formal and informal support mechanisms.

(6) a fundamental orientation of the student towards a dynamic conception of life and human relationships, in which disease and hospital care are regarded as mere episodes within the life span.

4.3 Change in nursing services

The implementation of a community approach to the provision of community nursing services calls for a change in basic attitudes on the part of many health workers. There is need to change traditional modes of thinking in regard to the providers and recipients of care, to alter long-lasting habits in the provision of care, to stimulate new thinking among health administrators, and to substitute flexibility for fixed notions of community health. More specifically, these changed concepts of community health require :

(1) a commitment to the accountability of the nursing service for the effective and efficient provision of basic health services including preventive, diagnostic, therapeutic, and rehabilitative care in all communities and for all populations. It is necessary to move aggressively towards this goal.

(2) the adaptation of the health services to the health needs and operating social systems of the community. Such adaptation must, of course, be commensurate with the resources of the health service and the level of social development of the community.

(3) the development of a community orientation that takes account of the various social strata and of the different ways in which the members of those strata cope with health problems. Nurses must help the community and its subgroups to assess their health needs, determine priorities, and establish realistic objectives.

(4) the sharing of responsibility between the nursing service, the community, and health educational institutions for the selection, preparation, and appropriate utilization of health personnel at all levels and areas of function, the recognition of the individual needs and strengths of staff, and the promotion of career mobility. This sharing of responsibility would demonstrate the interdependence of service and education.

(5) the enlargement of the pool of personnel available to supplement nursing services by the inclusion of indigenous groups. These groups should be properly trained and should work under the direction and supervision of the nursing service.

(6) the active promotion of community self-help in all aspects of its social structure (e.g., educational, legislative, and industrial).

5. APPROACHES TO STRENGTHENING COMMUNITY HEALTH NURSING

Each country and each community must decide for itself what methods can be used and what steps can be taken to develop a sound, vigorous, and effective health programme. Therefore it was considered pointless and inappropriate for the Committee to describe ways of implementing the concepts it had advanced for the improvement of nursing in the community health care system in local, national, or world settings. The Committee did, however, describe the fundamental characteristics of a community nursing service as the encompassing of the whole community with

a system of basic health care, the services being so organized as to ensure continuous, comprehensive, coordinated, accessible, and relevant services to all.

In addition, the Committee considered a variety of suggestions for strengthening community nursing services. These suggestions dealt with the expansion of health manpower resources, concomitant changes in roles and functions of personnel, the educational implications, and evaluation processes.

5.1 Expansion of manpower resources for community health

The provision of primary health care for all segments of the population is perhaps the most crucial health problem of most communities of the world today. Various attempts have been made to cope with this problem. In developed countries primary health care is provided by physicians, dentists, nurses, physiotherapists, and similar health professionals. In response to the increasing need for primary care, schools preparing these professionals are expanding enrolments, new schools are being established, and all groups, especially nurses, are being prepared to extend their roles in providing diagnostic and therapeutic care.

In the developing countries, where the problem is excessive and resources sparse, other approaches are being taken. Indigenous healers, village health workers, birth attendants, and similar groups within the community are looked to for health care. These lay personnel, in the role of primary health workers, provide the first contact with the community at the peripheral level. They carry out simple curative functions and "front-line" measures for the protection and promotion of health.

Although these primary health workers have arisen out of a critical need of populations for primary health care, they are often not included in the health care delivery system of the country. Consequently they lack proper training, supervision, and support and the essential referral or backup system is not available to them. In spite of these handicaps they have shown their potential for supplementing health resources in their communities.

To the problem of providing health care services to the millions of people who are not at present covered, the promotion of primary health care workers—members of the community trained within the community, and supported by it—offers a realistic and effective solution, especially in rural and peripheral communities. But in order to guide and supervise their activities and to increase their efficiency and effectiveness primary health workers must be recognized and integrated into the health care system of the country. Because their functions are among those provided by nursing

services, the inclusion of the primary health worker in the community nursing system is not only logical but essential to ensure the safe and appropriate care of the populations served. This means that the community health nurse will have to assume responsibility for the training of primary health workers, for helping them to develop the necessary health services, for providing the support needed, and for serving as the link between the primary worker and the rest of the health system.

If the primary health worker is responsible for giving direct health care to communities in the areas of communicable disease control, maternity care, child health, the treatment of common diseases, and home and village sanitation (alone or in conjunction with other personnel), the role and function of the community health nurse also will have to change.

5.2 Changes in roles and functions of nursing personnel

Each country and each community within the country is encouraged to develop its pattern of community nursing services in accordance with its unique needs and available resources. However, all workers included in this service pattern should be part of the total nursing system of the country and of the community health nursing system in particular. Similarly, the classification of personnel within the nursing system depends on the local situation and on the national development plan for health manpower. In most countries at least three levels of function are reflected in personnel classification systems—the local or peripheral level at which direct care is given to the community, the intermediate level at which guidance and supervision are given to local staff, and the central or administrative level at which overall direction, consultation, and managerial support are provided for the total community health programme. These three distinct groups of nursing personnel are interdependent and their functions interrelated. It should be emphasized that all personnel are involved in decision-making and in the implementation of services but with varying degrees of programme responsibility.

The scope of functions of each group depend on the size and complexity of the community, the number and preparation of personnel, the public acceptance of and policy regulations governing health practice, and the organizational health structure. As an example, a general description of a few representative community health nursing functions at the peripheral level is given below.^a These functions might be provided by primary health workers, family health visitors, and/or community health nurses.

^a Asterisks against a number of these functions indicate that the peripheral health worker may be aided by others, including, for instance, patients, family members, other health and non-health workers or community representatives.

Nursing process

Peripheral level functions

Assessment	Participates * in the examination of individual, family, and community health states and health behaviours, including the knowledge, attitudes, and perceptions of groups regarding health and illness. Describes and analyses resources available and patterns of utilization.
Problem identification	In accordance with the assessment process, identifies * health problems in individuals, families, and community groups, determines basis for each problem, and draws inferences for appropriate nursing action. Points out gaps or deficiencies in community resources and assists in developing plans to meet these needs. Develops * service priorities and plans for intervention based on above analysis, community expectations, and accepted standards of practice.
Implementation	Implements * the "agreed upon" services to individuals, families, and community groups which may include: direct therapeutic and curative care; health education; the planning of care with family members; referral to appropriate service or health professionals; case-finding; instruction and services to high risk groups; community health promotion and health education; and establishments of needed resources. Develops * specific activities for promotion and general maintenance of health which may include: demonstrations in home gardening, water purification, the building of wells, and the safe disposal of wastes; and the development of individual, family, and community competence to cope with and to take responsibility for their health needs.
Evaluation	Develops * service objectives in terms of problems identified above; determines measures to be used to reflect attainment of objectives and of safety and quality of care; ensures that necessary evaluative data are collected accurately and systematically; monitors health services for desired quality; analyses the results of service in relation to the proportion of population served and programme objectives reached.

In order to attain the goal of community health services for all, major changes within the present roles of all health personnel are essential. As indicated in section 5.1, with the greater use of indigenous groups as health manpower resources and the delegation of many services traditionally performed by nurses, physicians, health educators, and others to this group, there will have to be a marked upward shift at all other levels of responsibility.

Perhaps the most dramatic change in the roles and functions of community health nurses will be seen in the additional diagnostic and therapeutic responsibilities required of them. First, they will be expected to teach primary health workers many of the functions traditionally performed by

nurses and guide these new personnel in case-finding, disease prevention, patient and family care, community programme development, health education, and curative and related functions. An even more demanding responsibility of the community nurse will be the fulfilment of roles usually ascribed to general medical practitioners. These include examining the sick and disabled, determining the source of the problems presented, and treating acute conditions as well as the major prevalent diseases in the community. As the nurse becomes more competent in these and associated nursing skills, her role as teacher, supporter, and consultant of the primary health worker will also expand.

Throughout this pattern of care, the community health nurse is seen as a generalist, able to work in a team, to teach and encourage other health workers, to communicate with and motivate population groups, and to interrelate community nursing with other systems. Since leadership of the team is determined by the nature of the presenting problem and not by professional status, the community nurse is expected to be able to provide team leadership but also to share the leadership role with the primary health worker, health educator, agriculturist, or other team member, depending on the area of concern and major functions to be carried out.

Fundamental to this plan and to the provision of safe, appropriate, effective, and efficient community health services is a dependable referral and support system at every level of function. Thus the primary health worker needs the direction, supervision, guidance, and assistance of a competent, readily available community health nurse. The community health nurse similarly needs the support of medical referral services to examine and treat patients and families with unusual or complicated conditions. Advisers, consultants, and clinical experts in other fields will also be needed to review programme plans, analyse presenting problems, assist in evaluation procedures, and recommend possible approaches for improving services in the community.

The administrator of nursing services also needs support—from experts in administration, community planning, and programme analysis, from behavioural scientists, educators, and clinical specialists, and from many other peer groups. Such assistance is necessary to maintain high quality programming in all aspects of service throughout the community nursing structure.

Implementation of health programmes with role formulation and staff development along these lines is envisaged as having a far reaching effect, resulting in the extension and strengthening of health services to all groups.

5.3 Implications for nursing education

Directors of schools of nursing and their faculties will be required to translate the new concepts of community nursing into action. The educational system will need to be reorganized so that learning starts in the community, a process that will help students to understand the working of community life, the nature of social structures, and the contribution of each to individual, family, and community function. Nursing education must emphasize health, the process of normal growth and development, and those individual, familial, and social forces that promote health as well as those that cause deviations from health. Educational objectives will have to be redefined to respond to community needs and health aspirations.

The unqualified acceptance of community nursing as the foundation of all nursing practice is implicit in the new concepts. This kind of preparation will thus be seen as essential for all nurses, and curricula should be revised accordingly. Care of the sick at home, following the development of skills in health maintenance and disease prevention, prepares the student for care of the sick in hospitals and other institutions. From this logical sequential pattern of learning, students understand why the sick behave as they do, why they become sick, and what factors influence their return to health. They gain knowledge of various styles of home life, of values, behaviours, and environmental influences, and of variations among social strata. Such experiences will guide students in nursing hospitalized patients and help to close the gap between hospital care and family and community life.

Developing curricula in which basic learning occurs in a practical setting is another test of faculty ingenuity. The broad base of primary health care is the area in which most effort will be required. The development of community practice sites, the adaptation of content and educational methods to the wide variety of persons to be trained as primary health workers, and the construction of a programme that provides the scope and quality of learning experiences desired all demand keen imagination and innovation.

But perhaps the most difficult aspect of the Committee's proposal for nursing educators is the essential expansion of programmes to prepare the numbers and types of nurses required and in as short a time as possible. This means that every graduate nurse must be prepared to teach other nursing and health personnel. A great many teachers are needed to instruct primary health workers, others to prepare all nurses in community health, and still others to teach specialities such as clinical subjects, hospital care, administration, and research. To reverse the diagram shown in Fig. 1 (page 13) and to align nursing service with health care needs will call for a

vast expansion and profound reorientation of education. At the same time such changes offer an opportunity for nursing to make an unprecedented impact on world health and the delivery of health care.

5.4 Evaluation

In line with its proposed new concepts and approaches to community nursing, the Committee considered various mechanisms of programme evaluation and made suggestions concerning basic elements to be included in the evaluation process.

Evaluation is seen as an integral part of the community health nursing programme at every level of care. It is as important to the work of the primary care worker and community health nurse at local and peripheral levels as it is to the administrator and health planner at the central level.

Just as communities need to be involved in setting their goals for community health services, in determining priorities, and in outlining plans of action, so must they be involved in the assessment of these services. In this way the people of the community not only share in planning and implementing their health care system but are an important force in assessing the quality of care and the type of services provided, in identifying the successes and failures, and in planning corrective actions as indicated.

The assessment of services depends first of all on drawing up rational objectives of health care and developing methods of determining the quality, safety, and appropriateness of care. This preliminary work should be done by the community itself, with the assistance of technical health personnel. Technical assistance is important since goals decided on by the community alone might be too limited to ensure optimum community health. Once the objectives have been formulated, it is possible to select methods of measuring the extent to which they are being met and to develop ways of collecting the necessary information. The jointly reached objectives and their rationale should be communicated to the administrative centre of the health service, which can ensure self-consistency in the subsequent collection, reporting, and analysis of evaluative data. When applied in various districts, this procedure also helps to ensure the collection of comparable data, which are needed for describing the health status of the country as a whole. The overall picture thus obtained helps the government to determine national priorities and the allocation of resources for health.

The strengthening of health services requires a knowledge of the major health problems and patterns of care in the community, in major subgroups of the population, and in groups at high risk. This information provides a baseline for determining the extent of the need and for guiding the community and technical health planners in developing the community prog-

ramme. Through the systematic periodic collection of these data it is possible to examine the effects of the health programme in moving toward community goals. It is also possible to determine the efficiency of the programme by analysing costs in terms of community utilization of service and in terms of programme effectiveness. Changes can then be made in the light of these analyses.

Measures have been suggested for evaluating the need for and the effectiveness of basic health services throughout the world. They include population coverage, immunization status, individual growth and development, nutritional status, disability, selected morbidity and mortality rates, and consumer utilization of services.^a

All these measures provide some evidence of the need for community health care and, analysed over time, show the changes in the health status of populations. They therefore give clues to the effects of health services in concert with other influences—social, biological, and environmental.

Population coverage is an important index that has been poorly collected and reported in the past. It is a basic index of the extent to which services are actually reaching those groups in need and for whom they are intended. The Committee agreed that it will be of even greater importance to community health nursing programmes in the future, for it will provide the one essential measure of the degree of progress attained in the provision of health services to all communities.

6. RECOMMENDATIONS

The Committee recognized the urgency of the health needs and lack of health services in communities throughout the world and recommended that the following plans of action be made to bring about the necessary changes as rapidly as possible.

(1) Decisions should be taken to initiate and further develop community health nursing services that are responsive to the needs of the community, encompass primary health coverage for all the population, and provide assurance of the safety and appropriateness of the services rendered.

In order to implement this recommendation, it will be necessary to :

(a) establish an organized nursing service within the context of community health with joint participation of community and health groups.

^a See: *WHO Chronicle*, 27 : 333 (1973).

- (b) incorporate the primary health worker into the nursing and health care system.
- (c) develop the community health nurse as a provider of primary health care and as the first level of support of the primary health worker.
- (d) provide preventive, therapeutic, and rehabilitative care based on a family-centred approach.
- (e) organize a system of support that includes referral for specialized services and consultation, educational guidance of health workers at all levels, and administrative planning and evaluation.
- (f) coordinate community health nursing with the other community development programmes.
- (g) establish mechanisms to ensure the safety and appropriateness of health care, these mechanisms being based on community participation combined with technical health service judgements.
- (h) make available the best-prepared community nursing personnel for service in the community.

(2) Nursing educational programmes should be developed that make community health the central objective of basic and continuing preparation. This may be implemented through :

- (a) the development of community-based extramural nursing educational programmes.
- (b) a curriculum focused on life processes with emphasis on health, physical and mental development, and illness, on meeting the needs and demands of populations, and on the principles of behavioural change.
- (c) the preparation of nurses in the biological and behavioural sciences and in diagnostic and therapeutic processes, which are necessary for teaching and guiding primary health workers.
- (d) the preparation of community-selected primary health workers through learning cycles built upon their potential and related to community health needs.
- (e) the recruitment of students and teachers from the area in which they will work. The teachers selected from the community should have the widest possible diversity of skills, knowledge, and experience.
- (f) the preparation of nurses and others to develop and guide primary health workers.
- (g) the provision of appropriate, dynamic, continuing education for all levels of health workers contributing to community nursing.

(3) Health manpower, of which nursing manpower is a part, should be developed within overall national development plans. These plans should reflect a rational distribution and utilization of personnel to provide community health coverage and essential support systems in the light of present and projected needs.

(4) Health care is a component of social policy. Therefore :

(a) health policies and legal and professional constraints that have a deterrent effect on health care should be reviewed by the communities involved and by their health workers and steps taken to remove these constraints.

(b) policies and goals of service and education should be guided by continuing cooperative relationships between representatives from the community, service institutions, educational programmes, and professional groups.

(5) WHO should :

(a) try to promote the acceptance of the concepts of community health nursing by Member States and should stimulate and assist in the development of programmes for training primary health workers to meet the needs of individual countries. In these tasks nurses should play a prominent role.

(b) promote and assist educational programmes for preparing a cadre of nurses and others to develop and guide community health workers at all levels.

(c) make available information on innovative approaches to community programmes and their impact on health and suggest adaptations where necessary for national needs.

(d) promote the further development of the work begun by the Expert Committee on Community Health Nursing towards the effective realization and implementation of the new concepts, ideas, and orientations involving the whole range of health professionals and the health system.