University of Tikrit

College of Nursing

Health Promotion

Year Two/Semester Two

General Nursing Program

STUDENT GUIDLINES

Introduction

Welcome to the Second Year-Semester Two in the General Nursing Program:

Course :Health Promotion, is one of the Nursing course for the general nursing curriculum. The syllabus attached is designed to provide each student with an explanation to the course content. Unite objective are required reading materials for the course.

Instructions for use of Student's Course Books

- Each Class Session identifies the content that will be covered in that class and the activities expected by the students.
- During the Class Session, ask for explanations of term that are not clear.
- You are advised to participate in class room discussion.
- You are advised to complete she study Questions given at the end of each unit that will help you to fully understand the course material.
- You are advised to complete the laboratory requirements for this course.

Health Promotion

1. **Course Title:** Health Promotion
2. **Course Number:** (206)
3. **Credit Hours:** Total (4) Credits:

   Theory (3) Credits

   Clinical (1) Credits

4. **Course Calendar:** Total

   (6) hours weekly of (15) weeks:

   Theory (3) hrs.

   Clinical (3) hrs.

4. **Course Placement:** Second year/ Second semester
6. **Instructor:** Mohammed Yahiya Ahmed, MSC. Nursing Education.
7. **Course Description :**

This course is designed to present the students with concepts and definitions of health and health promotion. It also provide relevant approaches , models, and skills that enable students to accomplish activities concerning injury and diseases prevention as well as promotion of positive healthy life style and behaviors throughout the lifespan.

8. Course Goals :

At the end of this course the students will be able to:

- Identify Concepts, principles and definitions of health and health promotion.
- Apply approaches to health promotion and diseases prevention .
- Differentiate health promotion from Health Protection .
- Overview models of health and illness.
- Discuss health promotion Model
- Understand levels of measurement of health and health promotion.
- Perform the nurse's Role in health promotion.

9. Course Outline :

<u>The Theoretical Content</u>

Part I: An Overview of Health and Health Promotion

Course Outlines

Health and Illness

Wellness

Measurement of Health

Disease Prevention

Disease Protection

Health Education

Health Promotion

Health and Illness

Part II: Theories of Human Behavior and Health

Health Belief Models

Protection Motivation Theory

Trans-theoretical Model of Behavior Change

Use of Multiple Theories in Behavior Change

Part III: Health Promotion Models

Pender Health Promotion Model

O'Donnell Model of Health Promotion Behavior

Holistic Health Model.

Part IV: Developing a Health Promotion- Prevention Plan

Assessment and data collection

Health planning process

Planning and implementation

Evaluation

Part V: Midterm Examination

Part VI: Domains fundamentals to Nursing Practice in Health Promotion

Physiological Domain

Psychological Domain

Sociological Domain

Biological Domain

Political Domain

Spiritual Domain

Intellectual Domain

Sexual Domain

Technological Domain

Part VII: Roles of the Nurse in Health Promotion

Activist /Proactive Change agent

Advocate

Educator

Empowering Agent

Communicator

Consultant

Coordinator of Care

Leader / Member of the profession

Provider of Care / Care giver

Researcher

Role Model

Part VIII: Overview of the Nursing Process

Assessment

Planning

Implementation

Evaluation

Re-evaluation

Part IX: Risk Factors and Health Promotion

Environment

Work

Socioeconomic level

Education

Gender

Cultural and spiritual Influence

Part X: Midterm Examination

Part XI: Using Communication for Health Promotion

Communication and Nurse

Types of Communication

Communication and the Therapeutic Relationship

Health promotion Model and Communication

Empowering Through Communication

What to Teach

How learners learn

The Learning Environment

Part XIII: the concept of Cultural and Lifestyle

Cultural Assessment

Lifestyle Assessment

Part XIV: Health promotion across the Life Span

The Child

The adolescent and young Adult

The Middle Age Adult

The Older Adult

Part XV: Evaluation the Effectiveness of Health Promotion

Purposes of Evaluation

Approaches for Health Promotion Evaluation

Evaluation of Health Promotion Implementation

Strategies for Evaluation of Health Promotion

Part XVII: Current factors Affecting Nursing Role in Health Promotion

Health care system.

Nursing roles.

Increasing technology.

Economic environment.

Individual behavior .

The Clinical Content

- Application of health promotion approaches to individuals, families, groups and communities. (15) hrs.

- Application of health promotion approaches in specific settings: MCH, school, workplace, and home. (10) hrs.

- Group interaction (dynamic) as mean for behavior modification and health promotion. (10) hrs.

- Application of interview technique as mean for health promotion through increasing health awareness. (10) hrs.

01. Learning Resources:

Blackboard, overhead Projector, and handouts.

00. Teaching /Learning Strategies:

Lecture, Role Playing, Seminar, group discussion, clinical practice.

01. Student Evaluation:

1st theory exam.	10:
2nd theory exam.	10:
Clinical skills & performance	20:
Seminars	10:
Clinical reports	10:
Final theory exam	20:
Final clinical exam	20:
Total	100:

02. References:

- Allender, J. and Spradley, B., Community Health Nursing Concepts and practice, 5th ed., New York, Lippincott, 2001.
- Kozier B, Erb, G, Berman A, et al. Fundamentals of Nursing, 7th Ed, New York, Pearson Education, 2004.

Project (written paper)

Choose one of the following topics for the subject of the paper:

1.
2.
3.
4.
5.

Guidelines for writing the paper

- Write a 100- 150 word paper explaining one of the above concept. Give illustration where required.
- Contents of the student course book is not allowed to used.
- Use at least three references from the library.
- You are free to use any other resources for completion of this paper.
- A list of references should be provided as policy.
- Type the report, Font style: Time New Roman, size,14.
- Use A4 Plain paper to print the report.
- Copy- paste strategy will never accepted.
- The paper is due as per the teacher's request.

Criteria for evaluation of Written Paper

SN	Criteria	Marks
1.	Introduction	1
2.	Contents with illustration	5
3.	Conclusion	1
4.	Tile page	1
5.	References/Resources used	1
6.	Organization ,Neatness, Language	1
Total		10

Curriculum Committee Members

- Ass .Prof: Dr. RadhwanHussain Ibrahim .Dean, Chairperson
- Mr. Mohammed Yahya Ahmed, MSC. Nursing Education.
- Mr. Rami Ramadhan MSC. Fundamentals of Nursing

Prepared by:

Mr. Mohammed Yahiya Ahmed, MSC. Nursing Education.

Date prepared: May,2013

Health Promotion

Part I: An Overview of Health and Health Promotion

Course Outlines

Health and Illness

Wellness

Measurement of Health

Disease Prevention

Disease Protection

Health Education

Health Promotion

Health and Illness

Learning Objectives

At the end of this chapter, the student should be able to:

1. Define Concepts
2. Discuss stages and degrees of illness.
3. Describe the models of health and illness.
4. Draw the illness wellness continuum.
5. Identify the components of wellness.
6. Analyze the three levels of diseases prevention.

Health

- As defined by the World Health Organization (WHO): state of complete physical, mental and social well-being, not merely the absence of disease or infirmity.

Characteristics

1. A concern for the individual as a total system
2. A view of health that identifies internal and external environment
3. An acknowledgment of the importance of an individual's role in life.

*A dynamic state in which the individual adapts to changes in internal and external environment to maintain a state of well-being.

Illness

- State in which a person's physical, emotional, intellectual, social developmental or spiritual functioning is diminished or impaired. It is a condition characterized by a deviation from a normal, healthy state.

Stages of Illness

1. **Stage of Denial** : Refusal to acknowledge illness; anxiety, fear, irritability and aggressiveness.
2. **Stage of Acceptance** : Turns to professional help for assistance
3. **Stage of Recovery (Rehabilitation or Convalescence)** : The patient goes through of resolving loss or impairment of function.

Degrees of illness

- A person with terminal cancer or end stage of renal failure is classified as "very ill"
- Person recovering from asurgery" thyroidectomy" is classified as "less ill"
- Person with infections like bronchitis is classified as " mildly ill"

Models of Health and Illness

0. Health-Illness Continuum (Neuman) : Degree of client wellness that exists at any point in time, ranging from an optimal wellness condition, with available energy at its maximum, to death which represents total energy depletion.

1. High – Level Wellness Model (Halbert Dunn) : It is oriented toward maximizing the health potential of an individual. This model requires the individual to maintain a continuum of balance and purposeful direction within the environment.

2. Agent – Host – environment Model (Leavell) : The level of health of an individual or group depends on the dynamic relationship of the agent, host and environment

- **Agent :** any internal or external factor that disease or illness.
- **Host :** the person or persons who may be susceptible to a particular illness or disease
- **Environment** : consists of all factors outside of the host

3. Health – Belief Model : Addresses the relationship between a person's belief and behaviors. It provides a way of understanding and predicting how clients will behave in relation to their health and how they will comply with health care therapies.

Four Components

- The individual is perception of susceptibility to an illness
- The individual's perception of the seriousness of the illness
- The perceived threat of a disease
- The perceived benefits of taking the necessary preventive measures

4.Evolutionary – Based Model : Illness and death serves as a evolutionary function. Evolutionary viability reflects the extent to which individual's function to promote survival and well-being. The model interrelates the following elements:

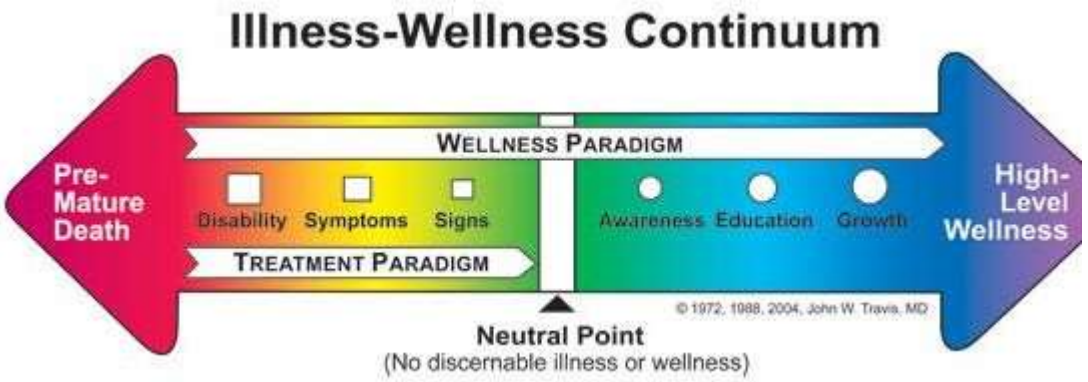
- Life events
- Life style determinants
- Evolutionary viability within the social context
- Control perceptions
- Viability emotions
- Health outcomes

6. **Health Promotion Model**: A ―complimentary counterpart models of health protection‖. Directed at increasing a client's level of well-being. Explain the reason for client's participation health-promotion behaviors. The model focuses on three functions:

- It identifies factors (demographic and socially) enhance or decrease the participation in health promotion
- It organizes cues into pattern to explain likelihood of a client's participation health-promotion behaviors
- It explains the reasons that individuals engage in health activities

Wellness

- Wellness is generally used to mean a healthy balance of the mind, body and spirit that results in an overall feeling of well-being.
- Wellness is an active process of becoming aware of and making choices toward a more successful existence. This is consistent with a shift in focus away from illness in viewing human health, typical of contexts where the term wellness is used.
- In other words, wellness is a view of health that emphasizes the state of the entire being and its ongoing development.



Dimensions of wellness

0. Physical dimension

The ability to carry out daily tasks achieve fitness by maintaining adequate nutrition, avoid using drugs and alcohol or using tobacco.

1. Emotional dimension

The ability to manage stress and express emotions appropriately. The ability to recognize, accept, and express feelings and to accept one's limitation.

2. Social dimension

The ability to interact successfully with people as a whole and within the environment of each person as part.

3. Intellectual dimension

The ability to learn and use information effectively for personal, family, and career development.

4. Spiritual dimension

Person's own morals, values and ethics.

Measurement of Health

Leading Health Indicators include:

1. Physical Activity.
2. Overweight and Obesity.
3. Tobacco Use.

4. Substance Abuse.
5. Responsible Sexual Behavior.
6. Injury, Violence and Safety.
7. Immunization.
8. Access to Health Care.

Disease prevention

Disease Prevention is to maximize public health and safety through the elimination, prevention, and control of disease, disability, and death**.**

The Three Levels of Prevention

Primary Prevention

primary prevention methods before the person gets the disease. Primary prevention aims to prevent the disease from occurring. So primary prevention reduces both the incidence and prevalence of a disease. Encouraging people to protect themselves from the sun's ultraviolet rays is an example of primary prevention of skin cancer.

Secondary Prevention

Secondary prevention is used

- after the disease has occurred, but
- before the person notices that anything is wrong.

A doctor checking for suspicious skin growths is an example of

secondary prevention of skin cancer. The goal of secondary prevention is to find and treat disease early. In many cases, the disease can be cured.

Tertiary Prevention

Tertiary prevention targets the person who already has symptoms of the disease

The goals of tertiary prevention are:

- prevent damage and pain from the disease
- slow down the disease
- prevent the disease from causing other problems (These are called "complications.")
- give better care to people with the disease
- make people with the disease healthy again and able to do what they used to do

Developing better treatments for melanoma is an example of tertiary prevention. Examples include better surgeries, new medicines, etc.

Application of preventive measures

0. **Primary prevention**
   include:
   a. **Health Promotion**
      - Health education
      - Environmental modifications
      - Nutritional interventions
      - Lifestyle and Behavioral Changes.

b. Specific Protection.

- Immunization
- Use of specific Nutrients
- Chemoprophylaxis
- Protection against hazards and accidents

1. Secondary Prevention

Include:

a. Early diagnosis

b. Prompt treatment

e.g. early detection of alteration of health/ Homeostasis and Treatment to reverse the condition.

3. Tertiary Prevention

Include:

a. Disability Limitation

To prevent or halt the transition of the disease process from impairment to handicap.

b. Rehabilitation

- **Medical Rehabilitation** : restoration of function.
- **Vocational Rehabilitation** : restoration of the capacity to earn a livelihood.

- **Social Rehabilitation**: restoration of family and social relationship.

- **Psychological Rehabilitation**: restoration of personal dignity and confidence.
- Provision of community facilities for retraining and education.

Health education

- Health education is a process that informs, motivates, and help to adopt and maintain healthy practice and lifestyles, advocates environmental changes as needed to facilitate this goal.
- Health education is an approach for teaching patients and families to deal with past, present and future health problems. This knowledge enable them to make informed decisions, to cope more effectively with temporary or long term alterations in health and lifestyle, and to assume greater responsibility for health.
- It can be defined as the principle by which individuals and groups of people learn to behave in a manner conducive to the promotion, maintenance, or restoration of health.
- Health education is any combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes.
- The goal of all teaching is learning. Learning is defined as" a process resulting in some modification of relatively permanent of the behavior, i.e. way of thinking, feelings, doing of the learner".

One way of understanding the nature of learning is to examine the three domains of learning.

Domains of learning

0. Cognitive Domain

The cognitive domain deals with the" recall" or recognition of knowledge and the development of intellectual abilities and skills.

1. Affective Domain

This domain describes changes in attitudes, values, and appreciation. In affective domain nurses influence what clients, families and student think, value, and feel.

It is difficult to change deep seated values, attitude, beliefs, and interests. To make such changes, people need support and encouragement from those around them. Praise is helpful. Group support also reinforce learning new behavior.

2. Psychomotor Domain

This domain includes the performance of skills that require integration of mental and muscular ability.

Three conditions must be met before psychomotor learning occurs:

1. The learner must have necessary ability.
2. The learner must have sensory image of how to carryout the skill.
3. The learner must have the opportunities to practice the learning

Health education ultimately aims at adoption of new ideas and practice. People pass through a series of changes before they adopt a new practice.

0. **Stage of Awareness**

   At this stage the person come to know about new idea or practice. He has only a general information about it and knows little about its usefulness and applicability to him.

1. **Stage of Interest**

   In this stage the person seeks more information, he is willing to listen or read or learn more about it.

2. **Stage of Evaluation**

During this stage the person weights the pros and cones of the practice and evaluates its usefulness to him and his family. It is a mental exercise results in decision to try or reject the practice.

3. **Trial Stage**

   in this stage education is put in to practice, he may experience the need for more information to solve the problems.

4. **Adoption Stage**

   At this stage ,person decides that new practice is good and adopts it. In a community , people may be in different stages of the adoption process. Adoption is usually slow in the initial stage.

Teaching –Learning Principles

Teaching Principles	Learning Principles
1. Adapt teaching to client's level of readiness.	1.the learning process makes use of clients' experience and is geared to their level of understanding
1.detemine clients' perceptions about the subject matter before and during teaching.	2.clients are given the opportunity to provide frequent feedback on their understanding of the material taught.
3.Create an environment that is conducive to learning.	3.the environment for learning is physically comfortable, offers an atmosphere of mutual helpfulness, trust, respect, acceptance, and allows for free expression of ideas.
4. Involve clients throughout the learning process.	4. Clients actively participate. They assess their needs and establish goals, and evaluate learning progress.
5.Make subject matter relevant to the clients' interest and use.	5. clients feel motivated to learn.
6. Ensure client satisfaction during the teaching-learning process.	6. Clients sense progress toward their goal.
7. Provide opportunities for the client to apply material taught.	8. Client integrate the learning through application.

The Role of the Health Educator

Health Promotion

Health promotion is the process of enabling people to exert control over the determinants of health and thereby improve their health .

Strategies of Health Promotion:

0. **Educational:**

   To change values, beliefs, attitudes, opinions and behaviors

1. **Policy:**

   To encourage adherence to healthy behavior and discourage unhealthy behavior

2. **Environmental:**

   To make the environment safe to encourage healthy behaviors

Components of Health education:

1. Increasing knowledge.
2. Developing skills.
3. Changing behavior.

Part II: Theories of Human Behavior and Health

Course Outlines

Health Belief Models

Protection Motivation Theory

Trans-theoretical Model of Behavior Change

Use of Multiple Theories in Behavior Change

Learning Objectives

At the end of this chapter ,the student should be able to:

1. Describe the health belief model.
2. Discuss the components of protection motivation theory.
3. Describe the Trans-theoretical Model of Behavior Change.
4. identify the stages of changes in Trans-theoretical Model of Behavior Change.

HEALTH BELIEF MODEL

- The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviors.
- This is done by focusing on the attitudes and beliefs of individuals.

- The Health Belief Model (HBM) is one of the first theories of health behavior.
- It was developed in the 1950s by a group of U.S. Public Health Service social psychologists who wanted to explain why so few people were participating in programs to prevent and detect disease.
- The health belief model proposes that a person's health-related behavior depends on the person's perception of four critical areas:
    1. the severity of a potential illness.
    2. the person's susceptibility to that illness.
    3. the benefits of taking a preventive action, and
    4. the barriers to taking that action.

- The HBM was spelled out in terms of four constructs representing the perceived threat and net benefits:
    a. perceived susceptibility.
    b. perceived severity.
    c. perceived benefits, and,
    d. perceived barriers.

These concepts were proposed as accounting for:

1. people's "readiness to act.
2. " An added concept,
3. *cues to action*, would activate that readiness and stimulate overt behavior.

- A recent addition to the HBM is the concept of **self-efficacy**, or one's confidence in the ability to successfully perform an action.
- This concept was added by Rosen stock and others in 1988 to help the HBM better fit the challenges of changing habitual unhealthy behaviors, such as being sedentary, smoking, or overeating.

Table from "Theory at a Glance: A Guide for Health Promotion Practice" (0997)

Concept	Definition	Application
Perceived Susceptibility	One's opinion of chances of getting a condition	Define population(s) at risk, risk levels; personalize risk based on a person's features or behavior; heighten perceived susceptibility if too low.
Perceived Severity	One's opinion of how serious a condition and	Specify consequences of the risk and the
	its consequences are	condition
Perceived Benefits	One's belief in the efficacy of the advised action to reduce risk or seriousness of impact	Define action to take; how, where, when; clarify the positive effects to be expected.
Perceived Barriers	One's opinion of the tangible and psychological costs of the advised action	Identify and reduce barriers through reassurance, incentives, assistance.
Cues to Action	Strategies to activate "readiness"	Provide how-to information, promote awareness, reminders.

Self-Efficacy	Confidence in one's ability to take action	Provide training, guidance in performing action.

Health-related behaviours are a product of five components:

0. **Coping Appraisal**

    - self-efficacy (e.g. 'I am confident that I can change my diet');
    - Response effectiveness (e.g. 'changing my diet would improve my health');

1. **Threat Appraisal**

- Severity (e.g. 'bowel cancer is a serious illness');
- Vulnerability (e.g. 'my chances of getting bowel cancer are high').
- Fear

According to the PMT, there are two sources of information:

1. environmental (e.g. verbal persuasion, observational learning) and
2. intrapersonal (e.g. prior experience).

This information elicits either an 'adaptive' coping response (i.e. the intention to improve one's health) or a 'maladaptive' coping response (e.g. avoidance, denial).

Protection Motivation Theory

- Protection Motivation Theory ,is describes adaptive and maladaptive coping with a health threat as a result of two appraisal processes.

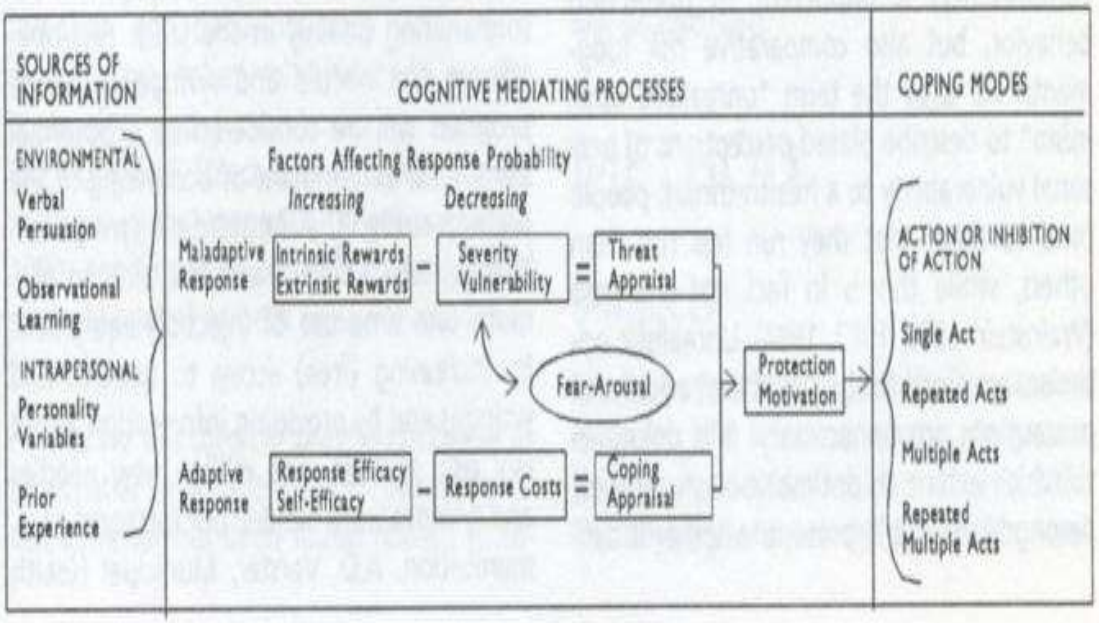
1. **A process of threat appraisal** and,
2. **a process of coping appraisal**, in which the behavioral options to diminish the threat are evaluated .

The appraisal of the health threat and the appraisal of the coping responses result in the intention to perform adaptive responses (protection motivation) or may lead to maladaptive responses.

- Maladaptive responses are those that place an individual at health risk. They include behaviors that lead to negative consequences (e.g. smoking) and the absence of behaviors, which eventually may lead to negative consequences (e.g. not participating in breast cancer screening and thus missing the opportunity of early detection of a tumor).
- The Protection Motivation Theory proposes that the intention to protect oneself depends upon four factors:
    1. The perceived *severity* of a threatened event (e.g., a heart attack)
    2. The perceived probability of the occurrence, or *vulnerability* (in this example, the perceived vulnerability of the individual to a heart attack) .
    3. The efficacy of the recommended preventive behavior (the perceived *response efficacy*) .
    4. The perceived *self-efficacy* (i.e., the level of confidence in one's ability to undertake the recommended preventive behavior).

Figure 1

Protection motivation theory (adapted from Rogers, 1983)



Trans-theoretical Model of Behavior Change

One of the key constructs of the TTM is the Stages of Change. Behavioral change can be thought of as occurring as a progression through a series of stages

The Stages of Change are as follows:

1. Precontemplation.
2. Contemplation.
3. Preparation.
4. Action.
5. Maintenance.

Precontemplation

In this stage the Individuals are not thinking about or intending to change a problem behavior ,or initiate a healthy behavior . Precontemplators are usually not armed with the facts about the risks associated with their behavior.

Contemplation

- An individual enters this stage when they become aware of a desire to change a particular behavior (typically defined as within the next six months).
- In this stage, individuals weigh the pros and cons of changing their behavior.

Preparation

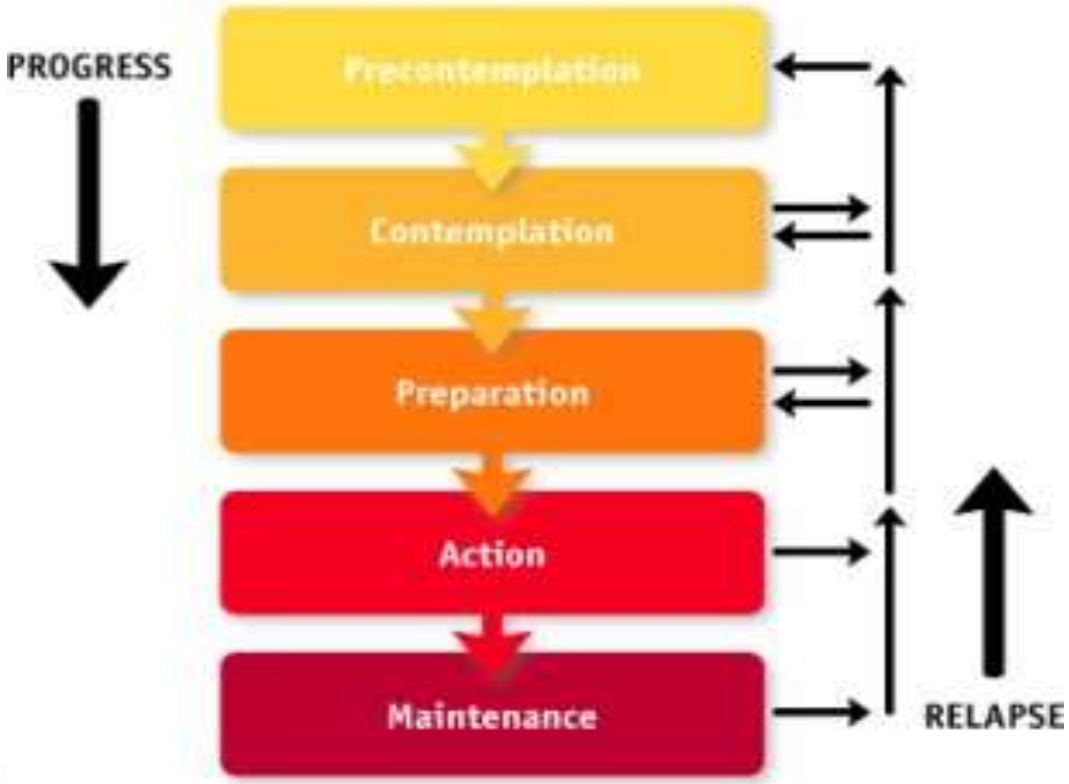
- By the time individuals enter the Preparation stage.
- the pros in favor of attempting to change a problem behavior outweigh the cons, and action is intended in the near future, typically measured as within the next thirty days.
- Many individuals in this stage have made an attempt to change their behavior in the past year, but have been unsuccessful in maintaining that change.
- Preparers often have a plan of action, but may not be entirely committed to their plan.
- Many traditional action-oriented behavior change programs are appropriate for individuals in this stage.

Action

- The Action stage marks the beginning of actual change in the criterion behavior, typically within the past six months.
- By this point, an individual is half way through the process of behavior change .
- This is also the point where relapse, and subsequently regressing to an earlier stage, is most likely.
- If an individual has not sufficiently prepared for change, and committed to their chosen plan of action, relapse back to the problem behavior is likely.

Maintenance

- Individuals are thought to be in the Maintenance stage when they have successfully attained and maintained behavior change for at least six months.
- While the risk for relapse is still present in this stage, it is less so, and as such individuals need to exert less effort in engaging in change processes.



Part III: Health Promotion Models

Course Outlines

Pender Health Promotion Model

O'Donnell Model of Health Promotion Behavior

Learning Objectives

At the end of this chapter, the student should be able to:

1. Discuss Pender Health Promotion Model.

2. Describe O'Donnell Model of Health Promotion Behavior.

3. Discuss the dynamic balance for O'Donnell Model of Health Promotion Behavior.

Pender theory

- **Pender Health Promotion Models theory** suggests that good health is not just the absence of any health ailment or disease, it is much beyond that.
- Good health implies a general and holistic state of well-being, healthy actions of an individual and a balanced, fulfilling way of life.
- It looks at steps in which a person can pursue better health or ideal health. To achieve that, the Health Promotion Model takes into consideration individual characteristics and experiences, behavior specific cognitions and affect and behavioral outcomes of a person.
- The factors that are delved into in the Health Promotion Model are

predominantly an individual's lifestyle, mindset, psychological health, social and cultural aspects as well as biological factors.

- The Pender Health Promotion Model is also a way to avert health ailments and problems associated with aging and an inactive or unfulfilling lifestyle

O'Donnell model

- Health Promotion is the art and science of helping people discover the synergies between their core passions and optimal health, enhancing their motivation to strive for optimal health, and supporting them in changing their lifestyle to move toward a state of optimal health.
- Optimal health is a dynamic balance of physical, emotional, social, spiritual, and intellectual health.
- Lifestyle change can be facilitated through a combination of learning experiences that enhance awareness, increase motivation, and build skills and, most important, through the creation of opportunities that open access to environments that make positive health practices the easiest choice.

- **Physical** : Fitness. Nutrition. Medical self-care. Control of substance abuse.

- **Emotiona**l : Care for emotional crisis. Stress Management

- **Social** : Communities. Families. Friends
- **Intellectual** : Educational. Achievement. Career development

- **Spiritual** : Love. Hope. Charity.

Part IV: Developing a Health Promotion- Prevention Plan

Outlines

Assessment and data collection

Health planning process

Planning and implementation

Evaluation

Learning Objectives

At the end of this chapter ,the student should be able to:

1. Discuss the assessment phase of health planning process.
2. Identify the methods of data collection.
3. Describe the components of community diagnosis.
4. List the factors affecting the implementation of health planning process.

Assessment of Community Health

Assessing community health requires gathering relevant existing data, generating missing data, and interpreting the data base.

The systematic collection of data includes:

- Gathering or compiling existing data

- Generating missing data
- Analysis and interpretation of data
- Identification of health needs/problems and capabilities.

Data gathering

It is a process of obtaining readily available data, which describe the demography of the community

- Age, sex, socioeconomic and racial distribution.
- Vital statistics, including morbidity and mortality data.
- Community institution
- Health manpower characteristics.

Data gathering

Is the process of developing data, that don't already exist, through interaction with the community members or groups, these data includes:

- Knowledge and beliefs.
- Values and sentiments.
- Goals, perceived needs, norms, problem solving process.
- Power and leadership and influence structure.

Composite data base

A composite data base is created by combining the gathered and generated data.

Data Interpretation

Data interpretation seeks to attribute meaning to the data. Data are analyzed and synthesized and the following themes are identified:

- Community health needs.
- Community health capabilities.
- Resources available to meet the needs.

Data collection methods

Methods of data collection could be classified as collection of direct data and reported data.

Following are methods of data collection:

- Informant Interviews
- Participant observation
- Wind shield Surveys
- Secondary analysis of existing data
- Surveys

Collection of direct collection

Informant interviews, participant observation, and windshield surveys are the three methods of directly collecting data. These methods require sensitivity ,openness, curiosity ,and ability in the nurse to listen , taste, touch, smell, and see life as it is lived in a community.

Informant interviews

It consists of directed conversation with selected members of a community about members or groups and events.

Participant observation

The deliberate sharing in the life of a community.

The above two methods are suitable techniques for generating information about community norms, beliefs, values, power and influence structures and problem solving process.

Wind shield surveys

Are the motorized equivalent of simple observation . The nurse driving a car or riding public transportation can observe many dimensions of community's life and environment.(e.g. common characteristic of people

on the street, neighborhood, gathering places, housing quality, geographic boundaries, etc..)

Collection of reported data

Secondary analysis and surveys are two methods of collecting reported data.

Secondary analysis means use the previously collecting data.

e.g. minutes of health meeting.

Public documents

Statistical data

Health records

Surveys

Report data from a sample population/groups. They are useful but time consuming and costly. Surveys are for identifying certain community characteristics and problems.

In public health nursing practice, nurses use several methods to collect data to reduce bias in data collection. Using such multiple complementary methods for collecting data is called ***triangulation***.

Community Diagnosis

Community Diagnosis refers to the identification and quantification of health problems in a community.

The statement of a community diagnosis must consists of the following three components:

- The problem faced by the recipient.

- The recipient of the care.
- The factors contributing to the problem.

While stating a diagnosis, the three components must be stated as follows:

- The risk of_____-
- Among_____-
- Related to_____-

Examples

- Risk of infant malnutrition, among families in X community related to lack of breast feeding and weaning.
- Risk of diarrhea in children under five, among families in town dwellings, related to unhygienic environmental condition/unsafe water supply.

Planning phase

Steps of planning phase are:

1. Analyze the community diagnosis in terms of the importance, magnitude and intensity of risk involved.
2. Establish priorities among them.
3. Establish goals and objectives
4. Identify intervention activities that will accomplished the objective.
5. Rational allocation of limited resources.

Implementation phase

Factors influencing implementation

1. People readiness to participate in the problem resolution.
2. Characteristics of social change process.

3. Nurse's choosing role: a facilitator/ expert role in helping community to select and perform appropriate tasks to achieve objectives.

Evaluation

Appraisal of the effects of the organized program:

- Documenting the progress.
- Comparing achievements against a performance standards.
- Preparing for needed modifications.

Part V: Midterm Examination

Part VI: Domains fundamentals to Nursing Practice in Health Promotion

Outlines

Physiological Domain

Psychological Domain

Sociological Domain

Biological Domain

Political Domain

Spiritual Domain

Intellectual Domain

Sexual Domain

Technological Domain

Learning Objectives

At the end of this chapter, the student should be able to:

1. Discuss the domains of fundamentals to Nursing Practice in Health Promotion

Physiological Domain

- Providing physiological care focuses on achievement of the basic needs such as oxygenation, circulation, sleep and comfort, nutrition, and elimination.

Psychological Domain

- Individuals have psychological needs for security, a sense of belonging, and self-esteem.
- Nursing actions that promote sense of emotional comfort include the following:
    b. Treating the client as a unique individual.
    c. Protecting confidentiality and privacy.
    d. Using touch and personal space in a therapeutic manner.
    e. Recognizing and respecting cultural differences.
    f. Decreasing anxiety through stress management techniques

Goals for clients experiencing unmet psychological needs

a. Improve self-esteem.
b. Establish trusting relationships.
c. Develop social skills.
d. Cope with losses

Sociological Domain

- Nurses need to assess the client's degree of dependence. Often, the nurse becomes involved in a balancing act in an effort to maintain equilibrium between the client’s needs for dependence and independence.
- Empowerment is a process of enabling others to do for themselves. It consists of encouraging the client to be an active participant in treatment rather than a passive recipient of care.

- Nurses empower clients by teaching them and their families how to develop skills for self-care and for healthier living.

Intellectual Domain

- The intellectual domain consists of cognitive functions such as judgment, orientation, memory, and the ability to take in and process information.
- Intellectual functioning can be impaired by multiple factors, including infection, exposure to toxins, substance abuse, trauma, and psychological problems.
- It is important for nurses to determine the client's intellectual abilities in order to communicate effectively.
- Using words that are easily comprehended by the client and implementing teaching strategies appropriate to developmental level promote client learning.

Spiritual Domain

- Spirituality is multidimensional in that it refers to one's relationship with one's self, a sense of connection with others, and a relationship with a higher power or divine source.
- Spirituality assists a person in determining the sense of meaning or purpose in one's life. It is an integral component of one's being.
- Spirituality is somewhat difficult to define as it is determined at an individual level.
- Spirituality is not the same as religion, which refers to a set of beliefs and practices associated with a particular church, synagogue, mosque, or other formal organized group.
- Spirituality is a personal, individualized set of beliefs and practices that are not mosque related.

- Health status can have an impact on spiritual beliefs and vice versa.
- For example, when they are seriously ill, many people turn to religion for support. On the other hand, serious illness may cause some people to question their beliefs;

Sexual Domain

- Sexuality is a complex set of human characteristics that refers not just to genital sex but to all the aspects of being male or female, including feelings, attitudes, beliefs, and behavior.
- Sexuality is a pervasive aspect of the total self from birth to death and is an important aspect of health for people of all ages.
- Sexuality includes a person's attitudes toward relationships with people of the same sex, toward relationships with those of the opposite sex, and about touching and being touched.
- The ways in which people dress, talk, and relate to others are indicators of their sexuality.

Biological Domain

Political Domain

Technological Domain

Part VII: Roles of the Nurse in Health Promotion

Outlines

Activist /Proactive Change agent

Advocate

Educator

Empowering Agent

Communicator

Consultant

Coordinator of Care

Leader / Member of the profession

Provider of Care / Care giver

Researcher

Role Model

Learning Objectives

At the end of this chapter, the student should be able to:

9. Identify the roles of the Nurse in Health Promotion.
10. Discuss the activities that carried out by health promotion nurse.

Roles and responsibilities of public health Nurse

Change Agent

- communicates, advices, coaches and provides feedback to bring change in any health and educational settings.
- educate people what change is needed .
- problem solver

Advocator

- help clients to gain independence.
- Protects the client
- Provides explanations in client's language
- Acts as change agent
- Supports client's decisions Protects the client
- Provides explanations in client's language

Educator

- Provides information
- Serves as counselor

- Seeks to empower clients for self-care
- Encourages compliance with prescribed therapy
- Promotes healthy lifestyles.
- Interprets information.

Empowering Agent

Communicator

- Using appropriate listening skills.
- Using appropriate responding skills.
- Establishing helping relationship.
- Communicate with people within their language.

Consulter

- Encourages the client to look at alternative behaviors, recognize choices, and develop a sense of control.
- Help the client develop new attitudes, feelings, and behavior.

Coordinator of Care

1. **Features**
    - During his shift, the clinical nurse coordinator implements, supervises and evaluates patient care on his unit. He promotes a safe environment for patients, families, visitors and staff.

Qualifications

- A clinical nurse coordinator has an associate degree in nursing (ADN) or, preferably, a bachelor's of science degree in nursing (BSN). Her employer may require two or more years of experience and/or certification in a relevant nursing specialty, according to AllHealthcareJobs.com.

Functions

- The clinical nurse coordinator serves as the eyes and ears for the nurse manager on a given shift. He makes rounds on patients and staff, leads by example, and serves as a liaison between the unit and other hospital departments.

Requirements

- The clinical nurse coordinator role is physically and mentally demanding. She'll spend a good deal of her time walking from one patient area to the next to evaluate situations. A competent clinical coordinator juggles competing demands, uses critical thinking skills and smooths over interpersonal disagreements that arise on her shift.

Salary

- According to SalaryExpert.com, average yearly salaries for clinical nurse coordinators in November 2119 varied from 923,279 to 941,258.

Plans, schedules, coordinates, and assigns work and establishes goals and priorities for nursing and support staff in a health care setting.

Provides supervision over the assessment, planning, implementation, and evaluation of patient care in an assigned health care setting.

Assists in the management of a comprehensive improvement program to ensure that program and services meet accrediting standards for the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and other accrediting programs.

Serves as a resource in clinical situations. Assess available resources, patient and unit needs and assigns staffing according to patient acuity.

Assists in the development and implementation of staff education and orientation, specific job related training, and other approaches to provide

opportunities for staff flexibility and development.
Resolves problems encountered by the employee or patient during the course of the assigned shift.

Coordinates and participates in the development of the performance evaluation program for functions
within the unit; monitors and documents performance; provides on-going feedback regarding levels of
performance; and formally evaluates employees in relation to performance. Directs, coordinates, and participates in the professional nursing care of patients within an assigned unit pursuant to the objectives and policies of the agency, the nursing process, and established nursing standards. Assists in the development and implementation of the interview and hiring process. Implements safety and quality improvement standards and develops procedures to ensure compliance.
Implements and interprets policies and procedures developed by higher level managers or supervisors. Assists in developing, recommending, and coordinating the implementation of new procedures for the assigned functions or unit. May assist in the development and monitoring of departmental budget. Give necessary instruction in the performance of special clinical or health procedures of in the utilization and maintenance of new equipment. Maintains personnel productivity at acceptable levels for unit based standards. Receives formal and informal grievances and conducts preliminary discussions for settlement when necessary.
Initiates and recommends disciplinary action for employees as necessary.
Participates in various agency and community outreach functions.
Performs full performance level professional nursing work and enhances professional growth and development through participation in educational programs, reviewing current literature, in-service meetings, workshops,

and research.

Nursing Clinical Coordinator

Member of the Profession

- Collaborates with others.
- Possesses highly skilled.
- communication methods.
- Performs therapeutic measures to assist with respiration (e.g. Oxygen administration, ventilators)

Leader

- Facilitating collaborative care for patients
- Providing mentoring to nursing staff
- Establishing and overseeing a healthy working environment
- Collecting and evaluating patient risks, outcomes, and care plans
- Coordinating direct care activities among nursing staff
- Providing lateral integration of healthcare services

As a clinician with advanced practice skills and knowledge, but serving in a role that is based in leadership, the role of clinical nurse leaders is unique and far-reaching, both within the clinical setting, and outside of it:

- *Clinician* – provide care across the lifespan and across all populations, with an emphasis on health promotion and risk reduction services.

- *Outcomes Manager* – integrate information and data to better ensure optimal client outcomes
- *Client Advocate* – ensure that clients, families, and communities are well-informed, serving as advocates for both the nursing profession and the healthcare team
- *Educator* – make use of all available technology to teach clients and healthcare professionals using evidence-based principles and strategies
- *Information Manager* – use information systems and technology to improve healthcare outcomes
- *Systems Analyst/Risk Anticipator* – review client care delivery quality and anticipate risks in an effort to prevent medical error
- *Team Manager* – delegate and manage nursing resources and serve as a leader and partner of the interdisciplinary healthcare team
- *Member of a Profession* – acquire the latest knowledge and skills to change healthcare practices and outcomes
- *Lifelong Learner* – recognize the value of the pursuit of new knowledge and skills.

Education and Degree Options

The American Association of Colleges of Nursing (AACN) Board defines a CNL as a generalist clinician who possesses an education at the master's degree level or higher. The Board notes that a master's degree is necessary because the CNL must bring a high level of clinical competence and knowledge to the nursing team. The AACN has reported that 85 CNL programs are now available in 34 states, as well as in Puerto Rico.

Caregiver

1. Traditional and most essential role.
2. Functions as nurturer.
3. Provides direct care
4. Is supportive.
5. Demonstrates clinical proficiency.
6. Promotes comfort of client

Researcher

- Collect and analyze data by making an investigation.
- Suggest and evaluate possible solutions.
- Select a solution for the investigated problem.
- Restart the investigation process over again.

Role Model

Manager

- Makes decisions.
- Coordinates activities of others.
- Allocates resources.
- Evaluates care and personnel.
- Serves as a leader.
- Takes initiative

Expert

- Advanced practice clinician.
- Conducts research.
- Teaches in schools of nursing.

- Develops theory
- Contributes to professional literature.
- Provides testimony at governmental hearings and in courts .

Part VIII: Overview of the Nursing Process

Outlines

Assessment

Planning

Implementation

Evaluation

Re-evaluation

Learning Objectives

At the end of this chapter, the student should be able to :

2. Define concepts.
3. Describe the benefits and characteristics of nursing process.
4. Identify the steps of nursing process.
5. Discuss the each step of nursing process.
6. Differentiate between medical diagnosis and nursing diagnosis.

Nursing Process

- The American Nurses' Association (ANA) defined nursing as:

"The diagnosis and treatment of HUMAN RESPONSES to actual or potential health problems".

Nursing process is:

- An organizational framework for the practice of nursing.
- Orderly, systematic.
- Central to all nursing care.
- Encompasses all steps taken by the nurse in caring for a patient.

Benefits of Nursing Process

1. Provides an orderly & systematic method for planning & providing care.
2. Enhances nursing efficiency by standardizing nursing practice.
3. Facilitates documentation of care.
4. Provides a unity of language for the nursing profession.
5. Is economical.
6. Stresses the independent function of nurses.
7. Increases care quality through the use of deliberate actions.

Characteristics of the Nursing Process

1. Within the legal scope of nursing.
2. Based on knowledge-requiring critical thinking.
3. Planned-organized and systematic.
4. Client-centered.
5. Goal-directed.
6. Prioritized.
7. Dynamic.

Benefits of using the nursing process

1. Continuity of care.
2. Prevention of duplication.
3. Individualized care.
4. Standards of care.
5. Increased client participation.
6. Collaboration of care.

The Steps of the Nursing Process

Steps of Nursing Process are cyclic, overlapping and interrelated:

- Assess
- Diagnose
- Planning
- Implementation, and
- Evaluation.

Assessment:is the most critical step

- Answers the questions: ―What is happening?‖ (actual problem), or ―What could happen?‖ (potential problem).
- Involves collecting, organizing, and analyzing information/data about the patient.

Data collection & Data analysis

Data Collection: A Holistic Approach

Types of data

4. **Subjective** data: ―symptoms‖ that the patient describes; e.g. ―I

can’t do anything for myself‖ .

5. **Objective** data: " signs" that can be observed, measured, and verified; e.g. swollen joint

Sources of data

- **Primary source**: the patient; is always the best source.
- **Secondary source**: everything/everybody else.

Methods of Data Collection

00. Observation

- Requires practice and skill
- Systematic, head-to-toe (cephalocaudal).
- Results in objective, factual information.
- Document exactly what you observe

Examples

- ― the patient frequently, had dark circles under eyes‖.
- NOT –Patient seems tired‖

01. Interview

- Structured form of communication
- Purpose: to provide care specific to this individual’s needs and problems.
- Focus: patient’s perceptions.
- Nurse must: explain purpose of interview, provide comfort and privacy, ensure confidentiality

- Result: A comprehensive Health History

Components of the Health History

- Demographic data .
- CC: chief complaint .
- HPI: history of present illness .
- PMH: past medical history .
- FMH: family medical history (genogram) .
- ROS: review of systems
  Psychosocial history

02. Examination

- Inspection.
- Palpation.
- Percussion.
- Auscultation.

Nursing Diagnosis:is a statement that describes a specific human response to an actual or potential health problem that requires nursing intervention .

Nursing diagnosis is commonly written in **P E** format

- **P** = Problem: use North American Nursing Diagnosis Association (NANDA) category
- **E** = Etiology: cause of the problem.

Differences between Medical diagnosis and Nursing diagnosis, examples

Medical diagnosis	Nursing diagnosis
Rheumatoid Arthritis	Self-care deficit: bathing, related to joint stiffness
Diarrhea	Fluid volume deficit
Fever	Altered body temperature

Planning :planning step is aimed to provide consistent, continuous care that will meet the patient's unique needs.

Includes :

- Set priorities
- Set goals and objectives.
- Set nursing orders.
- Write interventions for each problem (Nursing actions).
- Set outcomes criteria.

Patient Goals should be a:

- Focused on the patient
- Clear and Concise
- Observable, Measurable, Realistic: how much? how far? how long? how well?
- Written with a specific time frame: by when should the goal be accomplished?
- Determined by the nurse and the patient

Implementation: Carry out the care plan.

- Reassess the patient
- Validate that the care plan is accurate
- Carry out nurses' orders
- Document on patient's chart

Evaluation

Compare the patient's current status with the stated Patient Goals

- Were the goals achieved? Why not?
- Review the nursing process

Part IX: Risk Factors and Health Promotion

Outlines

Environment

Work

Socioeconomic level

Education

Gender

Cultural and spiritual Influence

Learning Objectives

At the end of this chapter, the student should be able to:

1. Identify the risk factors for health.
    - discuss the risk factors of health promotion.

1.

3._____

4._____

Risk factors and health promotion

Risk factors to health

Health and wellbeing are affected by many factors, and those that are associated with ill health, disability, disease or death are known as risk factors. Risk factors are presented here individually, however in practice they do not operate in isolation. They often coexist and interact with one another.

1. Behavioral risk factors

Risk factors that can be eliminated or reduced through lifestyle or behavioral changes include:

- tobacco smoking
- excessive alcohol consumption
- poor diet and nutrition
- physical inactivity
- excessive sun exposure
- insufficient vaccination
- unprotected sexual activity.

2. Biomedical risk factors

Biomedical risk factors may be influenced by a combination of genetic, lifestyle and other broad factors. Biomedical risk factors include:

- overweight and obesity
- high blood pressure
- high blood cholesterol
- impaired glucose tolerance

3. Environmental risk factors

- The environment often predisposes a person to disease processes. Living conditions may promote illness. For instance.

  a. bacterial .

  b. viral infections.

  c. tuberculosis is more prevalent in crowded living conditions.

  d. Persons in areas of contaminated water are at an increased risk for intestinal infections if sanitation measures are neglected.

- Environmental determinants of health cover a wide array of topics, and can be split into two broad categories.

  a. Social, economic, cultural and political
  b. Physical, chemical and biological

3. Genetic risk factors

Some diseases, such as cystic fibrosis and muscular dystrophy, result entirely from an individual's genetic make-up whereas many others reflect the interaction between that make-up and environmental factors.

There are three broad groups of genetic diseases / disorders:

- **single gene (monogenic) disorders**, for example hemophilia;
- **chromosomal abnormalities**, for example Down syndrome; and
- **multifactorial diseases**, such as asthma.

4. Demographic risk factors

Demographic factors include age, sex, and population subgroups. Examples of risk associated with demographic factors include:

- Stroke death rates increase dramatically with age, with 81: of all deaths from stroke occurring among those aged 75 and over.
- A woman's risk of developing breast cancer before age 75 is 1 in 11, whereas for men the chance is only 1 in 12426.
- Aboriginal and Torres Strait Islander people are far more likely to die from rheumatic fever and rheumatic heart disease than other Australians.

5. Work

Work influences health and wellness. Many employers-suchas

a. Hospitals.

b. Factories.

c. large institutions.

- today provide health screenings and health prevention programs for employees.
- Work safety is imperative for optimum health and wellness
- The number of dependents living in the home and the headof the

household play a large part in the status of the family andof the individuals within the household .

- The nurse may take an active role in developing community programs for individuals and their families.
- Often the small business owner is not able to provide health education programs routinely.
- The nurse may collaborate with small business owners to provide the needed information to employees .

7. Socioeconomic Level.

- The socioeconomic level of an individual influences the affordability of health care and health-promotion activities.
- Often .funds are limited and the resources are unavailable to access the care required for optimum health.
- Persons may delay seeking treatment or information due to a lack of money.
- Nutrition and living conditions may affect the health risk of the individual as well .

8. Education

- Education may influence the level of understanding among the public.
- Laypersons often do not have the knowledge base to know what causes a disease, much less how to prevent its development.

- Public education announcements and offerings of health information provide a beginning knowledge level and promote further learning.
- Education must be simple, clear, and understandable.
- Intellectual differences may influence the type and length of educational offerings.
- Nurses should speak at the educational level of their patients, communicating the message in simple terms.
- The caregiver may also require explicit information regarding patient needs.
- This information should be given at the educational level of the caregiver
- Health-seeking behavior is critical to implementing health promotion.

Assumption essential to integrating health promotion into nursing practice

1. people have the capacity for self-direction, abstraction, and critical thinking.
2. the environment can affect a person's ability to live a long and prosperous life.
3. people are capable of learning and adapting and can be made aware of the things that promote well-being.
4. as open systems, people are capable of change.
5. people are biological, psychological, social, and cultural beings who

form families and/or networks.

6. communication, both verbal and nonverbal, is essential to the achievement of health throughout the life span.

Cultural and spiritual Influence

Cultural context of different countries are their social standards and value system. Culture is the sum of learned ways of doing, feeling and thinking t and present of a social group within a given period of time.

Culture is complex integrated system which includes knowledge , beliefs, skills, arts, morals, laws, customs habits, roles, attitudes. Lifestyle, community life and acquired capabilities of human beings. All these provide a pattern for living together.

a. Values

- Value system determines the attitude and pattern of behavior in a group.
- Cultural value system decides how people should behave in various situations.
- Values tend to change or disappear over the years, e.g. possession of happy family life, clean environment, close friends, religion, good income, health preservation,…etc.

b. Beliefs, customs, norms and taboos

- Middle-eastern people believe in fatalism, they don't plan for future rather leave them to the will of God.
- Traditional women tend to breast feed the baby for extended period of time.
- Children are believed to be a blessings to the family.

- They believe their success of their parenthood is on Wight gain, healthy and normality of their children but not on cognitive skills.
- Religion and magical ideas and practices exist in the form of various beliefs, taboos, ethical code, rituals, mythology, which may positively or negatively influence health.
- They believe in evil eye. Therefore , in health care setting avoid suspicious of the evil eye.

c. Religion

- All religion allow certain kinds of such enjoyment that are known in religious language "permissible". , and sensor others that are designated as " forbidden".
- In middle eastern countries, Islam is a dominant religion. In the Glorious Qurans, it is primary source of law.
- Islam pays particular attention to marriage, showering it with such distinctive veneration that makes it unique among all human contracts.

d. Roles

- In Islam , men tend to have earning position.
- women on the other hand tend to be in control of household affairs.
- Men have a great control over all situations. Therefore in health care setting, it is best to ask the man's permission or opinion.

Part X: Midterm Examination

Part XI: Using Communication for Health Promotion

Outlines

Communication and Nurse

Types of Communication

Communication and the Therapeutic Relationship

Health promotion Model and Communication

Empowering Through Communication

What to Teach

How learners learn

The Learning Environment

Learning Objectives

At the end of this chapter, the student should be able to :

1. Discuss the relationship between nursing and communication.
2. Describe the purposes, essential skills, and level of communication.
3. Identify the levels of communication.
4. Discuss the phases of therapeutic communication.
5. Describe Factors that influencing patient's teaching.

Communication and Nursing

- Communication in nursing is a complex process of sending and receiving verbal and non-verbal messages.
- Allows for exchange of information, feelings, needs, and preferences
- Communication is at the heart of who we are as human beings. It is our way of exchanging information; it also signifies our symbolic capability.

- health communication is seen to have relevance for virtually every aspect of health and well-being, including disease prevention, health promotion and quality of life.

Purposes of Communication

- To establish nurse-patient relationship.
- To be effective in expressing interest/concern for patient/family.
- To provide health care information

Essential skills

- Personal insight.
- Sensitivity.
- Knowledge of communication strategies

Levels of communication

- **Social**: safe**.**
- **Structured**: interviewing, teaching**.**
- **Therapeutic**: patient focused, purposeful, time limited
  Nurse comes to know the patient as a *unique individual.*
  Patient comes to *trust* nurse.

Types of Communication

1. **Verbal Communication**
   - Conscious**s**, use of spoken or written word.
   - Choice of words can reflect age, education, developmental level, culture.
   - Feelings can be expressed through tone, pace, etc.

Characteristics of Verbal Communication

- Simple, brief, clear.
- Well timed, relevant, adaptable, credible

1. Non-Verbal Communication

- Use of gestures, expressions, behaviors (body language).
- Contribute 85: of communication.
- Less conscious than verbal.
- Requires systematic observation and valid interpretation.
- Nurse must be aware of personal style.

How we communicate non-verbally:

- physical appearance.
- Posture/gait.
- Facial expressions, gestures.
- Touch (tactile defensiveness)

Therapeutic Communication

Phases of therapeutic communication

0. Orientation Phase

- The orientation (or introductory) phase is the first stage of the therapeutic relationship, in which the nurse and client become acquainted with each other, establish trust, and determine the expectations of the other.
- Usually, the only knowledge the client and nurse have of each other is preconceived ideas.
- The nurse gets to know the client as an individual by giving up

biases and judgmental thoughts.

- The orientation stage is especially important because it is the time in which the foundation for the relationship is established.

1. Working Phase(exploitative)

- In this stage the problems are identified, goals are established, and problem-solving methods are selected.
- Actions are chosen after carefully considering both the consequences of actions and the client's values.
- It is important that nurses consider clients' feelings of personal control and intervene to increase perceptions of control, especially for clients treated in inpatient facilities .

2. Termination Phase (concluding Phase)

- This phase is focused on the evaluation of goal achievement and effectiveness of treatment.
- It is important that the client has been prepared for the final stage of the relationship by encouraging discussion of feelings.

Health Promotion Model and Communication

- Communication plays a central role in effectively promoting healthy lifestyles .
- health communication is seen to have relevance for virtually every aspect of health and well-being, including disease prevention, health promotion and quality of life.
- Communication is at the heart of who we are as human beings. It is our way of exchanging information; it also signifies our symbolic capability.

What to teach

- As a nurse one of our principal responsibilities is to educate our patients.
- Nurses can teach healthy and ill people about the followings:

2. Medications (old and new).
3. Procedures.
4. Wound care.
5. Signs and symptoms to be aware of.
6. Health habits, how to continue caring for themselves once their home and more.

- The teaching can occur as spontaneous answers to questions from our patients or more formal educating including a plan and resource materials.
- The information the nurse provide to the patients during their hospital stay will hopefully help them gain a full recovery and decrease the risk of readmission.

Factors that influencing patient's teaching

0. Provide a hospitable learning environment:

- Learning environment should be free from excess noise, disruption.
- is private and conducive to learning.
- While we can't always choose the physical location where the learning will take place, we can try to provide planned learning at a time of day when those disruptions would be minimal; possibly

mid-morning after breakfast, morning hygiene, assessments and rounds. Each floor has a different rhythm, choose what will work best for you and your patient.

2. **Help the patients decide who should be involved in the learning process**.

   Parents, friends, caregivers may be necessary to involved in teaching plan to prevent or reduces embarrassment and modesty that may interfere.

3. **Establish a baseline of knowledge**.

   - What do they already know?
   - Is the patient a young or old.
   - newly diagnosis of the patients.

4. **Ask your client what they think they need to know**.

   - This is one way to involve people in the learning process, by allowing them to guide their learning they will be more invested and will increase their willingness to participate, motivation and ability to retain information.

5. **What do they need to know to go home safely?**

   - Not only are patients staying in the hospital for shorter stays, our time with patients is limited as well. Staffing, complexity and resource issues all play a part in how much time there will be to educate.

- Establish priorities. Decide what is vital for the patient to know upon discharge and get to that information first.

6. **Are there any cultural, religious or beliefs and practices**

- Asking your client if there are any beliefs they hold that would interfere with what they are learning would be appropriate.

7. **Assess a patient's motivation prior to embarking on a teaching plan.**

- no learning will happen if the client is wholly unmotivated.
- Remembering that illness, fatigue, depression and anxiety are all factors in motivation toward learning; they can also be readily present in a health care setting.
- Working with the patient and the patient's family and team of health care givers to help promote the motivation to learn is essential.

Part XIII: the concept of Cultural and Lifestyle

Outlines

Cultural Assessment

Lifestyle Assessment

Learning Objectives

At the end of this chapter, the student should be able to:

1. Discuss the components of cultural assessment.

2. Identify the Guideline for assessing lifestyle factors that affect the health and well-being.

Cultural assessment

- Data obtained from a cultural assessment will help the patient and nurse to formulate a mutually acceptable, culturally responsive treatment plan.
- The basic premise of the cultural assessment is that patients have a right to their cultural beliefs, values, and practices, and that these factors should be understood, respected, and considered when giving culturally competent care.
- The first step in cultural assessment is to learn about the meaning of the illness of the patient in terms of the patient's unique culture.

Questions to Ask During a Cultural Assessment

- What do you think has caused your problem?
- Why do you think it started when it did?
- How severe is your illness? Will it have a long or short course?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to get from this treatment?
- What are the chief problems your illness has caused for you?
- What do you fear most about your illness?

By asking the patient and family these questions you can obtain valuable information needed for a teaching plan. It is important to remember that the patient's personal interpretation of the illness experience is more significant than your view of the disease

Lifestyle Assessment

Guideline for assessing lifestyle factors that affect the health and well-being.

1. **Sleep habits:** sleeping from 6 – 8 hours a night; waking feeling rested, alert and able to function during the day.

2. **Eating habits:** eating a variety of foods each day; including foods from each of the 4 food groups each day; feeling satisfied after eating; no adverse physical reactions to food.

3. **Physical activity:** engaging in 30-60 minutes of moderate physical activity 5-7 times per week; a combination of cardiovascular activity, strength training, and flexibility exercises.

4. **Low to moderate alcohol consumption:** limiting alcohol consumption to 2 or fewer standard drinks per day, with a maximum of 14 servings per week for males, and 9 servings per week for females.

5. **Stress management:** being aware of factors affecting your stress level; practicing activities that reduce negative effects of stress.
6. **Effective time management:** identifying a structure or system that helps you keep on track; recognizing time wasters; learning to prioritize; setting realistic goals; balancing your time between work and leisure activities.

Part XIV: Health promotion across the Life Span

Outlines

The Child

The adolescent and young Adult

The Middle Age Adult

The Older Adult

Learning Objectives

At the end of this chapter, the student should be able to:

1._____

2._____

3._____

Part XV: Evaluation the Effectiveness of Health Promotion

Outlines

Purposes of Evaluation

Approaches for Health Promotion Evaluation

Evaluation of Health Promotion Implementation

Strategies for Evaluation of Health Promotion

Learning Objectives

At the end of this chapter, the student should be able to:

2. Define concepts.
3. Describe the purposes of evaluation of the Effectiveness of Health Promotion.
4. Identify Principles for the evaluation of health promotion initiatives.
5. Describe the Approaches for Health Promotion Evaluation.

Evaluation is a way of assessing whether the promotion **activities** has met its **objectives**. It is important to evaluate the **activities** because:

1. it will give a sense of achievement.
2. help to work out ways to improve it for next time, or
3. enable other people to learn from it when developing their own plan.

It is important that **evaluation** is built during the planning phase and is not an afterthought at the end of the activities.

There are two general approaches used for evaluation — quantitative and qualitative.

- **Quantitative evaluation** is based on numbers and things that can be measured, whether it is the number of people who attend an **activities of health promotion** or the number of people who change their behavior. It is a more structured way to evaluate and would usually require a base to start from. For example, if the **objective** was to halve the number of people who smoked in the community by the end of the project, it would need to know how many people smoked at the beginning of the project
- **Qualitative evaluation** is more about how well an **activity** was delivered and received. It relies more on:
    a. people expressing their thoughts and opinion.
    b. how people engaged with the activities.
    c. how they felt about doing the **activity**, and ,
    d. what they think could have been done better.

Depending on the plan of health promotion, might:

- Record the number of people who attend the event or activity
- Record the number of people who turn up for health checks
- Prepare a short survey or questionnaire to get people's feedback on the activity (perhaps measuring people's awareness of the factors contributing to chronic disease and whether they felt they had enough information to make healthy lifestyle choices)
- Organize a community meeting to discuss the project or activity after it has taken place

PROCESS, IMPACT AND OUTCOME EVALUATION

There are three main methods of evaluating a health promotion program. These include process evaluation, impact evaluation and outcome evaluation.

1. Process evaluation

- involves *assessing or measuring the activities* in the program and the quality of the program.
- It often takes account of the views and involvement of the program's target group.
- This type of evaluation can be done throughout the program, for example on a weekly, fortnightly or monthly basis.

The main questions to consider when doing process evaluation are:

a. Is the program reaching the target group?
b. Are all parts of the program reaching all parts of the target groups?
c. Are participants satisfied with the program?
d. Are all the activities of the program being implemented?
e. Are all the materials and components of the program of good quality?

2. Impact evaluation

- involves assessing or measuring the immediate effects of the program: for example:

a. on the individuals within the target group or the group as a whole;
b. the physical environment.
c. the motivators for change; or the individual's, group's or community's level of involvement prior to, duringand toward the end of the program.

- impact evaluation is related to looking at the objectives of the program and assessing if they have had any effect on the target group or individuals or in the community.

3. Outcome evaluation

- involves assessing or measuring the longer-term effects in a program.
- This is generally associated with the goal; therefore when developing a goal always keep in mind the end point or the outcome that you are trying to achieve.
- Outcome evaluation is related to looking at the program and assessing if the program has had any effect on the target group or individuals or in the community over a long period of time.
- Generally these outcomes can be measured over twelve months or longer.

Principles for the evaluation of health promotion initiatives

1. **Participation** : at each stage of evaluation those with an interest should be involved. These can include policy-makers, community members and organizations, health and other professionals, etc.
2. **Multiple methods** : evaluations should draw on a variety of disciplines and employ a broad range of information gathering procedures.
3. **Capacity building** : evaluations should enhance the capacity of individuals, communities, organizations,etc.

4. **Appropriateness** : evaluations should be designed to accommodate the complex nature of health promotion interventions and their long term impact/

Recommendations for the evaluation of health promotion initiatives

1. Those who have a direct interest in a health promotion initiative should have the opportunity to participate in all stages of its planning and evaluation
2. Adequate resources should be devoted to the evaluation of health promotion initiatives (at least 10:).
3. Health promotion initiatives should be evaluated in terms of their processes as well as their outcomes.
4. The use of randomized controlled trials to evaluate health promotion initiatives is, in most cases, inappropriate, misleading and unnecessarily expensive.
5. Expertise in the evaluation of health promotion initiatives needs to be developed and sustained.

Approaches for Health Promotion Evaluation

1. **Effectiveness** : the ability of an intervention to achieve its intended effect in normal conditions e.g., the 'real world'.
2. **Efficacy**: the ability of an intervention to achieve its intended effects under optimal conditions of delivery and compliance by its recipients e.g., an 'Ideal world'.
3. **Efficiency**: the effectiveness of an intervention in relation to costs.

4. **Evaluable** : able to be fairly or appropriately judged or evaluated; a programme is evaluable when its activities, goals and objectives are articulated in such a way as to provide meaningful and measurable information.

5. **Evaluation** : the process by which we judge the worth or value of something .

6. **Evidence** : 'anything that makes clear or obvious; that which makes truth evident, or renders evident to the mind that it is truth' .

7. **Evidence-based healthcare**

    - the conscientious use of current best evidence in making decisions about the care of individual patients or the delivery of health services.
    - Current best evidence is up-to-date information from relevant, valid research about the effects of different forms of health care, the potential for harm from exposure to particular agents, the accuracy of diagnostic tests, and the predictive power of prognostic factors .

8. **Evidence based clinical practice** :an approach to decision making in which the clinician uses the best evidence available, in consultation with the patient, to decide upon the option which suits that patient best.

9. **Evidence-Based Medicine** : is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means

integrating individual clinical expertise with the best available external clinical evidence from systematic research .

10. **Evidence-based health promotion**: involves the systematic integration of research evidence into the planning and implementation of health promotion activities.

11. **Formative evaluation**: evaluation for the purpose of improving the programme as it is being implemented

12. **Impact evaluation** : concerned with the immediate short-term effects and reach of the programme, generally measures achievement of programme objectives

13. **Outcome evaluation** : measures long-term effects, whether a programme has achieved its goals.

14. **Process evaluation** : measures to what extent a programme has been implemented as planned, by measuring reach, participant satisfaction, implementation of activities, performance of intervention components and quality assurance.

15. **Summative evaluation** : the same as outcome evaluation

16. **Transfer evaluation** : assesses the replicability of a project's mechanisms/processes and outcomes, can they be transferred to another setting or population and achieve the same effects?

Part XVI: Measuring Outcomes of Health Promotion and Prevention

Definition of Health Outcomes

Health Outcomes are a change in the health status of an individual, group or population which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status.

- Such a definition emphasizes the outcome of planned interventions (as opposed, for example, to incidental exposure to risk), and that outcomes may be for individuals, groups or whole populations.
- Interventions may include government policies and consequent programs, laws and regulations, or health services and programs, including health promotion programs.
- It may also include the intended or unintended health outcomes of government policies in sectors other than health. Health outcomes will normally be assessed using health indicators.

Which Health Outcomes to Measure

A: Healthy environment

1. access healthy and nutritious food and water.
2. buy or rent accommodation.
3. access training and education opportunities.
4. meet personal and family expenses, such as transport

5. access medical and health services
6. access support.
7. maintain contact with family and friends
8. participate in the community.
9. access entertainment and social events.

B: Health promotion outcomes involves the results creating the educational, organizational, economic, and environmental supports that enables work toward a state of "optimal health". Promoting health could help many lead healthy:

- satisfying lives and translate to a population less dependent on medical treatment,.
- less likely to develop chronic diseases or self-destructive behaviors, and
- more likely to become productive,
- generally happy members of our community.

C: Health care outcomes refers to a traditional view of health, diagnosis and treatment of disease, to repair of injury, some people may describe the health care system as an " illness-care" or " curative system"

Challenges in Measuring Health Outcomes

Part XVII: Current factors Affecting Nursing Role in Health Promotion.

Health care system.

Nursing roles.

Increasing technology.

Economic environment.

Individual behavior .

Learning Objectives

At the end of his chapter, the student should be able o:

0.----------

1.----------

2.----------

Health Care System

As a developing country with vast human resources and a rapidly-growing economy, reforming Egypt's health care sector is a top priority for the national social development agenda.

This sector had not been overlooked, even before the Egyptian revolution took place in early 2011, there was a concrete governmental vision for a healthcare system in 2025. Today, the current political situation confronting Egypt as it weaves its new future poses numerous challenges on many fronts, most important of which is mobilizing more economic resources for developing our human assets. Therefore, it is only natural that such a vision for health enhancement will gain more traction and becomes a paramount pillar guiding the process of the needed health care reform to build upon achieved past successes, while working to address upcoming challenges.

Ten work streams already demonstrate the defined dimensions of the Egyptian health reform program, the most crucial of which include providing high quality care through financially-sustainable health

insurance, spreading the coverage of primary care services, enhancing family planning services at a national level, institutionalizing and strengthening consumer protection, in addition to encouraging public-private partnerships.

Overall, Egypt's health indicators have improved significantly since 1960, with a health profile that is increasingly similar to developed countries. This continuous improvement in all aspects of public health in Egypt has indeed been internationally recognized. Some of the prominent successful initiatives include the progress made on the health-related Millennium Development Goals, mandatory immunization that eradicated Poliomyelitis in Egypt, the setting up of an Egyptian national program to combat tuberculosis, developing a national program for prevention and control of Viral Hepatitis B/C, and the near eradication of Bilharziasis. All of the aforementioned initiatives are provided at no cost to all Egyptians, thus uniquely embracing the concept of equity as a guiding principle in healthcare services provision.

However, still concurrent with these successes, the spread of non-communicable diseases remains prevalent, most notably cancer, diabetes, cardiovascular diseases, and chronic respiratory diseases. In response, Egypt has embraced the WHO Strategy and Action Plan to control and prevent these illnesses. Several initiatives were, in fact, launched in this regard at no cost to all Egyptians, including--but not limited to--the Children's Cancer Hospital "57357", the National Breast Cancer Screening Programme, the National Hepatitis Campaign, and the National School Feeding Program. This, while also running multiple campaigns to promote increased awareness of these common diseases that have inflicted Egyptian society.

A noteworthy establishment is the Regional Centre for Women's Health

and Development in Alexandria, with a primary responsibility to focus on research aimed at improving women's health. This encompasses creating and building databases for collaboration at the community, national, regional and international levels; along with the dissemination of information and the creation of model clinics among others. In addition, one of the priorities is to map out outreach programs through mobile clinics and awareness campaigns, which touch on various aspects of women's health, especially with regard to the prevention and early detection of diseases like cancer.

The successes of Egypt's health reform program are numerous, such that it has positively contributed towards the social and economic development for all Egyptians throughout the years. This has manifested itself in longer life expectancy, higher productivity and even trickling down to increased household income. More deliverables in the health sector are certainly what the new, post-revolution Egypt will remain vigilant in pursuing in the upcoming period, as we strive to advance the community's wellbeing through continued extensive reforms in this crucial sector.

Overview of the Healthcare System in the Kingdom of Saudi Arabia

The Ministry of Health is responsible for the supervision of healthcare and hospitals in both the public and private sectors. The system offers universal healthcare coverage.

The healthcare system has two tiers. One is a network of primary healthcare centers and clinics that provide preventive, prenatal, emergency, and basic services, as well as mobile clinics for remote rural areas. The second tier is represented by the hospitals and specialized treatment facilities located in urban areas.

In 1970, the first of the government's five-year plans to promote development in a variety of areas, including healthcare, was instituted. In healthcare, the plan only meant establishing the necessary infrastructure of hospitals, clinics, pharmacies, laboratories, and research facilities, but hiring expatriate staff to work in the facilities and encouraging Saudis to pursue careers in the healthcare field.

In 1970, there were 74 hospitals with 92039 beds. Recent statistics from the Ministry of Health for hejira year 1431, which corresponds generally to 2009, show a total of 415 hospitals in the Kingdom, with 58126 beds. The country also had 16 government and five private colleges of medicine, 12 government and seven private colleges of dentistry, and 15 government and six private colleges of pharmacy.

The Ministry of Health operates 62: of the hospitals and 53: of the clinics and centers; the remaining facilities are operated by government agencies, including the Ministry of Defense, the National Guard, the Ministry of the Interior, and several other ministries, as well as by private entities.

The breakdown of facilities is as follows:

0) Ministry of Health Facilities

These serve the general public and are located in both the large cities and the small towns throughout Saudi Arabia.

1) Military Hospitals

These serve members of the Saudi Arabia armed forces and members of their families, according to the branch of the military in which the individual serves.

Saudi Arabian National Guard (SANG)

SANG is the branch of the military that is involved with defense against external threats and internal threats. SANG has four hospitals which provide care to the soldiers of the Saudi Arabian National Guard and their dependents:

- King Abdulaziz Medical City - Riyadh (690 beds, formerly the King Fahad National Guard Hospital);
- King Abdulaziz Medical City - Jeddah (350 beds, formerly the King Khalid National Guard Hospital);
- King Abdulaziz Medical City - Dammam (112 beds);
- King Abdulaziz Medical City - Al Ahsa (300 beds);
- The Saudi Arabian National Guard also operates clinics in Riyadh and Taif.

Saudi Arabian Ministry of Defense and Aviation (MODA)

MODA provides defense against primarily external threats. It includes the Saudi Arabian Army, the Royal Saudi Naval Forces, the Royal Saudi Air Force and Royal Saudi Air Defense. MODA operates nine hospitals which provide care to the soldiers of MODA and their dependents:

- Riyadh Armed Forces Hospital (also known as Riyadh Military Hospital Al Kharj), Riyadh (12100+ beds);
- Prince Sultan Cardiac Center, Riyadh (150+ beds);
- North West Armed Forces Hospital, Tabuk (350 beds);
- King Fahd Military Medical Complex, Dhahran (316 beds);
- Armed Forces Hospital at King AbdulAziz Airbase, Al Khobar (280 beds);
- King Fahad Armed Forces Hospital, Jeddah (400+ beds);

- Armed Forces Hospitals, Southern Region (King Fahad Military Hospital and the King Faisal Military Hospital), KhamisMushayt (total 258 beds);
- Al Hada Hospital, Taif (500+ beds; also operates the Prince Sultan Hospital, the Prince Mansour Hospital, and a rehab centre);
- King Khalid Military City (also known as Hafr Al-Batin Armed Forces Hospital), Hafr Al-Batin (330 beds);
- Wadi Al-Dawassir Hospital, Wadi Al-Dawassir (100 beds).

2) Ministry of the Interior

This serves members the ministry of the interior, including the police and customs collectors.

Security Forces Hospital, Riyadh (500 beds), serves the Ministry of Interior personnel. There is also a Ministry hospital in Mecca.

3) Referral Hospitals

Every citizen is eligible to go to the referral hospitals for specialized care. These facilities include:

- King Faisal Specialist Hospital & Research Centre-Riyadh Site (894 beds);
- King Faisal Specialist Hospital & Research Centre-Jeddah Site (320 beds);
- King Khalid Eye Specialist Hospital, Riyadh (360 beds);
- Sultan Bin Abdulaziz Humanitarian City, Riyadh (300 rehabilitation beds).

4) Private Facilities

Here are just a few of the private facilities in Saudi Arabia:

- For-Profit: Saudi German Hospital, Jeddah; Dr. Erfan&Bagedo

Hospital, Jeddah; Kingdom Hospital, Riyadh

- Saudi ARAMCO Hospital, Dhahran & Al Hasa (405 beds and 80 beds); serves employees of the oil company Saudi ARAMCO, and their family members
- Riyadh Care Hospital (also known as Social Insurance Hospital (GOSI)), Riyadh (255 beds)
- Royal Commission Hospitals, which serve employees and their family members of the Industrial cities located at: Jubail, on the east coast of Saudi Arabia; Yanbu, on the west coast of Saudi Arabia
- SAAD Medical Centre, Al Khobar
- SolimanFakeeh Hospital, Jeddah (600 beds, and the largest private hospital in Saudi Arabia; it is contracted to Saudi ARAMCO)

For more information, see:

- Ministry of Health
- Embassy of Saudi Arabia in Washington, About Saudi Arabia-Health & Social Services
- **Iraq is struggling to recover its healthcare system after years of war and insurgency. However, a boost in budget will only yield results, if spending focuses on three essentials: high-class medical training, proper management – and safe medication.**
- As *IRIN*, the news service of the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), recently put it: »Of all the areas of Iraq's development that were affected by the US-led invasion 10 years ago, healthcare has probably taken the biggest hit.« Iraq's health system is now but a mere shadow of its former reputation as a leading regional force back in the 1970s.

- According to the World Health Organisation (WHO), only 83 percent of the Iraq's population currently has access to local health services, which places the country among the lowest ranks in the region, with less access to healthcare only in Yemen, Afghanistan, Sudan and South Sudan. This situation, which especially pertains to primary healthcare, is, in part, a result of the enormous exodus of qualified personnel during and after the 2003 invasion. UK-based NGO Medact estimates that in the period between 2003-2007, 50 percent of Iraq's doctors left their home country, plummeting health care access ratio to 8 doctors per 10.000 citizens.
- To boost the insufficient primary healthcare supply, the Iraqi government is heavily investing in medical infrastructure, beginning with the construction of 360 primary care services throughout the country. A good start, a drop in the ocean nevertheless, as »with the current rate of newly trained family doctors entering the Iraqi healthcare system, it will take 230 years to meet the demand of the population«, as Dr. Salman Rawaf of the WHO Centre at the Imperial College London predicts in front of international and regional experts attending the »Iraq Healthcare Conference« in Erbil.

You might be examined by someone, who has never seen a medical school from the inside«

- However, problems don't stop here, as Rawaf bluntly states: »The Iraqi healthcare system, from hospital management level up to the Ministry of Health, significantly lacks leadership skills and

expertise.« The poor state of administration is reflected in the absence of any sort of regulations and accreditation standards for medical practitioners and facilities. »When you walk into a doctor's office in Iraq, you might be examined by someone, who has never seen a medical school from the inside. However, this will not prevent him from prescribing you medications.«

- But even purchasing correctly prescribed medicine, does not protect Iraqis from receiving one of the many counterfeit drugs that are flooding the Iraqi market. The Kurdish Ministry of Health estimates that in 2012, around 18 percent of medicines entering the region were fake and some independent bodies assume that 90 percent of drugs are not tested before they go on sale. Dr. Bahram Resul, founder and CEO of the first Kurdish pharmaceutical company Awamedica, has made the fight against counterfeit drugs from within and outside of Iraq his personal cause. Speaking at the »Iraq Healthcare Conference« during the »Iraq Medicare Exhibition«, he demands strict import regulations for pharmaceuticals as well as a system of certification and inspections for local manufacturers to prevent fatal incidents as a result of counterfeit medicine.

- As for 2013, more than 95 percent of Iraqi citizens are not covered by health insurance. Of total healthcare expenditure, 81 percent is paid by the government and 19 percent out of pocket. Dr. Finn Goldner, Health Finance Expert and former Director for Health System Financing at the Abu Dhabi Health Authority, thinks the

Iraqi government should consider a mandatory health insurance scheme that could be beneficial for both government and citizens: The financial burden would shift from the government to employers and employees, financial and clinical transparency and efficiency could be increased and access to healthcare services might broaden.

51 percent of the health budget flows back to the Ministry of Finance

- In 2012, health budget amounted to 4 billion USD. By 2015, the Iraqi government plans to spend more on healthcare than Saudi-Arabia – which would be 23 billion USD, provided, Saudi Arabia's health care expenditure stays at the same level as in 2012. However, a budget boost is not going to change anything as a comment of a Ministry of Health employee at the Iraq Healthcare Conference in Erbil in late May aptly summed up: »60 percent of the health budget flows back to the Ministry of Finance every year«. Apparently, the staff does not know where to invest the attributed capital.
-
- An appropriate first step to improve the healthcare system would be to staff the Ministries of Health of the central government in Baghdad and the Kurdish Regional Government with highly qualified health management experts and medical practitioners who can take the lead in reforming the current system. To this end, in the modernization of education and training for medical staff, the implementation of international standards in healthcare facilities and a sound public health education to enable the development a healthy society, are critical. How successfully the

government will push for reforms in the coming twelve months will be assessed by next year's edition of the »Iraq Healthcare Conference« during the 5th »Iraq Medicare Exhibition« in spring 2014.

Current Factors Affecting Nursing Role in Health Promotion

Health promotion is the key phrase in the health care work -place today.

Nurses are essential for promoting public health.

Factors influencing health promotion today are

1. Health care system.
2. Nursing roles.
3. Increasing technology.
4. Economic environment.
5. Individual behavior .

Nursing role in health promotion

1. The domains fundamental to effective nursing practiceare biological, psychological, sociological, environmental, political, spiritual, intellectual, and technological.
2. Health promotion is a continual, active process designed to achieve and maintain wellness.
3. Holistic nursing practice views health care in terms of

   the whole individual .
4. The role of the nurse is complex and includes activist, advocate,

educator, coordinator of care, leader/ member of the profession, provider of care, research user, role model, empowering agent, and change agent .

5. The nursing process is the accepted guide for developing appropriate nursing care and wellness outcomes for persons.

Increasing technology

The development of specialized medical technology was a natural successor to the advances in medical science.

The first hospital laboratory was opened in 1889, and X-ray were used in diagnosis of diseases in 1896. The electrocardiography (EG) was discovered in 1903 and the electroencephalography (EEG) was discovered in 19029.

The first way that health information technology affects health care is by improving adherence of patients and doctors to guidelines and protocols. This is done by the decision support system, often in the form of computerized reminders, embedded either in electronic health records (EHRs) or computerized provider order-entry systems (CPOE). For instance, adherence to fecal occult blood test (FOBT) for colorectal cancer has been reported to increase from 12 percent to 33 percent (Overhage et al, 1997), following the use of decision support system. Another example is influenza vaccination. Szilagyi et al. (1992) reported a 23: increase in the absolute influenza vaccination rates for eligible patients (30: in the intervention group versus 7: in the control group), as the result of the installation of a computerized database system to

generate reminder letter for influenza vaccination to eligible patients.

The second way health information technology affects health care is by facilitating large-scale data integration and analysis. For instance, aggregation of electronic health records can be used to identify adverse drug events and devise interventions to avoid these events. Such approach was shown to reduce the rate of adverse drug events significantly (2.2: in the intervention group versus 7.6: in the control group) (Evans et al., 1992;1993). HIT also enables automated evaluation of quality of care and identification of procedures or tests that are ineffective, for instance, tests with high false positive rates.

The third way that health information technology affects health care is by reducing medical errors. HIT system enables integration of automated decision making tools and knowledge updating tools and reduces errors due to the gap between doctor's knowledge and the current standard-of-care. The use of EHRs was shown to reduce medical errors by 20-86: and improve correct medication dosing by 12-20: (Chaudhry et al. (2006)).

Since infants and children are at higher risk for serious medication errors, HIT is expected to have major impacts on pediatrics. Fortes cue et al. examined medication errors occurring in pediatric units and reported that computerized provider order-entry systems and clinical decision support system (CPOE+CDSS) would prevent 75.8: of harmful errors.

The fourth way that health information technology affects health care is by lowering utilization and provider time. Several studies report a decrease of 8.5-24: in utilization rates due to the use of decision support system at the point of care. Kucher et al. (2005) reported a decrease of 9: in total office visits, at 2 years following the

implementation of comprehensive EHRs in Kaiser Permeante health care network. More specifically, primary care visits are reduced by 11: and specialty care visits are decreased by 5:.

References

Health economics is a branch of economics concerned with issues related to efficiency, effectiveness, value and behavior in the production and consumption of health and health care. In broad terms, health economists study the functioning of the health care systems as well as health-affecting behaviors such as smoking.

A seminal 1963 article by Kenneth Arrow, often credited with giving rise to the health economics as a discipline, drew conceptual distinctions between health and other goods.[1] Factors that distinguish health economics from other areas include extensive government intervention, intractable uncertainty in several dimensions, asymmetric information, barriers to entry, externalities and the presence of a third-party agent.[2] In healthcare, the third-party agent is the physician, who makes purchasing decisions (e.g., whether to order a lab test, prescribe a medication, perform a surgery, etc.) while being insulated from the price of the product or service.

Health economists evaluate multiple types of financial information: costs, charges and expenditures.

Uncertainty is intrinsic to health, both in patient outcomes and financial concerns. The knowledge gap that exists between a physician and a patient creates a situation of distinct advantage for the physician, which is called asymmetric information.

Externalities arise frequently when considering health and health care, notably in the context of infectious disease. For example, making an effort to avoid catching the common cold affects people other than the decision maker.[3][4][5][6]

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