ORIGINAL ARTICLE

Exploring the Position of Community-Based Nursing in Iran: A Qualitative Study

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Abstract

Background: Community-based nursing focuses on providing health services to families and communities in the second and third levels of prevention and this can improve the individuals, families and communities' quality of life, and reduce the healthcare costs. The aim of this study was to explore the status of community-based nursing in Iran.

Methods: This qualitative study was conducted from March to November 2015, in Tehran, Iran, using the content analysis approach. The study setting consisted of Iran and Tehran Faculties of Nursing and Midwifery, Tehran, Iran. The purposive sampling method was used. Twenty faculty members and Master's and PhD students were interviewed by using the face-to-face semi-structured interview method. Moreover, two focus groups were conducted for complementing and enriching the study data. The data were analyzed using the Graneheim and Lundman's approach to content analysis. The trustworthiness of the study findings was maintained by employing the Lincoln and Guba's criteria of credibility, dependability, and confirmability.

Results: In total, 580 codes were generated and categorized into three main categories of conventional services, the necessity for creating infrastructures, and multidimensional outcomes of community-based nursing.

Conclusion: Introducing community-based nursing into nursing education curricula and creating ample job opportunities for community-based nurses seem clearly essential.

Keywords: Community-based nursing, Qualitative Research, Iran

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Introduction

Community-Based Nursing (CBN) focuses on providing care to people and families in their home or work environments. In CBN, specialized community-based nurses provide comprehensive preventive care to clients for preventing them from entering the lengthy and arduous processes of diseases and treatments.[1] They encourage the idea of prevention-based health in communities. The basic aims of CBN are to develop and modify self-care strategies and skills at community level.[2,3] Through CBN, nurses can plan and implement healthcare programs for all clients in order to postpone and even eradicate most contagious and non-contagious diseases and prevent clients from losing potential years of their lives due to diseases, disabilities, or premature death. The major benefits of CBN are, but not limited to, decreased healthcare costs, deeper client satisfaction, and greater participation of people, families, and communities in maintaining and promoting their own health.[4]

During the past two decades, economic burdens and advances have caused significant changes in healthcare delivery systems around the world. One of these changes was clients' greater inclination for referring to health centers instead of medical facilities for receiving disease prevention and health promotion services. These significant changes have increased the people's need to and desire for CBN. Currently, CBN services have been extended to homes, schools, industries, and health-centered clinics.[5,6] In Canada, CBN emerged in 1987,[7] and maintenance and health promotion of persons, families and communities was its mission;[8] also other countries such as Sweden,[9] Japan,[10] and Norway,[11] conducted such delivery of services in their community some decade ago. Like other advanced countries, health authorities in Iran have found it necessary to shift from treatment-based approaches to community-based healthcare services.[12,13] In Iran, increases in urbanization and elderly population, changes in geographical epidemiology of diseases, occurrence of emerging and re-emerging diseases, and shifts in the leading causes of death (from infectious diseases to diseases of modern life such as hypertension, diabetes mellitus, obesity, cancer, and accidents) have highlighted the necessity for dramatic healthcare reforms.[14] Accordingly, providing healthcare-related education and consultation by specialized nurses at community level has assumed greater importance.

One of the major reforms in the Iranian healthcare system for achieving the goal of 'health for all' was the establishment of the extensive nationwide Iranian Primary Health Care Network (IPHCN) in the 1980s. Accordingly, three types of health centers were established all over the country—even in small villages—for providing healthcare services at the three levels of prevention. The first type of such health centers includes health houses, rural and urban healthcare centers, and health bases. As the first line of healthcare delivery, these centers provide primary health care to a wide range of clients. The second-level centers are district health centers which provide supportive, planning, and supervision services to the first-level centers. Moreover, diagnostic and medical care services are provided in these centers. At the third level, advanced diagnostic and rehabilitative services are provided to clients in provincial health centers.[15]

Formal nursing education initiated from 1915, and behavior and social sciences were considered as an important section of nursing curriculum in 1958, and finally with the reform of medical sciences education in Iran in 1986, the disciplines of community-oriented nursing and community-based nursing were considered by educational politicians. Then, community health nursing and epidemiology were considered as mandatory courses in the curriculum of bachelor degree in nursing in Iran.[16] Currently, nurses receive education and training —during their formal university educations at the Bachelor's level— for providing CBN services to the clients,

families, and communities.[17] However, official statistics indicate that the majority of nurses provide healthcare services at the third level of prevention, mainly in medical facilities and hospitals.[12,13]

Currently, knowledge about the status of CBN is very little in Iran. For planning and improved role of CBN in the society, we should know the status and type of the delivered services by CBN in Iran. On the other hand, researchers have a rich experience about training of CBN and delivery of health care in the community as a nurse. Investigating this concept through a qualitative research, which includes multiplicity of data collection procedure and an event examination method, norms and values from the participants' viewpoint, provides the possibility of an in-depth examination, clear and comprehensive understanding, and recognition of the phenomenon. Therefore, the aim of this study was to explore the position of community-based nursing in Iran.

Materials and Methods

Design

This qualitative study was conducted by employing the qualitative content analysis approach, from March to November 2015.

Participants

Eleven faculty members and four students graduated in community health nursing as well as five PhD students in nursing were recruited from Iran and Tehran Faculties of Nursing and Midwifery, Tehran, Iran. Inclusion criteria were willingness to participate in the study, at least five years' experience for faculty members engaged in clinical and theoretical teaching of community health nursing, PhD students with the base of community health nursing and engaged in community health nursing, and MSc students of community health nursing field in the second year and more of their course. The only exclusion criterion in this study was lack of willingness to continue participation in the study.

Data Collection

Semi-structured face-to-face personal interviews were performed for collecting the data. Before each interview, we contacted the intended participant to determine the time and place of interview. All interviews were conducted in a private room located in the Department of Health of Tehran Faculty of Nursing and Midwifery. In total, 20 interviews were conducted. Besides interviews, we also conducted two focus groups for complementing and enriching the study data. Two researchers, one as the team leader and the other as non-participant observer and the recorder of verbal and nonverbal reactions, contributed in the focus group. Four participants took part in each focus group- eight in total. These participants were recruited from the aforementioned 20 faculty members and students. Focus groups were held by the first and second authors. The first author managed the focus groups while the second one strived to cover all the intended topics. Focus group and interview questions were: What kinds of gap exist in delivering healthcare services in Iran? How can community-based nurses help bridge these gaps? What roles and tasks do you envisage for community-based nurses? What are the prerequisites for training competent community-based nurses? What are the position and the functions of CBN in health canters? Moreover, pointed questions (such as Can you explain more? Would you provide an example?) were also asked during the interviews and focus groups for enriching the study data. The focus groups helped us confirm and validate interview-related data and findings. Interviews lasted for 30–40 minutes while the length of the focus groups was 35–45 minutes. Sampling and data collection were continued until reaching data saturation and obtaining no new data from the interviews.[18]

Data Analysis

For data analysis, we performed data collection and data analysis concurrently. The

data were analyzed by using the Graneheim and Lundman's content analysis approach.[19] Primarily, interviews were transcribed verbatim. We listened to the interviews and read their transcripts for several times to reach a general understanding of their contents. A whole interview transcript was considered as the unit of analysis while meaning units included words, sentences, and paragraphs. Meaning units were sets of words or sentences which conveyed a similar meaning or were related to the same concept in some ways. Meaning units were condensed and coded accordingly. Codes were compared with each other and sorted into more abstract categories according to their similarities. Finally, categories were also compared with each other and grouped into higher-level main categories.[19] The MAXQDA 10 software was employed for managing the coding and the categorizing the processes and linking the research notes to the codes.

Trustworthiness

To determine the data trustworthiness, we used the Lincoln and Guba's criteria of credibility, confirmability and transformability for maintaining the trustworthiness of the study findings.[20] Accordingly, for credibility we attempted to have a close relationship with the study participants and a prolonged engagement with the study; in addition, we made an attempt to recruit a maximum variation sample of participants who varied in age, gender, work experience, expertise, and working position. Also, we performed expert panels, for reaching the data. For conformability, we asked several participants to determine whether our findings conform to their experiences and viewpoints. The researchers tried to be reflexive through rereading and revising the interviews and then coding and double checking the codes with the participants. We also attempted to maintain reflexivity and avoid our own viewpoints from affecting the study data through reading interview transcripts, comparing codes with the raw data, and checking the findings with the participants for several times. Moreover, two faculty members having expertise in qualitative research were invited to assess and confirm our generated codes and categories. In addition. For transferability of data, the researcher tried to present all steps of the study with comprehensive detail. As to ethical considerations, all the participants were informed about the aim and the methods of the study and they were assured of the confidentiality of their information. The data were managed anonymously. The participants had the right to voluntarily participate in or withdraw from the study. They were asked to provide written informed consent. Member check was used to assess the dependability of data (to ensure stability and reliability of data). To this end, comments from colleagues familiar with qualitative approach and review of participants' transcriptions were used.

Ethical Considerations

The participants were briefed on the purpose and nature of the study, the voluntary nature of participation, the right to withdraw from the study at any time, and its guarantee of confidentiality and anonymity. Informed written consent was obtained for participating in the study and for voice recording. Interviews were carried out in complete privacy, and an attempt was made to keep the subject of the interview hidden from other people, including companions and acquaintances of the participants.

Results

Eighteen females and two males with a mean age and a mean work experience of 38±8.3 and 17±7.4 years, respectively, participated in the study. In total, 580 codes were generated which were categorized into three main categories and eight sub-categories (Table 1). Categories and sub-categories are explained in Table 1.

Conventional Services

The first main category of the study was conventional services. Healthcare services in

Table 1: Participants' experiences and perceptions of CBN in Iran

Categories	Sub-Categories
Conventional services	*Doing repetitive works in a predetermined framework*
	Perfunctory services
The necessity for creating infrastructures	*Creating job opportunities for community-based nurses*
	Changing health policy-makers' attitude towards CBN
	Preparing communities' for receiving CBN services
Multidimensional outcomes of CBN	*Direct access to first-hand healthcare services*
	More effective preventions
	Improved public's health literacy

Iranian healthcare settings are mainly provided based on pre-established routines rather than specialized job descriptions. This main category consisted of two sub-categories including doing repetitive works in a predetermined framework and perfunctory services.

Doing Repetitive Works In a Predetermined Framework

Currently, healthcare services in Iranian health centers are provided by technicians in environmental health, occupational health, family health, vaccination, and disease prevention. However, instead of assessing the communities' health needs and problems, these technicians do routine jobs such as completing checklists and forms. In other words, they provide healthcare services superficially; hence, they cannot develop and implement effective strategies for fulfilling the communities' health needs and resolving their health problems. On the other hand, lack of an effective management and supervision system had yielded to the provision of routine and repetitive health services. As to this situation, a Master's student said, "*...Filling checklists and forms is the predominant practice in different units of health centers. Healthcare services are limited to merely performing frequent visits without making any significant changes or providing follow-up care...*" *(P. 1; a Master's student).*

Perfunctory Services

According to our participants, family physician teams in Iran make home visits superficially. Because of poor supervision, if any, the members of these teams value treatment more than prevention and provide healthcare services without considering individuals, families, and communities' needs. Consequently, disease prevention and health promotion have been taken for granted; a faculty member with nine years of experience mentioned, "*...Home visit has been neglected. Family physicians either reside in urban health centers or simply refer to rural health centers once a week together with their teams which include a midwife. In fact, visiting patients is the only function of these teams...*" *(P 4; a faculty member).*

An interesting point is that there is no place for nurses in family physician teams. Most of health authorities in Iran believe that nurses either cannot provide significant services in family physician teams or their services are not appropriate for public health. A PhD student engaged in home health care services mentioned that he heard from a family physician manager, "*...What services can nurses provide which family physicians are unable to? [The participant meant that besides their own services, family physicians can also provide all services which nurses can]. Therefore, it is not necessary to include nurses in family physician teams...*" *(P. 12; a PhD student).*

The Necessity of Creating Infrastructures

The second main category of the study was

the necessity of creating infrastructures. This category included the three sub-categories of creating job opportunities for community-based nurses, changing health policy-makers' attitude towards CBN, and preparing the communities for receiving CBN services. These categories are explained below.

Creating Job Opportunities for Community-Based Nurses

Most of our participants highlighted the necessity to create infrastructures for training and employing community-based nurses. Currently, CBN has not been included in the Iranian nursing education curriculum. According to our participants, it is necessary to introduce public health nursing into nursing education curriculum and develop strategies for changing educational planners and instructors' attitude towards CBN. A faculty member with fifty years of experience mentioned, *"...Nurses should be educated in such a way that they view the patient as a unique person located in a family instead of a single, detached individual. If they gain such a perspective during their university education, they will adopt it practically. In fact, instructors should instill such an attitude in students..." (P. 20; a faculty member).*

Community-based nurses have been rarely employed in health centers in Iran. Despite the great need to their services, most of community-based nurses cannot accomplish the aims of CBN due to lack of a clear job description. They are mostly employed in clinical settings as staff nurses or in educational settings as instructors. Consequently, they simply provide stereotypical routine clinical care instead of public education and counseling. A Master's student studying in the fourth term said "…*Community-based nursing is only a 'title' for enrolling students in Master's degree and does not have any other utility..."(P. 6; a Master's student).*

Moreover, unclear job description has prevented the community-based nurses from providing efficient CBN services. About the importance of job description, a faculty member mentioned, "…*Training a Master's CBN student incurs huge costs. However, they cannot offer any benefit due to having no clear job description; therefore, we cannot employ them for promoting public health..." (P. 14; a faculty member).*

Currently, despite community-based nurses' great communication and counseling skills, treatment and preventive services in Iran have been defined to be provided solely by family physicians. The reason is that there is no position for community-based nurses in family physician team. About this situation, a faculty member with twenty years of experience stated, "…*Currently, there is no official position for graduate community-based nurses; hence, most of them are practicing nursing in clinical settings..." (P. 9; a faculty member).*

Changing the Health Policy-Makers' Attitude towards CBN

An essential prerequisite to CBN is to change health policy-makers' attitude towards it in such a way that they understand the necessity for community-based nurses' specialized services. According to our participants, the main reason behind community-based nurses' unemployment in specialized positions is lack of an efficient management system. A faculty member said "…*Given the great need to community-based nurses' preventive care services, health policy-makers need to do strategic planning for using their abilities optimally ..." (P. 2; a faculty member).*

Preparing the Communities for Receiving CBN Services

Participants highlighted that communities should be or become ready for receiving CBN services; otherwise, major health challenges will arise and affect people's health and quality of life. A faculty member with twenty three years of experience about importance of change in the policy-makers' opinion stated, "…*Iranian health policy-makers also need to change their attitudes. Otherwise, major*

negative outcomes will affect the individuals, families, and communities. Treatment is like administrating an [short-acting] analgesic. Health policy-makers need to understand that CBN is beneficial to communities…" (P. 2; a faculty member).

Another prerequisite to CBN is the public confidence in community-based nurses' abilities and services. In other words, people's attitudes towards community-based nurses' abilities and services should also be changed. About the importance of changing people' attitude, a PhD student stated, "*…People need to understand community-based nurses' abilities and importance in order to trust them and use their expertise…" (P. 3; a PhD student).*

Multidimensional Outcomes of CBN

The third main category of the study was multidimensional outcomes of CBN. Three sub-categories fell into this main category which included direct access to first-hand healthcare services, more effective preventions, and improved public health literacy.

Direct Access to First-Hand Healthcare Services

Easy and direct access to first-hand healthcare services is one of the main outcomes of employing community-based nurses. They can make home visits and collect valuable information which people might avoid sharing them while attending healthcare settings; a faculty member with long experiences in community health nursing stated, *"...One of the instances which highlight the necessity of CBN is the issue of home visit. Community-based nurses can provide specialized healthcare services during home visits for promoting public health and minimizing the families' health-related costs…" (P. 17; a faculty member).*

More Effective Preventions

Study findings highlighted the critical role of community-based nurses in providing healthcare services at the three levels of prevention. Currently, the elderly population and, hence, the rate of chronic diseases are increasing progressively. Therefore, community-based nurses have a major role in public education and disease prevention. On the other hand, health problems such as addiction, AIDS, and hepatitis are endangering the adolescents and youths' health and lives. Given the fact that Iran has a large young population, training and employing community-based nurses for more effective disease prevention and health promotion seem clearly crucial; in this regard, a faculty member with seventeen years of experience in clinical and theoretical teaching of community health nursing stated, *"...A community-based nurse can play an important role at the three levels of prevention through communicating with families and identifying their problems. Consequently, they can promote a healthy lifestyle, improve quality of life, and support the families' domestic economy..." (P. 16; a faculty member).*

Improved Public's Health Literacy

According to the study participants, another outcome of CBN is improved public health literacy. Improved health literacy can, in turn, help people shift from receiving care from healthcare professionals toward actively engaging in self-care activities which finally reduces the families and communities' health-related costs and also decreases the disability-adjusted life years. With regard to this, a PhD student engaged in delivery of health services to public in the health centers stated, "*…Nurses can improve the public's health literacy. For instance, they can minimize the clients' repetitive attendance at specialized care settings and reduce healthcare costs through educating palliative care remedies to them…" (P. 7; a PhD student).*

Discussion

This study aimed at exploring the status and functions of CBN in the Iranian healthcare

system. The findings revealed that, currently, health services in Iranian health centers are provided conventionally and superficially by non-professional care providers who have poor professional communications with each other. The findings of other studies also showed that role conflicts and role ambiguities as well as poor inter-professional communications have caused healthcare services to be non-holistic, repetitive, and non-organized.[21,22] The findings of the study also indicated that family physician team in Iran has conventionally encouraged the idea of treatment-centeredness. The aims of this initiative were to promote public health based on the three levels of prevention and organize the patient referral system.[23] However, family physician teams which are directed by physicians mainly focus on administrating medical treatments instead of providing preventive care, and don't have proper referral follow-up and communication to people;[24] also, in these teams, nurses have been defined to be assistants to physicians. Such an approach to nursing and nurses is not consistent with health education, counseling, and disease prevention tasks of professional community-based nurses. An important point highlighted by the participants was that CBN has not been included in nursing curriculum at Bachelor's degree. The aim of Bachelor's nursing education in Iran is to train nurses who have a holistic approach to care and value CBN. However, this aim is not fulfilled and nursing students do not acquire the necessary skills for practicing nursing at community level. Rather, they are simply familiarized with the roles and the functions of community-based nurses; in line with result this study, another study reported that graduate nurses in Iran are not have ready for delivery of service in the community.[25] Other studies also reported the same findings.[26] Studies highlighted that in contrast with the aims of the Bachelor's nursing education program in Iran, Iranian nursing graduates can work only as staff nurses at hospitals.[17,25] The results also indicated that the current infrastructures of the Iranian healthcare system have been developed and are suitable mainly for secondary prevention. Other studies conducted in Iran also showed that most Iranian healthcare authorities consider nursing as a hospital-based profession and allocate nurses mainly to clinical work settings. The reason behind such practice is probably the fact that most Iranian healthcare decision- and policy-makers are physicians who have disease-oriented approaches to care and view hospitals as the main site of care delivery. In line with our findings, the results of a study indicated physician-based management as a negative point in the health care system of Iran;[27] such an attitude is apparently in conflict with and negatively affects community-based healthcare delivery.

The statistics released by the Iranian Ministry of Health and Medical Education also indicate that almost all Iranian nurses are providing healthcare services in hospitals and other clinical settings.[12] Moreover, although Iran is among the signatories of the Alma-Ata declaration, Iranian nurses having Master's degree in CBN are not employed in primary healthcare delivery centers. The Alma-Ata declaration of health for all was issued in the 1978 International Conference on Primary Health Care for promoting the health of all people worldwide through providing primary health care services. These findings highlighted the importance of and the necessity to develop measures for training and employing community-based nurses in Iranian primary health care settings.

We also found that one of the positive outcomes of CBN would be direct access to first-hand healthcare services through home visits and home health care by community-based nurses. In line with the results of this study, another study showed that home health care was a community-based service[28] that can be cost beneficial and decreases the rate of readmission and hospital complications.[29] During home health care, the clients' healthcare needs are assessed, planned for, and fulfilled in their natural environment. However, currently more than 80% of such services are provided by professional and non-professional healthcare providers who have a

disease-centered approach to care.[30]

There were limitations in the present study. Firstly, this study was conducted using qualitative method and we cannot generate data in other areas. In addition, participants in this study were people in nursing field; if other people in the health care team, such as policymakers, physicians and health care workers, had participated in study, we could have gathered more data.

The present study had several important strengths. We performed expert panels to enrich the data; moreover, we interviewed the pioneers of community health nursing in Iran. Through their assistance and use of their opinion, we could highlight the significant role of community health nursing in Iran.

Conclusion

Health services in Iranian health centers are provided stereotypically and superficially. Accordingly, employing community-based nurses, establishing effective inter-professional communications, and supervising healthcare providers' care practice are necessary for improving the quality of health services. The necessary infrastructures for CBN are creating positions in the healthcare organizational chart for community-based nurses, changing health policy-makers' attitude towards CBN, and preparing communities for receiving CBN services. Employment of community-based nurses can produce positive outcomes such as direct access to first-hand healthcare services, more effective preventions, and improved public health literacy. Community-based nurses can effectively manage home visits, assess clients, families, and communities' real needs, and plan and provide effective home care, but we could not explore the activities of CBN in this fields; hence, we suggest further investigations should be conducted for identification of CBN roles in various fields.

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