CHAPTER - 9

POLICY ADVOCACY AND LEADERSHIP IN COMMUNITY HEALTH NURSING

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ABSTRACT

Community health nurses can address socioeconomic determinants of health, impact public health policies, and spearhead revolutionary changes in healthcare delivery through policy advocacy and leadership. The theoretical and practical facets of leadership and policy advocacy in the context of community health nursing are examined in this chapter. This study investigates the efficacy of leadership models and advocacy tactics in attaining health equity using a mixed-method research methodology. The results emphasize the value of teamwork, evidence-based procedures, and community involvement in promoting long-term health results. The chapter ends with practical suggestions for nurses looking to improve their leadership and advocacy skills. Everyone has the right to health. The concept of equity in health suggests that, in theory, everyone should have an equal chance to reach their maximum potential in terms of health and, in practice, that no one should be prevented from doing so. In order to promote higher wellbeing among individuals, families, and communities, it is necessary to employ creative solutions to minimize risk factors and strengthen protective factors in order to address the multifaceted health requirements of ethnically and culturally varied people in Asian countries. It is crucial that we outline strategic initiatives that promote improved access to primary care, targeted community-based programs, multidisciplinary clinical and translational

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research methodologies, and more, given the increasing diversity of ethnicities and nationalities and the notable shifts in the constellation of multiple risk factors that can affect health outcomes.

Key words: Policy, Advocacy, Community health, Leadership, health Policy

9.1 INTRODUCTION

The concerning consequences of poor health status among numerous individuals, families, and communities were detailed in a recent World Health Organization report titled U.S. Health in International Perspective: Shorter Lives, Poorer Health . Comparing seventeen peer countries on life expectancy, certain medical conditions, and health outcomes—specifically, infant mortality and low birth weight, injuries and homicides, disability, adolescent pregnancy and STDs, HIV and AIDS, drug-related deaths, obesity and diabetes, heart disease, mental health, and chronic lung disease—is made easier with the help of this historic report. One noteworthy and persistent conclusion indicated that the impoverished, neglected, and vulnerable populations inundated with bad consequences are represented by the people who suffer the most, are most severely impacted, and are most at risk for negative outcomes. People from poorer socioeconomic backgrounds have the lowest health results, even in nations like the Asian Countries that are economically powerful and have many people with sufficient means. By advocating for health equity and establishing standards for international health efforts, public health professionals, researchers, physicians, and policymakers must take the lead in closing the wealth gap in health-related matters.

To tackle the issue of health disparities, social justice needs to be extended to a wider audience that is less exclusive and more inclusive. The CSDH three principles of action must be actively promoted by leaders: (1) improve the everyday living conditions in which people are born, grow, live, work, and age; (2) address the unequal distribution of power, wealth, and resources; and (3) precisely measure the issues, evaluate action plans, expand the body of knowledge, and develop a workforce of

individuals with social Furthermore, "achieve health equity, eliminate disparities, and improve the health of all groups" is one of Healthy People 2020's main objectives. With moral and determined public health officials leading the charge, this can be achieved. It is appropriate to: 1. precisely define the health problem or opportunity; 2.identify the cause or risk factors involved; 3 identify what works to prevent or ameliorate the problem; and 4.determine how to replicate the strategy more broadly and evaluate the impact, according to the public health approach, which begins and ends with surveillance . An overview is provided on the contributions made by the organizations involved with these strategic partnerships. The ingredients for establishing successful, strategic partnerships are also identified. It is hoped that nursing and health care leaders striving to address the nursing shortage could consider statewide efforts such as those used in Texas to develop nursing workforce policy and legislation**. (7)**

To strengthen this function of nursing organizations, exam ning their policy spheres of influence and impact, decision-making processes, and advocacy approaches can be particularly meaningful. While much can be learned from the policy advocacy work of organizations in other disciplines, advocacy organizations are not equal in their ability to influence public policy(8)

9.2 RESEARCH DESIGN

9.2.1 Approach

The narrative research approach will be engaged in creating the content for this book. This technique will juxtapose a literature review, expert interviews, case studies, and empirical data, illustrating an evidence-based consideration toward community health nursing. This qualitative research method, the narrative approach, assesses and appraises the experiences or experience of individuals or groups. The narrative method is used in Community Health Nursing, a Public Health Perspective, to investigate how patients, communities, public health personnel, and community health nurses experience health-related phenomena. With this qualitative research method, the researchers will

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be able to understand how social, cultural, and environmental factors interrelate in affecting various nursing practices and health in local communities. Narrative research makes it possible to gather rich descriptions of how community-based nursing interventions,

9.3 OBJECTIVES

1. To analyse the role of community health nurses in influencing healthcare policies and advocating for public health improvements.
2. To examine the impact of nursing leadership on the development and implementation of community health policies.
3. To identify the challenges and barriers faced by nurses in policy advocacy and leadership roles.
4. To evaluate the effectiveness of nursing-led policy initiatives in improving healthcare access and outcomes.
5. To recommend strategies for strengthening the leadership and advocacy skills of community health nurses

9.4 METHODOLOGY

Due to the large body of literature on the review topic, as indicated by an initial preliminary search, a thorough search was conducted utilizing six databases: Medline, CINAHL, Embase, Scopus, ProQuest, and Health STAR. Six important databases that are renowned for their thorough coverage of nursing and healthcare policy literature were chosen after an initial search was carried out to gauge the extent of the literature that was accessible. The included studies, which concentrated on nursing advocacy and policy involvement, were published in English between 2010 and 2023.

9.4.1 Health Inequalities: A Universal Issue

In order to promote greater well-being among individuals, families, and communities, it is necessary to employ creative strategies to lower risk factors and strengthen protective factors in order to address the complex health needs of ethnically and culturally diverse people in the United States. The diversity of different countries and ethnicities is increasing. We must outline strategic initiatives that support improved

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access to primary care, targeted community-based programs, multidisciplinary clinical and translational research methodologies, and health policy advocacy initiatives that may enhance people's longevity and quality of life because the constellation of multiple risk factors that can affect health outcomes has changed significantly.

Addressing Health Disparities from a Community Perspective

Everyone should have equitable access to health care regardless of their level of education, financial situation, gender, ethnicity, or geographic location. This is known as health equity. Aiming for the best possible standard of health for everyone while paying particular attention to those who are most at risk of poor health due to societal circumstances is known as pursuing health equity Addressing the social determinants of health is necessary to attain health equity. Income/wealth, food, nutrition, education and lifelong learning, water and sanitation, decent work, fair employment, health care, and the environment are all examples of social determinants of health. When everyone gets the chance to reach their maximum potential for health, health equity is attained. Eliminating health disparities that are consistently linked to underlying social disadvantage or marginalization is the operational definition of achieving equity in health.[3]

9.5 DETERMINANTS OF HEALTH EQUITY

Globally, the number of deaths of children under 5 years of age fell from 12.7 million in 1990 to 6.3 million in 2013. In developing countries, the percentage of underweight children under 5 years old dropped from 28% in 1990 to 17% in 2013. Globally, new HIV infections declined by 38% between 2001 and 2013. Existing cases of tuberculosis are declining, along with deaths among HIV-negative tuberculosis cases. In 2010, the world met the United Nations Millennium Development Goals target on access to safe drinking-water, as measured by the proxy indicator of access to improved drinking-water sources, but more needs to be done to achieve the sanitation target.

The United Nations Millennium Development Goals (MDGs) are 8 goals that UN Member States have agreed to try to achieve by the year

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2015. The United Nations Millennium Declaration, signed in September 2000, commits world leaders to combat poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women. The MDGs are derived from this Declaration. Each MDG has targets set for 2015 and indicators to monitor progress from 1990 levels. Several of these relate directly to health.

Progress report on the health-related MDGs

Globally, significant progress has been made in reducing mortality in children under 5 years of age. In 2013, 6.3 million children under 5 died, compared with 12.7 million in 1990. Between 1990 and 2013, under-5 mortality declined by 49%, from an estimated rate of 90 deaths per 1000 live births to 46. The global rate of decline has also accelerated in recent years – from 1.2% per annum during 1990–1995 to 4.0% during 2005–2013. Despite this improvement, the world is unlikely to achieve the MDG target of a two-thirds reduction in 1990 mortality levels by the year 2015. . (WHO)

Table 01 summarizing the information provided about the progress in reducing under-5 mortality globally:

	Number of Deaths (Millions)	Under-5 Mortality Rate (per 1,000 live births)	Rate of Decline (per annum)
1990	12.7	90	--
2013	6.3	46	-
1990–2013	-	-	49% decline in mortality
2005–2013	-	-	4.0% annual decline

More countries are now achieving high levels of immunization coverage; in 2013, 66% of Member States reached at least 90% coverage. In 2013, global measles immunization coverage was 84% among children aged 12–23 months. During 2000–2013, estimated measles deaths decreased by 74% from 481 000 to 124 000.(WHO)

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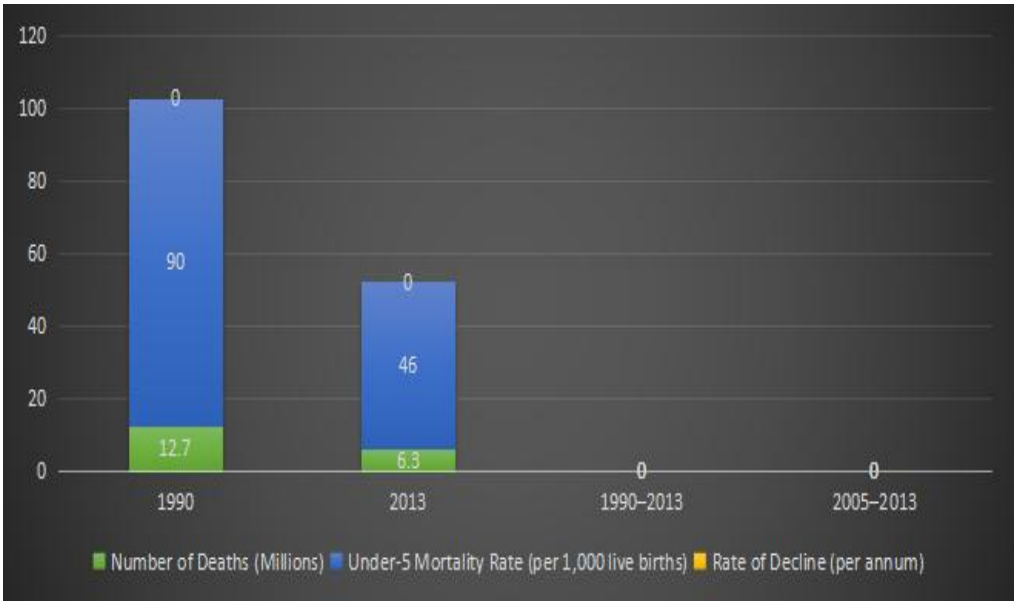

Figure 1. summarizing the information provided about the progress in reducing under-5 mortality globally

9.5.1 Millenium Development Goals 6 Target 6A. Have halted by 2015 and begun to reverse the spread of HIV/AIDS

In conclusion, while progress has been made towards the goal of universal access to HIV treatment, there is still much work to be done, especially in ensuring that those in low- and middle-income countries have full access to ART. The decrease in new infections and the increasing number of people on ART are positive trends, but achieving universal treatment access will require continued effort and resources. Declining new infections from 3.4 million in 2001 to 2.1 million in 2013 indicates hopeful advancements in prevention programs, increased access to treatment, and promotion of awareness schemes. The lowering of new infections is an integral aspect of meeting the goal for universal access to HIV treatment because with fewer new infections, there will be fewer individuals requiring ART. The 12.9 million individuals on ART indicate that major progress was made, although the UNGASS target of universal access was not reached in 2010. The widening coverage of ART treatment will have contributed to better life expectancy and well-being for

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individuals living with HIV. That 11.7 million of them reside in low- and middle-income countries shows that treatment has been prioritized for those regions at highest risk with less healthcare resources. Although the proportion of individuals on ART is substantial (39.5% of individuals living with HIV), the majority (approximately 60%) do not yet have access to ART. Closing this gap is still imperative to realizing universal access to treatment Stronger systems are necessary to increase access to ART in low- and middle-income countries, and further strengthen prevention to decrease new infection 36% of individuals who live with HIV in low- and middle-income countries being on ART, there are still hindrances to achieving universal coverage that exist in these regions, including healthcare infrastructure, stigma, and financial resources. The promise of increasing ART in these countries is fundamental to the attainment of equitable treatment access and eventual global control of the HIV epidemic

Malaria

Target 6B. Provide universal access to treatment for HIV/AIDS for all those who need it by 2010. In 2013, about 2.1 million people became newly infected with HIV — a decrease from 3.4 million in 2001. By the end of 2013 about 12·9 million people worldwide were receiving antiretroviral therapy (ART). Of these, 11.7 million, or 36% of the estimated 32.6 million people living with HIV in these countries, lived in low- and middle-income countries. If current trends persist

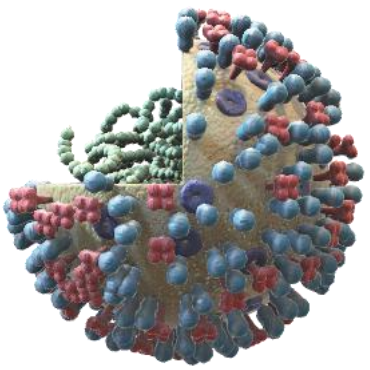

Figure 2 malarial Diseases

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The goal of putting 15 million people on ART by 2015 will be surpassed? The increase in ART availability, combined with the decline of newly infected people has caused a significant drop in mortality levels from HIV – from 2.4 million people in 2005 to around 1.5 million in 2013. Because fewer people die from AIDS-related causes, the number of people with HIV will likely keep rising. Target 6C About half the world's population is at risk of malaria, and an estimated 198 million cases in 2013 led to approximately 584 000 deaths – most of these in children under the age of 5 living in Africa. During the period 2000–2013, malaria incidence and mortality rates of population at risk have both fallen globally, 30% and 47% respectively. The coverage of interventions such as the distribution of insecticide-treated nets and indoor residual spraying has greatly increased, and will need to be sustained in order to prevent the resurgence of disease and deaths caused by malaria. Globally, the MDG target of halting by 2015 and beginning to reverse the incidence of malaria has already been met.

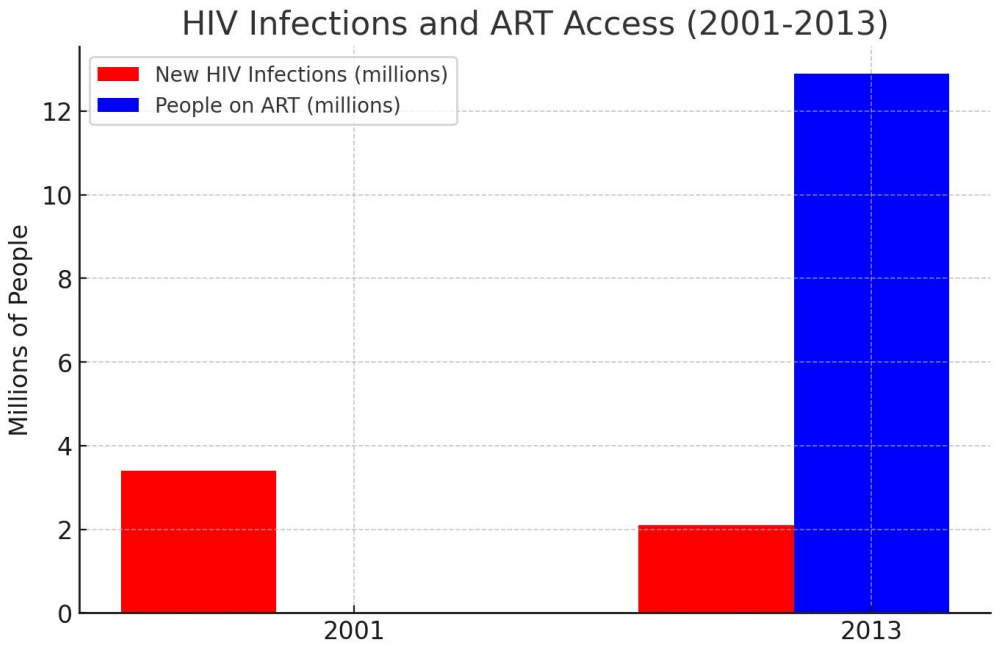

Figure 3. Graph HIV Infection and ART CASES

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Table 02 summarizing the information provided about malaria incidence and mortality globally:

Year	Estimated Malaria Cases (Millions)	Estimated Malaria Deaths (Thousands)	Global Malaria Incidence Decline (2000–2013)	Global Malaria Mortality Decline (2000–2013)	Region Most Affected
2013	198	584	-	-	Africa, especially children under 5
2000–2013	-	-	30% decline in incidence	47% decline in mortality	-

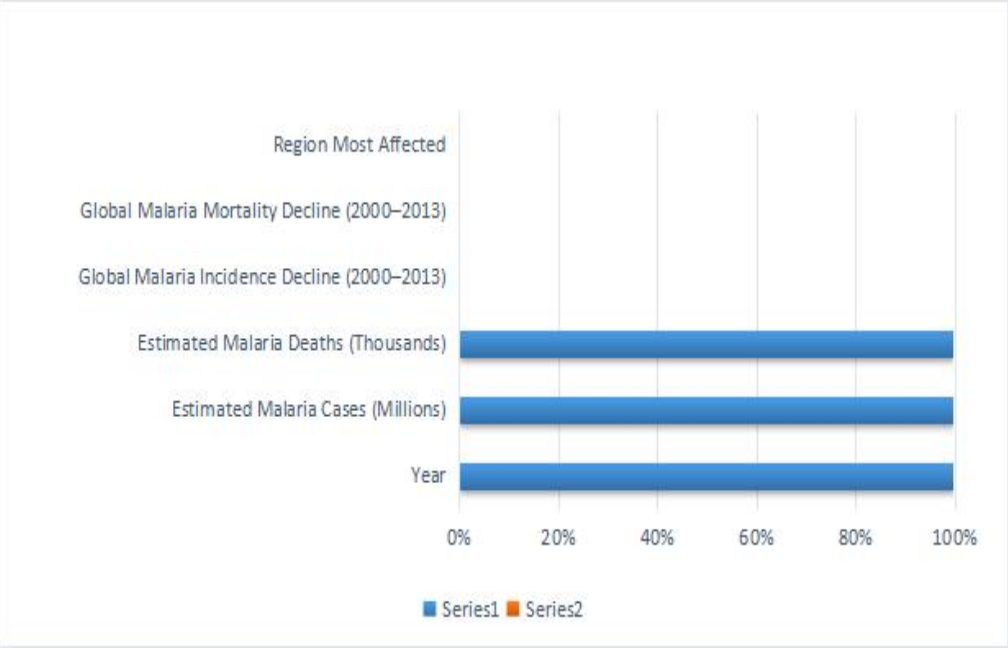

Figure 04 malarial Morbidity and mortality

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Millennium Development Goal 7: ensure environmental sustainability

Target 7C: By 2015, halve the proportion of people without sustainable access to safe drinking water and basic sanitation The world has now met the MDG target relating to access to safe drinking-water. In 2012, 90% of the population used an improved source of drinking-water compared with 76% in 1990. Progress has however been uneven across different regions, between urban and rural areas, and between rich and poor. With regard to basic sanitation, current rates of progress are too slow for the MDG target to be met globally. In 2012, 2.5 billion people did not have access to improved sanitation facilities, with 1 billion these people still practicing open defecation. The number of people living in urban areas without access to improved sanitation is increasing because of rapid growth in the size of urban populations.

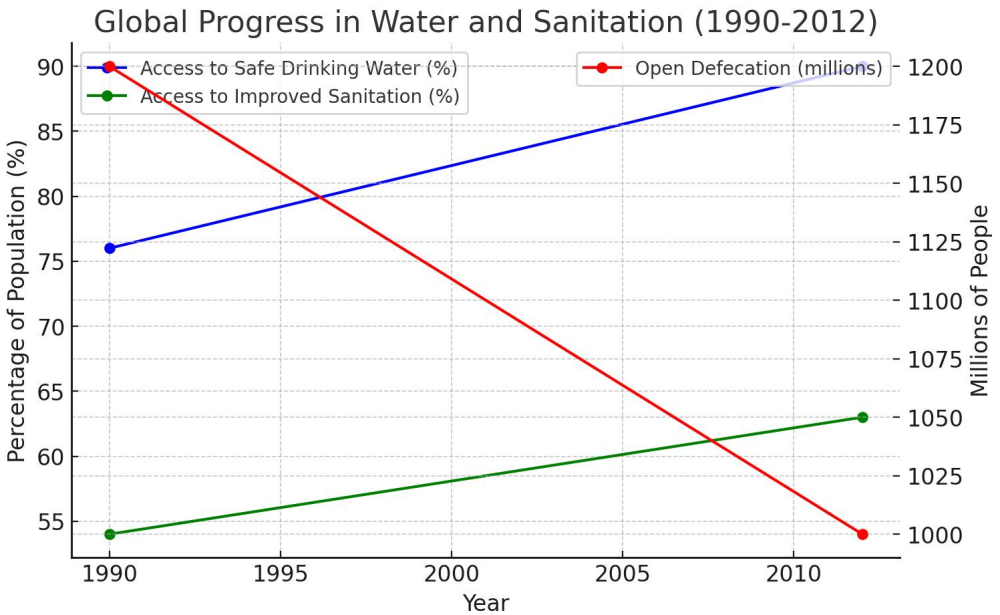

Chart 05 Global Progress in water sanitation

Here is a table summarizing the progress towards Target 7C related to access to safe drinking water and basic sanitation:

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Table 03 Health Indicator

Indicator	1990	2012	Progress/Key Points
Access to Improved Drinking Water	76% of the population	90% of the population	**MDG Target Met** globally. Uneven progress across regions, urban/rural areas, and income groups.
Access to Improved Sanitation	-	2.5 billion people lack access	**Current progress too slow** to meet the MDG target globally. 1 billion people still practice open defecation.
Urban Areas Without Improved Sanitation	-	Increasing due to rapid urban growth	Growing number of people in urban areas without access to improved sanitation.

Meeting Development Goals (MDGs)

1. UNFPA seeks to improve the lives and expand the choices of individuals and couples.
2. Over time, the reproductive choices they make multiplied across communities and countries, alter population structures and trends.
3. UNFPA helps governments, at their request, to formulate policies and strategies to reduce poverty and support sustainable development.
4. The Fund also assists countries to collect and analyse population data that can help them understand population trends.
5. It encourages governments to take into account the needs of future generations, as well as those alive today.
6. The close links between sustainable development and reproductive health and gender equality.
7. The other main areas of UNFPA's work were affirmed at the 1994 International Conference on Population and Development (ICPD) in Cairo.
8. UNFPA was guided in its work by the Programme of Action adopted there. At the conference, 179 countries agreed that meeting needs for

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education and health, including reproductive health, is a prerequisite for sustainable development over the longer term. They also agreed on a roadmap for progress with the following goals:

- Universal access to reproductive health services by 2015
- Universal primary education and closing the gender gap in education by 2015
- Reducing maternal mortality by 75 per cent by 2015
- Reducing infant mortality
- Increasing life expectancy
- Reducing HIV infection rates

Reaching the goals of the Programme of Action is also essential for achieving the Millennium Development Goals. These eight goals, which are fully aligned with the ICPD roadmap, have the overarching aim of reducing extreme poverty by half by 2015. UNFPA brings its special expertise in reproductive health and population issues to the worldwide collaborative effort of meeting the Millennium Development Goals

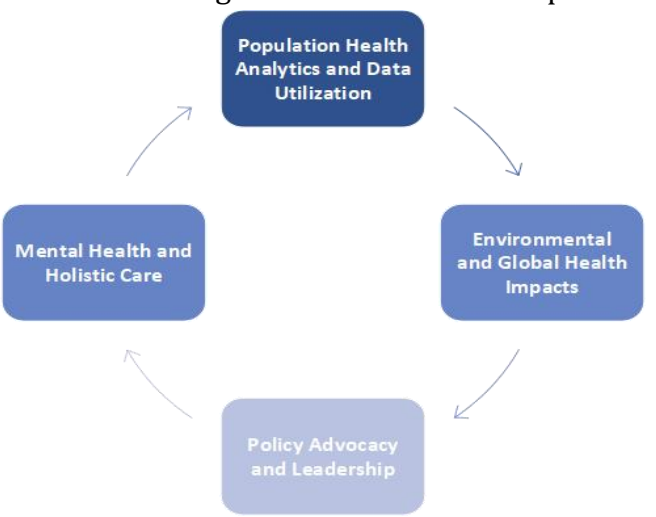

Figure 6 Meeting Development Goals (MDGs)

A conceptual diagram showing the hierarchical relationships between the terms used in the study. This diagram does not show evolutionary pathways, just the relationships between the terms

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We trace the evolution of behavioral strategies for controlling disease across species—that is, the evolution of what we call the 'healthcare system.' We borrow from the primate behavior literature to develop a new, definition of 'the healthcare system' which is informed by the theoretical approaches of socioecology and evolutionary biology and applicable across species. This allows us to track the evolution of behavior patterns across species, revealing a surprising amount of continuity through evolutionary time. This theoretical advance facilitates novel analyses for how different behavioral strategies may have been shaped by natural selection and how they may interact producing a 'system.' Similarly to how social systems are understood to be emergent effects of individual behavioral interactions healthcare systems can be understood as the emergent effects of individual interactions with conspecifics, with pathogens, and with the environment in health-relevant contexts. It is also important to note, that because healthcare systems are emergent properties of the behaviours of individuals, they can result from the selection that occurs largely at the level of the individual. In other words, healthcare systems can result from selection without, themselves, needing to die or reproduce like biological entities.

Our definition of a healthcare system does not prioritize (or exclude) the highly technological, biomedical healthcare system that is currently dominant in human societies. Instead, it situates the healthcare system as one, albeit highly complex, system with unusual traits that require explanation. In doing so, our study maps which elements of human healthcare systems are unique to us and how they have been a key part of our success as a species. We then place our behavioural methods for controlling COVID-19 into this evolutionary framework, examining how the evolutionary processes driving the evolution of healthcare systems creates conflicts within these systems. We highlight the evolutionary pressures that make the modern healthcare system vulnerable to breaking down—including during our response to COVID-19. We discuss the significance of understanding how healthcare systems evolve for thinking about the role of healthcare systems in society, during and after the time of COVID-19.

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9.6 RESULTS

Decisions at the policy formation and leadership level for community health nursing have impacted public health outcomes, healthcare access, and community-based intervention considerably. The active involvement of community health nurses in policymaking led to the promulgation of laws that emphasize preventive care, health promotion, and disease control. Among the good outcomes is that community-based health programs are getting integrated more into maternal and child health service provision, vaccination coverage, and management of chronic diseases. Advocacy has also increased the availability of healthcare resources among underserved population members, ensuring that essential services are available and equitable for all worldwide. Leadership on community health nursing has brought a strong contribution into formulating policies concerning environmental health, sanitation, and control of infectious diseases. Frameworks of collaboration between government agencies, NGOs, and local communities have been put in place toward sustainable health care initiatives by nurses. Involvement of nurses has put in place school-based health programs, mental health support systems, and home healthcare models for vulnerable groups. In addition, policy advocacy has advanced nursing education and workforce development, thereby improving nurses' training and skill enhancement in community settings. By influencing legislative change, nursing leaders secured recognition of community health nursing as a specialized field with attendant funding and avenues for professional advancement. Altogether, the results of policy advocacy and leadership in community health nursing depict improved infrastructure for public health, greater community engagement, and a stronger focus on preventive health care. This is more enhanced by the continuing process of ensuring a resilient and responsive healthcare system that duly responds to the needs of diverse populations.

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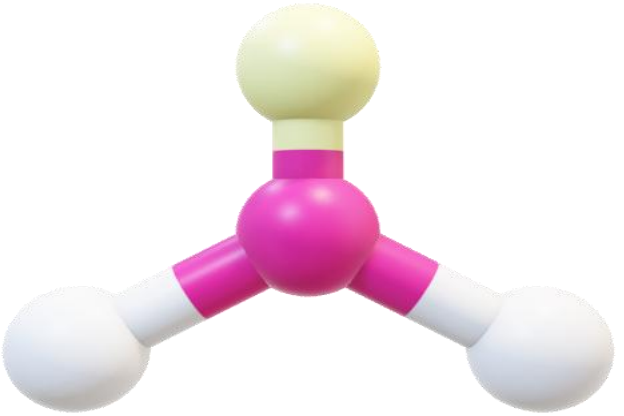
Professional Interactions



Individual Nurse Obstacles **Power Dynamics and Gende**

Figure 9 Shows the Result of Advocacy in nursing

9.6.1 Professional Enganment This review offers a thorough analysis of the current body of research that attempts to analyze the policy advocacy activities that nurse organizations engage in. This seems to be the first scoping review that looks into the kind, extent, and scope of scholarly work focused on this topic. A comprehensive overview of the body of current literature was produced by the inclusive criteria, which made it possible to examine and assess both studies and non-research pieces. In order to improve this study program, this conversation highlights the knowledge gaps that have been found and offers ideas for additional research topics and questions.

Table 4 shows Individual Nurse Obstacles

Professional Interactions	Lack of effective communication and collaboration among nursing staff	The disparity in power restricts the ability of nurses to express their perspectives and impact policy dialogues. Medical professionals frequently overshadow the viewpoints of nursing staff.

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	Lack of effective communication and collaboration among nursing staff	Insufficient collaboration and a fragmented voice stemming from inadequate cooperation among nurses, stakeholders, and leaders.
Power Dynamics and Gender	negative public perception of nurses	Diverse public perception obstructs political backing and advocacy from government officials or professional organizations
	Lack of motivation or disinterest in participating in political activities	A significant number of nurses exhibit a deficiency in motivation or engagement when it comes to involvement in political and policy processes.
Individual Nurse Obstacles	Limited resources and time restrictions	Time constraints and resource limitations impede nurses' involvement
	Lack of guidance from seasoned nursing leaders	The absence of guidance from seasoned leaders hinders the growth of advocacy skills and participation in policymaking
	Limited involvement of nurses in the policymaking process	Studies show that there are low to moderate levels of involvement among nurses in national policymaking, with a considerable number not participating whatsoever

9.6.2 Individual Nurse Obstacles

Advocacy and leadership in community health nursing are subject to power dynamics and gender issues that dictate the ways of decision, influence in policy, and professional recognition. Traditionally, nursing

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has been dominated by women in terms of numbers, although leadership roles for women in healthcare policy and administration have primarily been occupied by men. This has implications for how much nurses can advocate for policies directly affecting community health. In reality, power dynamics in healthcare keep doctors and policymakers at the top of the hierarchy, which suppresses community health nurses from influencing public health policy. Nurses, who often have first-hand experience and therefore deep understanding of needs of the community, may miss out during decision-making due to such hierarchical structures. Nevertheless, collective action advocacy has enabled professional organizations towards policy engagement to challenge that status quo such that nurses are now increasingly being acknowledged as chief protagonists in healthcare reform. Gender also speaks much about leader opportunities available. It is common in nursing leadership for women to face barriers like differences in payment, representation at the higher levels of policymaking, and societal expectations that indeed tend to undervalue their advocacy effort. On the contrary, increasing awareness and policy husbandry have empowered yet more female nurses to take a step higher in leadership roles related to community health programs. Advancing gender equity in community health nursing would call for structural changes to include equal opportunities for leadership, fairness and equality in pay, and inclusion in policy. Strengthening the nurses' role in advocacy will also ensure that healthcare policies are effective in a community-centered way of implementation. Solving the gender-based power dynamic will result in community health nursing as an area with a more inclusive approach to healthy and broad outcomes for all.

Advocacy and leadership in community health nursing are greatly influenced by perceptions of power and gender roles. This leads to decisions made by persons involved, misinformation and disempowerment of policies made, and professional recognition. This has always been said to have been a female-dominated profession and yet leadership roles have usually been confined to men in health care policymaking and administration. This malefaction is bound to reduce the extent to which nurses can effect health policies that directly affect the community.

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9.6.3 Power Dynamics and Gender

Power dynamics in healthcare tend to place physicians and policymakers above community health nurses. Nurses have little power in the arena of public health policymaking. Even if something was said about the frontline experiences and having deep knowledge of community needs, it will not preclude the barriers arising from hierarchy structures in decision-making. However, common campaign and coalescing with the professional organization and policies will see nurses empowering themselves against such power imbalances while convincing the world as an important partner in health care reform.

Gender bias within that space is yet another significant driver toward inequality in leadership. Female nurse leadership thus transforms such variables as pay, representation in higher echelons of policymaking, and societal expectations of their advocacy. However, on the whole, this means the modus operandi becomes increasingly liberal , which could lead to policy direction changes becoming more practical and empowering more female nurses to take on leadership roles in community health programs using dimensions like increased awareness coupled with varied policy changes. It requires institutional changes towards the promotion of equity in community health nursing vis-a-vis equal accession to effective leaderships, equitable earnings, and deeper incorporation in the policy consideration. More effective community-based health policies result from strengthening the role in advocacy for nurses as it serves to develop inclusive and better-oriented community health nursing into more and more egalitarian and transformational fields. That, in turn, will ultimately benefit the health outcome for all.

9.6.4 Impact of patient outcome

Through addressing systemic challenges that affect the quality of treatment, nurse leaders' involvement in health policy has a direct impact on patient outcomes. For instance, nurse leaders may help lessen gaps and guarantee that more patients receive the services they require by supporting policies that increase access to healthcare. Better care coordination and better patient experiences are the outcomes of policies

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that concentrate on improving care delivery models, such as integrated care systems. Additionally, nurse leaders are crucial in advocating for measures that improve patient safety, such lowering hospital-acquired infections and enhancing medication administration procedures. The relationship between better patient outcomes and nursing leadership is evident. Strong nurse leadership is typically associated with improved patient outcomes, such as decreased mortality rates, increased patient satisfaction, and fewer adverse occurrences. In order to ensure that policy decisions align with patient needs, nurse leaders provide a patient-centered viewpoint to the process. Nurse leaders have the power to significantly enhance the healthcare system by continuing to advocate for and lead health policy.

The relationship between better patient outcomes and nursing leadership is evident. Strong nurse leadership tends to improve patient outcomes in organizations, including decreased

9.7 Discussion

When promoting improvements to health policy, nurse leaders frequently face formidable obstacles. Resistance from lawmakers, who could be reluctant to enact reforms that could upset current systems, is one of the main challenges. When suggested measures disrupt the status quo or demand a large financial expenditure, this resistance may be very powerful. In order to overcome these obstacles, nurse leaders must form alliances with organizations, patient advocacy groups, and other medical professionals. In this manner, they may raise their voices and show that their efforts are widely supported. Reluctance can be overcome and reform momentum increased by interacting with the public and educating them about the advantages of suggested policy changes.

The lack of funding and assistance for policy lobbying is another issue that nurse leaders must deal with. With their clinical and administrative duties, many nurse leaders are already overburdened. They have less time and energy for policy work as a result of their increased obligations.

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Therefore, it is crucial to provide settings that assist nurse leaders in their advocacy work in order to overcome this obstacle. These kinds of settings necessitate allocating specific time and resources for policy work in addition to providing instruction in successful advocacy strategies.

9.8 FUTURE TRENDS IN HEALTHCARE POLICY AND ADVOCACY

Preventive care is receiving more attention as policymakers realize how crucial it is to enhancing health outcomes. **Increased usage of technology**: Policymakers are looking for ways to use technology to enhance patient care as it plays a more and bigger role in healthcare. Policymakers place more focus on **patient-centered care,** which entails collaborating with patients to create treatment programs tailored to their specific need.

Emerging trends that highlight accessibility, technology integration, and workforce empowerment are expected to shape the future of healthcare policy and advocacy in community health nursing. As the healthcare system transforms, community health nurses will be the key to influencing policies toward preventive care, health equity and patient-centered services. A major trend observed is the intensifying focus on universal healthcare coverage and the policies to address health disparities. Governments and healthcare organizations are working toward models that would allow equal access to healthcare, particularly for vulnerable populations. Community health nurses will continue to advocate for these policies, working toward increasing funds for public health programs and improving the social determinants of health. Another area of interest pertains to the integration of digital health technologies into community-based care. Such technologies as telemedicine, mobile health apps, and electronic health records are now gaining their rightful recognition as clinical management and advocacy tools. Nurses should advocate with the key principles of policy supporting digital literacy, data security, and accessibility for such technologies so they can successfully be applied to all members of the community. Moreover, there is a heightened concern for mental health advocacy and the ensuing policies for integrating mental health services into primary

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and community healthcare settings. Community health nurses will be instrumental in tackling the stigma around mental health, ensuring that policies are designed for holistic care. Nursing leadership in policymaking is gaining traction. There is increasing demand for nurses in key policy advisory positions so that nursing expertise can informedly shape healthcare frameworks in the years to come. Strengthening nurses' leadership roles will be vital in advancing sustainable community-driven healthcare policies.

9.9 STRATEGIES FOR STRENGTHENING THE LEADERSHIP AND ADVOCACY SKILLS OF COMMUNITY HEALTH NURSES

Increasing awareness: Raising Awareness: Nurses have a great part to play at the moment in bringing to the table issues affecting both patients and healthcare providers. They attract frontline experience in patient care, giving them unique insights into the barriers to quality healthcare. This makes them valuable advocates for change. Nurses even share experiences with their colleagues, legislators, and the public so that they bring beam-lighted issues such as inadequate staffing, lack of resources, and unfilled space in patient care.

One of the ways through which nurses will amplify awareness towards issues is by coming out on open forums with their colleagues. Sharing real cases and challenges will bring nursing person out of themselves and bring about collaboration in finding potential solutions. Teamwork and sharing of knowledge among healthcare professionals bring out the best practice being followed in solving some common inconveniences. Just to let Janice know that workers can bring about

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changes in policy decisions, by narrating their experiences to legislators about their working conditions and workplace safety for patients. Active involvement in professional organizations, town hall meetings, and public policy for discussion on health can be done by nurses for better working conditions, increased patient safety measures, and increased healthcare funding. Writing letters and attending meetings is another way to bridge the gap between policy and practice. Nurses can interact with the lay public in creating further national consciousness about healthcare issues outside the professional setup. They use social media, community seminars, and health campaigns to disseminate health information on disease prevention, mental health sensitization, and the urgency for access to healthcare. Public education programs empower people to take charge of their health by enhancing community buy-in for necessary reforms. By amplifying their voices, nurses serve as a great catalyst in creating a positive change in accessing healthcare services and bringing about better outcomes in healthcare for both patients and providers.

Humans, like all living things, have co-evolved with pathogens. Selection pressures to combat diseases are ubiquitous, stimulating species to evolve complex batteries of defenses A comparative, cross-species approach allows us to track how and when these defenses evolved and how they fit together today—in both nonhuman and human animals. Defenses against infectious diseases are often divided into the physiological and behavioral immune systems, with the physiological immune system serving primarily to defend the body against infections after exposure Its complement, the behavioral immune system, evolved to prevent exposures to disease and to supplement the physiological immune system when infected However, the behavioral immune system concept is limited to individual-level psychological and behavioral responses to cues of disease (i.e. disgust responses) This study will also trace the evolution of cooperative group-level defenses which have evolved convergent in eusocial insects and humans The analysis will highlight both the similarities and the differences between species' defense systems, including how cooperative defenses may fail in humans because of the ways we are different from eusocial insects.Here, we refer

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to behavioral defenses as healthcare behaviors [39] and divide them into two overarching categories based on how they operate: care behaviours and community health behaviours [39]. Care behaviours refer to behaviours that benefit the health of a targeted individual (who is often sick). We subdivide care behaviours into self-care, kin care, and stranger care based on the relationship between the carer and the recipient. These behaviours do not require compassion or empathy. Community health behaviours generate indirect benefits for the group through actions which are not directly targeted at a sick individual. We subdivide community health behaviours into environmentally-mediated protection (environmental protection) and organizationally-mediated protection (organizational protection). Environmental protection consists of actions that make the environment more hygienic and hence less favorable to the growth of pathogens. Organizational protection includes subgrouping of behavior patterns in space or time in ways that reduce opportunities for transmission, e.g. divisions of labour, synchronization of hygiene behaviours, and so on. The different types of healthcare behaviours which benefit others (kin care, stranger care, environmental protection, and organizational protection, discussed below) are categories of behaviours which can produce group-level defenses like social and organizational immunity These different categories of behaviours are useful because they highlight how they may be driven by different selective pressures and/or occur in some species but not others. The distinction between care and protection also closely mirrors the common medical contrast between treatment and prevention. Figure 1 is a conceptual diagram showing the hierarchical structure of these definitions.

We also focus on socially transmitted infectious diseases, although our model for the evolution of the healthcare system does not exclude responses to non-infectious diseases or injuries. Individuals are likely to be under selection to distinguish between infectious and non-infectious conditions, but are unlikely to do so with perfect accuracy. Therefore, the evolution of care is likely to include responses toward individuals suffering from both infectious and non-infectious conditions, as the etiology of a condition is not always distinguishable Because non-

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infectious conditions are less costly to carers (as they won't be infected), the inclusion of care for some non-transmissible conditions should reduce overall selection against care making care more likely to evolve.

Community health behaviours are the evolutionary roots of human public health practices and institutions. While care behaviours are generally direct interactions between a career and a recipient, community health behaviours are indirect interactions in which individuals reduce the risk to the group. This can be done through interactions with the environment or through engaging in patterned social interactions (i.e. division of labour, synchronizing hygiene behaviours). That both care and community health behaviours are widespread across the animal kingdom suggests that the two types of behaviours probably have deep, intertwined evolutionary roots. This evolutionary perspective does not conflict with historical perspectives that credit current public health practices with advances in civic hygiene in the 19th century and modern concepts of disinfection and sanitation While these modern understandings underpinned rapid developments in public health they do not undermine the evidence that the precursors to public health already existed in the behavioral repertoire of humans and other animals. Moreover, it is not necessary for a species to have a concept of hygiene in order to benefit from doing it, e.g. nest hygiene in birds and insects

Similarly to how self-care evolved before sociality, environmental protection behaviours likely also predate sociality. These are hygiene behaviours in which an individual modifies the physical or biological environment to change the distribution of pathogens in that environment. Importantly, such behaviours are examples of niche construction behaviours (and their consequences) that can mean there is not only genetic inheritance, but inheritance of environmental modifications, the latter of which can have an impact on the selection pressures faced by that species, and by other species living in that environment, such that evolutionary outcomes are different than they would otherwise be (e.g. allow otherwise deleterious traits to persist, or exacerbate and ameliorate competition between species). In this way, niche construction can be considered an independent evolutionary force that has an impact on the

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evolutionary history of the species living in that environment In particular, hygienic behaviours can result in the inability of pathogenic species to take hold in the local environment, leading to a reduction in infection rates.

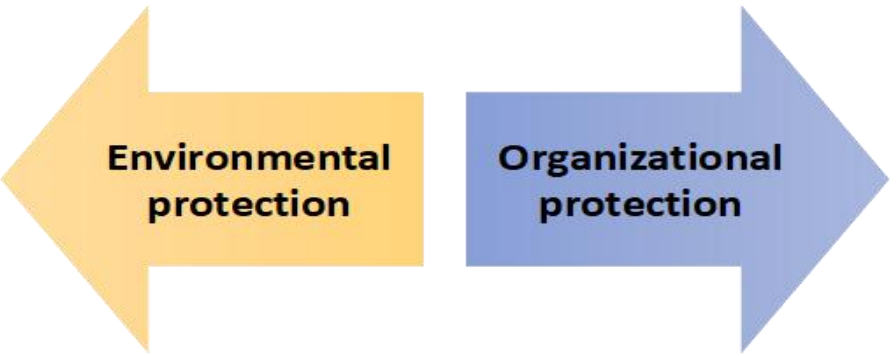

Figure 7. Environmental protection

Whereas some healthcare behaviours are direct (in the sense of involving self-care or individual-to-individual interactions), the benefits to others from environmental protection are necessarily 'indirect,' as they only involve modifications to the environment in the first instance. The primary motivation of the behavior is to modify the local niche; it is only the consequences of later interactions with those niche constructions that determine who benefits. While environmental protection behaviours are widespread, the particular behaviours that are performed can be highly taxon specific, with extreme forms representing convergent evolution. Examples include strategies for reducing pathogens in nests: eusocial insects build antimicrobial/antifungal secretions into the walls of their nests while birds and nest-building mammals may include anti-parasitic materials. Similarly, insects and humans, both of which live at high densities, dispose of their dead (see also reports in mice and wolves Though these particular behaviours are probably convergent, the proximate mechanisms underpinning them are likely to be multimodal and may vary across taxa according to which senses species use to perceive their environment. **For example**, insects rely heavily on odour cues to determine when to dispose of the dead (see also mice while humans likely rely more heavily on behavioral, tactile, and visual cues for

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recognizing when someone has died. Overall, this pattern suggests that while environmental protection behaviours may be ubiquitous and ancient, some niche dimensions, like nest-building, may exert particularly strong selection for these behaviours, producing the convergences that we see in distant lineages. In our lineage, the sophistication and scale of niche construction] that we engage in—agriculture animal domestication building cities—is a derived state, in that it is far more elaborate than the nests built by nonhuman primates including other apes. Our environmental protection behaviours are also unusually elaborate compared to other species; we build sewer systems, dispose of trash, and purify our water. While cities and other constructed environments did not evolve for the exclusive purpose of pathogen control, constructing them in ways that control pathogens may have contributed to their ability to persist over time. Environmental protection behaviours (Table 1) are fundamental aspects of human public health responses

Organizational protection

A final step in the evolution of human care systems came with greater economic specialization, through organized divisions of labour, institutionalization of care for strangers, and rules for coordinating or synchronizing the hygiene behaviours of populations. We call this 'organizational protection'. Organizational protection may have some (but likely not all!) of its evolutionary roots in environmental protection. Both types of protection may produce indirect benefits to the broader group and both frequently (but not always!) involve cleaning behaviours. However, the two types of protection have an important difference: organizational protection involves some form of group-level organization, while environmental protection does not. For example, sanitation behaviors like disinfecting surfaces are environmental protection, however having a specialized subgroup of individuals perform this service for the group (i.e. sanitation workers) is a form of organizational protection. While the boundary between the two can be difficult to define, at their extremes the two concepts are very different. Environmental protection probably originally evolved to benefit the self, even before

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sociality evolved. Organizational protection requires coordinated patterning of behaviors of individuals in space or time, often via involvement in some institution, which alter the distribution of pathogens, i.e. division of labour or synchronised behaviours of groups. Notably though, organizational protection is not exclusively about the division of labour. An example of organizational protection which involves synchrony across individuals without a division of labour would be population-wide social distancing. It demonstrates spatial and temporal coordination.

Organizational protection is hypothesized to have been under strong selection during the Neolithic when human populations became more sedentary, engaged in more agriculture and animal domestication], and had denser, larger populationsThis is argued to have changed the pathogens that humans deal with, potentially increasing the burden of helminthes and faecal and water-borne illnesses, and making populations more vulnerable to crowd diseases], creating pressure on populations to devise institutions to provide environmental protection services (i.e. rules about cleanliness of water and food, disposal of sewage, etc.). Stranger care was likely integrated into organizational protection as a type of division of lab our. Groups of professional careers, such as nurses and other healthcare workers, started caring for strangers as a full-time activity. There were probably efficiencies involved in embedding both care and protection services in the same institutions since individuals can tend to change from at-risk to sick status without warning. Once instituted, support services such as administration of the institution itself became required as part of delivering protection and care. A similar form of organizational protection, although not for strangers, is present in some eusocial insect species. In these societies, community health may be undertaken by particular castes who engage in behaviors that provide benefits to the entire colony, such as removing the dead or blocking entry to the colony by diseased individuals the ways in which organizational protection is delivered differ in important ways in eusocial insects and in humans. In eusocial insects it happens through the behavioral decisions of individuals belonging to the appropriate caste (bottom-up organization),

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which are stimulated though cues given by the recipient (e.g. chemical], behavioral], etc.). In humans, organizational protection can emerge through the behavior of individuals acting on their own initiative (voluntary social distancing by the American public during H1N1 through community-led mask sharing and protests for border closures during COVID-19 in Hong Kong and/or through top-down policy directives (i.e. governments)

Similarly, the selective pressures driving the evolution of organizational protection in the two taxa likely differ. In eusocial insects, it occurs primarily through kin selection, due to the typically high level of kinship between nest-mates In humans, it likely occurs through complex and dynamic selective processes, similar to those driving stranger care This may include multi-level selection in which the individuals benefit, contribute to benefiting their kin, and also benefit unrelated others, creating group-level selection and indirect reciprocity effects Coordinated behaviors which change the distribution of pathogens in space or time are also likely to be reinforced by network reciprocity and processes of environmental inheritance Similarly to stranger care, organizational protection also creates significant inter-dependence among participants, and is expected to be fragile to the preconditions for such inter-dependence, such as trust and the reliability of punishment for defectors This may be why organizational protection, like stranger care, is often professionalized (many public health jobs) and reinforced with forms of immediate benefits like payment. These benefits may be a form of direct reciprocity when the payment comes from the recipient of the service or indirect benefits when it comes from a larger collective (like a town or company). These benefits are immediate in that they are not an emergent benefit, like a reduction in pathogens due to the behavior of the group.

The Role of Nurses in Healthcare Policy and Advocacy

When it comes to lobbying and healthcare policy, nurses are essential. They are in a unique position to provide remedies because they are frequently the first to identify deficiencies in patient care. Policy-making can be influenced by nurses through: Taking part in professional

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organizations: Becoming a member of organizations such as the National League for Nursing (NLN) or the American Nurses Association (ANA) might offer chances to promote patient-benefitting policies. Lobbying with elected officials: To show their support for laws that advance high-quality care, nurses can meet with elected officials. Testifying before legislative bodies: In order to offer their professional perspectives on proposed policies, nurses may testify before legislative bodies.

Figure 8 Role of Nurses in Healthcare Policy and Advocacy

Figure 8 figure advocacy techniques that nurses can employ:

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Creating coalitions: The roles of nurses have ranged from being advocates for high-quality care to collaborative efforts with other stakeholders. Coalition with medical professionals, patient associations, and community-based organizations provides nurses with a consolidated voice towards bringing about effective change in the health policies and practices. One of the advantages of this coalition is that it bears a diverse experience. It can improve the quality of care for the patient when a patient nurse collaborates with a doctor, therapist, and other medical personnel on the health solutions needed for the patient. It would also promote patient-safety policies that address the required standards on staffing and accessibility to quality healthcare services. Patient associations are just as valuable partners when it comes to advocacy. When patients and their families talk about their experiences with the healthcare system, they provide powerful testimonies for debate about policy development. For instance, the work between nurses and patient organizations would yield evidence for hearings by lawmakers regarding the implication of healthcare policies, which in turn would lead to changes regarding public and political support. Nurses have been able to advance the grassroots public health agenda by partnering with these local organizations and community groups. Through the work they have done with advocacy groups, civic leaders, nonprofits, and others, they can organize and mobilize efforts for amending policies that are ultimately about social determinants of health (e.g., access to clean water, affordability of medications, preventive care programs). Strength coalitions can often amplify voices, affect legislation, and mold a necessity into their hands to create a healthcare system with high treatment quality and patient welfare.

Giving testimony: Nurses are a kind of professional who experience firsthand the many problems of the healthcare system, thus giving them a unique voice to present during legislative debates. They can testify in front of legislative bodies thereby providing professional opinions on the discussed policies and ensuring that laws and regulations accommodate the real requirements of patients and providers of healthcare.

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When nurses testify, they lend credibility and veracity to the discussion. Legislators weigh data and evidence, but when some enterprising legislator can listen to nurses' real-life experience, the discussions are humanized and that makes a lot of difference. Nurses can recount cases of patients suffering, stories of staff shortages, or how healthcare legislation affected frontline workers. This testimony gives lawmakers insight on how proposed policies will be relevant in the context of health service delivery and, ultimately, patient outcomes. The act of giving testimony itself requires preparation, clarity, and confidence. Nurses have to proceed with evidence-based arguments—with statistics, with research, and also with personal experience. They can advocate for policies that will favor patient safety, funding for healthcare services, or perhaps to remedy workforce challenges like nurse-patient ratios. In so doing, by doing more or less pros and cons, nurses help stories protect an informed decision. This testimony not only informs lawmakers but also educates the public. The media can carry news stories on these hearings and thereby amplify their voices in the arena of public opinion. When communities see and understand the real impacts of policies, they become much more likely to support initiatives that ensure high-quality healthcare. Harnessing opportunities for testimony, nurses are agents of change. They contribute their expertise and commitment to ensure favorable working conditions for healthcare professionals and care for patients.

9.10 SUMMARY

Community health nursing policies and leadership have a significant role in shaping the health policies, establishing healthy public outcomes, and ensuring that there is equality in accessing quality health care. This study defines the indispensable role of community health nurses as frontline advocates, policymakers, and leaders working towards influencing health policies in matters related to social determinants of health, healthcare disparities, and public health priorities. Findings of the research suggest that the nurses are major stakeholders in policy development but are always restricted due to limited policy knowledge,

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lack of institutional support, and little representation in decision-making forums. On the upside, this research reveals that the leadership and advocacy training can prepare nurses for energizing involvement in the formulation and implementation of health policies. Professional development, complemented with policy engagements as well as public health activities, encourages positive alterations within community health.

The study also points out the importance of including policy advocacy into the curriculum and training for nursing education and encouraging leadership development programs for nursing professionals. Another development to support the impact of community health initiatives and sustainable health reforms is to strengthen partnerships among nurses and healthcare organizations as well as policymakers. In summary, investing in nursing-leadership and advocacy skills is crucial for moving forward with effective public health and health equity. Future research should be concentrated on creating structured frameworks for nursing advocacy, affecting policy outcomes, and identifying systematic barriers to nurses' involvement in policymaking. Community health nurses will continue to leverage their voices in all levels of governance in health care to bring about reform in public health policy and practice as they match these efforts with policies.

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