INTERNATIONAL COUNCIL OF NURSES

Nursing Perspectives and Contribution to Primary Health Care

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Contributor

Sally Kendall, Ph.D., B.Sc. (Hons), RHV, RGN

Sally Kendall began her career as a health visitor in London in 1981 before taking up a research post at Kings College, London University, where she was part of a research team investigating the health promotion role of nurses, midwives and health visitors. In 1991 she gained her PhD and took up a lecturing post at Buckinghamshire University College where she set up and directed the Centre for Research in Primary Health Care.

In 1999, Dr Kendall moved to the University of Hertfordshire as Professor of Nursing and in 2001 was also appointed as the Director of the Centre for Research in Primary and Community Care (CRIPACC).

Her main research interest is in primary health care nursing and especially in client/patient perspectives and family health promotion research, having published and supervised doctoral research widely in these areas. She is the co-editor of Primary Health Care Research and Development and the co-chair of International Conferences in Community Health Nursing Research, a UK charity that convenes international nursing research conferences around the world. A member of Sigma Theta Tau, Dr Kendall is currently leading a national study, funded by the Department of Health to investigate the nursing, midwifery and health visiting contribution to chronic disease management and an international study on parenting support funded by the British Council.

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Introduction

Since the early years of the Primary Health Care (PHC) and Health for All (HFA) movement, the International Council of Nurses (ICN) has provided global leadership to bring about a shift in nursing education, practice and research towards Primary Health Care. A key component of PHC is the concept of community development. As part of its commitment, ICN has worked to mobilise the nursing workforce towards community based and population focused care and developed publications and position statements that support the principles of PHC and community development. As well, ICN has published a position statement on *Nursing and Development* and an implementation guide for this policy.

In many parts of the world nurses are the main providers of Primary Health Care. As community development is a cornerstone of PHC, ICN is keen that nurses are equipped with the knowledge and skills to support communities in their efforts and aspirations for development. As nurses work closely with communities, their role in community participation and community action for health is crucial for healthy communities and sustainable development.

One way to enhance nursing's competence and contribution to community development is through current publications such as this one. This paper sets out the trends and issues in community development from a nursing perspective. It outlines the process of community development and highlights the importance of working with other sectors that have a bearing on health. Most importantly, the paper presents a comprehensive role for the nurse in community development as facilitator, advocate and key member and leader of the health team. The experiences from several countries provide real life examples of how nurses around the world are playing key roles in community development.

Primary Health Care as an approach to achieving 'Health for All by the year 2000' was embraced by all World Health Organization (WHO) member states at the 1978 conference held in Alma Ata, USSR. Fundamentally, the assembly endorsed that access to health care was a basic human right and that Primary Health Care was the way in which this should be achieved. More than a quarter of a century has elapsed since the original Declaration of Alma Ata was published. During that time there has been significant global and economic change: ideologies and political beliefs have shaped health care provision; significant changes in patterns of diseases such as HIV/AIDS and SARS have altered both the shape of communities and the ways in which nurses respond to health need; we are increasingly faced with new threats from terrorism, war and natural disaster such as the tsunami in South-East Asia in 2004; health technologies have altered beyond recognition; populations have changed demographically and health care resources have fluctuated widely.

Central to the WHO notion of Primary Health Care is the concept of bringing health care much closer to the homes and workplaces of the people and communities who most need it. There has been a widespread and engaging debate about the extent to which the original goals of HFA have been achieved. However, while all the world changes have been taking their toll, PHC and community nurses have been actively pursuing the goal of providing accessible and equitable health care close to and within the communities with which they work.

"WHO commends the commitment of nurses to care for all persons across the life cycle: pregnant women, infants, children, adolescents, adults and the elderly; and especially their commitment to vulnerable groups, such as the poor, refugees and displaced persons, street children and the homeless."

Dr Gro Harlem Bruntland
WHO (2000)

The purpose of this paper is to explore the extent to which nursing has contributed to the achievement of the goal of Health for All. It is important to engage in a debate about the global and economic constraints that nursing has faced and to make critical assessments of the ways in which nursing worldwide has deliberately and systematically tackled the challenges posed by the goal of HFA. Nursing has been singled out for this assessment, within a framework of intersectoral collaboration, because most frequently it is nurses (and midwives) who deliver Primary Health Care. Nurses often live within the communities, understand the indigenous cultures and languages, assess the health needs and provide the health care for generations of families. This means preventing disease, promoting health, treating illness, managing chronic conditions, and assisting with childbirth and death. It is this sense of being at the forefront of Primary Health Care that provides a rationale for exploring the particular contribution nursing has made to Health for All in the past 30 years.

This paper provides an overview of the Primary Health Care and Health for All movement and incorporates the competing arguments provoked by academics, politicians, economists and health care providers over the last 30 years, thus providing the contextual basis for the assessment of the nursing contribution. Principles of PHC are deconstructed and explored, using examples from nursing policy and practice, to attempt to bring greater clarity to the view that nursing has made, and will continue to make, a significant contribution to Health for All. It is hoped that the paper will provide a basis for further discussion and debate within nursing organisations and professional arenas worldwide.

A wide range of international nursing data has been integrated into the discussion to demonstrate trends, patterns and examples of the impact of PHC nursing over the past 28 years. Some of these have been identified as case examples and are examined in more depth to provide a richer description of the practice and policy of PHC nursing globally. While some case examples are representative of PHC issues from across the WHO Regions, it is also notable that detailed accounts are not always readily available from all countries. However, the principle of learning from the whole PHC nursing community is regarded as important here, while recognising that variation in social, political and economic contexts does not necessarily enable an easy extrapolation. The final analysis attempts to use a finer brush to synthesise, from the total picture, some conclusions for PHC nursing in the future.

1
Primary Health Care and the Health for All Movement

A main social target of governments, international organisations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

Declaration of Alma Ata, 1978

1.1 What is Primary Health Care?

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

Declaration of Alma Ata, 1978

The starting point draws on the key concepts that were agreed at the Primary Health Care conference at Alma Ata, USSR, 1978. These fundamental statements underpinned the worldwide movement that evolved subsequently in the interest of providing affordable and sustainable health care within the community. For the purposes of this paper, it is necessary to critically assess whether Health for All has been achieved, what the possible constraints have been on Primary Health Care as an approach to achieving HFA, what the nursing contribution has been towards the achievement of HFA and what the implications are for the future for nursing policy, practice and education.

The Alberta Association of Registered Nurses (AARN 2003) has drawn together the five principles of PHC as a framework for developing and shifting nursing practice in Alberta, Canada.

These five principles are themselves distilled from the Declaration of Alma Ata, are supported by the ICN (see appendix 2) and serve as a useful framework from which to analyse the nursing contribution to PHC:

1. Accessibility to health services;
2. Use of appropriate technology;
3. Individual and community participation;
4. Increased health promotion and disease prevention; and
5. Intersectoral co-operation and collaboration.

In section 3 of this paper, each of these principles is addressed in turn and case studies and other evidence are provided to show how PHC nursing has contributed to Health for All by applying these principles in practice.

1.2 What is Health for All?

The first question is – what is health and how should it be defined? Perhaps the best-known definition of health is that developed by the WHO in 1946:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity.

This definition was later refined to include the idea of health as a dynamic state and the spiritual component of health (WHO 1998a).

It is important to consider this definition of health if we are to think about how, as a global endeavour, we are to achieve Health for All and, in particular, what nursing can contribute to this. For example, is it feasible to think in terms of all people being in a state of complete physical, mental and social well being? In a WHO publication, *Health Crisis 2000*, O'Neil (1983) estimated that only 20% of Western diseases could be cured, suggesting that complete physical health may not be possible. But statistics of this kind should not suggest that little could be done to promote the health of 80% of the population and prevent disease wherever possible. On the contrary, health promotion and Primary Health Care have much to offer since only a small proportion of patients require a curative model of health.

The WHO definition of health is widely accepted, but is not without its critics. Seedhouse (1986), for example, suggests that it is a utopian ideal that can never be achieved, although it should be borne in mind that goals set by WHO should perhaps be concerned with achieving the ideal. Seedhouse himself has suggested that health is concerned with building foundations for achievement and he therefore defines a person's optimum state of health as:

"equivalent to the state of the set of conditions which fulfil or enable a person to work to fulfil his or her realistic chosen and biological potentials. Some of these conditions are of the highest importance for all people. Others are variable, depending upon individual abilities and circumstances." (Seedhouse 1986)

This is a useful definition from which to consider Health for All as there is scope to determine health physically and mentally and socially, but within realistic parameters that people can decide for themselves. Seedhouse talks about health promotion in terms of removing the obstacles that prevent people from reaching their potentials. For example, a physically disabled person may achieve their potential to work and make an active contribution to society where employers and employment policy enable the person full access to work and where social attitudes to disability are positive. Being able to work fulfils the person and thus, within this definition, it is possible to conceptualise that health may be possible even in the presence of disease or disability.

If we accept the WHO definition, the next question is one of measurement. How do we know when health has been achieved? What standards and indicators can be used and what systems can be put in place to effectively sustain health where positive outcomes have been gained? It is the methods and approaches to health indicators that can cause as much controversy as the definition of health itself. So called 'hard indicators' tend to emphasise outcomes related to

mortality and morbidity which critics argue only reflect the absence of disease. For example, a study of infant mortality in The Gambia (Hill et al. 2000) was a relatively rare example of a controlled study of the effect of PHC on infant and child mortality in the region. Villages were allocated to the PHC or non-PHC group and observed longitudinally over a period of 15 years. The results found some impact on infant mortality in the 1-4 age group in the PHC villages compared with non-PHC. But overall it was found that factors such as improvements in vaccination and ante-natal care across The Gambia were confounding the results such that infant mortality figures in the non-PHC villages improved just as well as in the PHC villages. While the authors take great care to report and explain their findings, it is evident that it is very difficult to design a study that can effectively isolate the intervention. Thus the 'hard outcomes' are difficult to identify as a direct effect of PHC.

'Soft indicators' that measure concepts such as health experience, social and spiritual well-being are more difficult to demonstrate and are open to much wider variation and contextual influence than mortality rates, for example. Nonetheless, the literature abounds with references from the health disciplines, psychology, sociology and health economics to address ways in which psychosocial measures of health can be developed and applied in standardised ways. A further extension of this is the argument that qualitative methods provide a more representative view of health as defined by individuals and communities themselves (Whitehead 2001) and that health is whatever people say it is as they are experiencing it. This lived experience of health has been discussed by ethnographers and taken up in the nursing literature; it has been increasingly used as an approach to understanding 'lay concepts' of health and illness. For example, a study conducted in Jordan (Nawafleh et al. 2005) used an ethnographic perspective to understand more about primary care nursing practice in relation to HIV/AIDS. Observation and qualitative interviews enabled the authors to explain the limitations experienced by PHC nurses in relation to preventing and controlling HIV/AIDS. They found that nurses were limited by educational opportunity, resource limitations, geographical isolation and lack of nursing leadership. Perhaps these important factors would not have been brought to light if the researchers had not attended to the views and experiences of the nurses themselves and had focused entirely on HIV prevalence.

This paper draws on the many ways in which health indicators can be used either alone or in combination with particular reference to the methods that have been adopted by nurses to try to reach some insights and understanding about their contribution to Primary Health Care.

1.3 The Ottawa Charter

The Ottawa Charter was the outcome of an international agreement reached at a conference in Ottawa in 1986 that was responsive to Alma Ata but was active in arguing for more progressive and radical action by both governments and non-government organisations. The Charter defines health promotion as:

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing. (1986:1)

The Charter goes on to express a number of principles that need to be adhered to in order for nations to aspire to Health for All.

Firstly, the Charter declares its prerequisites for health:

1.3.1 Prerequisites for health

The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic prerequisites. (1986:1)

Throughout the discussion above it has been apparent that there have been global challenges, perhaps unforeseeable in 1986, to these fundamental prerequisites. Nonetheless, there are also examples of how nurses have faced these challenges and developed approaches to health promotion that respect the principles of advocacy, enablement, mediation, building healthy public policy, creating supportive environments and strengthening community action; principles that signatories to the Ottawa Charter claim to uphold. The Ottawa Charter led to a paradigm shift in the public health and health promotion movement that became enshrined in notions such as 'the new public health' and 'upstream thinking'. The shift was a positive move away from a medical model of health and disease with associated issues of curative and expensive technologies and top-down approaches to health care decision-making, towards the rights of citizens to be involved in health care decision-making that represented a positive construct of health. It explicitly and actively encouraged a shift towards all public policy being 'healthy' through the recognition that health is dependent on those prerequisites cited above and therefore cannot be separated from any aspect of public decision-making. This was neither an easy nor an effective transition for many health care systems, and even 20 years on governments still struggle with the concept of healthy public policy.

Whitehead (1988) used the metaphor of 'upstream thinking' in her report on the implementation of health promotion into the British system. Her report was entitled '*Swimming Upstream*', which conjures up the struggle of swimming against the current towards some better place, i.e. health. The report provides a critique of the progress of various contributors to health promotion in the British system. Historically, it is a fascinating document because it shows how

rapid and responsive the British government was in many ways to the principles of Alma Ata and the Ottawa Charter. For example, the Health Education Council (that no longer exists in the UK) funded health promotion posts in universities and research to evaluate health promotion initiatives. The concept of the "healthy school" was adopted and schools were exhorted to develop curricula that developed the whole student and did not just focus on medical aspects of health and disease. General Practitioners were encouraged with incentives to provide health promotion clinics, screening and special care for older people. Importantly for this report, the British nursing education system underwent a radical change during the late 1980s that was led by a new Act of Parliament.

The nursing curriculum became health led with much emphasis on health promotion skills (e.g. see McLeod Clark et al. 1987 and 1990) and recognition of the individual in the community, not just as a person in hospital. Primary Health Care became a prominent aspect of work-based experience for all students of nursing, not just an add-on to the hospital-based, medical model of nursing that had dominated nurse education prior to that period. This was supported by an earlier major report entitled '*Neighbourhood Nursing*' (Cumberledge 1986) that laid down the needs and requirements for nurses to work closely with communities and to develop strategies for health needs assessment that were community or neighbourhood based. This would enable local responsiveness and effective health care to become possible outside the hospital environment. This approach has persisted in the evolving curriculum, but not without some difficulties. At the time, Whitehead (1988) commented on issues such as curriculum overload and the problems of, as well as the need for, continual curriculum shake-up. A problem that affects nursing education is that medical education has continued to be curative in orientation and health promotion is seen in the medical schools as fairly low status. More recently, in the British and American health care systems, the need to educate nurses to become independent practitioners, prescribers, clinical specialists and nurse consultants has shifted the emphasis back towards technological expertise rather than skills and knowledge to promote health.

1.4 Constraints and challenges to meeting Health for All

With the benefit of 30 years of data, analysis and argument it is possible to reflect on the evidence available and take a view on the degree to which HFA has been achieved. The Consensus of the WHO meeting 'Primary Health Care 21: Everybody's Business' (WHO 1998) was a reflection of 20 years since the Declaration of Alma Ata. The second paragraph of the consensus statement says:

'In spite of obstacles and constraints, substantial health gains have been achieved in these 20 years. Health has improved in many parts of the world and coverage with the essential elements of Primary Health Care (PHC) has expanded considerably to reach almost all populations. PHC has substantially influenced prevailing perceptions about health and its determinants and it has been adopted as a core health policy in many countries. Community participation has, for the most part, contributed to health development wherever communities have been empowered.' (p2)

This statement is a qualifier for the remainder of the document that goes on to discuss the inherent problems of achieving HFA. But even within the paragraph above, while there is a sense of hopefulness, there is also a lack of precision

about what the 'substantial health gains' have actually been and scope for speculation and ambiguity around such terms as 'prevailing perceptions about health' and 'wherever communities have been empowered'. What do these terms actually indicate and what evidence has been accumulated to assess degrees of empowerment, for example? Section 3 provides examples of specific PHC nursing projects that have tackled some of the conceptual and methodological problems of evaluating community health initiatives.

The consensus statement goes on to describe some of the problems with achieving HFA. It states that 'progress has been inequitable' and that in some countries or areas within countries, health has actually worsened. This is largely attributed to an increase in communicable diseases such as HIV/AIDS, tuberculosis and malaria but also to other problems such as violent trauma and substance abuse. Deterioration in health status is also attributed to inadequacies of PHC implementation and a lack of political commitment to allocate adequate resources to PHC. It argues that concepts such as community participation and intersectoral strategies 'have often not progressed beyond words'.

The inequities in progress can be supported by evidence from sources such as the World Bank and the Pan American Health Organization (PAHO). For example, PAHO (2003) reported in its 132nd session of the executive committee on '*Primary Health Care in the Americas: Lessons learned over 25 years and future challenges*'. In this document, the committee considers the impact that PHC has had on the health of the Americas in the 25 years since Alma Ata. Impact is assessed in terms of gains in life expectancy at birth as a global indicator of the impact of PHC on the health of the population. During the 25 year period, the Americas witnessed a 25% reduction in the risk of dying (from 9 to 7 per 1000 population) and an increase of six years in life expectancy for both sexes (from 66 to 72 years). Almost 50% of the increase in life expectancy is attributed to the reduction in risk of communicable and cardiovascular diseases. However, these apparent health gains are not equitably distributed. The paper describes demographic trends that are significant in terms of impact assessment: population growth (increased by 217 million in the region between 1980 and 2000), urbanization (major shifts from rural to urban living with associated economic changes), and demographic aging (the over-85 population growing at a rate of 3-5% per year). These in turn are related to economic growth in the region. There has been a tripling of the income gap between the richest and the poorest, despite a doubling in the Gross National Product (GNP) per capita. Of course the poorest are likely to be the elderly, women, children, the unemployed, unskilled and chronically sick and disabled – those who are also the most disenfranchised and most in need of effective PHC. The impact of PHC has been lower in countries within the region where there is the highest inequality of income distribution. It is clear from the evidence presented that North America enjoys a greater impact than Latin America and the Caribbean, although there are also substantial inequalities between the southern countries of the region. The document cites fertility rates, public spending on health, access to safe drinking water, institutional care in childbirth and literacy as showing significant geographical, gender-based and socio-economic inequalities when disaggregated by income. The committee argues that this evidence demonstrates the need to 'incorporate an equity perspective into PHC', which was what originally inspired the Declaration of Alma Ata.

Bergstrom (1996) has described the massive problems of inequity as the 'pathology of poverty'. He turns his attention to Africa where the World Bank has judged 65% of the population to be living in absolute poverty, a condition of total deprivation of the minimum living conditions essential for human dignity (McNamara 1981). Whitehead (2001) has referred to the 'medical poverty trap' where inequity is explained in relation to health sector reforms, in particular to the market orientated reforms that have led to massive increases in user fees in developing countries. Whitehead argues that families worldwide are being pushed further and further into debt and poverty through their need to fund access to health care and treatments, often at a cost several times higher than the monthly household income.

The key messages from these earlier documents are reviewed and updated in the WHO document *Primary Health Care: A Framework for Future Strategic Directions* (WHO 2003). For example, it quotes that the burden of disease from HIV/AIDS alone is projected to increase by nearly 20% between 2000 and 2010, and that the improvements in life expectancy in many parts of the world have been totally reversed by the impact of HIV/AIDS in others, especially sub-Saharan Africa, where the life expectancy at birth may only be half that of the wealthiest nations. Other global trends reflected in disease rates and risk factors are also quite startling in their potential impact on Primary Health Care services and, conversely, the impact that PHC could have on populations. For example, while perinatal morbidity looks set to be reduced by 60% worldwide, road traffic accidents are projected to increase by 88% and violence by 109%. These figures mask the inequity of the likely distribution of the changes – perinatal health in developed countries is already much higher than sub-Saharan Africa and will continue to rise as resources are put into maternity services and particularly into perinatal and neonatal intensive care services.

While the developed world enjoys the financial freedom and economic capacity to benefit from new technologies in road safety, it is ironically the poorest countries, such as India, where the highest percentage of road traffic accidents occur due to poor technology, under-resourced maintenance and patterns of urbanisation. The WHO report on the Global Burden of Disease (Murray et al. 1996, quoted by World Bank) clearly shows that road traffic accidents are the major cause of death for people aged 15-44 worldwide and that the high toll from road traffic accidents in the developing world has received little public health attention.

Carpenter (2000) makes the case for the Declaration of Alma Ata continuing to be as relevant and achievable today as it was in 1978. As Carpenter and others have clearly shown there have been significant health gains across the world since 1978 as measured by life expectancy, infant mortality and changes in communicable disease rates. There are, as indicated above, significant worsening health conditions that only serve to reinforce the enormous gulf between the richest and poorest countries of the world. Yet Carpenter insists that by drawing on policies based on 'community development' principles, i.e. the notion that the 'social dimension is positively important to health, that equality and community empowerment build social capital and a socially cohesive society conducive to health' (p. 348), then an alternative to the idea that globalisation is a force that is irreconcilable may be on offer. In other words, there may be a solution through focusing on local communities, a principle that PHC nurses have tended to adopt and which was always the inspiration for the Declaration of Alma Ata.

Primary Heath Care cannot solve all of the world's problems, and certainly nursing cannot solve them. But by analysing the work that is being done 'on the ground' and drawing on the more descriptive and qualitative accounts of health than can be readily obtained from global surveys, it may be possible, as Whitehead (2001) suggests, to understand in more depth what underlies decisions made by individuals and communities in relation to health behaviour and health care, what factors influence how they access and use the services and how Primary Health Care responds to health needs. It is perhaps here that the important issues about the nursing contribution can be located.

1.5 Summary

There continue to be major constraints and challenges towards meeting Health for All given the major global changes of the past 30 years. HFA continues to be an ideal that ethically, morally and economically (Bryant 2002) should be pursued. Trends in some important health indicators are in a positive direction and it seems that there is at least ideological commitment to reducing health inequalities and maximising the conditions that contribute to health. Primary Health Care has been pivotal to the health trends that are apparent, despite varying degrees of governmental commitment and shifts in health care policy often towards a market led system in which PHC has to struggle for viability. There are important lessons to be learned by exploring PHC 'on the ground' and looking at community development type models and qualitative accounts rather than simply relying on global data. Following a deeper discussion on the policy context of PHC in section 2, the part that nursing 'on the ground' has played in this trend is explored further in section 3.

2
The policy context for nursing practice in Primary Health Care

2.1 The ICN definition of nursing

Appendix 1 provides the ICN definition of nursing that is itself reflective of the spirit of Alma Ata and used as a basis for defining nursing throughout the paper. For the purposes of the following discussion, the whole range of nursing roles will be included within the definition of nursing. Thus, public health nurses, community nurses, health visitors, maternity nurses, practice nurses, nurse practitioners, school nurses, community mental health nurses, learning disability nurses, district nurses, home care nurses, palliative care nurses, community paediatric nurses and family nurses are all seen as coming under the umbrella of PHC nursing. In some countries, nurses also adopt midwifery roles and therefore midwives are not excluded from the discussion. However, the discussion will not extend to the roles and competencies of the wide range of nurses working in PHC worldwide, but aims to be inclusive rather than exclusive. It is hoped that PHC nurses will recognise something of their own contribution throughout the discussion.

2.2 The implementation of PHC

It has been argued that the policy initiatives for PHC as conceived by Alma Ata were slow to develop in the West (Johnstone and McConnan 1995). The models for PHC based on community participation and intersectoral collaboration originated in developing countries, such as China, where the introduction of barefoot doctors was hugely significant in reducing infant mortality from 175 to 49 per 1000 live births during the 1960s (World Bank 1993). For example, Johnstone and McConnan explain some of the apparent reluctance of the West by the supremacy of the medical model of health in the West accompanied by an imperialist belief that developing countries should be supported to follow this model. During the 1990s, Western governments 'discovered' the social determinants of health, openly acknowledged health inequalities and recognised the strengths of community involvement and intersectoral collaboration. The UK example of this new paradigm shift in PHC is hugely evident over the past 10 years in a range of Department of Health policies that report on the primary care led NHS (DH 1996, 2000), health inequalities (DH 2002a), health improvement strategies (DH 1999a), and involvement of the public (DH 1999b, 2002b), for example.

More recently, the Canadian government has received a report on the re-structuring of PHC services in Canada (Lamarche et al. 2003). The report provides an analysis and synthesis of the models of PHC services that have been used in Canada and other parts of the world. These are drawn together in a taxonomy of PHC models that incorporates professional models of PHC and community models of PHC. Strikingly, the authors of the report favour the community models of PHC and challenge the Canadian government to move away from predominantly professional models towards an integrated community model.

This was based on an analysis of key components including effectiveness, productivity, continuity, accessibility, equity, responsiveness and quality. The authors highlight that '*the integrated community model maximises attainment of the greatest number of effects and emerges as the most beneficial in several areas: health and service effectiveness, technical quality and appropriateness of services, cost control, continuity and equity of access*' (p.20). It is recognised by the authors that the integrated community model does not rank so well as the professional model on responsiveness and accessibility, but the analysis is based on the Canadian health care system where access to PHC is predominantly through a visit to the family practitioner's office. This type of access is not available to most of the populations of the developing world as argued by Whitehead (2001), thus the value of this type of access and responsiveness is based on a Westernised health expectation model, rather than what is actually experienced by most people in the world. Nonetheless, the authors of the Canadian report recommend that '*the integrated community model be used as a benchmark for changing primary healthcare across Canada*' (p.20). This snail-like progress towards adopting the Alma Ata principles within two highly developed countries has undoubtedly constrained the progress that PHC nursing has made towards Health for All in the Western world. This is contrasted with the rapid evolution in Korea, for example, where PHC quickly developed following the 1979 *coup d'état* (Cho and Kashka 2000, see section 3.4) and in South Africa where a community oriented approach to primary care was readily accepted and reported to influence the development of PHC in Western countries (Mullan and Epstein 2002).

Throughout these more recent policies there is a discourse that favours notions of community involvement, empowerment and collaborative partnerships across the health and social care sectors that are all within the spirit of Alma Ata, although rarely are these ideas deconstructed to a level where health practitioners could implement and evaluate them effectively. This results in PHC nurses having to constantly struggle with concepts of community involvement and re-cycle old arguments in order to demonstrate their contribution.

2.3 The nursing response

Internationally, the PHC nursing response has been to incorporate the spirit of Alma Ata (see appendix 2, ICN position statement on PHC nursing) and to develop strategies and interventions that reflect the principles of PHC as described at Alma Ata within the constraints of their own health care systems and political ideologies.

In 1996, the 49th World Health Assembly passed resolution 49.1 on Strengthening Nursing and Midwifery (appendix 3). This resolution was important for the recognition required by nurses working in PHC to ensure that they were more closely involved in national health policy and to demonstrate their effective use in '*priority areas of equitable access to health services, health protection and promotion, and prevention and control of specific health problems*' (para 4).

It is not uncommon to find references to PHC nursing research and practice from all parts of the globe that fully incorporate the principles of PHC. For example, in 1986 Sally Shaw described the role of nursing in PHC in the New Zealand health care system. She argues '*that this emphasis on mortality, hospital based health services should change. Much more attention is required to other important health concerns. Of particular concern is the category of health problems associated with socio-economic factors such as employment, housing, family mobility, income etc.*' (p.23). Her paper is in effect a wake-up call to the New Zealand health ministry and the nursing profession to develop health care policies that reflect the Alma Ata principles, pre-dating the UK and Canadian policy shifts by 13-17 years. However, New Zealand is an example of a country that was drawing on these principles long before Alma Ata. This was reflected by the work of the Plunket Society, in operation since 1907. This association works as a collaborative service between professional nurses and volunteers to all families with young children.

While it is recognised that the Plunket Society itself has evolved since its inception from a voluntary organisation to an embedded collaborative organisation, it is possible to speculate how the nursing profession of New Zealand was learning some of the lessons of the Plunket Society in the deliberation around its own PHC work. A practical example is the active role the Plunket society has taken in collecting breastfeeding data since 1922, enabling New Zealand to produce some of the best statistics in the world on exclusive breastfeeding – 79% of New Zealand mothers breastfeed exclusively at six weeks (Plunket Society 2003).

Even in the UK, while health care policy was catching up with Alma Ata, nurses were ahead of the policy shift. In 1977 the Council for Education and Training for Health Visitors published its findings on the principles of health visiting (CETHV 1977). The four guiding principles were as follows:

The principles of health visiting, UK
That health visitors should be concerned with:

- The search for health needs;
- The stimulation of an awareness of health needs;
- The influence on polices affecting health; and
- The facilitation of health enhancing activities.

Council for Education and Training for Health Visitors (1977)

The Plunket Society New Zealand

Plunket is in touch with local needs: the needs of Maori and Pacific people, the needs of those in isolated communities from Bluff to the far north and the needs of those who most need its care and support. Its policies and services are based on the real knowledge of local need that staff and volunteers develop in the communities in which they operate.

Plunket programmes aim to nurture and support families/ whanau with young children, linking them to additional support networks in their communities. Plunket's strategic approach to improving health is based on the principles of health promotion implicit in the Treaty of Waitangi (New Zealand's founding document) and the Ottawa Charter. These principles are implemented through Plunket's clinical and support programmes, educational activities, community partnerships, health research programme, and advocacy efforts.

Plunket Society website, 2003, www.plunket.org.nz

Health transition in Japan

In Japan, home care nursing and public health nursing play very important roles in health care provision. The health transition approach stems from changes in health care provision and financing schemes introduced into Japan in 2000, but intrinsically recognises the changing nature of health need. Health transition is seen as the unifying concept that explains the shift from health promotion and disease prevention to direct health care for acute and chronic illness through to support and care for an aging population. Nursing plays an important part at each transitional phase, but most significantly is described as having a 'triangulating role' through the growing awareness and practice of nurses in PHC influencing health care policy. This is not dissimilar to the fourth principle of health visiting as described in the UK.

Interestingly, health visiting, like the Plunket Society, also has its roots in public health and voluntary work in support of families with young children. Health visiting did not become part of the National Health Service until 1973. Prior to that time health visitors worked with the local authority and had social care responsibilities such as the adoption of children, as well as their health education responsibilities. The principles of health visiting have enabled a social model of health to be developed, mainly outside the health care system, for the promotion of family health in the UK. This has been a core identifying aspect of the health visitor's work that differentiates her from mainstream nursing. The principles were revised in 1992 (Twinn and Cowley 1992) but it was agreed that little was required to update them. Indeed, they have recently been applied in UK nursing legislation to support the more generic role of community public health practitioner.

As the changes in policy and practice have evolved globally, new models of PHC nursing have emerged. For example, the Japanese WHO Collaborating Centre for Nursing Development in Primary Care (Hishinuma et al. 2003) has developed an approach to PHC nursing based on the concept of health transition (see side bar).

In 1998, WHO Europe introduced the concept of the Family Health Nurse (FHN) as a possible means of developing and strengthening family and community orientated services. The definition of the FHN described in Health 21 (WHO Europe 1998b) states that the FHN will '*help individuals and families to cope with illness and chronic disability, or during times of stress, by spending large parts of their time in the patients' homes and with their families …With their knowledge of public health and social issues and other social agencies, they can identify the effects of socio-economic factors on a family's health and refer them to the appropriate agency…*'

In their review of *The Family Nurse*, Schober and Affara on behalf of ICN (2001) develop the evolving picture of the FHN in terms of roles and responsibilities, education, regulation, introduction into health care systems and their relationship to populations and communities. They also consider the competency base and possible models of practice. They conclude that FHNs make PHC more accessible and co-ordinated to the communities in which they work and that the model heightens the visibility for nurses as an entry point to services. The underpinning argument here is that FHNs have the potential to reach populations through working in partnership with families and communities. Macduff and West (2003) have evaluated the development of the FHN role in rural and remote areas of Scotland. This was based on the introduction of a new educational scheme for FHNs and followed the principles of a case study evaluation where nursing caseloads were studied as the units of analysis. These evaluators found evidence that the new curriculum was innovative and different from the existing nursing curriculum but there were problems with practice supervision and the integration of the new role into existing caseloads. FHNs found the practice to be satisfying but in many settings also demanding due to the failure to support and integrate the role locally. Families were generally very satisfied with the new service. However, it is arguably yet to be shown that the FHN offers an enhanced model of PHC practice and should be considered to be a piece of a jigsaw puzzle of nursing approaches that each makes a contribution to the big picture.

The FHN, as described by WHO, has been introduced into many European health care systems. For example, a study from Poland (Marcinowicz and Chlabicz 2004) found that the introduction of the FHN significantly increased home visits by nurses to families and patient satisfaction with the service. It is notable that the underlying principles of health needs assessment, working with families in the community and recognising the socio-economic determinants of health and acting on them are common to the practice of PHC nursing in Canada, New Zealand, Japan, Hong Kong, Poland and the UK, as well as many other countries.

Thus we find that, as PHC shifts towards its new paradigm, the policy representation of Alma Ata becomes increasingly apparent and the opportunity for PHC nursing to demonstrate its value within the health care system is simultaneously more demanding and more possible. The next section reviews a collection of examples from nursing policy and practice to demonstrate the diverse and complex nature of the nursing contribution to PHC.

Primary Health Care Nursing in Hong Kong

Twinn (2001) has described how PHC nursing in Hong Kong has developed to address the health needs of the community outside of their mainstream PHC work. For example, public health nurses in Hong Kong have been undertaking work in cancer care and education to increase the cancer-screening rate of women on the island. Nurses have also worked on a community based HIV/AIDS intervention project with apparently good effect. The nurses focused on psychosocial interventions with individuals and families in the community living with HIV/AIDS. The project offered an emerging opportunity for nurses to develop their skills and respond to the health needs of the community. Twinn also describes the opportunity that nurses in Hong Kong have used to work with the chronically sick in the community, again outside government-funded mainstream PHC. The examples are significant because they demonstrate an enthusiasm and willingness by nurses to face challenges and develop new ways of thinking in order to address particular health needs that are arising in communities such as in Hong Kong.

3
The Nursing Contribution to PHC – Reviewing the Evidence

3.1 The principles of PHC

This section reviews the evidence for the nursing contribution to Primary Health Care in relation to the key principles of PHC, as discussed by WHO (1978). In examining where nursing has made a difference, the precise nature of the contribution is considered. To this extent, reasonable judgements are made about the role of nurses as community developers, as health promoters, as managers of ill health and as public health experts. It is also evident how trends in PHC nursing have moved increasingly in favour of participatory and qualitative approaches towards evaluation, providing in-depth and 'on the ground' accounts, thus shifting from a more traditional outcome based model.

The Alberta Association of Registered Nurses (AARN 2003) has drawn together the five principles of PHC as a framework for developing and shifting practice in Alberta, Canada. These five principles are themselves distilled from the Declaration of Alma Ata, are supported by ICN (see appendix 2) and serve as a useful framework from which to analyse the nursing contribution to PHC:

The Principles of Primary Health Care (AARN 2003)

1. Accessibility to health services;
2. Use of appropriate technology;
3. Individual and community participation;
4. Increased health promotion and disease prevention;
5. Intersectoral co-operation and collaboration.

This section reviews each principle in turn and illustrates with examples from PHC nursing policy, practice and research around the globe in an effort to demonstrate that despite political pressures, economic constraints and the myriad global changes in health and disease over 30 years, nurses have risen to the challenge of making a difference at individual, family and community levels.

3.1.1 Accessibility

The AARN document refers to the key component of accessibility to health services as meaning that 'all health services are universally accessible to individuals and families in the community' (2003:1). To achieve this level of accessibility the document refers to the need to shift from single entry and exit points to multiple points of entry, including direct access to a nurse or physiotherapist, for example. It also refers to a shift from fragmented services to integrated inter-disciplinary teams who address the health needs of the population in partnership. This could improve the chances of reaching a state of health but this is often dependent on the *equity of access to such services*. Accessibility is often closely related to equity because the means by which people access services (fiscal, geographical, socio-economic, physical) are not equally distributed, leading to inequalities in health as discussed in section 1.

The concept of equity has been discussed by Almond (2002) in relation to the British health visiting service. Concluding from a concept analysis, she provides a definition of equity that '*involves conscious and deliberate efforts to ensure and monitor whether appropriate services are provided, and are accessible to those who stand to benefit most from their uptake. This may involve making decisions that result in unequal distribution for some. Yet the standard and quality of services should be the same for all, regardless of class, position, race, disability, age or gender*' (2002:604).

Almond's definition of equity includes the notion of accessibility and differs from the Canadian concept in that it does not assume universality of distribution. Rather, Almond argues that equitable access should be based on need and that need itself varies inversely to accessibility (i.e. those who need it most are least able to access health care).

Minority communities and vulnerable people are often at the sharp end of inequity – minority ethnic groups, people from socially deprived areas, people from very rural areas, the very old, the disabled, the disenfranchised. It is in these aspects of PHC that nursing can be seen to have made a contribution, both by working towards increasing equity of access to services and improving access to health.

***Example 1:** Nursing Care of People with HIV/AIDS in South Africa*
As highlighted in sections 1 and 2, one of the greatest impacts on Health for All over the past 30 years has been the arrival of HIV and AIDS. Nowhere has this been more devastating than in sub-Saharan Africa. UNAIDS estimates that between 270,000 and 380,000 deaths from AIDS occurred in South Africa in 2005. This compares with 9,600-24,000 deaths in the USA in the same year. The prevalence rate of AIDS for people aged 15-49 in South Africa is 18.8% compared to 0.6% in the USA (UNAIDS 2006). With the increased use of anti-retroviral drugs in the West, more people are now living with HIV, while in South Africa anti-retroviral drugs are not as readily available to the public meaning the mortality rate will therefore increase. Many of these deaths occur in the home with the support of home-based palliative care services, although such services do not provide 100% coverage. Uys (2003) conducted an evaluation of one such model of home based care in South Africa to assess the adequacy of counselling offered to clients, the site and quality of death and the provision of holistic palliative care by clinics and hospitals. Seven sites were studied which spanned five provinces in South Africa. The study period drew on data collected between six months and four years after implementation of the counselling service. Quantitative and qualitative methods were used, drawing on questionnaire data, interviews with community care givers, nurses and people with AIDS, on site visits and observation of home visits.

The importance of this study is that while the gross inequity of access to anti-viral therapy in South Africa is acknowledged, as well as the absolute poverty that exists, it is also recognised that people with AIDS have a right to die in dignity in their own homes and that nurses and community care givers can contribute to this process. It is also significant in its recognition of the need to evaluate services that are often under-valued because they represent *caring work* rather than *curative work*. Uys (2003) also demonstrates through her evaluation that, while over half of her sample died at home with the support of a community carer, the majority of those who died in hospitals were away from family, friends and the individualised care and dignity that home can provide. "Good" deaths

were also highly associated with dying at home, indicating further that more support should be put in to the care-at-home services. The counselling provided by community care givers and nurses was highly valued by clients, although it was not always possible to provide this in some sites due to staff resourcing pressures. Uys urges that more people with AIDS be recruited to help with counselling, as many are willing and able to do so. She also recommends that more HIV/AIDS counselling courses are made available, especially in relation to family caregivers, children and bereavement counselling. Overall, Uys concludes by recognising the enormity of the problem but also by offering practical ways forward for Primary Health Care in South Africa that will at least help people with AIDS to die in dignity. This example of nursing 'on the ground' contributes to our understanding of how health potential can be aspired to even in death.

***Example 2:** Health for Two, Kimak, Capital Health Region, Alberta, Canada*
Health for Two is a community-based programme that promotes healthy birth outcomes among marginalised women. The programme is a key strategy in linking at-risk pregnant women to primary health services in the Capital Health region of Alberta, Canada and to community support that addresses social and economic issues influencing women's health. It is therefore a development that addresses issues of access and equity. Capital Health serves approximately one million people in the urban and rural areas surrounding Edmonton, Alberta. Almost 20% of families are classified as 'low income' and almost 15% of Edmonton's population are members of immigrant/refugee communities, whose access to services is limited. The Health for Two model was designed to address barriers to access.

The programme reflects all of the WHO principles of Primary Health Care and is an interesting model in that it integrates all of the five components while specifically addressing the accessibility and equity needs of a targeted group. It reaches 2000 women per year, for many of whom this is their first contact with the Primary Health Care services.

Access is enabled through the provision of practical help as well as through an intersectoral approach to care provision that is largely nurse-led. Multiple barriers to healthy pregnancy have been identified such as poverty, poor nutrition, social isolation, substance abuse, teenage pregnancy, language and culture. Practical steps such as the provision of free milk, prenatal vitamins and bus coupons have enabled women facing many of these barriers to access the programme and return.

Community nurses work with social workers, youth workers and early years' development specialists to facilitate women's access to health information, social support and referral to appropriate services. A team of six nurse specialists work in the programme, which covers 30 public health centres across the region, to provide interventions for women with complex medical and social issues. Community nurses also work with the Multicultural Health Brokers co-operative, a team of peer counsellors who are members of immigrant and refugee communities. They provide perinatal outreach, including home visits, mothers' groups and prenatal groups for women with language and cultural barriers. All new parents are visited by a community nurse and this can provide the basis of a trusting relationship for follow-up services or links to other programmes, such as substance use or parenting. The programme also demonstrates appropriate use of technology through its use of community resources and its home-based monitoring services for eligible mothers.

Health promotion is an integral part of the programme and community nurses provide access to practical and relevant information through drop-in services on a wide range of issues. Participants have commented on the fact that they feel cared for, listened to and supported to make changes.

Overall, Health for Two is a wide-ranging programme that is resourced through a health care system (Capital Health) in association with other community agencies such as Social Services. It demonstrates the use of PHC nurses and a range of ways in which their knowledge and skills are used. However, the report does not provide a formal evaluation of the programme in terms of how Health for Two has changed perinatal outcomes or in terms of parental perceptions of the service. Its significance lies in the inter-agency commitment to making a difference to marginalised women and their children and its stated philosophy of building a programme around the principles of PHC. It appears to have made an impact that nursing agencies in particular might wish to consider following up and that meets the benchmark of an integrated community model for PHC as discussed by Lamarche et al. (2003).

***Example 3:** The role of nursing partnership interventions in improving the health of disadvantaged women*

A third example of the PHC nursing contribution to the access debate is the study by Lazenbatt et al. (1999) which describes an evaluation of the nursing contribution to improve the health of disadvantaged women in Northern Ireland. The project was carried out within the context of the Targeting Health and Social Need policy initiative that was specifically concerned with addressing inequalities in health status and social well-being. The aim of the programme was to detail the contribution that nurses, midwives and health visitors were making to targeting health and social need. Initially, this involved a survey of 1000 nurses working in areas of social disadvantage in Northern Ireland to assess their own judgements of the interventions they had developed to work with disadvantaged women. A response rate of 39% was achieved, detailing a total of 392 nursing interventions. The majority of these were health promotion interventions and included issues such as breast and cervical screening, childhood accident prevention, smoking cessation, adolescent suicide, AIDS/HIV awareness and lay health worker programmes, among many others. From this survey, the authors selected 22 interventions that had described an evaluation strategy for a more in-depth analysis. These case studies were selected according to criteria that would illustrate 'effective practice' involving nurses, midwives or health visitors.

Eight characteristics were identified that defined aspects of effective practice. These were:

1. Holistic view of health and social need;
2. Health alliances and inter-agency working;
3. Empowerment;
4. Research based approach;
5. Multi-disciplinary team working;
6. Needs assessment;
7. Community development;
8. Audit and evaluation in practice.

These criteria clearly reflect the Alma Ata principles. One of the case studies identified was the work of the Derry Well Woman Health Centre. Derry Well Woman aims to develop health programmes relevant to women living in the northwest of Ireland. Lazenbatt et al. (1999) identify the Derry Well Woman project as based in an area with one of the highest levels of unemployment and poverty in Europe. Its holistic view of health and social need has contributed to the group establishing itself as a model of effective practice in Northern Ireland, as recognised by the government (Meehan 2000). The authors argue that such groups are contributing to the evidence base on empowerment of women through the development of equal relationships. It would appear that the collective evidence from the 22 selected studies provides a promising insight into the nursing contribution through the illuminative approach to qualitative data and experience.

As argued earlier, and supported by Lazenbatt et al., perhaps one of the most significant contributions nurses in primary care have made over the past 30 years is to recognise the value of user perspectives, explanatory models and subjective experience in the evaluation of their work.

Summary
The nursing work from South Africa, Canada and the UK described in the above section all conform to Almond's (2002) concept of equity. They all address need within a social context and they all aim to increase accessibility to health and health services by those who need them most. Each selected example takes place within a very different health care system and yet we see some similarities in the ways in which nurses in primary care are working to achieve equity and accessibility. Common themes appear to be around equality and empowerment, needs assessment from the perspective of the person or group, partnership and involvement and evaluation using participatory and qualitative techniques. There continue to be huge variations in equity and access across the globe, but at least the examples that we see from nursing are encouraging. The next step will be to persuade governments of the merits of these approaches and the value of a range of different types of evidence on which to base health care and resourcing decisions. Some of these issues are picked up in section 3.1.2 in thinking about the appropriate use of technology.

3.1.2 Appropriate use of technology
The *ICN Code of Ethics for Nurses* (ICN 2006) refers to '*the nurse, in providing care, ensures that the use of technology and scientific advances are compatible with the safety, dignity and rights of people*'. To practise ethically and responsibly, PHC nurses must be aware of the range of health technologies available to them and be knowledgeable about their safety and efficacy.

The meaning of the word 'technology' has shifted in relation to Primary Health Care over the past two decades. Twenty-five years ago, technology may have referred more specifically to technical medical advances and the increased use of information technology. In the 21st century the AARN suggests that technology can 'refer to the structure and delivery of health services, human resources, medical equipment, pharmaceutical agents, or new interventions or techniques' (2003:2). In the western world, health technology assessment (HTA) has come to refer to the scientific evaluation of *any* health care intervention. HTA includes, for example, a review of the effectiveness of domiciliary health visiting (Elkan et al. 2000) and a study of the costs and benefits of community post-natal support workers (Morrell et al. 2000).

The AARN suggests that a shift is required from using new technologies without appropriate health technology assessment towards the '*appropriate use of technology based on evidence*'. It also involves 'valuing alternative and low tech. (viz) therapies or interventions that have a proven benefit.' (2003:3). There is therefore a relationship between the development of nursing knowledge and the way in which new health technologies are put into practice.

There are many examples in the literature of health technologies that nurses in primary care have developed and evaluated, some of which are discussed in detail below. Perhaps a more challenging problem for PHC nurses is the mechanisms by which knowledge is transferred into practice on a wide, if not global scale. The development of the World Wide Web, rapid access to massive databases of evidence, the growth of institutions such as the Cochrane Collaboration and the plethora of new journals, e-based discussion groups and teleconferencing facilities have provided the opportunity for knowledge to be shared globally more than ever in our history. And yet it is obvious from observation and from the research in this field that PHC nurses do not always make effective use of the technologies that are available. For example, a recent study (McKenna et al. 2004) has shown that there are multiple barriers for nurses and doctors in primary care to make use of evidence in practice. The following sections address the issues around appropriate use of and assessment of health technology that are particularly relevant to PHC nursing and the framework for evidence-based practice that supports ethical and responsible nursing practice.

Attention will also be drawn to the way in which PHC nursing interventions (technologies) are evaluated and here particular attention will be given to the evaluation of home visiting, a health technology that is at the disposal of PHC nurses throughout the world.

The assessment of health technologies in PHC nursing

If the definitions of health technology described by the AARN (2003) and the HTA programme in England (Dept. of Health) are accepted as being sufficiently broad to encompass health technology needs on a global level, then it is self-evident that almost any intervention undertaken by a PHC nurse or a PHC organisation can be described as a health technology. The assessment of such technologies in terms of effectiveness, efficiency, cost and quality become paramount in the discussion of what makes use of the technology appropriate. For example, is it an appropriate use of technology for PHC nurses to be involved in community out-reach or group work with teenage mothers? What is the exact nature of such interventions and how do they compare with alternatives? How effective is the use of telephone triage and electronic records in PHC? These clearly are enormous debates in themselves that cannot be fully covered within the scope of this paper. However, by examining the assessment of domiciliary or home visiting as an example of a health technology that is common to many PHC nurses across the world, the trend towards assessment of a technology and its utility can be explored and some lessons for the next 25 years of PHC nursing identified.

***Example 4:** A review of the effectiveness of home visiting – a 'low tech.' health technology*

Elkan and colleagues undertook the single most comprehensive assessment of home visiting in 2000. The authors of this report make it clear that the parameters of home visiting vary according to background and experience of staff, the target population, the target client group, the intensity and duration of the service, the administrative arrangements and the extent to which home visiting is the primary service or one of several, such as access to a health centre or clinic. Thus home visiting is not easily defined, especially when the ethnic and cultural variations of what is recognised as a 'home visit' are taken into account. For example, in some cultures the word 'home' has multiple meanings. We might consider what 'home' means to a refugee or a victim of war or flood for instance. Equally, the home, while traditionally seen as the domicile of the family unit, could also mean a group experience as in 'care home for older people'. People who are nomadic may have a different sense of 'home' to people who stay within a fixed abode. The review undertaken by Elkan et al. is therefore limited by its focus on a westernised understanding of home visiting to the family home where health activities with an individual or the whole family take place. Nonetheless, the review is significant because the intervention is 'low tech' and has the potential for PHC nurses anywhere in the world to use it appropriately. The appraisal of home visiting was publicly funded (and therefore acknowledged by policy makers) to assess the effectiveness of home visiting and therefore provides something of a milestone in the history of PHC nursing, where home visiting has played an historically important role.

The objectives of the review were:

- To assess the effectiveness of home visiting;
- To assess the cost effectiveness of home visiting, where possible;
- To assess the impact of home visiting on a range of client groups;
- To assess the relative merits of professional versus non-professional home visiting;
- To discuss the relative merits of universal versus targeted home visiting strategies;
- To identify the gaps in the literature and to establish where further primary research is necessary.

To achieve these objectives, the authors used the approach of the systematic review as an assessment technique. This enabled a large amount of evidence to be assessed (102 studies) in order to reach some conclusions about home visiting. However, the review was also limited by the inclusion of a criterion that studies under review should include a comparison group (including randomised controlled trials, non-randomised controlled trials and controlled before and after comparisons). Overall, the review did find evidence that home visiting was associated with improvements in parenting skills, amelioration of child behaviour problems, improved intellectual development among children, reduction in the frequency of unintentional injury, improvements in detection and management of post-natal depression, enhancement of the quality of social support to mothers and improved rates of breastfeeding. In relation to elderly people, the review found evidence to suggest that home visiting is associated with reduced mortality among the general elderly population and frail, 'at risk' elderly people, and reduced admission to long-term institutional care among the frail at risk elderly population.

An example from Brazil

Ceara, a poor state in Brazil, presents a model of care that may be achievable for other countries in which resources, income and education levels are limited (Svitone et al. 2000, cited by WHO). In 1987, auxiliary health workers, supervised by trained nurses (one nurse to 30 health workers) and living in local communities, initiated monthly home visits to families to provide several essential health services. The programme was successful in improving child health status and vaccinations, prenatal care and cancer screening in women. It was also low cost: salaries for the health workers were normal wage, few medications were used and no physicians were included. Overall, the programme used a very small portion of the state's health care budget. In 1994, the health worker programme was integrated into the Family Health Programme that includes physicians and nurses on the team with the health workers. For the first time in Brazil, large scale integrated, preventive health services were in place.

A limited number of studies reviewed indicated the cost-effectiveness of home visits to parents and their children and to elderly people and their carers. The review is limited by its exclusion of qualitative evidence; it does not synthesise the evidence about parental or family perceptions of the value of home visiting or their experience of it. The review also highlights the fact that many of the studies that were appraised by the authors were methodologically weak in terms of sample size, outcome measures, follow-up periods and response rates. Overall, the reviewers conclude that there is evidence to support home visiting to families with children and older people and their carers with some qualifications. Briefly, these are that the visit should be sensitive to the needs of the client; that professional judgement is required on the targeting of home visits; professional expectations about the outcomes of a visit should be realistic; that broadly focused home visits are more effective than those with a narrow focus and; that non-professionals can also play an important role in home visiting.

While Elkan's review makes no claims at all for generalisability beyond the objectives of the review, it provides a synthesis of knowledge that has potential for a wider applicability given the nature of the home-visiting intervention.

The message here is that, in order for PHC nurses to deliver an appropriate health technology, such as home-visiting, we need to understand much more about how and why it actually works. This suggests that there needs to be a generalised improvement in the methods and approaches used to evaluate interventions as well as methodological developments in the ways in which evidence is gathered and disseminated. It is equally important to address the issues of how PHC nurses can most effectively access and use the evaluations of health technologies so that interventions that most effectively meet the needs of the community and the policy requirements can be developed locally.

Home visiting as an intervention has been successful in Brazil (see side bar), but it remains the case that, in many parts of the world, PHC nurses do not have access to the knowledge needed to develop services – not only electronic access but libraries and journals where research and evaluation is reported. PHC nurses, working in remote and under-resourced areas of the world where the health needs are often the greatest, need support and access to technology that will enable them to have a more effective and more resource-efficient impact on their care. For thousands of PHC nurses this means technical equipment such as sterile needles and dressings, vaccine and antibiotics, anti-retroviral agents, a mobile phone or radio, clean water and a fresh food supply, but for all nurses there is also a real need for access to information technology. Knowledge itself, as a technology to be used as a tool to improve care, is under-rated and under-used by western nurses (McKenna et al. 2004) where the priorities based on need are very different to those in the developing world.

The challenge of transferring knowledge about health technologies between PHC nurses and between countries is therefore enormous if nurses are to share knowledge effectively and to make a difference to health outcomes. While there are many health technologies potentially available to PHC nurses, the next step should be to find effective and innovative ways of facilitating access to knowledge that enables nurses to develop their practice within their health care system. It is also important to ensure that governments and non-governmental organisations are aware of the need for the access to communications technology and the time required for PHC nurses to make real and lasting use of knowledge for

practice. This will undoubtedly include educational and training needs as well as resourcing the infrastructure requirements at local and national levels. The possibilities for the transfer of knowledge are endless, but can only be achieved for PHC nursing if planned systematically into resourcing models for health care delivery that take account of the development and learning needs of nurses.

3.1.3 Individual and community participation

The Declaration of Alma Ata (WHO 1978) states in Paragraph IV: '*The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.*'

Primary Health Care is seen as '*essentially health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation.*'

It is also suggested that Primary Health Care '*requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care...*' (WHO 1978).

Essentially, WHO sees participation operating at three levels - individual, family and community. While it is unclear precisely how WHO defines participation, it can be seen to include aspects of planning and decision-making at both individual and community levels and also encapsulates concepts such as self-help and self-empowerment.

It is within this context that health professionals working in the fields of Primary Health Care and health promotion have come to recognise participation as desirable and appropriate.

The AARN (2003) argues that to work towards the principle of individual and community participation in Primary Health Care, there needs to be a shift in thinking from the perception of the public as incapable of making complex decisions about health care towards meaningful and informed public participation in decision-making about personal health care and health care systems issues. This also means a shift away from the control of information by health care providers. The AARN paper also suggests that '*in the primary health care model the patient/client becomes a partner in care and the public becomes more involved in making decisions about how scarce health resources should be allocated*' (p.3). This notion of working towards a partnership approach in PHC is a dominant theme throughout the policy and practice related literature. To reach an understanding and possible conclusions around the contribution of PHC nursing to the debate, it is relevant here to attempt to explore some definitions of participation.

The concept of participation has a broad range of meanings that have been argued in the literature over the past 30 years. Morgan (2001) argues that there are two distinct perspectives that have emerged. Firstly, participation can be seen as a utilitarian effort to use community resources to offset the cost of providing services. Communities 'participate' through the use of incentives or persuasion to collaborate in an externally determined project. Their collaboration usually is in the form of contributing labour. The second perspective that Morgan refers to is participation as empowerment. This is more concerned with

communities identifying their own needs and working together to solve their health problems. Both perspectives are fraught with further convolutions of meaning; empowerment in particular is subject to its own body of literature (see Kendall 1998 for example). On the other hand, Brownlea (1987) has suggested that participation means '*getting involved or being allowed to become involved in a decision-making process or the delivery of a service or the evaluation of a service, or even simply to become one of a number of people consulted on an issue or matter*' (p.605).

Brownlea's definition conforms to a community approach to participation that coincides with the World Bank definition that suggests it is '*a process through which stakeholders influence and share control over development initiatives and the decisions and resources that affect them*' (World Bank 1996).

The necessity to shift the balance of power towards those communities which are disenfranchised or marginalised has become the emergent theme in recent years in PHC policy and practice, often embedded in an empowerment approach. These definitions and reflections on participation that emerged in the last 10-15 years can be recognised in the development of health care ideology and policy. Policies directing the ideological shift from a provider model to a community model have predominantly espoused patient and public involvement in every aspect of PHC. This includes participation in decision-making, resource allocation, heath care planning, and research priorities as well as at the family and individual level (e.g. Dept. of Health, England 1990, 1999, 2000, 2001).

There is, however, a tension between traditional non-western PHC models of community involvement and westernised models where the rhetoric is about empowerment but the evidence is thin. For example, research by Kendall (1993) found that health visitors in the UK demonstrated considerable difficulties in promoting a participatory approach to home visits to mothers with small children, despite the claims in health visiting literature that they work 'in partnership'. Themes identified through a process of conversation analysis suggested that the power base for health promoting interactions in the home lay clearly with the health visitor. Parents' ability to participate in the health promoting agenda was restricted by conversational 'rules of engagement' that prohibited parental involvement in the interaction.

Where PHC nurses have demonstrated their engagement with the concept of participation, it has been at the local or case-study level. The real value of PHC nursing in respect of participation is perhaps most promisingly articulated where several approaches to involving individuals and communities are brought together. Two examples from PHC nursing are drawn upon to show how nursing has both embraced and struggled with individual and community participation.

***Example 5:** The Crowfoot Village Family Practice*
Calgary Health Region Partnership project: Nurses' Roles in advancing Primary Health Care in a Primary Care Setting. Besner J. 2003.

The Crowfoot Village Family Practice is a collaboration involving five family physicians and staff from the practices including a public health nurse and a home care nurse, working as an integrated team to deliver high quality care for the people served by the family practice: a population of some 12,000 individuals residing in an urban area of Alberta, Canada.

The objectives of the project were:
1. To strengthen client decision-making skills and self-care ability;
2. To increase appropriate use of services;
3. To improve timely access to community and secondary/tertiary services;
4. To enhance management of professional resources;
5. To improve continuity of care;
6. To improve cost-effective resource utilisation.

The Crowfoot project arose out of a national/regional requirement to 'do things differently' in primary care. Thus the overall aim of the project was to change how service delivery is planned and organised, by creating a system that is more responsive to client needs. This was set in a context of a change in the way that family physicians were remunerated, moving to a per capita fee rather than fee for service. The practice agreed to provide a more comprehensive range of services, improved access and a greater role for nurses. Patients were encouraged to engage in a proactive approach to managing their health. What difference did this new way of delivering PHC make to the community?

The interim evaluation of April 2003 indicates that the project did make some positive changes for the population. One of the services introduced to help improve access and increase the capacity for self-care was Nurse Telecare. This provided an out-of-hours and during hours service and enabled triaging of patients to take place as well as self-learning opportunities. This resulted in a reduction in the number of minor ailments (such as sore throats and runny noses) seen by physicians. Moreover, the patient survey based on a random sample of 800 adults showed that overall the community were very satisfied with the services being offered. The project reports on an increase in teamwork but also suggests that there continues to be more 'physician down' communication than shared communication.

The project seems to reflect the utilitarian approach to participation rather than empowerment as discussed by Morgan (2001). This is evident through the fact that the project was externally determined by the Calgary Health Region Board, rather than being initiated by the community itself. There appears to be an incentive for the community to take part in the form of a wider range of services and the promise of better access. These have worked in the sense that people are satisfied with the service and have reportedly increased their self-caring abilities. However, it raises the question of sustainability and how able the health care practitioners are to change in the longer term to enable an empowering approach to evolve. This can be contrasted to an Australian study led by Koch and colleagues (2004).

Example 6: *Development of a collaborative model of care for long-term management of incontinence for people living in the community with mental illness.*
Koch T et al., Royal District Nursing Service, Australia, 2004

This study, conducted in South Australia, demonstrates how involvement of community groups can improve health care and outcomes. It also shows how participatory approaches to projects can involve a range of methods and a range of participants from health and social care. The messages from this project report are particularly powerful because they relate to a client group that has been traditionally vulnerable and disenfranchised: those with an enduring mental illness. This project shows valuable potential for real impact, not only on primary care services in Australia, but also on the ways in which nurses conduct and evaluate their practice.

The project draws on participatory action research methods in order to assess the needs and plan appropriate care for people living in the community, who have enduring mental illness and a continence problem. The issue was brought to the attention of the project team by mental health workers who were aware that for people with mental illness, living in Supported Residential Facilities (SRF) in South Australia, there were problems associated with management of continence and quality of life. A big issue was that SRFs are not funded nor have any requirement to undertake care of problems such as incontinence and therefore people with quite severe mental illness had to cope with protracted and unacceptable levels of poor hygiene, poor quality of life and medication mismanagement.

The objectives of the project were:
1. To develop a participatory, collaborative and transferable model of care that will promote effective management of urinary and faecal incontinence for people with mental illness living in the community;
2. To identify how key community services can collaborate in order to reduce the incidence of incontinence for people living with mental illness;
3. To develop, disseminate and evaluate training packages and resource material to services and accommodation providers across Australia that will provide a focus for the problem and strategies for management of incontinence for people living with mental illness.

These objectives were addressed through participatory action research (PAR) groups with the clients (22 clients over 10 hours in four PAR groups), SRF staff and community mental health workers (five PAR groups). These were facilitated by the project team who themselves are very experienced in this approach. The report provides some detail as to the conduct of the PAR groups that enables insight into the processes that are vital to participatory practice. The project also included the services of a continence nurse advisor who helped to co-ordinate services and plan and provide care for clients. Quality of life was measured over the period of the project using the Client Generated Index of Quality of Life tool (CGI QOL, Annells et al. 2001). Significantly, the approach of the PAR groups was to generate discussion that enabled clients to explore their views of being incontinent and to seek their own solutions.

The solutions and care plans generated were therefore drawn from the clients' own perceptions and ideas, but were supported by the continence nurse advisor in order to enable the necessary resources to become available. Clients identified some self-managing strategies such as drinking less at night and using a bedside receptacle to pass urine into that helped them to manage night-time wetting. Dietary changes and exercises were also well received, as were reviews of anti-psychosis medication. Overall, the project team found there were noticeable improvements both in continence and in quality of life. Importantly, the team found that the participatory approach enabled some SRF staff to become more willing to be involved in the care of clients.

This project is an example of how nurses in primary care can work in a participatory way with professionals and the community to arrive at some agreed strategies that make a positive contribution to alleviating a health problem. The alternatives might have been to have imposed regulations on the SRFs to manage incontinence according to a set of guidelines, to have supplied huge quantities of incontinence aids or to have simply accepted the status quo. The participatory approach appears to have overcome many of the problems that these alternatives might have generated, for example resistance on the part of the SRFs to accept guidelines. The project is therefore a model of participation through empowerment that has led to a genuine transfer of power from the professional to the client and to real improvements in both continence outcome and quality of life. This model should be transferable to other areas of PHC nursing practice and used as a template on which to build educational resources and conceptualise approaches to community participation.

The two examples of PHC nursing projects presented above that have both drawn on participation as an approach to improving Primary Health Care provision can be seen to represent both the utilitarian and empowerment approaches. Both approaches can be useful in involving the community in arriving at decisions about health care. Both approaches require detail in their accounts so that primary care providers in other contexts can usefully draw on the information and use the principles in the development of their own services. To move beyond the rhetoric of community and individual participation, it is essential for nurses to make use of the evidence that is becoming increasingly available and to share knowledge around implementation and evaluation issues that is underpinned by theories of participation.

3.1.4 Health promotion and disease prevention

The AARN discusses the need for PHC nursing in Alberta, Canada to move towards a shift from a disease based health care system to one where health and well-being is the focus; an increasingly community based system of health enhancement and maintenance, where the client is meaningfully involved in health care decisions and a proactive or upstream approach in which there is early identification of health risk, health promotion and disease prevention. These principles are totally convergent with the Declaration of Alma Ata and relate to subsequent worldwide debate such as the Ottawa Charter on Health Promotion (WHO 1986).

PHC nursing and health promotion effectiveness
Globally, the extent to which PHC nursing has explicitly been a part of the health promotion movement has varied from region to region but the evidence would suggest that nursing activity has certainly made an implicit contribution to heath promotion and disease prevention and in many areas has become a *raison-d'être* for PHC nursing. Examples from the nursing literature over the past 30 years of effective health promotion activity by nurses are too numerous to evaluate in their entirety, thus examples are evaluated here that attempt to demonstrate some of the successes and challenges faced by nurses working within or alongside the principles of health promotion.

***Example 7:** Nursing for Health*
Nursing for Health (Elliot et al. 2001) is a systematic review of reviews. It focuses on public health and is one of the only fully comprehensive syntheses of evidence on public health nursing available. It therefore provides detailed evidence of effectiveness of what the authors describe as public health nursing. Public health nursing is not, however, clearly defined by the authors, but apparently embraces all aspects of nursing activity that contribute to public health. Public health is defined as 'the process of mobilising resources to ensure the condition in which people can be healthy' (p.2). It refers to the prevention of disease and promotion of health in communities, by which is meant geographical regions, client groups such as older people, disadvantaged people and those with particular health problems such as heart disease. It therefore reflects the spirit of the Ottawa Charter although the authors of this review pay less attention to the contribution of nurses to healthy public policy than they do to specific interventions by nurses. The scope of public health nursing in this report includes the community, the home, the workplace, and schools. The report originated in Scotland but covers a huge range of evidence from a wide range of international initiatives and systematic reviews and has implications for nursing across international contexts.

The aims of the review are:
- To construct a comprehensive list of published and unpublished primary studies and review articles using a pre-defined search strategy.
- To appraise and critically assess the evidence for effectiveness of interventions relevant to public health nursing.

The reviewers identified 14 health topics that are major health priority areas and where nurses had a major input. The search covers the period 1989-1999 and uncovered 700 primary research studies and 300 review papers. The topic areas are: coronary heart disease, cancer, mental health, accident prevention, child and adolescent health, maternal health, care of the elderly, smoking, alcohol abuse, illicit drug use, diet, physical activity, sexual health and inequalities in health. Within each topic area there are several sub groupings related to client groups, types of intervention and settings.

The reviewers found many examples of effective interventions across all the health topics. However, Elliot et al. summarise from their appraisal:

- There is only weak evidence that short-term reductions in alcohol consumption resulting from school based programmes are successful and that indeed there is some evidence that alcohol consumption may increase in the short term.
- There is some evidence to suggest that community based programmes may be more effective than school based programmes for reducing or preventing smoking among young people. Many studies show no impact at all on smoking, alcohol or drug use.
- More encouragingly, the reviewers found stronger evidence for nursing interventions concerned with diet and exercise among young people. For instance, a review of school based interventions (Lister-Sharp 1999) found strong evidence of increases in food knowledge, although less evidence of behaviour change.
- Overall, the most successful programmes were those that involved parents, were long term and provided choices.

Throughout the review, Elliot et al. comment on the need for more qualitative evidence of nursing interventions. This is partly explained by the fact that this review excluded qualitative reviews but also by the apparent lack of good qualitative evidence from previously published reviews (including the review of home-visiting by Elkan, cited above). Such additional evidence would help us to understand more about *why* the school based programmes have not significantly reduced alcohol intake – perhaps the programmes have not been tailored to the young people's needs for example. It will be of interest to future reviews of nursing to see how the application of such methods develops our understanding of nursing interventions, especially in topics such as health promotion that are difficult to evaluate on quantitative data alone.

PHC nursing and healthy public policy

Whilst the review by Elliot et al. provides a large database of information on the effectiveness of public health nursing in health promotion, it does not provide sufficient commentary or evaluation on the contribution that PHC nursing has made to healthy public policy. It would appear that PHC nurses are well prepared to develop interventions at the individual and community level, but less involved in utilising the success of interventions or analysing the reasons why interventions have failed, to inform the development of policy at local and national levels.

Hannigan and Burnard (2000) have argued that nurses should be more aware of policy and politics but that this should be through a much more critical analysis of the policy process and context rather than a simple exposure to government documents. The nursing curriculum has not been explicit or dynamic in this respect. These authors draw on the notion of nurses as 'street level bureaucrats' (Lipsky 1980, cited by Hannigan and Burnard) professionals who are enacting and developing policy on the ground and are therefore influencing its evolution and impact at the practice level, perhaps without the skills to articulate action. They argue that nurses need to understand and critically analyse the ideological and power issues that sustain the policy process in order to have a more direct effect on the policies that affect health.

Critical accounts of this type of policy analysis are, however, rare in the nursing literature, especially those making any direct link to Primary Health Care and Alma Ata. It was therefore a rare and exciting occurrence to find Cho and Kashka's (2004) paper on the evolution of the community health practitioner in Korea.

***Example 8:** Nursing leadership in Korea*
This paper details how PHC nursing leadership in Korea has directly influenced and had a relationship with health care policy in Korea since the *coup d'état* in 1979. One nursing leader in particular, Mo-Im Kim (former president of ICN), took the opportunity to bring the principles of Alma Ata into the post-1979 health care reforms and to ensure that community health nurses had a voice and power within the new political system. For example, some of her earliest work was to collaborate with government to bring PHC to the poorest fishing and agricultural communities, demonstrating not only a model of health care provision by nurses that is sustained today in Korea but also that this can be provided equitably through a combination of critical awareness, negotiation, knowledge and skills. Kim argued that '*nurses must approach the above nine roles (of community health nursing) with positive attitudes of nurses' position to promote community health, rather than merely helping others in the provision of health care.*' (Kim 1978).

Despite the successful programme of community health nursing that evolved in Korea over a 25-year period, Cho and Kashka warn that this is being undermined by the pressures of debt repayment to the International Monetary Fund. They implore international nurses to draw on the skills and knowledge of Mo-Im Kim to influence international policy that affects health care provision. This recent paper represents a challenge to the international nursing community in its evolution towards political awareness.

***Example 9:** Nursing and policy in North America*
The American Nurses Association (ANA), that has all registered American nurses in its membership, has exhorted nurses to become more involved in public policy, especially around older women's health (Gonzalez 2000). Again, the significance of nursing leadership is discussed here in recognising how powerful arguments and advocacy for older women's health issues can be played out at government level. For example, the ANA has directly and successfully influenced the inclusion of breast reconstruction after mastectomy as a right for women into health care law reform by the United States Senate. Gonzalez argues that nurses should continue this type of political argument and lobbying by using a unique set of advocacy conditions, their roles as nurses, women and constituents. These conditions can be best fulfilled when they are facilitated by outstanding leadership qualities.

***Example 10:** Nursing and policy in Pakistan*
In Pakistan, an experimental curriculum was introduced for nurse teachers to enable them to conduct research that had a direct impact on health care decision-making by developing their leadership skills (Lee et al. 2002). A small cohort of nurses undertook a two-week programme of research and data collection that enabled the Pakistan Nursing Council to update its newly introduced computerised system of registering nurses, midwives and lady health visitors. This research in turn provided updated and corrected data on the nursing workforce in Pakistan, data that has a direct impact on the development of health care services. For most of the nurses involved in the project, this was the first time they had used a computer or been involved in any kind of data collection on this scale. The project proved invaluable not only in the provision of relevant

national data, but also in raising the skills and knowledge base of nurses who could interpret the relationship between their research and its potential for impact on nursing workforce development and health policy.

Summary

This section on the principle of health promotion and disease prevention has discussed the significance of the Ottawa Charter in the health promotion movement and, as part of this, the need to critically consider the role that PHC nurses can and have played in health improvement and health policy. There are hundreds of examples of nursing innovations that have not been described – nurses' role in immunisation and the prevention of communicable diseases; their role in the promotion of breastfeeding and childhood nutrition; or their role in working with families who have been ravaged by war or famine. These are all acknowledged as significant developments worldwide that have made a difference to international health improvement. The emphasis here has been on the need to establish an evidence base for health promotion by PHC nurses that was illustrated by reference to *Nursing for Health*. While it was possible to highlight the necessity and value of the synthesis of evidence for public health nursing from this report, it was also apparent that there are shortcomings in the available evidence, particularly in the analysis and synthesis of qualitative studies. Over the next five years, PHC nurses and faculty in universities should try to use their expert skills in undertaking qualitative studies to ensure that methodologies are enhanced so that this evidence can be drawn together and more widely applied.

The second strand of this section has been to examine some examples of where nurses have been directly involved in developing healthy public policy. Lessons can be learned from the way in which nursing leadership in Korea, Pakistan and the USA has been influential in the evolution of the nursing curriculum and the impact that nursing had had on policies affecting health. This analysis has provided some insight into the ways in which nurses can engage in upstream thinking and make a positive contribution to health promotion in their communities. The orientation in the future for PHC nursing should be to identify effective practice, articulate through qualitative studies how and why interventions work for different communities and to incorporate this into programmes of work that are *directly linked* to local and national policy initiatives.

3.1.5 Intersectoral collaboration

Intersectoral collaboration is the fifth principle of Primary Health Care to be considered here. The concept of collaboration between a range of agencies is a cross-cutting one that fundamentally incorporates the principles of equity, use of technology, participation and health promotion. While these principles could, theoretically, function in isolation it is difficult to envisage how they could operate *most effectively* without actively ensuring that agencies together with the health care system are working in co-operation towards common goals. The AARN has argued for a shift in the Canadian system from the health care services having sole responsibility for health towards better integration with other sectors that impact on health such as education, labour, justice and social services. It also argues that this approach is more successful if there is a shift away from an individualised focus on health care to one where the population and the individual in the community context becomes the focus. This is convergent with Lamarche's (2003) analysis of the integrated community model of PHC discussed in section 2.2 and would seem applicable to all countries.

***Example 11:** The Healthy Cities movement*

The principle of intersectoral collaboration can be clearly recognised within the Healthy Cities movement. The WHO Healthy Cities Project (1988) was central to the shift towards the recognition of the multi-factorial nature of the determinants of health. There was a plethora of publications in the late 1980s and 90s that emerged from the Healthy Cities/new public health movements that legitimated health promotion work outside the health services. There was an explicit understanding that health promotion was integral to primary care and that primary care extended beyond the doctor's surgery into local government, housing, education, justice and environmental policy. Global urbanisation was (and is) both a threat and an opportunity for Health for All. The key to achieving a sustainable urban environment for health was therefore the effectiveness of integrated decision-making and professional groups and agencies working together 'on the ground'. The degree to which this approach can be said to have been successful depends, again, on the evaluation methods employed and the measures used to judge whether or not a community is healthy. The network of Healthy Cities around the globe that have emerged since 1988 are testament to an international commitment to intersectoral collaboration as can be seen from the range of papers that were presented at the 2003 Healthy Cities conference in Belfast (www.belfasthealthycities.com/2003/).

The extent to which PHC nursing has become integrally involved in this movement is less conspicuous. Beverly Flynn is notable as a nursing leader in the USA who has made a major contribution to the Healthy Cities Project and discussed the ways in which nurses can work in partnership with the community to improve health (Flynn 1997). Flynn has argued and demonstrated that community-oriented advanced practice nurses (APNs) have skills and expertise to support community leaders in their efforts to build healthier communities. She recommends that APNs draw on examples such as community leadership development, community assessment, nurse managed services, research and policy advocacy. These are skills that are not always seen as part of the nursing curriculum, although, as seen in section 3.1.4 above, it is possible to develop such skills among PHC nurses and to re-orientate nurses to think and practise in such a way that the community becomes the focus of their work as well as the individual in the community. This is a cultural challenge for nurses who have been socialised through their education and life experience to think of the nurse as the carer of individual patients rather than the assessor of community health needs, the community advocate or the inter-agency worker. However, these challenges are not insurmountable as Flynn (1997) has shown in the USA.

***Example 12:** The Teamcare Valleys Project – an example from the UK*

The following example is from the UK where nurses practised alongside other agencies in a regeneration project in South Wales, one of the most impoverished areas in Britain. The South Wales valleys have been traditionally an area of coal mining and industry. Mining has taken its toll on the health of the South Wales communities, but during the economic slump of the 1970s many of the mines closed, industry dried up and unemployment rose to unprecedented levels. An area that was already in relative poverty and demonstrated gross inequalities in health, in terms of both mortality and morbidity, became further engulfed in the effects of low income, poor housing and the psycho-social effects of the loss employment and the ensuing post-industrial decline. The project was funded by the Welsh Office from 1990-1993.

In her introduction to the project report, Bryar (1994) reminds us that the South Wales valleys met the criteria identified in the Vienna Declaration on Nursing Support of the European targets for Health for All:

'*The persisting inequalities in peoples' health status, both between and within countries of the WHO region are politically, socially, economically and professionally unacceptable and are therefore of common concern to all nurses*' (WHO 1988:5).

The overall aim of Teamcare Valleys (TCV) project was to help to develop Primary Health Care in the Valleys area. The integration of the principles of equity, participation and health promotion are embedded in the project's philosophy and strategy. The most significant feature of the TCV project was that it was multidisciplinary. Nurses, doctors, social workers, community workers, social scientists and management personnel worked together in small teams to tackle particular problems across a wide range of geographical locations in South Wales. The nurses involved in the study were employed by the University of Wales as 'clinical fellows', giving them the opportunity to both practise within the local community and to develop their research and evaluation skills. The fellows were supported and facilitated by a senior lecturer from the University and a lecturer in social science. Five full time clinical fellows were employed and many of these went on to complete PhDs or Masters degrees, thus enhancing their leadership qualities as well. In addition, the funding allowed for the appointment of 16 short-term clinical fellows over the period of the study. The clinical fellows were challenged by the move away from a traditional style of PHC nursing practice focused on the individual towards a community orientated approach in which they worked in partnership with other disciplines. However, it proved to be one of the most successful and enriching outcomes for the project that people learned from each other's expertise and experience. Essential to the success of the project was how the clinical fellows could use their skills and experience to involve the whole Primary Health Care team at the local level. This was approached through the identification of locally based projects that were relevant to those communities and the PHC staff that worked within them. For example, projects were undertaken on leg ulcer management (Rees 1996), continuity of midwifery care (Marx 1996), community needs assessment (Thomas 1996), interpersonal skills development (Coles 1996) and understanding depression in the community (Proctor et al. 1996). In total, 21 projects have been reported, each taking place within the complex environment of PHC in the Welsh valleys. Six key concerns for PHC nurses were Support, Teamwork, Research, Education, Audit and Management, expressed by the mnemonic STREAM.

Within this framework, Bryar then applied a structure, process and outcome evaluation approach to each strand. The detail of these can be found in the report, but of interest here is the teamwork and multi-disciplinary learning that the TCV project facilitated. Throughout the TCV project, there was an expectation that multi-disciplinary and inter-disciplinary teamwork would be promoted through educational and practical measures. Previous work by Bryar (1991) had identified a distinct lack of attention in the British PHC nursing education system on either the theory or practice of teamwork. This led project leaders in TCV to consider new and innovative ways of developing this aspect of PHC nursing practice. Innovations such as inter-disciplinary work-based workshops, facilitation in practice, road shows and a short course entitled 'Team working in practice' all contributed to the development of a team-based culture. Slater (1996) found through her project on occupational stress in PHC that high levels of job satisfaction were related to high measures of teamwork.

The TCV project supported several multi-disciplinary courses on topics such as community and public health, management of child abuse, wound management and prevention of cancer in primary care. At the time, these courses were described by the Welsh National Board for Nursing, Midwifery and Health Visiting as unique in Wales. The outcome of this approach was positive, although it is recognised by the evaluator that bringing people together in a room does not in itself correspond to a shift in inter-disciplinary thinking. The courses therefore included opportunities for debate, discussion and small tutorial groups that enabled an improved understanding of professional roles and perspectives.

The health outcomes for the community as a result of TCV are less conspicuous than the obvious gains for nurses and other practitioners. There is an implicit understanding within the TCV project that better outcomes for nurses would lead to better outcomes for the community. This may be so but clearer evaluation objectives for the community would have enhanced our understanding of this complex relationship. For example, Proctor et al.'s (1996) project focused on depression in the community and the ways in which community psychiatric nurses (CPNs) and general practitioners (GPs) define depression. They found that GPs differentiate between depression and sadness, leading to different referral mechanisms. CPNs, on the other hand, could offer support to both the depressed and the sad. The authors conclude that joint learning would enable these divergent views of depression to be explored so that people suffering with depressive symptoms might benefit from a team-based approach and improved referral systems. It is not possible from the reported study to say whether the community did in fact benefit from multi-disciplinary learning.

One of the overall conclusions from the TCV project was that:
'*a multi-disciplinary resource which provides a unique combination of expertise is effective in supporting the development of primary health care nursing*' (Bryar 1994).

There is no doubt that the TCV project provides an excellent example of a government funded initiative to improve PHC through the explicit involvement of nurses in a multi-disciplinary context. The lessons that should be learned from TCV for the future development of the principle of collaboration are that funding should be at a sustainable level so that new innovations can be fully evaluated and built upon (TCV was funded for three years only); that such sustainable programmes should then be in a position to evaluate the short and longer term health outcomes for the community; that the educational and learning opportunities arising from such projects should be transferable into other settings; and that those decision makers responsible for developing national nursing curricula should be aware of the significance of innovative projects such as TCV.

Summary

This section has reviewed the potential for PHC nurses to be involved in the application of the principle of intersectoral collaboration. Opportunities have been drawn upon from the WHO Healthy Cities Project and from a different geographical perspective in one UK region. While it is self-evident in many ways that working across professional groups and agencies should provide an opportunity to enhance health outcomes, there is scant evidence that PHC nurses have fully developed or utilised the skills or knowledge to really embrace intersectoral collaboration. This evidence base needs to be enhanced, perhaps through a systematic review of the effectiveness of collaborative practice or at least through a focused literature review that distils the qualitative evidence of the impact on PHC practice of intersectoral collaboration. Currently, the knowledge base as to *how* collaboration works effectively and for *what* particular groups and *why* is somewhat lacking from a PHC nursing perspective. Good examples of practice such as those cited above, need to be widely disseminated and promoted by WHO and ICN so that PHC nurses in other settings can build on good practice and develop an iterative approach to building knowledge.

The final section of this paper will attempt to address the overall conclusions from the diverse range of issues discussed above and speculate about how PHC nursing might develop over the next decade in order to enhance the nursing contribution to HFA.

4
The Way Forward – the Future of PHC Nursing

This paper started with the task of reviewing how PHC nursing has contributed to the aims of the Declaration of Alma Ata. This was not a simple task and as the review of published and unpublished literature, expert opinion and web-based materials has grown the complexity and immensity of the overall aim has become increasingly apparent. Conclusions of the paper must therefore be preceded by some caveats and qualifications.

Firstly, it would have been an impossible task to review all of the global evidence since 1978. The decision was taken to use a broad-brush approach and provide some detail to the picture through the use of examples of what seems to be good practice. Clearly, there are many, many others that are not mentioned here and apologies are due to those practitioners and researchers who may have rightfully expected to have their work cited. This omission paves the way for future reviews of good and effective practice.

Secondly, to overcome some of the problems of managing the volume of material, existing systematic reviews have been drawn on. This has enabled a more rapid analysis of the evidence that has already been subjected to a rigorous appraisal. These reviews have been used as a tool to find the evidence but also as an example of how health technologies can be appraised and the transfer of knowledge activated within PHC nursing.

The individual examples of good research or practice have been selected by the author and may well be subject to considerable bias. Decisions have been made on the grounds of how well the examples demonstrate the principle under discussion, what they tell us about PHC nursing practice that contributes to our understanding of HFA and what lessons we can learn from examples. In this respect, every effort has been made to be globally representative. While the examples represent good research or practice, they are not perfect but in most cases do lead us to consider how things might have been improved in different regions of the world and how that knowledge might be transferable to other settings.

Having stated these qualifications, what conclusions can be drawn about the contribution of PHC nurses to the principles of Alma Ata?

In 1985, the Director-General of WHO, Dr H. Mahler, proposed that nurses could "lead the way" in Primary Health Care. He suggested that the profession would experience the following changes:

- The roles of nurses will change; more of them will move from the hospital to the everyday life of the community, where they are badly needed;
- Nurses will become resources to people rather than resources to physicians; they will become more active in educating people on health matters;
- Nurses will increasingly innovate and participate in programme planning and evaluation;
- Nurses will participate more actively in inter-professional and intersectoral teams for health development;
- More and more nurses will become leaders and managers of Primary Health Care teams; this will include guiding and supervising non-professional community health workers;
- Nurses will thus assume greater responsibility for taking decisions with health care teams.

It does seem apparent from the review of the principles of PHC that nursing has made an important contribution to the progress that has been made over the last 30 years towards HFA and in so doing has achieved many aspects of the changes in nursing that Dr Mahler predicted. Nursing has indeed shaped PHC and the achievement of Health for All through its adherence to the major principles and values that underpin PHC. Throughout the above discussion, reference has been made to the way in which PHC nurses have developed practice with the principles of accessibility to health services, the use of appropriate technology, individual and community participation, increased health promotion and disease prevention and intersectoral co-operation and collaboration at the heart of their care.

At the outset of the paper, it seemed a little like looking for a needle in a haystack when trying to unpick the nursing contribution to PHC. The enormity of global change and the associated health problems, such as HIV/AIDS seemed alien to the concept of nursing making a difference. Likewise, the power of institutions such as the World Bank and the International Monetary Fund are not instantly recognisable as organisations that nurses interact with and yet these have been enormously influential to global health. However, it has been by isolating the individual projects and contextualising them in the economic and political environment that some reconciliation of the tension between PHC nursing practice, health care policy and health improvement has been attempted. In so doing, many of the changes that Dr Mahler foresaw in 1985 have become apparent and are beginning to make a real difference to community health.

The concepts and factors that can guide PHC nursing towards a continuing and effective contribution to health improvement will be drawn together in a framework headed under education, research and practice.

4.1 Education

Throughout the previous discussion of the nursing contribution to the principles of PHC, there has been an underlying assumption that nurse education has a significant relationship with nursing practice. In some cases, as the study by Lee et al. (2002) in Pakistan and Bryar's (1994) study in Wales have shown, educational initiatives were explicitly part of the overall programme. In other cited examples the educational element is implicit or assumed to have been part of the general nurse preparation. In some, there is scope for learning within and between nations about best practice. Features that appear to be common are where there is a lack of awareness or the potential for further development of nursing skills and knowledge that could add value to their role in health improvement.

4.1.1 Implications for education

The curriculum for PHC nursing should be clearly and explicitly based around the principles of PHC

Evidence from the examples above would suggest that where PHC nurses are fully engaged with concepts such as community participation and health promotion they will be more likely to practise in a community orientated way. This is becoming evident from the work on Family Health Nursing (Schober and Affara 2001; Macduff and West 2003) and the work from the Healthy Cities Project (Flynn 1997, 1998). The curriculum in Indiana University where Flynn has based her work has long been intrinsically linked to the Alma Ata principles. In some parts of the world there continue to be nursing curricula where the focus is still hospital based and medically dominated; this report should strengthen the evidence that it is time to shift the emphasis towards PHC.

Multi-disciplinary learning should become a mandatory component of the PHC nursing curriculum as far as possible

Carpenter's insistence that the 'social dimension is positively important to health, that equality and community empowerment builds social capital and a socially cohesive society conducive to health' (Carpenter 2000 p.348), leads us to suspect that to learn about Primary Health Care from a purely medical or disease-driven standpoint would be mistaken. Health in the 21st century is concerned with socio-economic and environmental determinants and health practitioners can best be prepared for this emphasis on social capital by learning together. Bryar and her colleagues in the TCV project showed how this enabled a range of professional disciplines to come together with a better understanding of their respective roles and perspectives.

Breaking down barriers and professional boundaries must be a significant factor in developing appropriate Primary Health Care services. Such multi-disciplinary learning, however, is not a code for everybody focusing on nursing. It should not ignore the essential contribution of epidemiology, immunology, statistics and risk assessment. These are areas where nurses have been traditionally quite poorly educated and where inter-professional learning with doctors, public health practitioners and epidemiologists could enhance the nursing knowledge base when there is the opportunity for debate and discussion.

Equally, political science, sociology and health economics are topics of social science where nurses have sometimes lacked knowledge and awareness. An improved approach to healthy public policy and the mechanisms and approaches PHC nurses could use to influence health policy could be achieved by building curricula where nurses can benefit from debate with other disciplines. Some universities are now moving towards the inter-professional curriculum and this should be promoted and encouraged on the basis of thorough evaluation studies.

Nursing curricula should involve innovative learning strategies
In order to learn about health promotion skills and complex concepts such as equity, nurses need to be introduced to innovative learning methods such as e-learning, blended learning, problem-based learning and work-based learning. Experiential approaches to adult learning and reflective practice are likely to be effective in enabling nurses to practise new skills and apply their knowledge of theory to practise.

PHC nurses should have equitable access to continuous professional development (CPD)
In order to update knowledge and skills and to keep abreast of rapid changes in health care policy and trends in health indicators, PHC nurses should have regular opportunities for professional development. Again, ideally these should be inter-professional and arrangements put in place to enable nurses to manage such learning within their work time. This has implications for workforce development as well as for recruitment and retention of nurses. These are major global issues for nursing, where working conditions for nurses have struggled to keep pace with the economy. Learning together and work-based learning are associated with job satisfaction and therefore it is in the interests of workforce planners and health care decision makers to promote retention of staff through effective CPD.

4.2 Research

In this paper, research and evaluation have been constantly drawn upon to establish the evidence base for the nursing contribution to PHC. The strength of the evidence is variable but there are recurrent themes that run throughout this paper that would both confirm and suggest directions for research.

4.2.1 Implications for research

Development of methodologies for synthesising qualitative research
Nursing knowledge has been enhanced through the development of qualitative techniques and there are numerous examples, indeed whole journals, dedicated to qualitative studies that are relevant to nursing practice. Such studies support Whitehead's (2000) contention that we should focus on 'on the ground' experiences of health if health practitioners are to gain a real understanding of what it means to be a healthy community. There has been less success in finding methodologies that bring the results of such studies together so that multiple studies of small populations could be used in a wider range of settings. The tension here has been the need to provide highly contextualised, in-depth accounts (such as Koch's 2002 study) that have no generalisability beyond that context, alongside the need to extrapolate from one study setting to another

and make a policy case for changing or evaluating a service. There is some sign of the Cochrane Collaboration developing ways of overcoming this tension and PHC nurses should be aware of and involved in such developments. Future reviews of PHC nursing research should be able to comment with confidence on the qualitative evidence base.

Systematic reviews of effectiveness

Alongside the serious need to develop qualitative techniques, PHC nursing needs to be more active in the production of systematic reviews of nursing effectiveness. This paper has referred to Elkan et al.'s (2000) review of home visiting and Morrell's (2000) study of community post-natal support. It has also drawn on a review of reviews of public health nursing effectiveness (Elliot et al. 2001). These examples form part of a small yet growing body of evidence on nursing effectiveness and outcomes. They need to be built upon to inform policy and decision-making about the use of resources in order to achieve the most cost-effective outcome for PHC in communities. Centres such as McMaster University in Hamilton, Canada and the Centre for Evidence Based Nursing at York University, England have made significant advances here. However, the dissemination of this type of evidence needs to be integrated with educational initiatives so that the knowledge is not restricted to the academic community and can be widely utilised.

Primary research of effectiveness

There is, however, still plenty of scope for PHC nurses to lead primary studies of effectiveness. While there are many excellent qualitative studies and equally good surveys of nursing attributes or characteristics of patient groups, there remains a dearth of high quality studies of nursing effectiveness. This means controlled, randomised studies that can isolate the independent variables. Such studies would add certain value to PHC nursing in the eyes of policy makers and would enable nurses to apply pressure for further resource allocation and workforce development initiatives. The argument has frequently been put forward (e.g. Kendall 1996) that PHC nursing relies on a different kind of evidence-base to that of medicine and that it is not appropriate to apply measures of effectiveness to nursing interventions. The epistemological arguments for and against qualitative and quantitative research will doubtless run for decades, but in a global environment of economic and political uncertainty it would be a challenge and an opportunity to PHC nurses to attempt to make their position more certain. Again, inter-professional collaboration with epidemiologists, statisticians and health economists would enable the culture of PHC nursing to develop confidence in these approaches. Equally, PHC nurses should demonstrate that in-depth qualitative studies of the experience of the community can provide important explanatory data alongside the evidence of effectiveness. This further enhances the argument for inter-professional learning, as it is in this regard that nurses can share their expertise with other professionals.

4.3 Practice

Ultimately, the most significant way in which PHC nurses can impact on health is through their practice. Practice is clearly informed by education and research but it occurs in varying and diverse contexts that globally represent economic uncertainty, political unrest, environmental disturbance and inequalities in health. To promote health and make an enduring difference to the communities in which they practise, PHC nurses have developed methods of practice that can be shared across settings. These methods need to be refined further. Examples of practice from extreme environments were drawn from Uys' (2003) work on AIDS in South Africa and Koch's (2004) work with people with enduring mental heath problems in Australia. Both of these projects demonstrate the value of participative approaches to practice that enable access to health care to vulnerable members of the population. In Uys' study, community nurses helped AIDS victims to die with dignity in their own homes; in Koch's study, the participatory action research approach enabled participants to identify their own health needs in relation to incontinence and find their own solutions. Both are powerful examples of how working with communities can empower them to achieve the health outcomes that are right for them. What lessons can be learned for practice from these and other studies reviewed?

4.3.1 Implications for practice

Practice should be orientated towards participation and empowerment

To practise in a participatory and empowering way, PHC nurses have to move away from a medically dominated approach to health care and recognise that individuals, families and communities are experts in their own health care and have internal resources that need to be nurtured towards finding their own solutions and self-care. The concept of empowerment has been the subject of much political rhetoric, as a means of imposing responsibility for health on individuals in circumstances where they do not have the means or power to change their situation. In some regimes, nurses likewise are not empowered to make changes and have to work within oppressive political systems. But where there is scope to act as advocates and to use skills of community health needs assessment, then PHC nurses should develop their practice towards a partnership approach. Thomas (1996) has shown how assessment of community health needs by the community itself can often demonstrate variance with the professional assessment. Recognition of the variance would enable a more appropriate allocation of resources and provision of services. Flynn's (1997) work on the Healthy Cities Project has shown how working closely with local communities can be effective in assessing and meeting health needs. Lazenbatt et al.'s study has shown how working with local communities can improve the health of women in severely impoverished conditions and communicate this right up to government level.

Practising in participation with communities also requires PHC nurses to enhance their communication skills. This can be at the interpersonal level (Kendall 1993; Coles 1996) or at the community level (Flynn 1998). Studies of empowering practice have shown that nurses can make a difference to their client group (Kendall 1998) but again this evidence needs to be made widely available to nursing communities so that practice can be developed and further evaluated.

Value should be attributed to nursing practice

Nursing practice needs to be valued at regional and country level to the extent that governments and local decision makers provide the necessary resources to ensure that the nursing workforce and nurse education are supported at a level that makes empowering practice possible. Many countries are experiencing a shortage of nursing and midwifery staff that renders it close to impossible to practise beyond the basic tasks necessary to maintain population health. Value can be demonstrated through high quality research and evaluation and through political awareness and nursing leadership.

Conclusion

Finally, this paper has provided an opportunity, on behalf of ICN, to explore and describe the wide-ranging issues with which PHC nurses have been involved over the past 30 years. It has brought together, under the principles of Alma Ata, many examples of the research and practice that PHC nurses have been engaged with and that has contributed to the global aim of Health for All. Nurses have accepted the challenge and the opportunity to make a real difference to community health. There are still many challenges to be faced and uncertainty in global health and economies present a threat to nursing practice. However, on balance, the evidence presented here would suggest that if PHC nurses are able to face the challenges to education, practice and research they are certain to grasp the opportunities for change and to continue to bring about further health improvements over the next 25 years.

It is imperative that these changes are well documented and evaluated so that the future for PHC nursing can be consolidated through a sound evidence base that will persuade policy makers of the cost effectiveness and value of nursing. As Bruntland (2000) stated and as shown here, there is no doubting the commitment of nurses, but in a primary care led future for health there is no room for complacency and nurses must be prepared to demonstrate their contribution and to become more politically aware in relation to health care delivery and social justice. It is self-evident that some of the most imposing health problems lie ahead – war, terrorism and natural disasters, new drug resistant diseases and diseases of life-style such as obesity, aging populations, long term conditions and as yet unknown problems associated with lifestyle and new technologies. All of these will require PHC nurses to intervene, support, counsel and treat. We must ensure that we use our knowledge from the last 30 years to inform our future and secure the place of PHC nursing in world health.

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Appendices

Appendix 1
The ICN Definition of Nursing

The ICN Definition of Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.

Appendix 2
ICN Position Statement on Nurses and Primary Health Care Nursing

The International Council of Nurses (ICN) believes that equity and access to primary health care services, particularly nursing services, are key to improving the health and wellbeing of all people.

Together with its member associations, ICN advocates for the rights of all people to equitable and effective health care services, and endorses the Alma Ata Declaration[1] on primary health care (PHC) as a means for attaining a level of health that will permit people to lead a socially and economically productive life.

Nationally and internationally, ICN and its members collaborate with governments and non-governmental organisations to ensure more effective implementation of primary health care.

In planning and implementing PHC services, ICN urges a multisectoral approach and adherence to the following principles:

- Health services are made equally accessible to all, encouraging to the maximum: individual and community participation in services planning and operation; a focus on illness prevention and health promotion; appropriate, affordable technologies; and a multi-sectorial approach necessary for wellbeing in a society.
- The focus of health care is the individual, family or group in need of services, whether for health promotion, protection from illness and disability, cure and rehabilitation, or care for peaceful, dignified death.
- Health provider education is both scientific and ethical and recognises the primacy of social determinants of health.
- Health care providers respect the rights of the individual, family and community to make an informed decision about care and related treatment.
- Research findings and evaluation of technologies are of direct benefit to patients and the public.
- In support of Primary Health Care ICN views it critical that PHC concepts be integrated into all levels of nursing education and that the nurse's role in PHC leadership be strengthened and articulated at all levels nationally and internationally.

[1] World Health Organization, **Alma Ata 1978 Primary Health Care**, Geneva, WHO, 1978.

Background
The world's population faces a future in which health and wellbeing may be adversely affected by rapid advances in technology; the depletion of natural resources and environmental degradation; population growth; the impact of new health problems (e.g. AIDS) and long recognised diseases (e.g. malaria). Other factors, such as ageing of the population and concern for those with chronic and terminal illnesses, place growing demands on health and social services.

In 1978 ICN declared its support for primary health care and its intent to co-operate at the national and international levels with governmental and non-governmental organisations in making primary health care an effective reality to meet the health needs of populations.

In the ensuing years ICN and national nurses associations have been instrumental in lobbying for inclusion of PHC principles and programmes in health provider education, in service planning and delivery, and in research and evaluation. Many NNAs are promoting initiatives to incorporate PHC into nursing practice and policy.

Nurses are the principal group of health personnel providing primary health care at all levels and maintaining links between individuals, families, communities and the rest of the health care system. Working with other sectors, other members of the health care team or on their own, nurses explore new and better ways of keeping well, or improving health and preventing disease and disability. Nurses improve equity and access to health care and add quality to the outcome of care. It is important that nursing education programmes integrate PHC at basic and post-basic levels.

Adopted in 2000
Revised and reaffirmed in 2007

Appendix 3
40th World Health Assembly Resolution WHA 49.1
Strengthening Nursing and Midwifery (1996)

The Forty-ninth World Health Assembly,

Having reviewed the Director-General's report on strengthening nursing and midwifery;

Recalling resolutions WHA42.27, WHA45.5, WHA47.9 and WHA48.8 dealing with the role of nursing and midwifery personnel in the provision of quality health care in the strategy for health for all and education of health care providers;

Seeking to apply the spirit of the International Conference on Population and Development (Cairo, 1994), the World Summit for Social Development (Copenhagen, 1995), and the Fourth World Conference on women (Beijing, 1995);

Concerned about the problems resulting from the emergence of new diseases and the re-emergence of old diseases as highlighted in *The world health report 1996*;

Recognizing the potential of nursing/midwifery to make a major difference in the quality and effectiveness of health care services in accordance with the Ninth General Programme of Work;

Recognizing the need for a comprehensive approach to nursing/midwifery service development as an integral part of health development to maximize the contribution of nurses and midwives to achievements in the field of health;

Recognizing also that such an approach must be country-specific and be assured of the active involvement of nurses and midwives at all levels of the health care system, together with the recipients of health care, policy-makers, the public and private sectors, representatives of professional associations and educational institutions, and those who have responsibility for social and economic development,

1. **THANKS** the Director-General for his report and for the increased support to nursing in Member States;

2. **URGES** Member States:

a) to involve nurses and midwives more closely in health care reform and in the development of national health policy;

b) to develop, where these do not exist, and carry out national action plans for health including nursing/midwifery as an integral part of national health policy, outlining the steps necessary to bring about change in health care delivery, ensuring further development of policy, assessment of needs and utilization of resources, legislation, management, working conditions, basic and continuing education, quality assurance and research;

c) to increase opportunities for nurses and midwives in the health teams when selecting candidates for fellowships in nursing and health-related fields;

d) to monitor and evaluate the progress toward attainment of national health and development targets and in particular the effective use of nurses and midwives in the priority areas of equitable access to health services, health protection and promotion, and prevention and control of specific health problems;

e) to strengthen nursing/midwifery education and practice in primary health care;

3. **REQUESTS** the Director-General:

a) to increase support to countries where appropriate in the development, implementation and evaluation of national plans for health development including nursing and midwifery;

b) to promote coordination between all agencies and collaborating centres and other organizations concerned in countries to support their health plan and make optimal use of available human and material resources;

c) to provide for the continued work of the Global Advisory Group on Nursing and Midwifery;

d) to promote and support the training of nursing/midwifery personnel in research methodology in order to facilitate their participation in health research programmes;

e) to keep the Health Assembly informed of progress made in the implementation of this resolution, and to report to the Fifty-fourth World Health Assembly in 2001.

Fifth plenary meeting, 23 May 1996

Appendix 4
Abbreviations used in this paper

AARN	Alberta Association of Registered Nurses
AIDS	acquired immunodeficiency syndrome
ANA	American Nurses Association
APN	advanced practice nurse
CPD	continual professional development
CPN	community psychiatric nurse
FHN	family health nurse
GP	general practitioner
HFA	Health for All
HIV	human immunodeficiency virus
HTA	health technology assessment
ICN	International Council of Nurses
NHS	National Health Service (UK)
PAHO	Pan American Health Organization
PAR	participatory action research
PHC	primary health care
SARS	severe acute respiratory syndrome
SRF	supported residential facilities
TCV	Teamcare Valleys
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

International Council of Nurses
3, place Jean-Marteau
1201 Geneva, Switzerland

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