

Informal Consultation on Community Health Nursing: China



Hong Kong (China)
4–6 August 2009

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REPORT

INFORMAL CONSULTATION
ON COMMUNITY HEALTH NURSING: CHINA

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NOTE

The views expressed in this report are those of the participants in the Informal Consultation on Community Health Nursing: China and do not necessarily reflect the policies of the Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for governments of Member States in the Western Pacific Region and for those who participated in the Informal Consultation on Community Health Nursing: China, which was held in Hong Kong (China) from 4 to 6 August 2009.

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1. INTRODUCTION

An Informal Consultation on Community Health Nursing: China was held in Stanley, Hong Kong (China) from 4 to 6 August 2009. The consultation was co-planned by the Ministry of Health, China; the WHO Regional Office for the Western Pacific; the WHO Representative Office in China; the WHO Collaborating Centre for Community Health Services at The Hong Kong Polytechnic University School of Nursing; the WHO Collaborating Centre for International Nursing Development in Primary Health Care at the College of Nursing, University of Illinois at Chicago; and the Maryknoll China Service Project. The informal consultation was intended to provide a forum for nurses, health leaders and partner stakeholders to discuss community health nursing (CHN) in China, lessons learnt and innovative approaches to education and service delivery, and to plan and take steps to fully equip nurses in China to deliver primary health care or community health nursing services in an accessible, effective and quality manner.

Nursing is recognized as a crucial service for the delivery of primary health care (PHC). "Globally, nurses constitute the majority of the health service workforce and make a significant contribution to delivery of health care in a wide range of environments, particularly in hospitals and primary health care settings."¹ Nursing education is focused on improving population health and health outcomes. By necessity, it concentrates not only on the production of adequate numbers of nurses, but more importantly, on preparing professionals with broad outlooks and skills needed to address the rapidly changing and emerging complex public health challenges. The broad foundation for a PHC curriculum is inclusive of the principles of PHC, namely: appropriate technology, patient involvement, community participation and empowerment, intersectoral collaboration, health promotion and prevention, continuity of care across the continuum of care, and serving disadvantaged, remote and vulnerable populations.

As China continues to reform its health service and health financing systems, there are increasing opportunities to develop urban and rural multidisciplinary health service provision teams, inclusive of physicians, nurses, nurse practitioners, midwives and pharmacists, to best meet community health needs. The principles of PHC offer opportunities to develop models of improved health service delivery, placing stronger emphasis on equitable and accessible health services and enabling nurses to increase their role in health and service delivery in the community and at home. Nurses are critical to the provision of comprehensive person-centred care and are quite capable of recognizing and addressing the impact of social determinants of health.

Essential components of PHC-oriented nursing and health professional education and service delivery are local governments, academe and community partnerships where service delivery takes equity into account. The delivery of such services requires concomitant policy, legislative and health financing support to bridge the health and education sectors and to address the recruitment and retention of PHC providers, including nurses and midwives at the PHC or community level.

¹ World Health Organization and Sigma Theta Tau Honor Society of Nursing. *Developing global standards for initial nursing and midwifery education*. Interim report of the proceedings. Geneva, 2005 (http://www.nursingsociety.org/aboutus/Documents/WHO_interim_report.pdf, accessed 25 February 2008).

The Informal Consultation on Community Health Nursing: China sought to build on the successes of an established network of partners, i.e. the China Nursing Leadership Initiative for HIV/AIDS Risk Reduction Programme,² by bringing the partners and key stakeholders together to discuss the context of primary health services in China and to prioritize strategies to maximize nursing contributions to improved population health outcomes through strengthened nursing and community health services.

1.1 Participants

The informal consultation was attended by 32 participants from China, including Hong Kong (China), the Philippines, the Republic of Korea, and the United States of America. A full list of participants is found in Annex 1.

1.2 Objectives

- (1) To review various documents, publications, data, institutional and survey reports of community health nursing, including selected models of service delivery in China to guide further strategic and action planning.
- (2) To identify community health nursing core competencies appropriate for nursing and population health needs in China.
- (3) To discuss and propose core curricular domains and accompanying teaching/learning methods for undergraduate and master's nursing programmes, including potential teacher training tools.
- (4) To formulate working groups and action plans for further operational research of CHN competencies; CHN teacher preparation tools and standards; and the formulation and testing of potential models of community nursing service delivery.

The meeting agenda is attached as Annex 2.

² The partnership, initiated in 2002–2003, consists of the Catholic Medical Mission Board (New York, the University of Illinois at Chicago/College of Nursing (UIC/CON), the Maryknoll China Service Project (Hong Kong), the Hong Kong AIDS Foundation, and the WHO Regional Office for the Western Pacific, in collaboration with the Chinese Nurses Association (Beijing), the Ministry of Health/Nursing Division (Beijing) and selected central and provincial university schools of nursing in China. During the programme, more than 2000 nurses underwent training in essential HIV/AIDS knowledge, attitudes, counselling and care. Further needs for palliative care and overall chronic care provision of services were identified during the course of the leadership programme.

2. PROCEEDINGS

2.1 Summary of sessions: Day 1, Tuesday, 4 August

Day 1: Getting to know one another – sharing and situational assessment

- Analysing preparation, resources, functions and service delivery options
- Introduction to competencies

2.1.1 Introductory remarks

The meeting commenced with welcoming and opening remarks by co-facilitators, Ms Kathleen Fritsch, WHO Western Pacific Regional Office; Ms Samantha Pang, The Hong Kong Polytechnic University; and Ms Guo Yanhong and Mr Liu Liqun, Ministry of Health, China.

Participants then introduced themselves and shared their expectations for the informal consultation. Ms Fritsch reviewed the intent of the community health nursing survey (Annex 3) as a preliminary situational analysis and announced the receipt of 12 completed surveys to date. The contents of the participant's folder were reviewed, noting the availability of PDF files for many of the readings. An overview of the readings made available for individuals and groups was provided. A list of references is attached as Annex 4.

2.1.2 Common issues and themes

Issues and themes noted during the meeting overview, introductions and sharing of expectations included the following:

- (1) reallocating resources to rural and remote areas – human resources and financing;
- (2) developing a community health nursing education and service delivery model that is consistent with Chinese values as well as social and political structures;
- (3) promoting universal access to services within the context of primary health care;
- (4) deciding what is needed for nurses to function and contribute fully to delivering health services to the most vulnerable members of Chinese society;
- (5) identifying what nurses can do at present and could do in the future and what nurses need to know to function in present and future roles;
- (7) describing the barriers to be overcome and regulatory frameworks needed;
- (8) linking service delivery needs to competencies and curricula;
- (9) planning the next steps and testing service delivery models; and

- (10) applying incentives (including those offered by communities) to keep nurses in the community.

2.1.3 National policy and planning frameworks

Ms Guo Yan Hong, Director of Nursing Services, Ministry of Health, China, described the national situation, including the development of integrated community health services in China, in the context of demographic and epidemiological trends, human resources for health and health reforms.

China, with a current population of 1.3 billion, has experienced slowed population growth rates and increased life expectancy. The urban population is 606 670 000, while the rural population is 721 350 000. The country has 19 712 hospitals and 1.65 million nurses (2008 data). The number of nurses has been increasing but remains less than the number of physicians. The majority of nurses are secondary nurses with less than three years of nursing education.

Common health problems include communicable diseases such as tuberculosis, HIV/AIDS (700 000 people were living with HIV in 2007), acute respiratory disease outbreaks, such as Pandemic (H1N1) 2009, as well as noncommunicable diseases (NCDs) including cancer, cardiovascular disease and chronic lung disease. Noncommunicable diseases account for 75% to 80% of all deaths. Disability adjusted life years (DALY's) also highlight NCDs as a major source of morbidity. China's ageing population poses significant health service and social challenges. Ongoing health reforms being implemented include:

- (1) medical insurance system expansions;
- (2) essential medicine lists and supply systems; and
- (3) primary health, public health and public hospital reforms, including four categories of medical insurance to cover all people, as well as a national essential drug system.

The National Nursing Development Plan aims: (1) to strengthen national health policies and plans to enhance the contribution of nurses to health outcomes; (2) to improve the quality and quantity of nurses in community facilities; (3) to strengthen health promotion including prevention as well as rehabilitation, chronic disease management and long-term care; and (4) to expand programmes in colleges and universities and ongoing training to strengthen the abilities of community health nurses to improve nursing services at community level.

Objectives of the Informal Consultation on Community Health Nursing consistent with the national nursing development plan are: (1) to establish a training packet for community nurses according to their requirements (in collaboration with partners, stakeholders, institutions and relevant units); (2) to implement a training-of-trainers course for participants from community health centres, which will serve as field-test sites, and for nursing colleges that have community nursing training programmes; and (3) to field-test community health nursing models in 10 pilot sites in different cities), to strengthen community health and nursing services.

Mr Liu Liqin, Deputy Director of Community Health Services, Ministry of Health, provided an overview of national health reforms and community health service strategic plans. Photographs of a newer community health centre in Beilin, Shaanxi Province as well as health

centres in Wuhan, Nanjing and Shanghai were shown, illustrating their general practice rooms, IV administration rooms, child health care examination rooms, waiting areas and traditional medicine services. The New Urban Health System was depicted as having two levels: (1) a community health level (community health centres, clinics, nursing homes, other facilities); and (2) associated general and specialty hospitals enabling transfers between levels. Health data from the community level are forwarded to the Center for Disease Control and Prevention and the Ministry of Health, as well as the Hygienic Supervision Centre. Presently, 752 cities have community health service (CHS) centres, with 21 895 CHS facilities (end of 2008).

Five key programmes of health reform were described. The first comprises a basic medical insurance scheme for urban employees and residents, a new rural cooperative medical scheme, and an urban-rural medical assistance system. The second involves the establishment of a National Essential Medicines System, including the issuance of a national essential drugs list, a fully supplied public grassroots health institutional system, and drug sales with no mark-up.

The third health reform programme is designed to strengthen grassroots-level health care institutions. Two thousand rural county hospitals, 2900 township hospitals, 3700 urban CHS facilities, and 11 000 health stations are scheduled for repairs or rebuilding. Training is required for 360 000 health care workers in township hospitals, 160 000 CHS workers, and 1.37 million village health workers. In 2009, 20 billion yuan were distributed by the central Government for health facility construction.

The fourth reform programme promotes equalization of basic public health services, as well as national public health services, through nine national public health programmes (including HIV, maternal and child health).

The fifth reform programme is targeted at public hospitals and includes the establishment of national public health services for all residents, health resident records, health education and health promotion. Targeted areas include child health care (0–3 years old); maternal health care (pregnant women and home visits for mothers and newborn infants); aged health care (65 years old and over); and disease control (immunizations, infectious disease control, NCD control, case management at community level, and mental health).

To ensure that such services are free of charge for all residents by 2009, 10.4 billion yuan have been distributed to local areas, including: (1) central Government areas: 15 yuan per person per year, which will increase to 20 yuan per annum by 2011; (2) western areas: 12 yuan per person (80% coverage by the central Government); (3) middle areas: 9 yuan per person (60% coverage by the central Government); and (4) eastern areas: different proportions covered by different provinces. Planned next steps include the development of guidelines for the national public health services, health workers training, and performance and impact evaluations.

The discussion following the national-level presentations covered a broad range of topics, including:

- (1) research, policy development and linkages with pilot sites;

- (2) building generations of community health teachers and nurse specialists within a framework of limited human resources for health at grassroots level and limited practical training;
- (3) training that supports improved quality and provision of better services – combining training programmes with service practice;
- (4) importance of nursing health assessment and decision-making skills for individuals, families and communities;
- (5) integration of service delivery skills and continuing education for health workers taking care of patients with HIV;
- (6) functions of nurses to enhance health – equipping them with new knowledge and skills focused on core competencies, including health promotion;
- (7) incentives to keep nurses in the community as well as necessary financing.
- (8) reimbursement of community health centre personnel for nine essential services to be provided free of charge; and
- (9) promotion of teamwork, interdisciplinary education, as well as communication and case management skills of doctors and nurses.

2.1.4 Provincial, institutional and service delivery interventions

2.1.4.1 Sichuan Province

Representatives from Sichuan Province addressed the development of community health nursing within the provincial context of 182 cities and counties and a multiethnic population of 81 million people, living within limited inhabitable land areas, resource allocation challenges and recurrent natural disasters, including earthquakes. Most of the 80 000 nurses (2008) in the province work in urban areas. Though the numbers of community health centres and nurses working in rural areas have increased, subsequent to national reform efforts, the number and educational and skill levels of peripheral nurses are still lower than nurses in urban areas. A problem analysis of community health nursing in Sichuan Province is presented in Table 1.

Table 1: Problem analysis of community health nursing in Sichuan Province

Issues	Solutions and/or answers	Outcomes and/or benefits
Uneven distribution of resources		
Capacity-building		
Issues related to the 2008 earthquake	<ul style="list-style-type: none"> ○ Training on how to help victims of trauma from the earthquake: clear purpose; partnerships with local and international experts; relevance of the training ○ Partnership with a university for research: community health needs assessment → health self-management kits (activities), health promotion strategies ○ Telehealth network covering 10 provinces serving 10 million people 	<ul style="list-style-type: none"> ○ Rich experience gained on integrating resources (human, financial, teaching) from the training and from the 2004 HIV/AIDS training ○ Needs of residents met

Sichuan Province health leaders have been encouraged by the improvements and developments in the health care system and plan to focus interventions on the establishment of community health service centres that meet the needs of the people, including the rebuilding of communities and hospitals post-earthquake, in partnership with local officials. The existing online educational offerings serve a variety of personnel in remote areas. China West University has plans to continue teaching community health nursing, to develop model sites for learning and to provide relevant continuing education.

2.1.4.2 Shandong Province

Shandong Province community health services are delivered through CHS centres affiliated with hospitals, serving about 2 493 700 (97% of target population) urban residents. The vulnerabilities and needs of the population served include:

- (1) unhealthy lifestyles and lack of knowledge;
- (2) need for disease prevention and health promotion;
- (3) maternal and child health service needs;
- (4) basic nursing care delivery; and
- (5) health education.

The Shandong University's undergraduate nursing programme is 36 credit hours, inclusive of two credits of compulsory community health nursing and a two-week community nursing practicum in the fifth year. An assessment carried out to consider the potential of piloting a family health nurse (FHN) service provision model indicated that there was no difference in job satisfaction between hospital nurses and community health centre nurses. An FHN model may better serve rural areas, in which there is demand for health education, intravenous therapy and intramuscular injections as well as individual support, parenting guidance, immunizations,

symptom control, physical exercise and physical therapy, medication guidelines for chronic disease management and support for those with disabilities. Such a model would require referrals and support from hospitals, changes in perception of community health nursing, strengthened nursing competencies and capabilities, policy guidelines for appropriate use of injections, as well as strong and sustained governmental support. A discussion following the presentation highlighted issues surrounding: the use of non-licensed practitioners such as nursing aides serving families; whether there is a concern for health worker safety in rural areas; how to build capacities of personnel at peripheral levels while facing a skill-mix of greater numbers of doctors than nurses; and whether the government policy directions will address bringing nurses to village level or not.

2.1.4.3 *Hong Kong (China)*

Ms Adela Lai addressed community health nursing in Hong Kong (China) and the various avenues of service delivery, e.g. through the Hong Kong Hospital Authority, the Department of Health, and via public and private agencies. Community health nursing in Hong Kong (China) focuses on prevention, health maintenance and recovery. Community-based nursing services provided by the Hospital Authority are linked to hospitals and focused on transitional care and support for discharged patients, with support from general practitioners and outpatient departments. Services are focused often on wound care, nasogastric tubes and feeding and urinary catheter care. The typical nurse's caseload is approximately 36 cases per month.

Vulnerable aspects of existing services include:

- (1) compartmentalization – separate areas, separate services, no integration;
- (2) disease focus;
- (3) lack of good indicators for community health nursing;
- (4) little human resource growth despite demands;
- (5) lack of leadership in terms of vision and commitment;
- (6) no information-sharing among stakeholders – no system for such communication;
- (7) weak funding/support/collaboration; and
- (8) poor working conditions → safety hazards.

In the face of a growing population with multiple chronic conditions, home care services and community call centres or nursing clinics have been instituted as well as the strengthening of community-based nursing services for medical-surgical and psychiatric clients.

A family health nurse model, based on a nurse and social worker managing a whole village and community health centre, has been piloted. Community resources were integrated to develop a "help network" to empower clients and families in becoming self-reliant. Outcomes of the pilot project include the following:

- (1) community resource bank: community members help each other;

- (2) nursing clinics: problems are solved at nursing clinic level;
- (3) volunteers partnered with patient support groups;
- (4) shortened hospital stays and fewer admissions to emergency departments; and
- (6) patients are not charged.

Lessons learnt for future CHN service interventions:

- (1) Be active in fulfilling the roles of a community health nurse.
- (2) Hospitals should be the ones to develop care protocols.
- (3) Nurses should have visionary leadership – smooth out politics.
- (4) Strategic partners are needed to mobilize resources.
- (5) Common platforms of action are necessary.
- (6) Measurement indicators as a basis for evaluation are needed.
- (7) Sustainable organizational development is required.

Future directions in Hong Kong (China) are envisioned as "service without boundaries" with core areas of emphasis on health maintenance and self-care; intensive and specialty care in the home; elderly care and support for the disabled.

2.1.4.4 Qingxin County, Quingyuan City

Mr Paula Choy presented on a community health nursing test model in Qingxin County, Quingyuan City, a resettlement area of 70 000 persons. As part of the pilot project, general and speciality nurses were trained to work independently in a nurse-led community health centre. The CHC was opened 1.5 years after the training of nurses, with supportive field supervision. The CHC is now a practical training site that offers the following core services:

- (1) health counselling;
- (2) health maintenance programmes;
- (3) infant and child health programmes;
- (4) school health programme based on WHO's Healthy School Programme;
- (5) health education programmes;
- (6) home care services; and
- (7) rehabilitation programmes.

Local government officials recognized a need for a community health centre and took action. Financial support was made available through a nongovernmental organization and hospital funding. As a result of the project, nurses have gained respect, recognition and trust from doctors, patients and clients in the community. Outcomes noted included:

- (1) mindset of nurses changing from healing diseases to preventing diseases;
- (2) decrease in hospital readmission rates; and
- (3) introduction of a seamless health care concept, i.e. a hospital without walls.

The project's success was felt to be related to the nurses' energy and love of the job, as well as their strengthened capacity for health assessment, decision-making and clinical reasoning. No longer were the nurses following doctors' orders because of limited assessment skills.

2.1.4.5 Henan Province

Community service interventions in Henan Province were described by Qin Bai. Of the province's 98.69 million people, 86% are covered by a network of community health service centres and stations, and 92% are participating in the Cooperative Insurance Scheme. Strategies to strengthen community health services have included:

- (1) establishing health data;
- (2) preparing community health workers;
- (3) promoting health literacy of the residents;
- (4) encouraging second-level hospitals to take care of the community, together with the establishment of community health services;
- (5) developing practice standards by the Health Bureau; and
- (6) building capacity of rural community health workers including graduate and postgraduate training.

Results have included increased access to health services as well as noted needs to improve community health service functions through quality improvement, improved health education and the raising of nursing academic levels. Core service areas are: emergency care, home visits, family nursing, family medical services, transfer of services, rehabilitation, mental health care, and maternal and reproductive health care, including counselling, family planning services.

2.1.4.5 Human resources for health in China

Professor Li Ming Yoo presented the human resources for health situation in China, as it pertains to nursing, based on health workforce collaborative research studies with Dr Linda Aikin supported by the China Medical Board. At present, most nurses enter the workforce from secondary-level nursing programmes and 55% of those taking the licensure examination pass

annually. By 2020, it is projected that there will be 4 million nurses, 2.4 million of whom will be in communities. Results from the research studies indicate:

- (1) some nursing programmes recruit too many students, possibly jeopardizing the quality of education;
- (2) the majority of graduates are diploma nurses;
- (3) graduates have difficulty in finding jobs as nurses;
- (4) the nursing workforce is young overall;
- (5) the level of education does not meet society's needs;
- (6) improved levels of nursing education are required; and
- (7) work conditions affect nurse as well as patient outcomes.

Factors noted as affecting the 'nursing shortage' included: some graduates not taking the licensure examination or failing the exam; entrance into other professions after graduation; a high dependence on and high turnover of contract nurses; and a high production of nurses without meeting service needs. Emphasis was placed on the need to improve the status of nurses and to apply incentives for this purpose and to further retention.

Day 1 concluded with reflections by participants on the consultation.

2.2 Summary of sessions: Day 2, Wednesday, 5 August

Day 2: Situational assessment, continued

- Analysing preparation, resources, functions and service delivery options
- Introduction to competencies

2.2.1 Summary of Day 1

Ms Fritsch summarized the discussions of Day 1 on health reforms, nursing strategies, and epidemiological scanning, which served as a backdrop for the upcoming work. Many questions remained about how to increase access to health services while reducing out-of-pocket expenses in community settings and homes and what strategies are needed to move community nursing forward.

2.2.2 Preliminary results: questionnaire for the development of integrated community health nursing services in China (Annex 3)

Mr Gabe Culbert summarized the data analysis of 12 surveys received from seven provinces in China, including Hong Kong (China). In mainland China, patients usually come to CHS centres, health stations and private clinics – whereas in Hong Kong (China), home visits are made by community nursing staff from health stations.

The roles of community health nurses were reportedly diverse, ranging from director and manager to nurse and educator. Future roles envisioned showed much more diverse settings and

roles. Issues identified included staffing levels, quality and training, salaries, transportation and resident trust and confidence.

Nine respondents stated that community health nursing was offered in universities at undergraduate level, with five respondents also describing graduate-level CHN education. The length of courses in China varied from 36 hours to 48 hours in classroom/clinics/practicum. Content also varied, e.g. health assessment, health promotion. The usual teaching methodologies were cited. Minimum course completion criteria varied across the country.

One fourth of respondents were dissatisfied with courses and indicated that:

- (1) courses needed to be adapted to local community needs.
- (2) learning objectives and outcomes needed to be more explicit;
- (3) community clinical sites and learning experiences needed to be set up; and
- (4) roles and job descriptions for community health nurses needed to be clarified.

Respondents, when asked to list the five most important health and/or development needs requiring more attention in communities, frequently listed mental health and palliative care.

A rich listing of knowledge/skills/attitudes required for community health nursing was obtained. The list of student evaluation criteria included problem-solving skills. Respondents also discussed the resources and issues for teaching community health nursing in their region, including student availability, budgets, policies, textbooks, Internet access, community health centres, learning laboratories, partnerships with other schools of nursing and ongoing and special projects. More coordination between educators and workers was felt to be needed. Nine respondents described partnerships to facilitate curriculum development or student learning activities as being in place. All participants said there were plans to build capacity in community health nursing in their region.

2.2.3 Community health nursing in the Republic of Korea

According to Prof Il Young Yoo, Yonsei University, primary health care has been on the country's agenda since the early 1980s. However, due to difficulties in recruiting physicians to run clinics, community health nurse practitioners (CHNPs) started providing PHC in remote fishing and farming areas in the Republic of Korea. Nurse practitioner training took place from 1981 to 1986 and has been repeated on an "as needed" basis. In 1994, CHNPs became permanent government workers. Today, there are more than 1900 CHNPs.

The CHNP curriculum comprises 24 weeks of training of registered, experienced nurses. The curriculum includes 312 theoretical hours; 12 weeks of clinical practicum at hospitals, clinics, nurse midwife offices and well-baby clinics; and a four-week internship at community health centres or posts. The course includes health education and promotion, coaching, management and administration, as well as health service quality improvement. CHNPs need to attend twice-yearly mandatory continuing education sessions. Yonsei University is currently the only university providing CHNP training.

Community health nurse practitioners in the Republic of Korea now focus on health promotion and primary health care. Nurses run the community health centres. Clear job descriptions are given – an absolutely vital component of human resources for health management. Their functions include the assessment and diagnosis of illnesses and diseases, management and treatment, prescription rights, referral and transport of patients to larger centres, trauma and emergency care, management of chronic illness, medication, immunization, family planning and normal delivery. Health promotion activities include healthy lifestyle promotion, water safety and nutrition. CHNPs are on call for 24 hours. They carry out home visits, assess community needs and set priorities, collaborate with community councils, and lobby for financial support for community health and development.

CHNPs have been extremely successful and are recognized as highly effective practitioners in the Republic of Korea. Their scope of practice and roles was established from the beginning. Incentives and high job satisfaction are in part due to their permanent government positions. Prof Petrini mentioned that nurses in Samoa provide all medical care outside of the cities using the same model as the Republic of Korea; additionally, in Cook Islands, CHNPs on outer islands also provide dental services.

2.2.4 *Community health nursing education at Xian Jiaotong University*

Professor Li Xiao Mei, the university's dean, explained that funding from the China Medical Board has enabled the establishment of two levels of community health nursing education, i.e. master's degree and certificate programme, developed with the assistance of the Ministry of Health, the University of Illinois Chicago (UIC), the China Nurses Association and WHO.

The three-year master's degree, which is covered in six semesters with the thesis carried out during the last semester, is aimed towards production of community nurse managers. The one-year certificate programme, meanwhile, helps registered nurses to function in the community. Teaching is combined with practice in the community, emphasizing the management of care for families and communities, learning by reflection and doing. The initial programme cycle included three courses taught by UIC faculty; eight community centres were used for practice. Sharing of resources occurred with faculty members of 27 other universities teaching in the programme. They have found that learning by reflection and doing is more important than learning by lectures and knowledge acquisition only. The university expressed hopes that the Ministry of Health would choose their city as the site of a pilot programme in community services. The presentation concluded with a lively discussion of the uptake of programme graduates into community nursing positions and the mismatch between production and service uptake.

2.2.5 *Competency-based curriculum at the University of the Philippines (UP) College of Nursing*

Jeremiah Carlo Alejo, an instructor at the university, described the development of UP's four-year undergraduate, bachelor's degree nursing programme, including curricular planning and mapping, within the country's health system, which includes village volunteers, nurses, midwives and doctors. The four developmental stages of programme formulation included:

- (1) work-setting scenario analysis, including identification of roles, responsibilities and appropriate learning experiences;

- (2) identification of professional roles and competencies;
- (3) translation of professional competencies to student competencies – terminal and course competencies; and
- (4) development of instructional plans and design of evaluation tools.

The programme's various courses/content/concepts that focused on health promotion and health evaluation were described, including links to established competencies and methods of competency achievement and evaluation. Photos illustrated students working in communities. An example of how tobacco-control competencies were incorporated into the curriculum was provided.

2.2.6 Integrating palliative care into community health

Dr Jeannine Forrest described the development of an across-the-lifespan palliative care certificate programme for nurse practitioners, and her teaching of palliative care to a wide variety of people in community aged care homes. The goals of palliative care include realization that death is a normal part of life. Also described were the differences between palliative care and hospice care. Palliative care starts from diagnosis, whereas hospice care (or end-of-life care) starts about six months before death. The key aspects of palliative care education and service provision were described as well as palliative care in the community and the outcomes that can be achieved. Many, if not most, palliative care programmes are run by nurses. The presentation included resources needed and available when providing such care, and what is involved in good practice.

2.2.7 HIV/AIDS palliative care in the community

Dr Marcia Petrini presented Mandarin-language teaching kits (booklets and CDs) on HIV management and explained how they were developed, revised and used by people living with HIV/AIDS during an orientation workshop. The responses of patients and doctors attending the workshop were very positive. The workshop empowered the patients and enabled the formation of networks of care providers. It is one of the examples of patients teaching themselves.

2.2.8 Ditan Hospital's Red Ribbon Programme

Ms Wang Kerong expressed her high sense of satisfaction with achievements in HIV care and described her role and expertise in the field. She has two levels of duties: one is in the hospital and the other is in the home of the Red Ribbon Society – established over 10 years ago for support, health maintenance and promotion, advocacy and legal support. Ms Wang introduced the medical support centre for patient education, including nutrition, opportunistic infections, self-monitoring, rehabilitation, and preventive measures. Hundreds of patients are under the care of the Society, including infants and mothers. Every day, about 20 patients seek support and counselling, including information and support provided by telephone hotline services. Persons are also referred to appropriate care as required.

Ms Wang also introduced a training programme conducted by patients, which is adopted from the Living Well programme in the United Kingdom. There are nine modules in the train-the-trainer programme, which requires professionals learning together with patients. She also introduced the dental and eye care services available in Ditan Hospital. The training she

provides to patients, their families and carers includes the use of disinfectants, management of common problems and general preventive health maintenance. Psychosocial interventions carried out by psychologists include coping skills and methods of stress reduction. HIV care includes the use of Chinese traditional medicine and palliative care, including acupuncture and herbs to relieve pain. Four nursing staff and two volunteers are working in the volunteer centre. Apart from these staff, there are about 20 000 volunteers from universities and colleges, as well as health care professionals and patient groups.

2.2.9 *Research on community health nursing in China*

Ms Guo Yanhong described the findings of research conducted on community health nursing in China, including a 2005 study on the link between service delivery models and competency-based education. Studies have consisted of a community nursing survey of experts in major cities, focus group discussions (clinicians, educators), field studies and epidemiological studies. One study examined health-centred, integrated care linking communities with hospitals, while another identified the roles of community nurses in nine areas. These nine core practice areas included health education, prevention, nursing care, implementation of treatment, home care, community rehabilitation, mental health care, elderly, maternal and child and palliative care. Studies revealed that the team approach depends on the needs of consumers and preparatory community nursing requirements include a registered nurse, experience (a minimum of five years of hospital nursing) and training in community care.

Other findings: Most doctors and nurses are working in hospitals and most community nurses are prepared at secondary level, transferred from hospitals. Sixteen provinces have started community nursing services and many felt the training was inadequate. Guidelines and protocols were unclear. There is a continued need to train qualified teachers and to investigate integration with hospital and in-service training. Service linkages with hospital care services are needed, as well as the strengthening of community care modules/subjects in nursing education to promote changes in community care. Practical teaching materials emphasizing skill application are important as well as methods of fully utilizing the trained community nursing professionals.

A subsequent discussion placed emphasis on outcome and impact evaluations of health system interventions as well as collaboration between professionals and community centres in China and Hong Kong (China), coupled with research on the pilot-site implementations with universities. Community partnerships, assessment and planning as well as health promotion and risk reduction skills were emphasized.

2.2.9 *Key nursing contributions to community health and development*

Group work followed the presentations, during which time participants considered and shared their views on the key benefits or contributions of community nurses to improvements in population health. Participants described the benefits or contributions as follows:

- home and family visits, chronic illness management, including mental health care, palliative care, health education and supervision of chronic illness care;
- care of vulnerable populations, including people with disabilities, mothers, children and elderly persons;
- continuity of care from hospital to home, care of discharged patients, rehabilitation;

- computerization of medical records and services between community health centres and hospitals;
- health education and health promotion, including healthy lifestyle; health maintenance and disease prevention activities, including immunizations for individuals, families and communities; health self-management focused on healthy lifestyles, including diet and exercise; smoking cessation; home safety, e.g. fall prevention, self-medication, symptoms management; coping with stress;
- health care education for common problems, e.g. respiratory disorders and flu; disease management, e.g. hypertension, stroke, cancer, chronic infectious disease such as hepatitis and HIV; care of patient family;
- symptom management leading to increased quality of life;
- more cost-effective care;
- psychosocial interventions and support;
- exploring resources available and referring to responsible organizations;
- being a partner in decision-making;
- empowering the community, community health assessments to identify actual/potential health problems and needs, strengths/attributes/resources and indigenous solutions existing in communities to address those health needs;
- committed and caring attitudes; therapeutic communication;
- nursing involvement in policy development: political involvement, crisis management;
- feedback to government to influence policy;
- patient/family teaching of chronic disease management;
- advanced role/autonomy and job satisfaction;
- use of traditional Chinese medicine;
- transitional care, integrated service, education and research;
- comprehensive, coordinated, collaborative and continuous care;
- protocol development and nursing health assessment and decision-making; documentation; implementing protocols;
- home, telephone and other methods of care and follow-up; and

- outcome measurement and evaluation, including measures such as symptom control, self-care management, adherence, quality of life indicators; health care outcomes, cost, patient satisfaction; use of the Omaha system.

The group work outcomes were consistent with core community health nursing and PHC-related nursing competencies delineated in the draft competency analysis framework (Annex 5).

2.3 Summary of sessions: Day 3, Thursday, 6 August

Day 3: Service delivery action planning, next steps Evaluation and closure

Day 3 of the informal consultation began with a review of the preceding two days of environmental scanning and situational assessment and lessons learnt from current community health programmes and services. Stakeholder analysis processes were discussed in terms of local, national and global partnerships. Stakeholders were identified as local government authorities, communities, universities, students and faculty, experts, community health centre and hospital personnel and others. Partnerships were emphasized with stakeholders representing "champions" for change and improved community health services. The importance of completing the mapping of China's education, regulatory and workforce systems was emphasized by the Regional Nursing Adviser, Ms Fritsch, as a starting point to serve as a "country snapshot" and a baseline for later assessments of progress.

Ministry of Health officials discussed the vision of achieving change through the selection of 10 pilot sites, meeting certain criteria for the purpose of assessing community and training needs, capacity-building and most importantly, strengthening community health and nursing services within the context of national health reforms. The sites would have agreed-upon and shared expected outcomes and framework for action, though each site may have a specific focus. Ongoing, longitudinal practice, operational action-oriented research, planning and training linked to agreed-upon, shared monitoring and evaluation indicators would be implemented. Consultation participants agreed upon the overall project aim of *enhancing nursing contributions to health outcomes and overall health reforms via the principles of primary health care*.

The pilot sites are envisioned as becoming recognized "centres of learning and practice" with strong client/community, research, education and practice partnerships and "learning by doing" working processes. Short- and longer-term products are to be identified with concurrent continued development of clinical pathways, required core competencies and job descriptions. Capacity-building exercises would utilize shared existing and/or revised, updated tools and educational packages.

Steering groups, both national (including the Ministry of Health, WHO, institutions, planned and existing WHO collaborating centres, other partners) and local were discussed as well as an expert panel composed of overseas experts in the informal consultation as well as potential donor partners, including the China Medical Board and the Maryknoll China Service Programme. The national steering group would report to the Ministry of Health and be under the overall stewardship of the China Community Health Association. Community representatives would be key members of the steering groups.

The national steering group would further delineate project objectives and targets; site criteria (within one month), planning and preparation for training of trainers (training package;

programme) and related evaluation and the research framework to be applied, inclusive of common indicators of success. Programme mid-term evaluation would take place after six months, followed by the provision of feedback, improvements and subsequent re-evaluation. Ongoing research on competencies and standards was seen to be a continued part of the CHN development work, building on preceding studies.

A component of the day's discussions focused on why primary health care is so important, reviewing the original 1978 Alta principles, including:

- access to all, affordable, promoting self-reliance;
- and building on empowerment, relationships and partnerships to promote individual and community health.

The WHO 2008 World Health Report on PHC was reviewed in terms of the four areas of reform needed for better health, less disease, greater equity, and better performing health systems (Table 2).

Table 2: WHO World Health Report of 2008: four areas of PHC reform

Service delivery reforms To make health systems people centred	Universal coverage reforms To improve health equity
Leadership reforms To make health authorities more reliable	Public policy reforms To promote and protect the health of communities

Building on a PHC framework, a joint proposal is to be developed representing the 10 pilot sites, aimed at enhancing nursing contributions to overall health reforms and health outcomes through improved community health nursing abilities and the development and implementation of core CHN functions. The envisioned PHC framework's core functional areas would include:

- (1) maternal and child health and family planning;
- (2) chronic illness management;
- (3) aged and elderly care;
- (4) rehabilitation;
- (5) community medicine; and
- (6) health maintenance, including health education, immunization, health promotion; risk reduction.

Mental health promotion and care and palliative care were seen by the participants as important cross-cutting core CHN functions.

Expected products of the pilot site initiatives would not only be strengthened theoretical knowledge but also community-health practice and new skill acquisition; the matching of CHN educational outcomes and CHN roles and responsibilities; and ongoing training of others. Common monitoring and evaluation indicators would serve as guides for the pilot sites and would be supportive of collaborative research, education and practice endeavours. Each pilot site would have agreed-upon minimum tasks, but flexible development would ensure development and priorities based on local needs.

Day 3 concluded with a round of participant evaluative comments and feedback:

- Satisfying and enjoyable.
- Happy to do something for China.
- Hope within one year to see change.
- Don't forget the care of the mentally ill.
- Impressed with the good community health projects, e.g. HIV/AIDS.
- Thanks to all for all the work.
- Great honour to be with nursing leaders of China. Expect to see something great out of this workshop.
- Pleasure to learn about all the projects and future plans.
- Glad to meet new friends and learn so much about Chinese nursing.
- Great to reconnect with Chinese friends and no doubt that it will be a great project.
- Very educational opportunity, hope to translate into practice.
- Enjoyed three-day conference from Ministry of Health and WHO and other provinces and universities to learn about activities and environment.
- Appreciation to all for new learning processes and role play experience.
- Enriching experience. Met many international nurses who struggle with health care reform. Have no doubt that there will be big progress in a short time.
- First time to work with nursing experts; hope have excellent project and promote China's development.
- Honoured and excited to be part of the meeting. In a short time, we shared experiences from China and abroad on the goal of meeting the health needs of people. Also in a short time, we developed a programme to improve health care in China. Hopefully, in a year we can meet again to celebrate success.

- Holistic retreat – holistic retreat from a very busy job; body retreat: ability to enjoy beautiful environment; mind retreat: share experiences with friends; knowledge retreat: learnt about the activities; and spirit retreat: so much is done for others.
- Learnt a lot and thankful to Ministry of Health and others.
- Thanks for the opportunity to broaden my knowledge from so many leaders and experts about other activities in China for the people.
- Knowledge great. Discussion interesting. Grateful for the opportunity.
- Demonstrate commitment. First opportunity to work with the Ministry of Health for three days and see progress since 1994.
- First time Ministry of Health officials have spent three days at a meeting; demonstrates commitment of Government to this programme for community health services and nursing in China to improve the health services for China Common goal, lots of discussion and steps for the implementation for the project. Thanks and look forward to working together for common goal. Enjoyed beautiful environment.
- Very good and interesting meeting, and welcome to Beijing.
- Glad to have the opportunity to meet old friends and make new friends. Learnt a lot from the presentations and role play. Learnt new ideas for doing community health nursing practice and education (e.g. Republic of Korea) and new methods for developing a curriculum (e.g. Philippines). I think that there is a lot we can do to support the development
- Thank you from Kathy – grateful for all participants, for Hong Kong Polytechnic, Lydia and Ada, Samantha, Frances, Fredrick and Eric from HKHA. Value coming together as a unit since the first time for a small group related to HIV/AIDS and last year's meeting and responding to the May 12th Sichuan earthquake, which demonstrated the ability to pull together to accomplish a task.

3. CONCLUSIONS

(1) A comprehensive environmental scanning and assessment of the community health initiative in the context of health reforms and trends was undertaken with accompanying lively discussions and debates about various aspects of community health nursing and related initiatives and plans.

(2) An overall community health programme aim was agreed upon: *Enhancing nursing contributions to health outcomes and overall health reforms via the principles of primary health care*. Building on a PHC framework, a joint proposal is to be developed representing the proposed 10 pilot sites, aimed at enhancing nursing contributions to overall health reforms and health outcomes through improved community health nursing abilities and the development and implementation of core CHN functions. The envisioned PHC framework's core functional areas would include:

- (a) maternal and child health, family planning;
- (b) chronic illness management;
- (c) aged and elderly care;
- (d) rehabilitation;
- (e) community medicine; and
- (f) health maintenance, including health education, immunization, health promotion; risk reduction.

(3) Mental health promotion and care and palliative care were seen by the participants as important cross-cutting core functions of community health nursing.

(4) The consultation participants expressed a common desire to undertake initial actions quickly and committed themselves to working collaboratively towards the identified common aim of strengthening and evaluating nursing's contributions toward stronger, more equitable and comprehensive community health systems, driven by the underlying PHC principles of social justice, participation and intersectoral collaboration.

**INFORMAL CONSULTATION ON COMMUNITY
HEALTH NURSING: CHINA**

**Hong Kong, China
4-6 August 2009**

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**INFORMAL CONSULTATION ON COMMUNITY HEALTH NURSING: CHINA
4-6 AUGUST 2009, HONG KONG, CHINA**

AGENDA

Time	Day 1 <u>Tuesday 4th August</u>
	Day 1: Getting to Know One Another; Sharing; Situational Assessment Analysis, Preparation, Resources, Functions, and Service Delivery Options Introduction to Competencies
0800	Breakfast
0830-0845	Registration
0845-1030	Informal Opening Setting the Stage: Aims, Objectives and Working Processes— Introductions Team, Institutional Presentations (using guidelines for community health nursing presentations) and Discussion: 10 min presentations
10:30-11:00	Group Photo and Morning Tea
10:00-12:30	Team, Institutional Presentations cont'd (using guidelines for community health nursing presentations) and Discussion: 10 min presentations
1230-	Lunch
1330-1430	Team, Institutional Presentations cont'd (using guidelines for community health nursing presentations) and Discussion: 10 min presentations
1430-1530	Plenary presentation: Summary/analysis of survey reports/presentations and Brainstorming discussion of Pilot Initiatives and Service Delivery Options
1530	Afternoon tea
1600-1700	Plenary group work: Factors Essential for Community Health, PHC Service Delivery
1700-1730	Introduction to compilation of competencies-- Reflections Closure
1800	Dinner

Time	Day 2, Tuesday) 5th August	Time	Day 3, Wednesday 6th August
	Day 2: Competencies Curricular Domains; CHN Nursing TOT Planning		Day 3: Moving Forward: Partnerships and Strategic Action Planning
0800	Breakfast	0800	Breakfast
0845-0915	Recap day 1 [5 mins] CHN Competencies-- Mini Presentation, Discussion	0845- 1030	Recap Day 2 Action planning: Research, Capacity-Building/CHN TOT
0915-1030	Competency Group Work and Plenary Presentation of Work		
1030-1100	Morning Tea Break	1030- 1100	Morning Tea Break
10:30-12:30	CHN Curricular Domains: Undergraduate and Graduate	1100- 12301	Service delivery guidelines action planning; moving forward with partnerships, pilots
1230	Lunch	1230	Lunch
1330-1400	Plenary review of curricular domain conclusions	1330- 1400	Plenary summary/discussion of morning's work
1400-1530	CHN Teacher Preparation and Teaching Learning Methods for Teachers/Learners/Students	1400- 1530	Moving forward--action plan/timeline/communicating/working together
1530	Afternoon tea	1530	Afternoon tea
1530-1630	Delineation of curricular modules and layout	1600- 1700	Continued planning Reflections, evaluation Closure
1630-1715	Plenary presentation of group work CHN TOT Action Planning		
1800	Dinner	1800	Dinner

ANNEX 3

**SURVEY TEMPLATE: DEVELOPMENT OF INTEGRATED COMMUNITY
HEALTH NURSING SERVICES IN CHINA**

Questionnaire for the Development of Integrated Community
Health Nursing Services in China

The PURPOSE of this survey is to collect information about community health nursing (CHN) education and service delivery in China in order to share this information with workshop participants and plan topics for consideration at the August 2 – 9, 2009 informal consultation on community health nursing in China. Four (4) areas related to CHN are covered in this survey including 1) the current NEEDS of educators and service providers, 2) the HEALTH and DEVELOPMENT NEEDS of communities in each region, 3) the COMPETENCIES for CHN that should be included in any future curriculum and 4) the RESOURCES that already exist for implementing a CHN curriculum in the PRC.

Under each question in **BOLD RED LETTERS** is an explanation of the question or key terms and any special directions. Please consult with other faculty members and staff from your institution as you complete this survey so that your responses capture the diversity of opinions and experiences that exist in your university or workplace. Thank you for taking the time to complete this survey.

Please contact Kathleen Fritsch, Regional Director for Nursing at fritschk@wpro.who.int, or Gabe Culbert, nursing intern at culbertg@wpro.who.int if you are unsure about your response to any question or if you have any general questions or comments about the survey.

Questionnaire Contents

Demographic information.....	1
<u>Part I</u> : Appraisal of CHN Service and Education.....	2
CHN Services	
CHN Needs	
<u>Part II</u> : Appraisal of Community Health & Development Needs....	3
<u>Part III</u> : Appraisal of CHN Core Competencies.....	4
<u>Part IV</u> : Appraisal of CHN Teaching & Learning Resources.....	4

Demographics

1. Your Name: Please enter your name and your title (e.g. John Smith, 'Associate Dean of Nursing).
2. Region Name: Enter the name of the province/city where your university/workplace is located.
3. School Name: Enter the name of the university or hospital in which your school is located.

Part I: CHN Service and Education Appraisal

The PURPOSE of this section is to gather information about the current practice settings, practice roles (including definitions and job description) of community health nurses. In this survey, you may decide to include clinical nurses whose practice setting is the community or who care primarily for persons in a primary health care setting.³ Information from this section will be used to assess the current practice and educational needs of community health nurses and CHN educators and to suggest directions for CHN development.

CHN Services

4. Describe the practice settings for community health nurses in your region: Please describe the types of practice settings (e.g. mental health clinics, community health centres, or home health agencies) where CHN's practice in your region.
5. Describe the practice roles for community health nurses in your region: Please describe the types of practice roles (i.e. what do nurses do in these practice settings) that CHN's fulfil in your region. Please describe the specific activities, contributions, *definition*, or *job description* of CHN's in these practice settings.
6. Describe the recent model of community health services in your region such as members of the team and how nurses link up with other health care professionals. What is the advantage and disadvantage of this practice model.
6. Describe what you would envision as a *future practice setting(s)*, *role(s)*, or *models of community-based care* for CHN's in your region: Please describe what CHN's *could* do that they are not doing already. Describe how you might change the current practice settings or practice roles for CHN's in your region. Please describe any plans that you have presently to develop CHN services or to expand CHN services to other locations or areas of the region.

³ In this survey, a Community Health Nurse (CHN) is any nurse who provides public health or primary health care services to individuals, families or communities. CHN practice is oriented toward providing care in the places where people live and work and applies the nursing process to populations.

CHN Education

7. Is community health nursing presently offered at your university at the undergraduate level?
- YES NO Please respond 'YES' or 'NO' as to whether a course in Community Health Nursing is part of the undergraduate curriculum in Nursing.
8. Is community health nursing presently offered at your university at the graduate level?
- YES NO Please respond 'YES' or 'NO' as to whether a course or concentration in Community Health Nursing is included in the graduate (i.e. Master's or PhD.) curriculum in Nursing.
9. If you *do* offer community health nursing as part of the undergraduate or graduate curriculum, briefly describe the structure, content and learning activities that comprise the CHN curriculum:
For any CHN course that you have, please describe how the course is organized, what is taught and how it is taught.
10. If you *do* offer community health nursing as part of the curriculum, are you satisfied with the course as it is presently taught? Why?
- YES NO Please respond 'YES' or "NO' as to whether you are satisfied with the structure, content and methods of the present CHN curriculum and why you are or are not satisfied with the present CHN curriculum.

Part II: Community Health and Development Needs Appraisal

The PURPOSE of this section is to collect information about the population health and development needs of communities in each region. The information from this section will be used to initiate discussions about content areas that should be included in any future CHN curriculum.

11. As a nursing leader, what are the five (5) most important health or development needs of communities in your area? Please describe at least five (5) 'high-priority' community health needs or issues of healthy population development that should be addressed in any future CHN curriculum. These population health needs might include, for example, health promotion, environmental health, maternal and child health care, specific diseases, chronic conditions, development goals, health indicators or other issues affecting the health sector.

12. Which of the following community health needs are presently addressed through community-based health services or programs? For this section, please rank each of the community health needs on the right side in terms of the degree to which this community health need presently is met. Please mark *only* one box for each health need.

Health Need	Frequency				
	Not met at all	Frequently unmet	Sometimes unmet/sometimes met	Frequently met	Met all the time
Mental health: (e.g. depression, addiction, dementia)					
Home care: (care provided to persons in the home)					
Chronic disease management: (e.g. hypertension, diabetes, HIV/AIDS, tuberculosis)					
Palliative care: (i.e. promote comfort and dignity for dying persons people facing the problem associated with life-threatening illness)					
Rehabilitation: (helping persons with injury or disability to adapt to their environment)					
Maternal and child health: (making pregnancy safe, immunization, etc.)					
Health promotion/Risk reduction: (learning activities that happen in the community)					
Promoting a healthy environment: (safe water, pollution, accidents, etc.)					
Disease Surveillance: (collecting data about the health of the population)					
Other: Please specify Care of older people (e.g. fall prevention program, immunization etc.) Adolescence health					

* Not met at all = Health need is *not* addressed for either 95% of persons, or 95% of the time; Frequently met/unmet = health need is/is not met 75% of the time or for 3/4 of persons; Sometimes met/unmet = this health needs is met/unmet for approximately 50% of people or only half the time.

Part III: Community Health Nursing (CHN) Core Competency Appraisal

The PURPOSE of this section is to gather expert opinions about the types of CHN core competencies around which any future CHN curriculum should be built. Information from this section will be used to stimulate discussion about the categories of competencies for CHN that should guide development of an integrated CHN curriculum.

13. Describe the foundational knowledge skills and attitudes upon which capable community health nursing practice is based. *Please think about your responses to questions 4 – 6 and consider the important skills, knowledge and attitudes that a community health nurse should have in order to perform her/his role effectively. Which things are essential for a nurse to know and be able to do for her/him to be safe and capable practitioners of CHN? If you already have a CHN curriculum, describe the fundamental or requisite knowledge, skills and attitudes upon which the curriculum is based. Consider also the indicators or evaluative criteria for effective and accomplished CHN practice and instruction.*

14. Describe the criteria that should be used to evaluate whether students are satisfactorily prepared or qualified to practice community health nursing? *These criteria may be similar to the knowledge, skills and attitudes you described in question # 13 but should include your understanding of the appropriate ways to measure successful attainment of the requisite knowledge, skills and practice for CHN. What are the expected outcome competencies of programme graduates?*

Part IV: CHN Teaching & Learning Resources Appraisal

The PURPOSE of this section is to gather information about the types of resources that presently exist for learning about community health nursing. The information from this section will be used to launch a discussion about how to use learning resources in our institutions and communities to strengthen any future CHN curriculum.

15. What resources do you have for teaching community health nursing (CHN) at your institution or region? *Please describe the resources at your institution or in your province that you feel would strengthen your ability to develop and implement a curriculum in community health nursing. Resources might include textbooks, internet access, instructors, facilities, budget, training programs or partnerships. Please describe anything in your school or area that could be used creatively to prepare students or instructors in community health nursing.*

16. Does you university have partnerships with community organizations, local community groups or representatives from the community that could facilitate curriculum development or student service-learning opportunities. *Please describe the relationships, collaborative agreements or partnerships that your university or workplace has with community organizations, groups, liaisons or representatives that could be used in developing any future CHN curriculum. How have these partnerships been used to support learning in the past?*

17. Have any instructors at your school had specific training or experience in community health nursing? If so, how did these instructors acquire that training? **Please tell us about the instructors at your university, including yourself, who have previous training or experience in community health nursing. How did the instructor(s) receive that training/experience?**
18. At present, are there any plans to build capacity for teaching CHN? If so, what are these plans? **Please describe any future plans for strengthening resources at your institution or workplace for teaching/learning community health nursing. Capacity building might include workshops for training community health nursing educators, strategies to recruit students for community health nursing courses, or establishing partnerships with local community health clinics or community groups or organizations to support student learning.**
19. Is there anything that we forgot to ask about that you would like us to know before the informal consultation on community health nursing in China? **Please describe anything else that you feel it is important for us to consider before we meet in Hong Kong this August. What else would you like to know from each of the other participants? Do you have other suggestions for what we should do with the information that we collect from these surveys?**

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- Core Competencies for Community Health Nursing (CHN)
- Curricular Development for Community Health Nursing (CHN)
- Community Assessment
- Community Diagnosis
- Health Promotion and Risk Reduction
- Environmental Health
- Chronic and Non-communicable Disease
- Communicable Disease
- HIV/AIDS
- Home Health Care
- Palliative Care
- School Health and Adolescent Health
- Mental Health & Substance Abuse
- Oral and Dental Health
- Vulnerable Populations
- Ethical Issues in Primary Health Care (PHC)
- Nursing Education and Learning Methods

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ANNEX 5

COMMUNITY HEALTH NURSING COMPETENCY ANALYSIS FRAMEWORK

Introduction, use of tool

This working tool was developed based on the ICN *Nursing Care Continuum Framework and Competencies*⁴, an updated competency framework continuum based on the ICN registered, generalist nurse competencies and the *Western Pacific and South East Asian Region Common Competencies for Registered Nurses*⁵ domains and accompanying competency units and unit competency elements. The ICN generalist nurse competencies were utilized in the development of common regional WPSEAR competencies.

Use the tool to assess each competency element (and add additional elements as needed) and ✓ whether each competency element is applicable to a newly qualified registered nurse in China, to the advanced practice or specialist community health nurse in China, or to both categories. Community health nurses are expected to have the competencies common to all registered nurses and to apply these in their community work. *Competency elements added or revised are highlighted in yellow.*

WPSEAR competency domains (categories), competency units and draft working competency elements for community health nursing.	Registered Nurse ⁶	Advanced Practice /Specialist Nurse ⁷	Comments
DOMAIN⁸ 1: LEGAL AND ETHICAL FRAMEWORK OF NURSING PRACTICE			
Functional Area 1			
Recognizes and accepts personal accountability and responsibility for all aspects of professional practice.			
1.1 Practices in accordance with current competencies and scope of practice			
1.2 Performs nursing interventions according to recognized standards of practice.			
1.3 Clarifies responsibility for aspects of care with other members of the health team.			
Functional Area 2			
Understands and demonstrates knowledge of the legal and ethical framework of the health system that relates to nursing.			
2.1 Recognizes and acts upon breaches of law relating to nursing practice and/or professional code of conduct.			
2.2 Applies ethical principles to the collection, maintenance, use and dissemination of data and information.			

⁴ International Council of Nurses. *Nursing care continuum framework and competencies*. Geneva, 2008.

⁵ Australian Nursing and Midwifery Council. *Western Pacific and South East Asian Region Common Competencies for Registered Nurses*. Dickson, ACT, Australia, 2006.

⁶ A licensed registered nurse with a minimum of at least 3 years of nursing education.

⁷ A registered and licensed nurse with advanced education, expertise and competencies for expanded practice.

⁸ Domains represent organized clusters of nursing competencies.

WPSEAR competency domains (categories), competency units and draft working competency elements for community health nursing.	Registered Nurse ⁶	Advanced Practice /Specialist Nurse ⁷	Comments
2.3 Practices in accordance with relevant legislation, national and local policies and procedural guidelines.			
2.4 Balances the rights of individuals with the rights of populations/communities (e.g. immunizations; fluoridated water supplies; communicable disease control; tobacco legislation and control)			
2.5 Maintains clear and legible documentation and records.			
Functional Area 3			
Understands and utilizes an ethical decision making framework.			
3.1 Practices in a manner that conforms with an agreed Code of Ethics.			
3.2 Engages effectively in ethical decision-making.			
3.3 Maintains patient confidentiality and security of patient information.			
3.4 Demonstrates an understanding of the challenges to ethical decision making in a broad range of circumstances and practice settings, including conflict and natural disaster situations.			
3.5 Identifies potential role conflicts in community, other settings—including boundary issues; resource allocation; legislated mandates; guest in home/community, value differences between community, clients, nurse, role overlap with other health professionals.			
Functional Area 4			
Advocates for and provides culturally sensitive care respectful of individual, family and/or community, rights, values and health belief systems, irrespective of their ethnic origin, religion or other factors [Consolidated functional areas]			
4.1 Protects and safeguards the interests and well-being of the patients/clients.			
4.2 Respects the values, customs, spiritual beliefs and practices of individuals and groups.			
4.3 Recognizes own beliefs and values and how these may influence care-giving.			
4.4 Respects patients/clients/ rights to access information.			
4.5 Identifies the role of cultural, social and behavioural factors in determining the delivery of community or public health services.			
4.6 Develops and adapts community approaches to problems that take into account cultural differences.			
4.7 Seeks out knowledge about specific traditional healing practices that are culturally relevant to individuals and communities.			
4.8 Makes changes to practice when appropriate, to address traditional healing safe practices.			

DOMAIN 2: MANAGEMENT OF CARE, INCLUDING HEALTH PROMOTION			
A. Professional Practice			
Functional Area 5			
Contributes to effective multidisciplinary team work by maintaining collaborative relationships.			
5.1 Collaborates with and coordinates health and social care teams and other relevant sectors involved in community well-being.			
5.2 Demonstrates critical thinking and decision-making skills.			
5.3 Participates with members of the health and social care teams in decision-making concerning patients/clients.			
5.4 Establishes and maintains linkages and collaborative working relationships to ensure participation of key stakeholders and partners.			
5.5 Coordinates stakeholders to develop, implement and evaluate comprehensive care planning [discharge planning; case conferences; social services; community referrals and care]			
Functional Area 6			
Provides public and population health focused nursing services across the continuum of care, within the context of PHC			
6.1 Demonstrate understanding of a population health approach to health and nursing services.			
6.2 Define, assess and understand the health status of populations, determinants of health and illness factors contributing to health and risk reduction, disease prevention, and factors influencing health service use.			
6.3 Identify and define common measurements and indicators of the health status of populations, communities, groups.			
6.4 Describe the key elements of PHC, their relation to good health and community health nursing.			
6.5 Describe the four principles of PHC and how they relate to community nursing.			
6.6 Demonstrate effective engagement with communities.			
6.7 Demonstrate understanding of community partnerships, empowerment and leadership in the context of primary health care.			
6.8 Demonstrate the ability to calculate, compile, assess and analyse basic epidemiological, including surveillance data.			
6.9 Demonstrate proficiency in selecting and applying crucial demographic, epidemiological and socio-economic data (target population ages, household sizes, geographical locations, average household incomes, educational levels, literacy, economic indicators, unemployment rates, sources of employment/income, transportation, water, sanitation) in planning, choosing priorities for interventions, implementing and evaluating primary			

health care or community-based services.			
6.10 Identify and apply basic research methods used in public health, community health.			
6.11 Demonstrate the ability to plan and implement a community assessment through observational walks; interviews with community members, stakeholders; surveillance data, records review (hospital emergency data, police reports, health data).			
6.12 Undertakes a comprehensive and systematic assessment involving analysis and interpretation of qualitative and quantitative data.			
6.13 Identify and interpret community risks, assets and available resources			
6.14 Demonstrate the ability to "map a community" and interpret the mapping, based on crucial community assessment data.			
6.15 Work in partnership with communities to interpret community assessment data and prioritize interventions.			
6.16 Identify effective strategies to ensure universal access to health services.			
6.17 Formulates a plan of care in collaboration with the patient/client, family/significant other.			
6.18 Work collaboratively with communities to plan, implement and evaluate interventions to improve the health of vulnerable individuals, populations and groups within communities.			
6.19 Implement and evaluate strategies to ensure universal access to health services.			
Functional Area 7			
Promotes health and wellness across the lifespan [inclusive of mental health]			
7.1 Identify the determinants of health (social, environmental, physical, biological and genetic, income and socioeconomic status, employment/working conditions, education/literacy, gender, cultural, personal health behaviours, coping skills, health services etc)			
7.2 Take actions to address poverty and gender, other determinants of health within the community context.			
7.3 Assess and monitor the overall developmental and health status and needs of infants, children < 5, school-aged children, youth child-bearing families, including prenatal and post-natal periods; adults and older adults, elderly and disabled persons.			
7.4 Implement interventions to support the well-being and to improve the health and development of infants, children < 5, school-aged children, youth child-bearing families, including prenatal and post-natal periods; adults and older adults, elderly and disabled persons.			
7.5 Plan, implement and evaluate primary and secondary preventive and risk reduction measures			

for the full range of non-communicable diseases, including accidents, trauma, mental health/			
7.6 Understand the principles of immunizations, various types of immunity; including cold chain maintenance, appropriate vaccine administration; modes of transmission of vaccine-preventable diseases, host susceptibility.			
7.7 Recognize the symptoms of communicable diseases, including those that are vaccine preventable.			
7.8 Educate clients, groups, community members on the population benefits and risks of immunization.			
7.9 Monitor immunization rates			
7.10 Conduct surveillance activities, interpret findings and implement appropriate actions based on surveillance findings.			
Functional Area 8			
Demonstrates abilities to empower and strengthen community capacities to promote and improve health			
8.1 Conduct health assessment of the social and physical environments of communities, schools, day-care centres, homes, recreational and community facilities, and workplaces.			
8.2 Apply the nursing process in Identifying and assessing individual, family and/or community health issues, working with patients, families or communities as equal partners			
8.3 Promote shared visions of health and healthy communities/			
8.4 Assess the readiness of individuals, groups or communities for action and change.			
8.5 Assess and understand the barriers that impede action and change.			
8.6 Apply a variety of techniques and strategies to provide individuals, families and communities with increased motivation to change, adopt and sustain behaviours that improve their health.			
8.7 Support and provide guidance to individuals, families and groups in planning and implementing healthy behaviours.			
8.8 Collaborate with stakeholders, community partners in analysing options and planning interventions to promote the health of individuals, families, communities and facilities/institutions within communities.			
8.9 Implement and evaluate with community stakeholders health promotion activities to promote health and well-being, including environmental health protective and improvement measures.			
8.10 Undertake health promotion advocacy and change through coalition building, lobbying, policy development, capacity-building, research and evaluation.			

Functional Area 9			
Ensures consistent, continuous, holistic, person-centred quality care			
9.1 Recognizes and respects patients'/clients', carers', family and community involvement in the planning and delivery of care.			
9.2 Provides care in manner respectful of client, family or community preferences, values, differences and expressed needs.			
9.3 Respects the patient's/client's rights to access information, privacy, choice and self-determination.			
9.4 Responds appropriately to comments or complaints from patients/clients and cooperates with complaints procedures.			
9.5 Implements and documents planned nursing care.			
9.6 Evaluates and documents progress towards expected outcomes and uses evaluation data to modify the plan of care.			
9.7 Utilizes well-conducted/evaluated research findings in practice as appropriate (evidence-based practice)			
9.8 Makes sound clinical judgements and provides appropriate nursing therapeutic interventions and procedures for the individual, patient, family and community.			
9.9 Assess, manage and/or refer ill infants, children using the IMCI—Integrated Management of Childhood Illness Approach.			
9.10 Teach patients/families/carers/health professionals aspects of care as appropriate.			
9.11 Ensures that no action or omission on the part of the nurse or within the nurse's sphere of responsibility is detrimental to the patient, family and community.			
9.12 Works collaboratively with nursing and other health professional colleagues to ensure continuity of quality nursing care.			
9.13 Reflects on practice outcomes and makes changes to practice when appropriate.			
9.14 Maintains and updates technical skills.			
Functional Area 10			
Palliative care provision			
10.1 Describe the role of palliative care within the overall continuum of care, within the context of the health and support systems.			
10.2 Describe home- and community-based models of care provision for the functionally impaired, seriously ill and dying			
10.3 Describe common needs, issues and challenges faced by caregivers and solutions for addressing them.			
10.4 Identify common barriers to talking about serious illness and death and how to overcome them.			

10.5 Feel more comfortable sharing perspectives and concerns about illness and death.			
10.6 Demonstrate palliative care patient, carer, family assessment, support and intervention approaches and core skills			
10.7 Describe effective approaches to pain and common symptom management.			
10.8 Demonstrate effective approaches to pain and common symptom management.			
10.9 Describe effective approaches and techniques to caring for the seriously ill and dying in the home, including helping families and volunteers care for the seriously and terminally ill.			
10.10 Demonstrate effective approaches and techniques to caring for the seriously ill and dying in the home, including helping families and volunteers care for the seriously and terminally ill.			
10.11 Advocate for, build coalitions and develop, implement and evaluate policies for palliative care.			
Functional Area 11			
Creates and maintains a safe environment through the use of quality assurance, risk management strategies, including infection, communicable disease, emergency and disaster prevention, management or control			
11.1 Participates in continuous quality improvement and quality assurance activities.			
11.2 Acknowledges limitations in knowledge and competence and declines any duties or responsibilities unless able to perform them in a safe and skilled manner.			
11.3 Delegates, monitors and supervises work performed by assistants, community workers/volunteers.			
11.4 Provides a safe environment for patients and staff, including implementing infection prevention and control procedures in facilities, homes and the community.			
11.5 Implements appropriate infection control practices to prevent transmission of infectious/communicable diseases.			
11.6 Recognizes signs and symptoms of emerging or re-emerging infectious diseases and identifies appropriate interventions to prevent their spread.			
11.7 Implements and evaluates interventions to prevent the spread of infectious diseases (surveillance, screening, case finding, outreach, health education, communication, consultation, referral and follow-up, management, necessary precautions).			
11.8 Recognizes signs/symptoms of common food- and water- borne illnesses and parasitic infections and identifies appropriate management and interventions to prevent their spread.			
11.9 Implements and evaluates interventions to prevent the spread of common food and water-borne illnesses and parasitic infections (surveillance,			

screening, case finding, outreach, health education, communication, consultation, referral and follow-up, management, necessary precautions).			
11.10 Plans interventions to prepare for and respond to emergencies and disasters.			
11.11 Prepares implements and evaluates emergency and disaster plans and interventions.			
Communication			
Functional Area 12			
Establishes interpersonal relationships based on public trust and confidence.			
12.1 Listens and interacts clearly and effectively by verbal, written and electronic means as appropriate, to patients/clients, families, carers and other health professionals.			
12.2 Listens to others in an unbiased manner, respects points of views of others and promotes the expression of diverse opinions and perspectives.			
12.3 Effectively presents accurate demographic, statistical, programmatic and scientific information for professional and lay audiences.			
12.4 Establishes trust and builds effective therapeutic and/or working relationships with individuals and groups in a variety of settings.			
12.5 Leads and participates in groups to address specific issues.			
12.6 Respects the professional boundaries of therapeutic relationships.			
Functional Area 13			
Displays cultural awareness and sensitivity in relation to verbal/non-verbal communication.			
13.1 Accesses and provides appropriate written resources for patients and their carers when needed.			
13.2 Uses appropriate professional interpreters when needed.			
13.3 Involves an advocate for the patient/client, if necessary to ensure effective communication.			
Functional Area 14			
Uses health and information technology effectively and appropriately			
14.1 Communicates and clarifies advances in appropriate technologies to the patient/client.			
14.2 Uses available information technology to access information and new knowledge.			
14.3 Undertakes training in the application of new health technologies as necessary.			
14.4 Manages information systems for collection, retrieval and use of data for decision-making.			
Professional Advancement and Development			
Functional Area 15			
Maintains competence by undertaking actions for professional development and education.			
15.1 Applies evidence-based and/or best practice knowledge and technical skills.			
15.2 Participates and contributes to research.			
15.3 Plans, implements and applies research, research findings.			

15.4 Contributes to the education and professional development of others.			
15.5 Takes steps to remedy any deficits in skill or personal knowledge.			
DOMAIN 3: LEADERSHIP AND NURSING MANAGEMENT			
Functional Area 16			
Understands and applies the principles of management and continuous quality improvement, incorporating them into practice.			
16.1 Explain the importance and use of health outcomes and indicators in planning and evaluating primary health care and other services.			
16.2 Collects analyses and utilizes data about incidents and trends and implement remedial changes to improve care delivery.			
16.3 Define and discuss the functions of management and human resource management.			
16.4 Applies human resource management skills to the management of organizations, motivation of personnel and conflict resolution.			
16.5 Demonstrates the ability to make appropriate management decisions.			
16.6 Demonstrate an understanding of community health centre operations, efficient resource allocation and human resource management.			
16.7 Develop and present a budget.			
16.8 Determine budget priorities and implement programmes within budgets, including monitoring of programme performance.			
16.9 Demonstrate the ability to plan and evaluate programmes and services, using common nursing and health service quality indicators and tools.			
16.10 Develop proposals for funding from external sources.			
16.11 Organize community health service delivery in a cost-effective manner, based on identified priorities and targeted towards those most vulnerable.			
16.12 Negotiate and develop contracts and other documentation for population-based programmes and services.			
16.13 Conduct cost-effective, cost-benefit and cost utility analyses.			
Functional Area 17 [Consolidation of two functional areas]			
Demonstrates an understanding of national health, social and political processes and communicates a clear vision of nursing within the health system context.			
17.1 Promotes and maintains the professional role of the nurse.			
17.2 Supports, collaborates and co-operates with colleagues.			
17.3 Demonstrates the ability to think laterally and critically within a problem-solving context.			
17.4 Accepts leadership responsibility in the planning, delivery and evaluation of nursing and health services.			

17.5 Initiatives and participates in dialogue about new initiatives and change processes in nursing and health care.			
17.6 Helps create key values and shared vision and uses these principles to guide action.			
17.7 Plays a leading role in the development, implementation and monitoring, evaluation of organization and professional performance standards.			
17.8 Actively seeks to participate in health policy development and evaluation, and programme planning			
Functional Area 18			
Promotes safe working and living environments			
18.1 Demonstrates knowledge of relevant aspects of occupational and public health and safety legislation.			
18.2 Interpret and apply legislation, regulations and standards to promote health and prevent adverse health events.			
18.3 identify actual and potential situations putting clients'/community members at risk (physical, verbal, financial, emotional abuse).			
18.4 Implement and evaluate interventions to deal with actual and potential situations posing risks to clients/community.			
18.5 Recognize risk-to-self situations (violence, drug use during home visits; and take and evaluate preventive or other interventions.			
18.6 Use formal and informal networks to facilitate access to information and resources to address risks to clients/community and/or self.			
18.7 Recognizes the need for rest and diversion activities to prevent burnout.			
18.8 Manages workloads effectively.			
18.9 Acts as a collaborative team member.			