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Report on the Evaluation of the WHO Multi-country Family Health Nurse Pilot Study

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ABSTRACT

The Munich Declaration calls for the enhancement of the role of nurses particularly in the field of public health. Furthermore, it promotes the development of family-focused community nursing and midwifery services. It also reinforces the importance of a sound evidence base for practice in nursing and midwifery. The WHO Family Health Nurse (FHN) Multi-national Study was very much in line with the spirit of the Declaration. The aim of the study was to test the FHN concept within different health care systems across Europe. This report details the rationale, the evaluation processes and the outcomes from the WHO (Europe) Family Health Nurse Multi-national study. These outcomes are intended to inform policymakers on the most effective way of developing community nursing and related services in the future.

Keywords

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FAMILY NURSING
NURSING – trends
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1. Executive Summary

> 'As stated in the 1998 World Health Declaration, the enjoyment of health is one of the fundamental rights of every human being. Health is a precondition for wellbeing and quality of life. It is a benchmark for measuring progress towards the reduction of poverty, the promotion of social cohesion and the elimination of discrimination. (...) Investment in outcome-oriented health care improves health and identifies resources that can be released to meet the growing demands on the health sector' (WHO 1998)

This report details the rationale, processes and outcomes from the WHO (Europe) Family Health Nurse Multi-national study. The family health nurse programme developed out of the recognition that there were significant challenges facing governments in the provision of health care to meet the changing needs of populations across Europe. New approaches to health provision were needed, which included radical changes to existing infrastructures and resources. Primary Health Care was identified as an effective means to provide appropriate health services, and has formed the basis of much WHO health care development activity over recent decades (WHO 1978, WHO 1988, WHO 1998, WHO/PAHO 2003c, WHO 2005).

Primary health care (PHC) has the capacity to improve peoples' health, by providing the basis of an efficient health system, stimulating community participation and the mobilization of social resources within health policy. It provides a gateway between the community and the health system and as a basic health system strategy offers improved coverage and equity of access to services (WHO/PAHO 2003, Jurgens 2004). An emphasis on PHC-led health care systems is premised on principles of universal access and coverage; its function as the site of first contact; a focus on community participation, and the integration of services, which are relevant to all populations and all communities (Kekki 2004). The modernisation of health services across Europe, where increasing amounts and a greater variety of health care interventions are delivered in primary care and community settings, requires new roles and new ways of working by health care personnel.

The 1998 policy framework 'HEALTH21 – Health for all in the 21st century' (WHO 1998) has heavily influenced the activity of WHO (Europe), with the goal of achieving 'full health potential for all' through its dual aims of promoting and protecting health throughout life and reducing the incidence of major diseases and injuries. HEALTH21 is underpinned by three main values:

- health as a fundamental human right
- equity in health and solidarity in action between countries, between groups of people within countries, and between genders
- participation by and accountability of individuals, groups and communities and of institutions, organizations and sectors in health development

HEALTH21 offered a comprehensive model to meet the challenge of existing and emerging health demands, noting that by being more productive, having a longer working life and participating more actively in their communities, healthier people could contribute to society and become more effective citizens. It also re-enforced previous commitments to primary care models of health care delivery. One of its major strategies for action was to promote integrated health service provision, with PHC as its basis, and with family- and community-orientated care. It highlighted public health activities rather than a focus on disease management, and the need for greater professional collaboration in PHC environments. Target 19 of HEALTH21 identified the

importance of developing human resources for health, including the establishment of two front-line primary care workers, the family doctor and the family nurse. These doctors and nurses are regarded as being at the hub of the network of primary health care services. It was noted that some Member States have these categories of worker already, but many do not.

HEALTH21 identified the need for highly qualified, multi-skilled nurses to support such developments. The Family Health Nurse (FHN) model provides this comprehensive approach to nursing in primary health care:

> Family health nurses can help individuals and families to cope with illness and chronic disability, or during times of stress, by spending a large part of their time working in patients' homes and with their families. Such nurses give advice on lifestyle and behavioural risk factors, as well as assisting families with matters concerning health. Through prompt detection, they can ensure that the health problems of families are treated at an early stage. With their knowledge of public health and social issues and other social agencies, they can identify the effects of socioeconomic factors on a family's health and refer them to the appropriate agency. They can facilitate the early discharge of people from hospital by providing nursing care at home, and they can act as the lynchpin between the family and the family health physician, substituting for the physician when the identified needs are more relevant to nursing expertise. (WHO 1998 p139).

In 2000, the Munich Declaration reiterated the importance of the family health nurse approach within the context of effective primary care. It advocated enhancing the role of nurses particularly in the fields of public health, health promotion and community development. It called for the establishment of family-focused community nursing and midwifery services, with the necessary legislative and regulatory support to enable nurses to work to their full potential as 'independent and inter-dependant professionals' (WHO 2000a, 2001a).

Literature reviews conducted prior to the implementation of the FHN indicated the great potential of such multi-skilled generalist nurses in meeting the requirements of the changes in health systems across Europe (Edgecombe 2001, McHugh & Cotroneo 1999, WHO 2000b). The FHN model was seen as providing front-line health workers, acting as a resource for the public through empowering clients to take responsibility for and make informed choices about their health and wellbeing. It was envisaged that FHNs would work with individuals, families and communities within a defined geographical area. Their activities would cover all age groups, and include health promotion, disease prevention and advocacy, curative care of illness, rehabilitative care, and care from birth to death (WHO 2000b). Further evaluation of the role was requested to provide empirical evidence to support its implementation.

Representatives from governments, health insurance funds, medical and nursing associations and consumers across the European region were invited to attend a meeting in Barcelona in April 2000 to discuss the implications of the FHN model, its infrastructure and financing requirements. Specific recommendations were made for the implementation of the concept of the FHN in different health care systems. Countries participating in the evaluation were invited to establish pilot sites and programmes appropriate to their health infrastructure. In-country evaluation processes were encouraged, to assess the impact of the FHN programme on existing primary health care structures, the processes of developing FHNs, and the outcomes of the FHN programme (WHO 2000c, WHO 2003a).

In addition to the in-country evaluation, countries were invited to participate in a multi-national evaluation. Ministerial approval was a prerequisite for being included in the multi-national study,

as a means of ensuring ownership by each country, and so some potential pilot sites were unable to participate due to a lack of government level support.

The FHN multi-national study was an exploratory process both for the participants and for the researchers. The nature of such international collaboration, with its associated linguistic, geographical and organizational difficulties, resulted in the need for a pragmatic approach to inclusion in the study, and processes of data collection and analysis. WHO did not provide dedicated funds, and so data was collected and collated by individuals within the context of their existing roles. The data collection tools were complex, as they attempted to identify the wide range of factors important in the development of family health nurses. The need to translate through various levels was an important issue, and one that the researchers did not have any degree of control over. There were very large differences in local and national circumstances at the starting point for the FHN multi-national evaluation, and differing levels of progress with in-country programmes. The relative contribution in terms of data available and the analyses conducted varies in line with these local circumstances.

The results demonstrate that there is strong commitment by policy makers and stakeholders and the providers about the FHN role. The core of the role across countries seems, on paper to be similar, and follows the WHO FHN definition adapted to the needs of the national health systems. Most countries had challenges regarding change management, demonstrated in the lack of clarity of the role as perceived by the public and by other health professionals. 'Receiver' resistance is a recognised change management issue that needs to be addressed within each country. Long term funding for sustaining the FHN service needs to be addressed by all participating countries.

The commitment of the participating countries to the very extensive demands made by both in-country and multi-national phases of the FHN evaluation should be commended. The differing levels of data received should be recognised as a consequence of the stage of development of each country at the time of the evaluation, as well as a product of the nature of such international comparisons. Importantly, the process was a learning experience for all concerned, and we hope that the networks developed and experiences shared will provide a useful basis for future work.

2. Background

2.1 Strengthening Health Services Delivery: Primary Health Care

The aims of the United Nations Millennium Development Goals focus on global efforts to achieve 'measurable difference in people's lives' (UN 2000). A major aspect of the WHO contribution to these goals is to enhance the capacity of national health systems to better meet the health and social challenges identified in the UN's programme. The WHO report 'Health and the Millennium Development Goals' (WHO 2005a) identifies five key health challenges:

- to strengthen health systems and ensure they are equitable
- to ensure that health is prioritized within overall development and economic policies
- to develop health strategies that respond to the diverse and evolving needs of countries
- to mobilize more resources for health
- to improve the quality of health data.

Additionally, specific points are made about the negative impacts of weak and inequitable health systems, addressing the universal crisis in providing suitably qualified health personnel and the urgent need for sustainable health financing.

The Millennium Development Goals (MDGs) reinforced an ongoing emphasis in WHO programmes on primary health care (PHC). WHO recognised that it was unrealistic to achieve any international health gains without a health system driven by effective PHC (WHO 2003c). PHC is seen as a basic strategy for attaining the MDGs, serving as a platform for strengthening health systems and emphasizing equity, shifting from vertical to horizontal approaches at the point of service, and strengthening inter-sectoral collaboration and social participation in health (PAHO 2003).

PHC is essential health care based on practical, scientifically sound, and socially acceptable methods and technologies, made universally accessible to individuals and families in the community. It aims to enhance community participation in service development and provision, promoting a sense of self-reliance and self-determination, at a cost that the community can afford (WHO 1978). For PHC to be effective, it must be a central function of the country's health system, and integral to overall social and economic development. It is the first level of contact with the national health system, for individuals, the family, and the community, bringing health care as close as possible to where people live and work. It constitutes the first element of a continuing health care process (Kekki P 2004, PAHO 2003).

International studies show that the strength of a country's primary care system is associated with improved population health outcomes, higher patient satisfaction and reduced total health care spending, with few adverse effects on quality of care or patient outcomes. In developed countries, a focus on specialist-based systems is associated with access inequities. Robust primary care systems in low-income countries tend to be more pro-poor, equitable and accessible. Studies analysing the shift of services from secondary to primary care showed such changes to be cost-effective (Hall & Taylor 2003).

Whilst research in general supports the promotion of primary care systems, the reality in terms of infrastructure, resources, content and modes of delivery are less clear (WHO 2004a, Hall & Taylor 2003). In addition, the expansion of PHC services does not necessarily reduce costs or

improve efficiency, as the process often identifies previously unmet needs, improves access, and expands service utilization. Significant problems with implementing health systems based on a primary care model have emerged. Insufficient coordination of health services are a major factor, with lack of inter-professional collaboration within PHC environments, problems at the interface between primary, secondary and tertiary health services, and between health and other welfare services (Saltman 2006). Other obstacles relate to inadequate funding, insufficient training and equipment, and weak data collection, analysis and evaluation frameworks, especially critical at a time when policy-makers demand a strong evidence base for decision-making (Hall & Taylor 2003).

In spite of these obstacles, there are strong indications that PHC can bring about major health gains. It is the gateway where patients are first seen and where decisions are made about referral to other providers. Strengthening primary care by developing the human resource skill mix or incorporating primary care principles into other levels of care has been identified as one way of overcoming some recognized barriers. Approaches include:

- professional role enhancement and innovations, such as substitution of doctors by nurse practitioners in appropriate environments or enhancing nursing roles e.g. nurse prescribing;
- changing the boundaries between primary care and other services, such as developing home care services, minor surgery and specialist outreach clinics in non-hospital settings (Saltman 2006).

2.1.1 WHO and Primary Health Care

PHC was identified as a core policy in 1978 with the Alma-Ata Declaration. Alma-Ata viewed primary care as the basis for health care reform, offering a framework for essential and universal health care provision for individuals, families and communities, based on 'practical, scientifically sound and socially acceptable methods and technology'. Self-reliance and self-development were important factors, with the adoption of a primary health care model as the means to achieve health for all 'at local and referral levels, (relying on) health workers, including physicians, nurses, midwives, auxiliaries and community workers, as well as traditional practitioners as needed… trained socially and technically to work as a health team and to respond to the expressed health needs of the community' (WHO 1978). These pronouncements were aimed at mobilizing political will and setting in motion national health system reform processes.

The undertaking to improve global health based on a primary care model was renewed in 1998 by the HEALTH21 programme, within which the commitment to PHC development was endorsed through its vision of full health potential for all. It focused on four main strategies:

- multisectoral strategies to tackle the determinants of health, taking into account physical, economic, social, cultural, and gender perspectives, and ensuring the use of health impact assessment;
- health outcome driven programmes and investments for health development and clinical care;
- a participatory health development process that involves relevant partners for health (at all levels) and promotes joint decision-making, implementation and accountability;
- integrated family- and community-orientated primary health care, supported by a flexible and responsive hospital system.

Health system reform with primary care at its core, and including active community participation, equity and sustainable financing, were major aims of the framework document.

The Munich Declaration in 2000 further reiterated the need for new public health models of service provision, aiming 'to tackle the public health challenges of our time, as well as ensuring the provision of high-quality, accessible, equitable, efficient and sensitive health services which ensure continuity of care and address people's rights and changing needs' (WHO 2000a). Munich highlighted the importance of strengthening the role of nurses and midwives in order to produce an effective primary care system.

The UN Millennium Development Goals consolidated the call for PHC to be major strategy in improving health and social welfare, with a focus on strengthening health systems, improving resource allocation and developing sustainable health frameworks responsive to diverse and evolving needs. Although specific models for delivering PHC are continuing to emerge, there is a realization that its principles – universal, access and coverage, its role as the site of first contact, community participation, integration of, services and programmes – are relevant to all populations and all communities (Kekki 2004).

Parallel to these policy developments, since Alma Ata dramatic changes have occurred in patterns of disease, international demographic and socioeconomic trends that present massive new challenges to PHC, and which informed the priorities identified in the United Nation's Millennium Development Goals. New health problems such as HIV/AIDS have emerged; non-communicable diseases have reached epidemic proportions in developed and developing countries, and chronic conditions and environmental risks present challenges for which most health systems are ill equipped. Population demographics have presented new trials, with substantial increases in birth rates in some countries, declines in others, ageing populations and dramatic changes in life expectancy and family infrastructure in countries affected by HIV/AIDS. Socio-economic trends such as globalization, industrialization and urbanization continue to impact on lifestyles, communities and determinants of individual health (WHO 2003c).

Health systems need to be developed and consolidated in order to meet both existing and new challenges. Countries across Europe are currently undergoing major health care reforms. Issues such as funding, coverage, quality, human resources, capacity building, social participation and accountability all need addressing as services are developed to better meet new demands, and to achieve the ultimate goal of 'measurable improvements in people's lives' (UN 2000). WHO recognise that in order for health systems to meet these demands, organizations delivering primary care services need to adapt and respond to circumstances. Changes are required in service infrastructure, working patterns and the knowledge, skills and responsibilities of all health professionals working in PHC (Kekki 2004, Saltman 2006).

2.2 Strengthening Nursing and Midwifery

The Vienna Declaration expressed the 'need for urgent action by governments and national health decision-makers to help nurses make the changes that are required in nursing if the regional targets for health for all are to be achieved' (WHO 1988). It called for greater involvement of nurses in the development of health policies at all levels, and an emphasis on nurses within primary care structures in line with the Alma Ata framework.

The Declaration called for nurses to be 'strong advocates for policies and programmes for health for all at national, regional and local levels (and for nurses to develop) innovative services based on a public health approach, achieving their traditional aims in new and independent ways whilst collaborating closely with professional colleagues, clients and communities'. Nurses had to play a more active role in helping people become more self-reliant and to take charge of their health, 'in empowering individuals, families and communities to become more self-reliant and to take charge of their health development'. In addition, policies had to be adopted to enable nurses to practise with sufficient autonomy to carry out their new role in primary health care. Changes were needed to improve nurse education, research and practice, to include a concentration on health rather than disease, and a move away from an absolute focus on individuals towards building relationships with families and communities (ibid).

In 1998, HEALTH21 (WHO 1998) identified 21 targets, ranging from policy level decisions to disease-specific activities, many of which had scope for enhanced nursing input. Target 18 identified the desire for all member states to ensure 'that health professionals and professionals in other sectors have acquired appropriate knowledge, attitudes and skills to protect and promote health'. Target 15 noted that 'at the core should be a well trained family health nurse, providing a broad range of lifestyle counselling, family support and home care services to a limited number of families' (ibid). The multifaceted 'skilled generalist' FHN role within primary care epitomises the contribution of nursing in reaching 20 of the 21 targets in HEALTH21 (WHO 2000b).

Building on these developments, the Munich Declaration (WHO 2000a) was adopted at the Second WHO Ministerial Conference on Nursing and Midwifery. The Munich Declaration forms the basis of the current activity in the WHO (Europe) Nursing & Midwifery Programme, stressing the potential of nurses and midwives as a significant political and social force and resource for public health. It affirmed that nurses and midwives had to be able to work to their full potential as independent and interdependent professionals, to contribute to fulfilling this objective. It also identified the development of key roles for nurses and midwives through:

- contributing to decision-making at all policy levels
- being active in improving public health and community development
- providing family-focused community nursing and midwifery services.

Part of this ongoing development to strengthen nursing and midwifery was to support an evidence-base for nursing practice and policy through research, coupled with wide dissemination of outcomes. Improvements in initial education as well as access to higher-level nursing and midwifery education were essential. International and inter-professional collaboration opportunities were vital to enable nurses, midwives, physicians and policy makers to work and learn together, to ensure more cooperative and interdisciplinary working, in the interests of better patient care. Importantly, it highlighted the need to establish and support family-focused community nursing and midwifery services. It advanced the Family Health Nurse as a means to fulfil this need.

A follow-up audit in 2001-2003 assessing the progress of the implementation of the Munich Declaration highlighted some major and widespread problems with promoting the development of nursing within the context of primary care. These included: the low status and gender bias of nurses; a lack of appropriate legislation enabling action; inadequate education programmes; dominance from the medical profession; a continued lack of participation in decision-making at all levels. In addition, there is evidence of the highly variable nursing role in public health across Europe, from participation in broad community-based and family-focused services to isolated

task-specific inputs such as immunization, wound care and record keeping. The ever-present problems of recruitment and retention were identified as a major obstacle (WHO 2003b). The Government Chief Nurses meeting in Madrid 2003 called for greater support for the Munich Declaration. 'Re-emphasizing Munich: Nurses and Midwives: a Force for Health' urged Member States to:

- strengthen, encourage and promote their efforts to implement the aims of the 2000 Munich Declaration, particularly the participation of nurses and midwives in decision-making at all levels of policy and practice development and implementation;
- reassess the contribution of nurses and midwives to meeting health needs and to realizing the professions' potential to tackle these needs;
- prepare a strategy for evaluating nursing and midwifery services;
- establish appropriate measures and systems for reporting on nursing and midwifery issues within their health care systems (ibid).

The 2004 audit did indicate some progress was being made to help nurses and midwives work as independent and interdependent professionals, especially with regard to legislative changes for regulating the widening the scope of practice and improvements to education systems. Hurdles such as the medical domination of health care systems, the lack of financial resources and difficulties defining the roles of nurses and midwives were still a problem. In addition, while nurses and midwives were often involved in decisions within their professional sphere, their contribution to wider health care decision-making remained limited. The inclusion of public health training in basic nursing and midwifery curricula had become more common, and the range of primary care activities reported had widened, with some evidence indicating that nurses were shaping more of the public health agenda. Although national research strategies were still the exception, there were increasing examples of nurses and midwives conducting research projects or participating in interdisciplinary research (WHO 2004b).

2.3 The Family Health Nurse model for Primary Health Care

Within the context of the global attempts to strengthen both PHC and nursing and midwifery, the concept of the Family Health Nurse (FHN) has proved very forceful. A well-trained FHN is a key primary care professional 'who can make a very substantial contribution to health promotion and disease prevention, besides being a care giver' (WHO 1998). The FHN role is envisaged as fulfilling many functions already available within health services, in an innovative way, 'encompassing elements which are already part of the role of several different types of nurses working in primary care across the European region. What is new is the particular combination of the various elements, the focus on families and on the home as the setting where family members should jointly take up their own health problems and create a 'health family' concept" (WHO 2000b). The WHO vision for FHNs was that they would work in partnership with families, communities and other health professionals, acting as a health resource and be key health promoters in society.

2.3.1 The Family Health Nurse – a WHO concept

Several studies and literature reviews informed the development of the FHN model. A literature review in 1999 attempted to provide a basis for the FHN model, through the identification of shared nursing constructs of the family throughout Europe and beyond. It highlighted trends in practice, education and research and provided a bibliography to underpin future work. It

advanced the importance of bio-psycho-socio-cultural approaches; the family as the unit of care; notions of continuity and reciprocity and the priority of health promotion/disease prevention. It also provided a theoretical basis for family nursing research and identified future directions for the FHN model (McHugh & Cotroneo 1999).

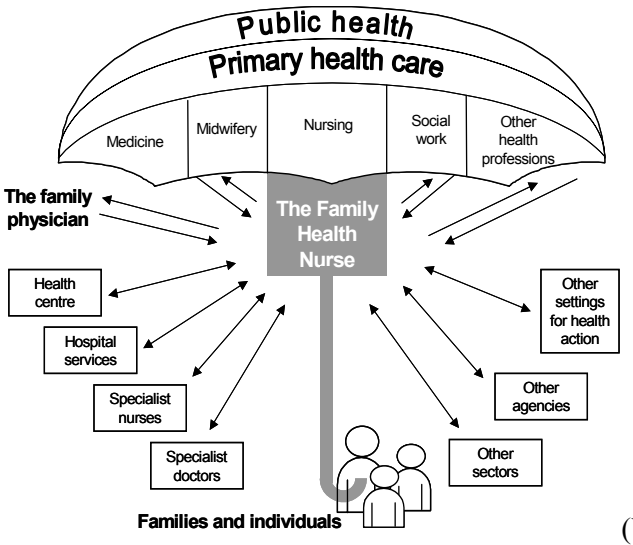
A survey of community nursing and midwifery in Europe (Whyte 2000) illustrated variations in educational preparation as well as inequalities in service provision across Member States. It also identified twenty-two different titles for nurses working in the community, including School Nurse; Mental Health Nurse; Community Nurse; Public Health Nurse; Home Nurse; Family Health Nurse; District Nurse; Health Visitor; Practice Nurse; Community Nurse (Mental Handicap); Feldsher; Paediatric Community Nurse; Midwife; Occupational Health Nurse; General Practice Nurse; Prison Nurse; Patronage Nurse; Social Psychiatric Nurse; Palliative Nurse; General Nurse; Labour Health Nurse; Community Chief Nurse.

The functions of some of the nurses within the Scottish community nursing services are summarized below:

Title of the RN	**Focus of activities**
District Nurse	attending the physically sick and disabled
Health Visitor	providing developmental screening and health promotion programmes
Midwife	caring for women through pregnancy and childbirth
Mental Health Nurse	caring for those with mental illness
Learning Disabilities Nurse	caring for those with intellectual developmental delay
Practice Nurse	providing screening programmes and chronic disease management
Specialist nurse	covering a range of disease specific conditions e.g.; diabetic, cancer
School Nurse	providing screening and health promotion programmes within schools
Occupational Health Nurse	caring for employees within their working environments

A discussion paper on public health nursing in 2001 (Edgecombe 2001) provided recommendations for a new vision for the 21st century and pointed out that the main factors for the development of public health nursing ‘crushing poverty, inequity, lack of basic health services, environmental pollution and infectious diseases’ were still problematic across Europe. Nurses and midwives had to promote their contribution to the WHO public health agenda, using new and innovative models. The review also vocalised the importance of understanding the implications of integrating new models into the existing frameworks.

The WHO Europe concept of the FHN was based on community nursing experiences from many countries, especially those of health visitor, district nurse and nurse practitioner models in the UK and the existing FHN model in Slovenia. The role and functions of the FHN contain elements that are already part of the role of community nurses working in primary health care all over the European Region. It combines many of these elements with a particular focus on families as systems, and on the home as the setting where family members are encouraged to manage their own health problems. The FHN is supposed to work in a multidisciplinary team and ‘under the umbrella of both public health and primary care’. Within this team, the FHN is a coordinator of the different health and social care professions, with the aim of providing appropriate care at all stages.



(WHO 2000b)

The FHN is a key professional together with the Family Health Physician, combining elements of public health including health protection and promotion, as well as curative and palliative care and facilitates co-operation between the family, the community and the health care system. This nurse is perceived to have an important role along the life course and at critical periods and life events, ensuring access to health care for all members of community.

2.3.2 Families and Nursing

The evolution of family health nursing emphasises relationships with families and working collaboratively with them to understand and act on their concerns, sharing care giving and attending to the effects of family processes on health and illness. The FHN role is active along the whole continuum of care throughout the lifecycle, and includes health promotion, disease prevention, and rehabilitation, providing care for those who are ill and those who are in the early or final stages of life, within the family or community setting.

Literature describes the relationship between families, nursing and health (e.g. McHugh and Cotroneo 1999, Wright and Leahey 2000). Historically patient care centred on individuals and their health issues, and whilst the family circumstances were of importance, the consideration of the family was not integral to the care process. Families have not been the focus for nursing in the sense that exists in the FHN model, and the considerable conceptual shift required when considering the family system rather than the individual as a unit of health care, should not be underestimated.

Fundamental to this concept is a definition of the family. HEALTH21 identifies the concept of 'family' as relating to that of 'household', and it identifies families (households) as the basic unit of society. Health care providers not only need to address health status but also account for wider psychological and social influences. The circumstances in which patients live - their housing, family circumstances, work, and social or physical environment all influence their health and illness patterns (WHO 1998).

The World Bank health development framework similarly focuses on 'household' to refer to whatever grouping of people share responsibility for health. This is not limited to biological relatives, and encompasses the broad array of kinship and household patterns around the world. It is a recognition that 'households matter in the health sector—more than most policymakers acknowledge. Improving the health of households is what the health sector is all about. People

rely on their health in their everyday lives, and for poor households, health is one of their major assets. Households are also key actors in the "production" of health. Indeed, they play a dual role—as users of health services delivered by professional providers and as producers of health through the delivery of home-based interventions and in their everyday health behaviours' (World Bank 2004).

The FHN pilot programme in Scotland took a wide definition of the family, whereby the family is seen as 'a group of individuals with relational connections that may be emotional and/or biological and/or legal in nature'. The focus of the role encompasses much more than the traditional concept of family to include all people in the community, whether they are living with others or alone, whether they have a home or are homeless and/or marginalized in some way. It embraces the community itself, and includes individuals with geographically distant relatives, friends providing a supportive role and traditional nuclear families with different generations being geographically close. The family therefore is self-referential i.e. 'the family is what individual members say it is' (Scottish Executive 2003). Although this definition has no legal bearing it reflects the variety of relationships that are encountered in today's society, and reflects much of the pertinent literature (Wright and Leahey 2000). Importantly, as noted by McHugh & Cotroneo 'family nursing needs to continually develop as the concept of family evolves. Family nursing research, practice, and education all benefit from an understanding of what the constructs of the family are and how they can be applied to assessing and intervening with families' (McHugh and Cotroneo 1999).

2.3.3 WHO FHN Curriculum

Based on the competencies derived from the WHO definition of the multifaceted role of the Family Health Nurse, a curriculum was designed to prepare qualified and experienced nurses for this new role. The WHO curriculum is structured around a 40-week full time equivalent post registration course. It is aimed at qualified nurses with at least two years post qualifying experience, and it places an emphasis on the integration of theory and practice. The competencies expected of FHNs in order for them to be fully functional as envisaged by WHO cover five major areas:

- care provider
- decision-maker
- communicator
- community leader
- manager (WHO 2000b)

The WHO curriculum consists of seven modules taught through a variety of recognised adult learning approaches, emphasising the use of care scenarios and family needs assessment processes. The aim is to produce a nurse who is:

- a skilled generalist, who is the first point of contact with the knowledge to refer on to specialists if required;
- a practitioner whose model is health rather than illness, taking a lead role in preventing illness and promoting health as well as caring for those people who are ill and require nursing care;
- focussed on the principle of caring for families rather than just individuals, and as a first point of contact. (Scottish Executive 2003)

2.3.4 Pilot Study to Evaluate the Family Health Nurse Model

Plans for pilot studies were initiated in order to evaluate the implementation and impact of the FHN model in Europe. A first FHN meeting was held in Barcelona in 2000 to discuss the implications of the family health model, its infrastructure, and financing requirements, and the management of the pilot schemes (WHO 2000c).

Sixteen potential sites were identified across Europe to test appropriate models of family and community nursing in different countries, health care systems and settings. The pilot studies were encouraged to start as soon a possible. In-country programmes have been reported elsewhere, and project documentation is available separately via WHO Europe.

The aim of the WHO Family Health Nurse Multi-national study was to evaluate the FHN concept, as defined in HEALTH21 and its implementation across different health care systems in Europe. In the first instance, twelve countries expressed an interest. The original schedule for the evaluation was two years for completion in 2003. However, participants were in varying states of readiness, and flexibility was built into the timeline of the study. In the event, the evaluation workshops ran from 2003–2005 and the data collection and analysis phase during 2005.

3. Research Context

The Munich Declaration (2000a) calls for the enhancement of the role of nurses particularly in the field of public health and primary care. Furthermore, it promotes family focused community nursing and midwifery services. It also reinforces the importance of a sound evidence base for practice in nursing and midwifery. The WHO (Europe) Multi-national Study on the Family Health Nurse is very much in line with the spirit of the Declaration. The outcomes of all phases of the Family Health Nurse study are intended to inform policymakers on the most effective way of developing community nursing and related services.

The WHO Multi-national study involved staff from WHO (Europe), independent researchers commissioned by WHO to manage and report on the evaluation, administration staff, health practitioners and policy-makers from countries across Europe, including Western, Central and Eastern Europe and Scandinavia. The evaluation process interacted across a range of health systems and FHN implementation levels. The research context was challenging and the process a learning experience for all concerned.

3.1 Cross-national research

Research involving international evaluations is always demanding. Comparative cross-national research in the health and social sciences is used in a wide range of circumstances to identify, analyse and explain similarities and differences across societies and systems. Regardless of the level of intervention, problems with the management, funding and co-ordination of cross-national research projects call for high levels of collaboration and negotiation in order for them to be successful. However, there are many potential benefits to be gained from such activities, including a deeper understanding of other systems and experiences, and meaningful opportunities for sharing learning and knowledge (Hantrias & Mangen 1996).

There has been a growth of interdisciplinary and international collaboration and networking across all disciplines, and especially in the health sciences. International comparative research is

especially relevant in policy-making areas as a means of evaluating solutions to dealing with common problems or assessing transferability of policies. In the health arena, whilst there is a growing body of evidence to be drawn from some areas, such as large-scale international epidemiological studies, there is relatively little work on cross-national health systems research. For the studies that are available, the data collected across borders is often presented side by side, as it proves not to be directly comparable.
The WHO FHN multi-national evaluation aimed to study the pilot implementations of the FHN model in different national contexts using a standard set of research instruments. It aimed to complement and build upon the in-country reporting.

3.2 Problems with cross-national research

Factors critical to cross-national research include issues relating to managing and funding projects, communication difficulties, gaining access to data and international differences in research concepts and system infrastructures (Hantrias & Mangen 1996, NAP 2001).

3.2.1 Funding and management

The successful inclusion of any country in an evaluation is often the result of factors external to the research itself, for instance political support and economic input. The financing of and time allocated to intra- and multi-country research activities will be very dependant on the priority that policy-makers give to them. It was for this reason that countries participating in the WHO FHN Multi-national evaluation had to obtain ministerial approval as a prerequisite for inclusion, to ensure the necessary level of ownership and commitment. This withstanding, even some of those who originally planned to participate, attending the final workshops and obtaining the necessary commitment, were not able to contribute data due to changes in the political climate during the data collection period. Additionally, some countries sent data up to five months after the collection deadline, due to organizational difficulties locally, which resulted in major scheduling problems for the data analysis phase. However, all the data received was included in the analysis.

3.2.2 Communication

Communication is a major issue in international research, where linguistic barriers can be prove an obstacle to collaborative efforts. The need for tools and data to be translated once or several times during the process of development, data collection and analysis, can potentially lead to loss of meaning or inconsistency of data. Additionally, a lack of personal contact can result in the processes of data collection being impeded. E-communication facilities can resolve some of these issues across the timeframe of a project, but anything beyond simple email demands a high level of ICT infrastructure, which is not always available.

Face-to-face, interactive communication is necessary to make the most of opportunities for sharing knowledge and learning. With regard to the multi-national study, although administrative contact was via email, the workshops run in 2003 and 2005 were essential tools for training and for sharing experiences, and to assess the state of readiness of the participants to collect the data required for the evaluation.

The first data collection workshop in Slovenia in 2003 was planned as a training session for rolling out the evaluation the following year. However, at that workshop it became clear that the participants were not ready for these developments, as most of the FHN pilot implementation

programmes were behind schedule. The multi-national evaluation process was subsequently deferred for a year. Had the first training workshop not taken place, the data collection would have commenced too early for the participants to provide sufficient data. A second data collection workshop was run in early 2005, where the translations were checked, the exact procedures for data collection specified, the final participants agreed to the data collection timetable and that they understood the requirements of the multi-national study. Both workshops were highly interactive and essential to the success of the evaluation, but it must be recognised that the resources and commitment required for such workshops were extensive.

3.2.3 Access to comparable data

Collection of data is influenced by cultural, political and structural conventions. The original source and purpose of the data, timescales, criteria, level of aggregation and methods for collection vary considerably. All influence the outcome of any international study and provide difficulties for analysis and comparison. In the multi-national evaluation, a major problem was the use of terms for health workers and activities, which were not comparable when translated into English; this was material from the Russian speaking countries. It was sometimes difficult to identity the meanings retrospectively.

3.2.4 Research concepts and parameters

Developments in large-scale datasets and international data collection tools are ongoing, but social and cultural frameworks remain problematic. Conceptual, demographic, geographical and timescale variations can cause obstacles to meaningful comparison. Several of the countries involved in the multi-national study commented at the workshops that they had little in the way of a nursing research culture, and so their understanding of the wider concepts and practicalities of a research project of this type was relatively low.

3.2.5 Infrastructure challenges

Approaches to health service organization, administration and financing are diverse, and this picture was complicated because many of those participating were in a period of social and political transition. The data required for effective cross-national research is often infrequently collected or non-existent, or the political will to collect is not forthcoming. High quality cross-national health care research will always be challenging as a result. Whilst all participants were supported by their health ministries, the WHO multi-national study did not have any funds allocated for in-country data collection, so all contributions were dependant on the good will of the personnel concerned, as part of their existing roles.

These problems are not easy to resolve, and researchers in cross-national evaluations have to be pragmatic, realising that research of this nature often requires a greater degree of compromise than in more localised studies. Building and managing a constructive international research environment requires negotiation and an acceptance that contributions to the work by participants are sometimes irregular. In spite of the difficulties that such inconsistencies provide for analysis, it is important to examine phenomena in terms of their wider societal context, and with regards to any limitations imposed by the original research parameters. Attempts to draw meaningful conclusions are dependent on the degree to which such problems of collaboration are resolved (Hantrias & Mangen 1996, NAP 2001).

3.3 Benefits of cross-national research activity

One major benefit of cross-national research is the networking opportunities offered to participants. Inter-country working can lead to deeper insights both into other systems, and also one's own. Gaps in knowledge in one location may be filled by experiences elsewhere. It can also highlight potential new directions for collaborative working opportunities. The value of international research lies as much in the experience of contact and communication as in the knowledge gained (Dean et al 2005). According to Baistow networks:

> 'serve an important instrumental purpose as the means of gathering information, exposing us to fresh ideas, confronting us with challenges to our own way of thinking and stimulating new ones, but they also serve to bring people together. Perhaps the greatest value of the interchange and exchange…lies in the human contact on which real understanding and co-operation are built' (Baistow 2000)

Countries vary in their provision of services to meet existing health care needs and in their responses to innovations. Cross-national research allows an evaluation of how these responses impact on new developments. Different settings provide 'natural experiments' and opportunities for countries to learn from each other in order to inform current and future decision-making (NAP 2001). Cross-country evaluations can be influential motivators for development, by providing a picture of phenomena as context-specific or universal, and by providing models for change.

The costs of quality research programmes provide an additional reason for cross-country evaluations. Providing evidence for policy change, and implementing and evaluating new models of health care are expensive processes. Coordinating research experiences and sharing outcomes is an effective strategy to obtaining the maximum return on investment. This is especially so in the case of developing countries, which can often benefit from building on the experiences of others to avoid making similar mistakes (Redmond 2003).

3.4 The WHO FHN Multi-national study: an example of a knowledge sharing and learning process

The sharing of experiences and development of partnerships from the WHO study and workshops were a hugely important outcome. The family health nurse project as a whole has offered opportunities for learning and networking, and the development of ongoing partnerships throughout the study should go a long way to ensuring strong developments in other areas in the future. Many of the resources developed in one region were relevant in others, and opportunities to build on previous experiences need to be maximised. One example within the FHN programme is the partnership developed between Scotland and Tajikistan, where the experience in developing competencies and standards for the project in Scotland have been shared, and they have been adapted for local circumstances in Tajikistan. Exchange visits between the countries have led to a strong long-term partnership.

Several of the participants identified the lack of a nursing research and professional training culture in many of the participating countries, and how this might be a barrier to future development. Developing an evidence base for nursing was difficult enough, without the additional problems of introducing a new community nursing framework. The learning from others within the workshop environments, and the involvement in a study of this scale in itself provided good experience of research activities. The support offered from colleagues from other countries was hugely encouraging.

Policy-makers and health care providers increasingly demand evidence-based clinical practice and a similar transformation in the assessment of health policy and performance is required (Murray & Frenk 2001). The FHN project aimed to produce evidence to determine the effectiveness or otherwise of a new model of community nursing in different environments, and should inform future developments across Europe. According to the World Health Report 2004 'harnessing the power of research to achieve treatment targets and to build health systems that respond to … complex health issues, requires an innovative approach to gathering and sharing information' (WHO 2004c p73).

The importance of inter-country collaborations on projects of this kind cannot be understated. At the time of the multi-national evaluation, the health systems of the participating countries were all at different stages of development, as were the family health nurse projects being implemented. Comparing and sharing information on their achievements and experiences provided valuable information as to the appropriateness of the framework in different organizational settings. The recognition of different perspectives and approaches on common themes can significantly enhance initiatives for health improvement and can help reinforce confidence in a particular approach. Partnerships are at the heart of health policy, and the highly interactive exchanges between participants at the data collection workshops proved this point very strongly. Participants shared experiences and difficulties, compared their FHN implementation programmes and their data collection management plans, and tried to suggest solutions to problems. The strengths of inter-country collaborations are the opportunities to share problems, solutions and successes. Without collaboration, different countries seeking similar goals are likely to duplicate unnecessary activities and loose opportunities for learning from others (Ollenshlager et al 2004).

4. The WHO FHN Multi-national Evaluation

The evaluation of the FHN model was originally planned on three levels:

a) in-country evaluation

b) WHO Europe regional level evaluation

c) inter-country evaluation.

The multi-national evaluation aimed to operate on levels b and c, assessing the structures, processes and outcomes associated with the implementation of this model of community nursing across Europe, to complement the evaluations being conducted in-country. The outcomes of the study are intended to inform policy-makers on mechanisms of developing future community nursing services

After receiving inclusion criteria and guidelines, all Member States were invited to participate in the multi-national study. In the first instance, twelve countries expressed an interest. The FHN in-country pilot implementations were due to start as soon as possible after the first meeting held in Barcelona in 2000 (WHO 2000c).

During the subsequent four years, it was recognized that the participating countries were in very different states of readiness and their rate of development are very different. Scotland started their implementation straight away, and they reported on the initial pilot at the end of 2003. They have now entered the second phase of implementation. Armenia has just started their WHO-

based FHN training curriculum and Portugal anticipates starting in 2006/2007. In order to carry out an inter-country evaluation, a sufficient numbers of countries needed to be at a minimum level of development for a useful assessment. To achieve this, flexibility had to be built into the timeline of the multi-national FHN pilot evaluation. In January 2005, a sufficient number of countries indicated that they were adequately advanced in their FHN pilot implementation to commence the inter-country evaluation with the aim of producing the final evaluation report in early 2006.

Due to regional spread of those countries who did participate, and the relatively small numbers involved, it was decided that the regional level evaluation (level b) was not viable. It might be that a re-evaluation of these regional developments might be useful when the countries involved have developed their programmes further.

4.1 A Brief History of the WHO FHN Multi-national evaluation

4.1.1 First WHO meeting on the FHN implementation: Barcelona 2000

As defined in HEALTH21, the family health nurse model provides a comprehensive approach to nursing in primary health care. WHO wished to select demonstration areas to test appropriate models of family and community-oriented nursing in different countries. Representatives of government, health insurance funds, nursing associations and consumers were invited to attend a meeting in Barcelona in April 2000 to discuss the implications of the family health nurse model, its infrastructure and financing requirements, and the pilot schemes.

The objectives of the first meeting of the WHO Multinational study on the Family Health Nurse were:

- to discuss the introduction and integration of the family health nurse concept into different health care systems;
- to examine the implications of this expanded model of community nursing in primary health care;
- to identify the structural and financing arrangements that would be required.

Working groups comprised of consumer representatives, nurses, midwives, doctors and third-party payers. It was recognised that the health system infrastructures within each country would influence the way in which the FHN model was introduced. Three models of health care system were considered: the Beveridge model, the Bismarck model, and that of countries in the transition phase. The groups discussed in detail issues relating to how family health nursing services could be integrated into and financed as part of primary health care in different health care systems. They considered how best to address the likely challenges associated with, for example, the very wide functional range of the FHN; the vision of the FHN as a first point of contact, and the focus on the family rather than the individual as the unit of health concern. Based on the discussions in the working groups, the participants made specific recommendations for the implementation the concept of the family health nurse in different health care systems (WHO 2000c).

4.1.2 Second WHO meeting on the FHN implementation: Madrid 2003

Twelve countries had expressed an interest in participating in the multi-national study at its outset. While progress had been made, particularly in one pilot site (Scotland), this was not true

for the majority of countries. The purpose of the meeting was to review progress across the implementation sites and to identify the types of support needed. Other objectives concerned:

- agreement of what is feasible in terms of assistance to those sites making slow progress
- identify who could provide such assistance
- in-country evaluation
- receiving a progress report on the work on cross-regional evaluation tools and methodologies.

A review was provided from the Scottish pilot implementation, which had progressed well. Their presentation covered issues such as ministerial and financial support, curriculum development, and training and employment infrastructure and the practice models that had emerged from the early stages, how to get started and the importance of community participation in developing services.

Each country presented an appraisal of their FHN programme developments, identifying what stage they were at and the problems encountered.

The framework for the in-country evaluation of the pilot sites was discussed. It was seen as essential to obtain evidence on the effectiveness of such community nursing programmes, in order to inform political decision-makers on how to restructure their health care systems and their nursing policies. The evaluation was to focus on structures, processes and outcomes.

The leading questions for evaluating *structures* were identified as relating to the changes made to existing primary health care structures in:

- the range of nursing services provided
- access to nursing services
- financing of nursing services
- iImpact on services provided by other health care professionals (e.g. family doctors)
- educational preparation of community nurses (where they exist).

The focus on *processes* related to:

- preparation of the Family Health Nurse
- functions within the new role
- area and population of practice
- interaction with other health care professionals and community based support services.

The *outcome* evaluation was to focus on:

- changes to existing primary health care nursing services
- financial costs of the services
- acceptance by families, patients, employers, other related services
- perceived effectiveness (health status of the families, promotion of equity, and quality of the Family Health Nurse Provision).

All these aspects were to be assessed by the participating countries and used to indicate how to develop or change the role of nurses in Member States.

In addition, the comparative analysis of the WHO FHN model across Europe was reviewed. The development of the research tools and the plans to pilot test them in Scotland were discussed. It was agreed that the multi-national evaluation would take place one year after the first FHNs started practice on completion of their education programme. This would ensure adequate experience to gather meaningful results on the impact of the concept (WHO 2003a).

4.1.3 Third WHO meeting on the FHN implementation: Slovenia 2003

The workshop was planned to prepare the participants for the data collection phase of the multi-national study. It was planned as an action-learning process for all countries participating in the project, aimed at:

- reviewing progress on FHN implementation in each participating member state and assessing the readiness for this stage;
- preparing each country for the collection of the data to be used for the multi-national comparison of practice and education of the FHN within the in-country pilot studies;
- assisting participants in the preparation of country plans for the data collection.

It was recognized that all participating countries would be at differing stages in their development. Workshop facilitators planned to work with individual pilot sites to assist them in whatever way necessary to bring the pilots up to speed. Opportunities for sharing experiences in education and practice from the more advanced sites were to be an important feature of the workshop.

The original programme was devised to provide an opportunity for the participants to learn about the tools and the guidelines being used in the pilot study, and to work through them in detail to ensure full understanding of the requirements prior to starting the evaluation. All the workshop participants received a copy of all the tools and guidelines prior to the workshop, translated as required.

The workshop facilitators discussed the current stage of the project within each country to assess which of those that had expressed an interest in the multi-national study were at a stage to progress further. Confirmation of their commitment at both local and national levels was requested.

The concept of the Family Health Nurse was reviewed. In terms of the WHO FHN multi-national study, it was essential that in-country training protocols were based on the WHO FHN model. The definition of the FHN was re-iterated, as a professional who:

- understands the socio-factors involved in family health
- is able substitute for the family doctor as necessary
- is a care provider
- is a decision-maker
- is a communicator
- is a leader in community and public health

- moves from doing to enabling others to do
- moves from knowing to being able to find out
- moves from following instruction to autonomous, accountable practice
- encompasses primary, secondary and tertiary care

In addition, a summary of the development process of the FHN Training Curriculum was discussed:

- it was devised after much consultation by WHO Europe Nursing;
- a basic requirement of 40 weeks of training was identified, but this could be adapted to a review of competencies and previous community nurse training, as necessary;
- the curriculum is focused on the FHN preparation for the role as defined by HEALTH21;
- it is competency and research-based;
- it combines theory and in-practice fieldwork.

It became apparent during the proceedings of the first day, that most of the participating countries had not made sufficient progress since the last meeting in Madrid for the planned workshop programme. The pre-workshop questionnaires and status reports indicated inadequate readiness to continue with the data collection procedures for the multi-national evaluation, for which their attendance had been planned. A new workshop programme was devised, whereby countries conducted a base line assessment of the development level and a SWOT analysis of their implementation progress. A review was provided of the purpose and process of research, the importance of research in policy-making and practice, and the relative lack of a good evidence base in nursing, especially community nursing.

The multi-national evaluation of the pilot programmes was delayed to allow participants to develop their in-country programmes to a level where comparison would be more useful (WHO 2003 3rd Workshop Report (Maribor): unpublished document)

4.1.4 Fourth WHO meeting on the FHN implementation: Glasgow 2005

The objective of the fourth meeting was to take the multinational study through to its completion. The meeting was planned as a knowledge-sharing and action-learning workshop for all countries participating in the FHN multi-national evaluation. It aimed to:

- review progress on implementation of FHN projects in each participating country
- prepare participants for the data collection phases of the inter-country evaluation
- assist participants in the preparation of country plans for the data collection for this study
- review the challenges faced in implementing a new nursing service in a country and identify issues that will inform future projects.

Following the Slovenia meeting in 2003 it was recognized that participating countries were all at very different stages in the development of their FHN programme. During this fourth workshop, facilitators worked with study sites to ensure that they would be able to contribute to the data collection process, regardless of their stage of development. A pragmatic approach was taken to inclusion in the study at this stage, as WHO and the research team realised that although progress was very uneven, the situation was unlikely to change within a reasonable timeframe. The

decision was taken that some sort of evaluation had to be completed in order to allow those countries who were in a position to proceed, to progress to the next stage whilst providing useful data on this initial stage. The countries that were running at a slower development rate would provide useful data on the processes of change they were undergoing and would learn from the experiences of others identified from the study.

Importantly, the workshop provided opportunities for sharing experiences in education and practice, which were viewed to be as fundamental as the setting up of the data collection procedures.

The participants were taken through the detail of the data collection tools, which had been translated as required, for the previous workshop. A data collection plan was developed for each country, and deadlines for returning data were agreed. Some countries opted not to participate in the full study, as their circumstances did not allow for it. However, seven countries did agree to participate in the full study: Armenia, Finland, Kyrgyzstan, Moldova, Portugal, Slovenia and Tajikistan. In addition, as Scotland had taken part in the pilot of the research tools. At the time of this tools testing phase, they were at a similar stage of implementation (in 2003) as the other countries were at the time of the multi-national evaluation (2005). As the tools were not fundamentally altered following the pilot process and as valuable data had been collected, it was decided to include their responses in the final analysis. The final deadline for receipt of the last set of data was agreed at 31st August 2005 (WHO 2005b).

5. The Development and Testing of the Research Tools

Dr Deborah Hennessy was commissioned by WHO to work on the multi-national evaluation of the FHN pilot sites and she had developed and used similar tools in previous environments. The criteria for the multi-national evaluation were laid out explicitly in the WHO document *Guidelines for the Evaluation of the Multinational Family Health Nurse Pilot Study*. Two draft questionnaires were developed in May 2002 and sent to WHO Europe Regional Office for consideration. A number of suggestions were made, which led to an extensive development of the two tools and guidelines for their completion.

The tools consisted of a Standard Questionnaire and a Comprehensive Questionnaire with detailed completion guidelines for each. In addition, guidelines were developed for the link-workers overseeing the data collection in each country.

5.1 The Standard Questionnaire

This is concerned with the role, practice and effectiveness of the FHN within the context of each pilot site. It requests the views of each FHN and other stakeholders concerned with the implementation of the FHN as a new model of community nursing, to include non-FHN community nurses and family doctors. The questionnaire has three parts:

1. the organization of the Family Health Nurse Pilot Study;
2. the role of the FHN compared to the role of other community nurses working in the community;
3. organizational issues that effect the role of the FHN.

It is an interesting and challenging questionnaire to complete, as it demands a thoughtful analysis of what is new and different in the role of the FHN. Each respondent completes all three parts of this questionnaire. Each section of the questionnaire has its own guidelines to explain how it should be completed.

5.2 The Comprehensive Questionnaire

This corporate questionnaire is addressed to the link person in each participating country. It investigates the implementation and effect of the concept of the FHN within the social and political context of each country concerned, and information is required from a range of respondents. For this reason, the comprehensive questionnaire has four detachable parts and each part has its own guidelines.

Part One: The FHN Pilot Project implementation. This asks questions as to how the FHN Pilot has been set up and managed, and is completed by the link-worker in each country.

Part Two: Social, Economic and Health Service details of the participating country. This is the longest and most complex part of this questionnaire and may need to be completed by a variety of people in Government and Health departments. The link-worker coordinates its distribution.

Part Three: Education of FHNs for completion by the Chief of Nurse Education or the FHN Course Programme Manager from the academic institution(s) that provides the FHN education.

Part Four: Role and impact of the FHN, for completion under the leadership of the Director of Nursing and the Manager of the FHNs at each site. Completion could be by a group consisting of representatives from general practitioners/family doctors, other community health nurses, social workers, user or patient groups and FHNs themselves, as appropriate/relevant.

Questionnaire distribution was planned via a cascade distribution process from a central link-worker, with responses being returned via the same route. Prior to the pilot testing of the tools, the guidelines for dissemination by the link-worker, and completion by respondents were formalised, along with the planned overall management of the data collection procedures. The anticipated data analysis, interpretation and reporting framework was devised. The Scottish FHN pilot site was chosen as the site to test the multi-national tools, as their implementation has started in 2001 and by 2002/2003 when the tools were ready for testing, they had shown strong progress in their programme.

5.3 The Importance of Pilot Studies

The term pilot study is used in two different ways in research of this kind. It can refer to so-called feasibility studies that are ‘small scale version(s), or trial run(s), done in preparation for the major study’ (Polit et al. 2001). However, a pilot study can also be the pre-testing or 'trying out' of a particular research instrument (Baker 1994). In this instance, both interpretations of the term were applicable. There are many reasons for undertaking pilot studies, including:

- assessing the feasibility of the (full-scale) study;
- designing and assessing the workability of a research protocol;
- identifying logistical problems which might occur using proposed methods, including problems relating to research sampling, study participants;
- determining what resources (finance, staff) are needed for a planned study;

- assessing the proposed data collection and analysis techniques to uncover potential problems;
- collecting preliminary data;
- training researchers;
- convincing funding bodies that the study is feasible and worthwhile; and
- providing valuable insights for others when developing and testing the adequacy of research instruments.

De Vaus notes that pilot studies are important in order to obtain advance warning on how and where the main research project could fail. Failure can relate to research protocols, proposed collection methods or instruments not being appropriate, or to anticipated participants not being suitable; 'Do not take the risk. Pilot test first' (De Vaus 1993).

Conducting a pilot study does not guarantee success in the main study, but it does increase the likelihood, and they are a crucial element of a good study design. Outputs from such activities are 'under-discussed, under-used and under-reported' (Prescott and Soeken, 1999). Full reports of pilot studies are rare in the research literature and when reported, they often only justify the research methods or particular research tool used (van Teijlingen et al. 2001). Research papers often only refer to one element of the pilot study, to the 'pre-testing' or 'pilot testing' of a questionnaire, stating 'the questionnaire was tested for validity and reliability" (De Vaus, 1993). They ignore other issues such as problems of a political or organizational nature. In addition, when pilot studies are mentioned in more detail in academic papers and reports, researchers regularly comment that they "had learned from the pilot study" and made the necessary changes, without offering the reader details about what exactly was learnt. Some of the processes and outcomes from both successful and failed pilot studies might be very useful to others embarking on projects using similar methods and instruments. This is particularly important because pilot studies can be time-consuming and fraught with unanticipated problems. However, it is better to deal with them before investing a great deal of time, money, and effort in the full study. It has also been noted that the current research climate demands accountability from researchers, which means that there is a need to ensure the best possible use of research results (Crosswaite and Curtice 1994). Researchers have an obligation to make the best use of their research experience and funding by reporting issues arising from all parts of a study, including the details of the pilot phase.

5.4 The Scottish Pilot

Testing of the tools and guidelines was undertaken in Scotland during January - March 2003. The process served to test the validity and reliability of the tools and guidelines, to identify specific stakeholders, understand the logistics of in-country data collection and test the suitability of the guidelines.

Scotland was selected as the country for the test of the tools for three reasons:

- their implementation plan was progressing well and trained FHNs were already in the field
- the spoken language is English so translation was necessary at this stage
- the geographical location provided easy access to the researchers.

It was also of particular interest that Scotland has developed their FHNs to serve its rural and remote populations. This in itself provided problems related to the collection of comprehensive qualitative and quantitative data. Scotland, therefore, with its dispersed population of FHN nurses provided an excellent geographical and logistical perspective for testing the tools and the collection of data by in-country link workers.

The objectives were to assess:

- the general applicability and relevance of the questionnaire to the study;
- the sources and availability of the information and statistics required to evaluate the new role within the service and cultural context;
- the validity and reliability of the tools and their specific measurements;
- potential difficulties with identified study/stakeholder groups;
- how the fieldwork may be done through a 'link person' situated in each country participating in the FHN study;
- the planned cascade administration of the questionnaire to pilot subjects, and address any problems identified;
- feedback from respondents to identify problems in completing the questionnaires, and assess whether revised versions give an adequate range of responses; and
- record the time taken to complete the questionnaire and decide whether it is reasonable.

In the absence of funding for the research team to manage the data collection across all pilot sites, the importance of the role of the link-worker in the multi-country evaluation was recognised. These individuals, probably already working on the in-country implementation of the FHN programme or within the community health system, had to ensure that the appropriate stakeholders in each country received and completed both the comprehensive and standard questionnaires, as required. To assist this process, a set of link-worker guidelines was developed for testing alongside the questionnaire guidelines and the questionnaires themselves. These included information on the process of distribution and collection of questionnaires and assistance with monitoring and follow-up.

5.5 Tools Evaluation

5.5.1 Tools and Guidelines development May–December 2002

This involved the development of appropriate tools and clear guidelines for the collection of information about the FHN Implementation processes and outcomes in-country.

5.5.2 Preparation for fieldwork

In association with the key link person (Lesley Whyte) in Scotland, the team:

- made initial contact with the FHN sites and stakeholders;
- identified National Stakeholders to complete questionnaires;
- dealt with responses and queries from the preliminary contacts;
- prepared Questionnaires and Guidelines as appropriate for each stakeholder and placed them in envelopes for distribution. These included stamped envelopes addressed to the in-

country link-worker for the return of the completed questionnaires. They also contained a letter with a copy of the objectives and purpose of the pilot and an explanation of what would be required of each site/stakeholder. All envelopes containing questionnaires and return envelopes were placed in a box and sent to in-country link-worker for distribution.

5.5.3 Follow-up in Scotland: January – April 2003

This was re-scheduled a number of times due to poor weather conditions in the remote areas to be visited. Eventually, the follow-up was conducted via telephone interviews.

5.6 Results of Pilot Testing in Scotland

In total, 28 Standard questionnaires were returned, from 37 dispatched. Overall, there appears to have been an acceptable response to the tools with a number of very useful points made during the telephone follow-up interviews. The outcomes did not require major adjustments to the questionnaires themselves, but required some careful thought about how to make the process more streamlined and to remove ambiguities in the guidelines. All parts of the Comprehensive questionnaire were completed and returned.

Following are the specific issues identified from the pilot test.

5.6.1 The tools

Helpfully a number of editing points were highlighted.

Question number Eight from the Standard Questionnaire (see Appendix) was felt to be inappropriate for the national stakeholders, as they did not possess information related to the activities of the nurses concerned. It was decided to remove them from the list of respondents for this section, for the main study.

There was a range of opinions from grassroots personnel about this same question. Whilst many enjoyed the reflection that completion required, others said that they did not have time to complete it. The structure of the questionnaire was altered to improve clarity, although the content of the question was not changed as it was felt to be important to cover all aspects.

The time issues were obviously important, and changes were made to the link-worker guidelines in an attempt to improve this. Additionally, the importance of evaluation processes relating to the new service was emphasised, with the recommendation that time had to be allocated to such activities and was not time wasted in the longer term. It required facilitation by management and support at a strategic level from national stakeholders.

A few respondents advised the need to access more qualitative information through interviews. Whilst this was acknowledged as a good practice, such an approach within the context of this study was not feasible.

The Comprehensive questionnaire was competed as requested. Part One was completed by the link-worker. Part Two was distributed to those respondents able to provide the necessary information. This proved a time-consuming process as it called for a great deal of liaison with many different individuals, but it generally worked well. Part Three was completed by the

Programme Manager for the FHN course, and was returned with a course syllabus as requested. The Directors of Nursing for two of the three regions involved completed the Part Four sections.

Data collection summary sheets were sent to the link-worker and the Directors of Nursing, to return with the questionnaires, providing details of to whom the questionnaires were sent. Some of these were not returned as requested and the process of establishing distribution and return was improved.

5.6.2 Type of stakeholders/institutions to be included

This information was identified with the assistance of the in-country link-worker. Each country will be different and the stakeholders should be generally identified early on in the research process. The guidelines must be clear and informative enough to be of use to a wide range of potential respondents.

5.6.3 The feasibility of working through a 'link-worker' situated in each country participating in the FHN study

This process proved to be very satisfactory and essential to the data collection process in the absence of in country management of the multi-national study.

5.6.4 The logistics of the in-county link-worker distributing and collecting the data

A cascade style of questionnaire distribution was attempted to reduce the total work for one person. This method of distributing the questionnaires worked well but problems did arise, with delays in both directions down and up the dispatch/collection chain, caused mainly by individuals being on holiday or off sick. The return processes were therefore disrupted and, by the initial deadline given, only four standard questionnaires had been returned. Follow-up processes improved the subsequent return of data.

As part of the pilot of the tools, twenty in-depth telephone interviews were carried out, and over 100 telephone calls made to check the whereabouts of the questionnaires sent to all respondents. This in itself was a very time-consuming process and indicated a need for greater control at the start of the process of questionnaire completion through to collection. It was suggested that allocating a set time for completion might be more effective for some respondents, e.g. at a specially arranged group meeting, where the questionnaires can be given out, completed and collected on the same day.

5.6.5 The suitability of the guidelines and their applicability to the inter-country evaluation of the FHN

The telephone interviews provided some very helpful information, which were used to improve the guidelines for the tools. Aside from some editing errors in the initial guidelines, the guidelines seemed to prove useful.

5.7 Plans for Data Analysis

Differential statistics, especially a one-way variance analysis for unrelated subject designs for each of the 48 items in the Standard Questionnaire, are planned, to identify:

- perceived importance of the FHN Role and other roles in different countries;

- perceived difference between the roles of FHNs and other community health nurses by country and for all countries;
- perceived performance of FHNs in different countries;
- perceived further training needs of FHN in different countries; and
- perceptions of a range of stakeholders in different countries.

It was anticipated that the data would be investigated for more sophisticated analysis opportunities, to look for clusters of activities specific to particular roles. The Organizational, Political, Economic and Health System information would be content analysed and descriptive statistics would be applied.

During this time, it was noted that whilst the data analysis should be straightforward, there would be some potential problems with time differential related to the stage of readiness of the countries involved. Scotland was chosen for the pilot study as it was most advanced in terms of education of FHNs and the in-post structure. Indications were that the FHN programme in other countries was not at the same stage of readiness. It was decided to review this situation at the meeting planned for Slovenia in September 2003. The researchers noted the need for an assessment of any data analysis implications arising out of the likely time differentials of the initiation of the study, and subsequent data collection processes, between the countries involved.

5.8 Recommendations from the Pilot testing of the tools for the multi-national evaluation

1. The minimally adjusted tools and guidelines are used for the inter-country evaluation.
2. The tools and guidelines required translation prior to the data collection FHN workshop in Slovenia in 2003.
3. The data collection workshop should be carried out immediately before the collection of data for the evaluation commences.
4. During the data collection workshop, the in-country link-workers will learn about the tools and guidelines and should prepare the tools for immediate distribution on return to their country. They should also prepare a realistic timetable.
5. The in-country link-workers should bring the names and addresses of National Stakeholders to whom the questionnaires should be distributed to the data collection workshop. The distribution packages can then be prepared during the workshop.
6. The responses should be translated into English before return to the research team.

6. Data Collection and Response

The data collection processes for the multi-national study were complex. After the data collection workshop in Glasgow in January 2005, seven countries agreed to participate in the final full-scale evaluation. They developed plans for the process of distribution and collection of questionnaires, and agreed a timetable for completion and return. They agreed to translate responses, as necessary, before dispatch to the research team.

The study was a multifaceted piece of international research. The problems and benefits of such research are discussed in Chapter Three. However, it is useful to re-visit some of these issues, especially those relating to communication and data collection within the context of this study. The research tools were developed in English and the responses were requested in English. The Russian-speaking countries had to translate the questionnaires into Russian and the responses back into English. The other non-native English speaking countries spoke and wrote English sufficiently well to complete the questionnaires without the help of translators. Translation services are expensive and time-consuming, and for those countries affected, these commitments were considerable and their efforts greatly appreciated. It was not known who were the translators, and the variation in the quality of the translations was noticeable.

The original cascade questionnaire protocols identified the numbers of standard questionnaires sent out and returned. However, one of the failings of the project was that there was little record kept by the link workers of the numbers of questionnaires disseminated. Although numbers of potential FHN respondents were known, there was a lack of accuracy in the sample sizes involved as FHNs in different countries had undergone different training schedules and identification was difficult. The research team were unable to remedy this issue retrospectively, despite many email communications to participants prior to publication. This outcome perhaps reflected the lack of research experience from within some of the participating countries, and the difficulties of 'long-distance' research management. In spite of this, the work was essentially exploratory in nature and the results therefore are still highly relevant.

The researchers have tried to reflect the data accurately, and assumptions were not been made in the case of missing data. However, the interpretation of the data attempted to understand the words as they were written but also to try to ascertain the meaning behind the texts, and to provide an honest reading of data.

The data response schedule agreed in Glasgow in January 2005 is shown below, although countries were unable to adhere to this.

2005	Jan.	Feb.	March	April	May	June	July	August	Sept.	October	Nov.	Dec.
Glasgow workshop	XX											
Write up workshop report		XX										
Countries conduct Phase 1 Data Collection (Comprehensive Part 2 & 3)		X	X									
Return of Phase 1 Data (Comprehensive Part 2 & 3)			by 30th April									
Analysis of Phase 1 data					X	X						
Preliminary report to WHO Europe						X	X					
Countries conduct Phase 2 Data Collection					XX	XX	XX					
Return of Phase 2 Data								by 31st August				
Data Analysis/Interpretation and reporting										XX	XX	
Final report to WHO Europe												XX

As mentioned previously, a large proportion of data was received after the agreed deadlines. The last data was received in mid-December and this obviously had an impact on the data analysis activity. In light of these circumstances, the researchers opted to include all of the data received in order to widen the scope of the evaluation, possibly at the expense of greater in-depth analysis. All of the raw data is available for countries to look at in more detail as they feel necessary. A summary of the country activities and final data response is shown below.

SLOVENIA WORKSHOP 2003

	Attend	Country Report	SWOT analysis	Agree WHO Curriculum	Agree Study Criteria
Armenia	√	√	√	√	√
Denmark	√	√	0	0	0
Estonia	√	√	√	√	√
Finland	√	√	√	√	√
Germany	0	√	0	0	0
Kyrgyzstan	√	√	√	√	√
Lithuania	√	√	√	√	√
Portugal	0	0	0	0	0
Moldova	√	√	√	√	√
Slovenia	√	√	√	√	√
Spain	0	0	0	0	0
Tajikistan	√	√	√	√	√
Scotland	√	√	√	√	√

	GLASGOW WORKSHOP 2005			FINAL DATA RESPONSES 2006				
	Attendance	**Full evaluation participation**	**Identify issues**	**Comp Q Part 1**	**Comp Q Part 2**	**Comp Q Part 3**	**Comp Q Part 4**	**Standard Q**
Armenia	√	√	√	√	√	√ * No curriculum	√	0
Denmark	0	baseline	0	0	0	0	0	0
Estonia	0	baseline	0	0	0	0	0	0
Finland	√	√	√	0	√	*Curriculum only	√	23
Germany	0	baseline	0	0	0	0	0	0
Kyrgyzstan	√	√	√	0	0	0	0	0
Lithuania	√	baseline/	√	0	0	0	0	0
Portugal	√	√	√	0	√	√	√ (11)	74
Moldova	√	√	√	√	√	0	√	45
Slovenia	√	√	√	√	√	√	√	50
Spain	√	baseline	√	0	0	0	0	0
Tajikistan	√	√	√	√	√	0	0	1
Scotland	√	√	√	√	√	√	√ (2)	28

7. Presentation of Results and initial discussion

The following section presents the main results from the WHO FHN Multi-national study. The data collected was extensive as the research instruments used were complex, aiming to identify the very wide range of factors likely to be influential in the implementation of the FHN pilot schemes. At the Glasgow workshop participants agreed to submit data in stages, and to ensure all data was submitted by the end of August 2005, at the latest. The data analysis and writing up phase was scheduled to run from September 2005 – December 2005.

Unfortunately, data was not received from some countries until November / December 2005, which resulted in the postponement of analysis until December 2005/January 2006. Although flexibility had been built in to the project timelines as far as possible, the extensive delays and the dissemination commitments of the final report resulted in a foreshortened analysis timescale. Regardless of the slippages, the participants had made huge effort to collate the data and the delays were due to unavoidable personnel and organizational difficulties. As such, the researchers were keen to include all data if possible so the deadline for receipt was re-scheduled for the end of December 2005.

In addition to the timescale slippages, some of the data returned was inconsistent. As noted in an earlier chapter, largely this was to be expected as a potential limitation of research in an international environment. In addition, the countries were all at different stages of development with regard to their FHN implementation, and as such, the data was often not applicable or not available. The research tools were detailed and required responses from different stakeholders: thus, the process of data collection was complex in each country. As discussed previously, no funding was available to support the processes of data collection for the multi-national study, and as such, the evaluation was dependant upon the good will and commitment of those involved. This commitment should not be underestimated, as much high quality data was submitted. Where possible, participants were contacted for clarification of data if appropriate, but the time limitations did not allow for detailed verification. All the data submitted underwent basic analysis, and the most relevant content selected for presentation in this report. The project management and data analysis team opted to concentrate on those areas where the data received allowed meaningful comparison and discussion. All analysed data files are presented as appendices or available on CD and participants are invited to use this wider data if they wish to.

Seven countries provided data to the main WHO FHN multi-national evaluation of the pilot implementations. These were Scotland, Slovenia, Finland, Portugal, Moldova, Armenia and Tajikistan. Some data was missing from across all sections. No data was received from Kyrgyzstan. Spain, Lithuania, Denmark and Estonia have contributed to other parts of the evaluation through their participation in the workshops held in Slovenia and Glasgow. These have been reported in the workshops reports. The Scottish data was collected via the pilot study of the research tools in 2003. It was decided to include this data in the final analysis as the questionnaires were not changed greatly from that stage, and the Scottish pilot was as developed at that stage (2003) as many other countries that provided data were in the final data collection phase (2005). The data collected from Scotland was therefore deemed equivalent and too valuable not to use in the analysis.

The Comprehensive and the Standard Questionnaires can be found in the Appendices. The results will be discussed under eight headings:

1. Socio political background in each country which provided the stimulus for participating in the FHN Multinational Pilot Study;
2. The population and education basic nurses, community nurses and FHNs;
3. Education of FHNs in the country;
4. Local organization of FHN pilot studies;
5. Employment Costs FHNs;
6. Family health nurse role and activities in each country;
7. Organizational Issues from the providers' views;
8. Role and Function and further development needs of FHNs.

(Countries with missing data have been omitted from sections as relevant)

7.1 Socio-political and health background in each country, which provided the stimulus for participating in the FHN multinational study

7.1.1 Basic demographics by country (Comprehensive Questionnaire Part 2 Categories 3 and 7)

VARIABLE	SCOTLAND	SLOVENIA	FINLAND	ARMENIA	TAJIKISTAN	PORTUGAL	MOLDOVA
Number FHN Sites	4	3	4	5	4	0	4
Total population	5,064,200	1,995,718	5,236,611	3,211,570	6,573,200	10,356,117	4,267,000
Population 0-5 years	334,349	89,594	403,648	183,726	837,800	539,491	1,700,000
6-15	636,025	213,226	523,361	229,919	869,900	1,241,564	--
16-18	188,361	131,026	318,105	320,142	818700	416,620	--
19-65	3,148,720	1,266,394	2831506	870,279	97,000	6,578,700	2,860,000
66-90	727,360	288,209	803,909	328,663	3,300	1,549,626	27,000
Over 90	29,385	7,231	27,031	--	--	30,116	--
Infant Mortality Rate (per 1000 live births)	5.5	3.9	3	2.8	13.5	5.1	16.5
Maternal Mortality Rate (per 100000 live births)	9.8	1.8	5	18.6	36.5	4	43.4
Proportion of GDP spent on health care %	8.0	8.99	7.6	3.5	--	9.3	--

The information included in **Table 7.1.1** provides a basic demographic description of the seven countries that participated in the full evaluation of the pilot implementations. The range in population size ranges from just under two million in Slovenia to over ten million in Portugal. The infant mortality ranges from 3 in Finland, to 13.5 in Tajikistan and 16.5 in Moldova. Maternal mortality rates varied from 1.8 per 100,000 births in Slovenia to over 43 per 100,000 births in Moldova.

7.1.2 Health priorities in each country (Comprehensive Questionnaire Part 2 Category 3)

SCOTLAND	SLOVENIA	FINLAND	ARMENIA	TAJIKISTAN	PORTUGAL	MOLDOVA
Cardiac Cancer Mental health Smoking Alcohol Drug misuse Accidents And safety Sexual health Infection control Child health	Reduction of inequalities Health policy development Changing damaging life styles Quality of environment Motivation of health staff Health system research Health protection children and adolescents Health protection adults Disease prevention in elderly Health protection for handicapped	Promotion of health and functional capability: - Reduction of inequalities in health - Prevention of obesity and excessive intake of alcohol - Promotion of mental health Increasing the attractiveness of working life Prevention (and care) of social exclusion Functioning services and moderate social security	Improve legislative system/Planning legal standards Improving FHN syllabus Establish quality control systems Amend public Health law to include Nursing to develop role Revise current provision of FHN according to WHO definition. Improve financial system Prepare staff for rural areas Improve access to health care in districts	Financing Health care Infectious diseases Maternal mortality Immunizations Family planning TB Disease First Medical Sanitary Aid Reform Hospital Service reform	Reorganization of primary health care Long-term illnesses Continuous care Palliative care Pain control units Public health Accessibility of national health care to elderly and dependent people Quality in health Services Financial sustainability	Health promotion for young persons Prophylaxis for AIDS/TB Prevention and treatment of infectious/chronic diseases: TB diabetes, cancer Continuous training for nurses Immunizations Increase Medical/technical equipment Mental health

Table 7.1.2 shows health priorities by country. Each list is as provided by the country and is in no particular order. Priorities cover organizational aspects such as hospital reform and finances for health care Tajikistan; primary care reform and financial sustainability in Portugal; health system reform, quality control and provider issues in Armenia. They also cover public health issues, such as control of infectious and chronic disease in Tajikistan and Moldova and the management of cardiac disease and cancer in Scotland and Finland.

7.1.3 The number of single person households, percentage of all households with no access to clean water and the number of general practitioners by country (Comprehensive Part 2 Categories 3 and 7)

VARIABLE	SCOTLAND	SLOVENIA	FINLAND	ARMENIA	TAJIKISTAN	PORTUGAL	MOLDOVA
Single person households %	32.9	21.9	39	27	20	44.9	0.08
No access to clean water %	0	5	0	> 20 in the main FHN site of Shirak; 10 nationally	33	8	100
Total Number of GPs in country	4192 whole time equivalents	1520 includes all physicians who work in health centre	2260 working in health centres	2532 doctors (general practice and family health physicians)	--	6961	--

Table 7.1.3 The single person households range from 0.08% in Moldova to 44.9% in Portugal. Only two countries, Scotland and Finland, had 100% of families with access to clean water while 100% of population in Moldova have no access to clean water at all. This data in itself provides an idea of the level and variation of public health priorities across participating countries. From the data, it is unclear whether all the countries have the same definition of a general practitioner. It is also unclear whether the numbers given are the numbers of doctors or the number of whole time equivalent doctors. From the response provided, assuming that the figures are whole time equivalents, Portugal has the highest and Slovenia the lowest number of GP's. This result needs to be compared with the size of the population in Table 1.1, where it can be seen that Portugal has a population of round ten million whereas Slovenia has less than two million head of population.

7.1.4 Views on Equity and access to health care (Comprehensive Questionnaire Category 9)

VARIABLE	SCOTLAND	SLOVENIA	FINLAND	ARMENIA	TAJIKISTAN	PORTUGAL	MOLDOVA
Does everyone have equal access to health care	Yes	No	Yes	No	No	Yes	Yes
Outline the differences identified above	Although NHS is universal some remote areas may have problems accessing tertiary services	Patients living outside Ljubljana do not have equal access to specialist oncology care in capital city	--	Unequal services mainly in rural areas which are isolated from secondary and tertiary services in towns	Plastic surgery, urology and stomatology are provided inequitably	Not applicable	Not applicable
Are community health and primary care provided on an equitable basis	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Explain any variations to above	--	Not applicable	--	Rural areas have difficulty accessing	Region suffers from financial difficulties for service provision and patient payments	Not applicable	Not applicable
Can members of public gain direct access to FHNs	Yes, especially community midwives	Yes	yes	No except after surgery hours	Yes	Yes	Yes
Any other gatekeepers to services	Some community nursing services are specialist referral only e.g. psychiatric patients.	Not applicable	Not applicable	Doctors	--	Not applicable	Not applicable
Are the FHN sites in areas with access inequity	Yes	Yes	Not applicable	Yes	Yes	Not applicable	No
Please name any FHN areas with inequity of access	--	Murska Soboto	Not applicable	-- Marz of Shirak: an area devastated by an earthquake in 2000, economically disadvantaged and difficult to attract medical staff	--	Not applicable	Not applicable

Table 7.1.4 demonstrates the variation in medical provision and access to medical care, indicating large differences between the countries. Scotland, Finland, Portugal and Moldova do not report equitable access problems in general, although Scotland does note problems of access to tertiary services for rural communities. Moldova and Portugal gave very little data, and it might be the case that equity of access is not a priority issue amongst their other concerns, so no information was provided on this issue. Slovenia, Armenia and Tajikistan do note inequitable access to specialist services often again for rural populations. Four countries reported that FHN sites were in areas with some degree of health care access difficulties: Scotland, Slovenia, Armenia and Tajikistan.

7.1.5 Policy contexts for participation (Comprehensive Questionnaire Part 2 Category 4)

VARIABLE	SCOTLAND	SLOVENIA	FINLAND	ARMENIA	TAJIKISTAN	MOLDOVA
Main policy objectives in past 5 years	Focus on health Model Reduce inequality Reduce morbidity Redesign services	Reduction of inequality in health status Nurses to bring health services closer to populations	Child well being, improve health and security Decrease smoking in young people Prevent increase in smoking and drug problems Reduce accidents and violent death in young men by 1/3rd Improve health of working people Improve functional capacity of people over 75	Post-soviet period – Addressing social justice, medical -prophylaxis, accessibility, centralisation and funding. deteriorating health status Reorganize health service/prioritize developments in cost effective manner Attention to maternal and child health Strengthen primary care and staff funding Introduction of family Medicine Strengthening prevention of diseases Easier access to health care for most needs in populations Funding for health care Improvement of standards, medical-socio economic care, environmental health and technology Regulation of family doctor and family health nurse	Health Care reform Equal access to medical services Develop well qualified human resources especially family doctor and family nurse	Implement primary care reforms and family health system Introduce medical insurance
Which policy objective influenced FHN development	All in above	Primary health Care/family care Health reform Early discharge	All priorities above Programme of public health Family orientation essential	Development of Institute of Family Medicine, focus on family doctors/nurses. Preventive health and encouragement of healthy life styles, cost effective measures	Personnel policy related to family medicine Specialist doctors and nurses Preventive health for all ages, family, and community	Develop family health medicine

VARIABLE	SCOTLAND	SLOVENIA	FINLAND	ARMENIA	TAJIKISTAN	MOLDOVA
Why did your country apply to join FHN Pilots study	Move to health improvement model Move away from community health nurse specialists Alternate model of care for remote and rural areas	Wish to share our existing FHN-based model with others	Need to develop family approach Matched other health related needs Ministry of Health wanted to join pilot	In 1997 Armenia started a reformation of health care system of primary care - focusing on continuity of care and co-ordination of family doctors/family health nurses/secondary care	To increase the quality of care and population health at FHN level	Improve quality of patients life To implement new concept of FHN Gain new experience
Why does your country need FHN service – (Policy makers viewpoint)	Poor health record in Western Highlands Declining population and need to move from specialist to Multi-skilled generalist	FHN since 1957 – keen to share	--	Improve accessibility and effectiveness, strengthen preventive aspects. Develop links between Family and family doctor. Family nurse provides assistance to families with chronic disease, stressful situations and spends time with families supporting/teaching. Armenia wanted establish highly qualified nurses to contribute to at risk populations in socio-economically disadvantaged rural areas	To increase the quality of care of the population at FHN level Laws and regulations about health reform President's program of health care reform Health Care Strategy until 2010	To improve health conditions of family.

Table 7.1.5 provides interesting and clear policy reasons why each participating country took part in the pilot study. Importantly, a major focus was on the importance of a family health approach and the need to provide highly qualified but multi-skilled nursing staff. Portugal did not respond, as they have not introduced FHNs to date. Slovenia has recognised the benefits of family health care models and has had Family Health Nurses since 1957. Armenia mentioned that as a WHO member state they wanted to take part in the study to increase the contribution of nurses to preventive health. Moldova explained that they wanted to improve family health. Scotland had particular concerns with rural health needs and felt this model would help address these.

7.2 Population and Education of Nurses

7.2.1 Population and education basic nurses, community nurses and FHNs (Comprehensive Questionnaire Part 2 Category 5)

VARIABLE	SCOTLAND	SLOVENIA	FINLAND	PORTUGAL	MOLDOVA
School leaving Age	17	19	18	18	--
Basic Nursing Qualifications	Diploma 90% Degree 10%	Degree 100%	Certificate (to 1996) 81% Degree (from 1996) 19%	Degree 100%	Certificate
Length of basic nursing education in years	3-4 years	3 years	3.5 years nurses; 4 years public health nurses; 5 years midwives	4 years	--
Community nurses education (not FHNs)	Diploma: basic community nurse Degree: specialist community nurse	Nil	Certificate till 1996 Degree from 1996: public health nurses	1076 post graduate specialist CHN education (2 years)	--
Population of nurses	41237	4000	33400	45906	22000
Population of CHNs (not FHNs)	6953	Nil	5740	7262	5000
Population of CHNs and FHNs	6984	850	5783	Nil	Nil

Table 7.2.1 provides brief information concerning the age of school leavers, the educational level of basic nursing education, the length of the course and the population numbers of all nurses, community nurses and FHNs. Scotland recruited their FHNs from the community nurse population; this seems to be the position too for Finland. Slovenia claim no non–FHN community nurses, Portugal has 7,262, a similar number to Scotland, although Scotland has a much smaller population. Armenia and Tajikistan provided no data on this subject.

7.3 Family Health Nurse Education

7.3.1 Preparation of FHN teachers, admission criteria for FHN training (Comprehensive Questionnaire Part 3 Category 10)

VARIABLE	SCOTLAND	SLOVENIA	ARMENIA
Training of FHN teachers	Most teachers experienced community nursing teachers; attended special FHN conferences.	University degree to enable them to teach academic aspects. Practical aspects: registered nurse with 5 years practical nursing experience. University certificate for teaching practical aspects.	A course on 'teaching in Family Medicine'
Admission for FHN training	2 years experience in community	Basic nursing education	Basic nursing education

7.3.2 Educational preparation of FHNs (Comprehensive Questionnaire Part 3 Category 10)

VARIABLE	SCOTLAND	SLOVENIA	ARMENIA
Educational preparation	3 year basic nursing and 2 years experience in the community plus 45 week course	3 years basic nursing education in college or university or trained nurse working in the community plus part-time 12 month university course	Basic nurse education selection for working in a primary care unit and 6 months course
Practical work	Practical work throughout the course incrementally developing a case load of families for whom they are responsible	Special nursing interventions at home e.g. home delivery, independent wound management, infusions and urinary catheterisation and practical work in health centres, homes for the elderly and hospitals	120 hours practical training in centres of family medicine
Do the FHNs have learning objectives for their clinical experience in the field	Yes	Yes	Yes
Have your FHNs been trained in the use of the WHO FHN assessment tool	Yes	Yes	Yes

7.3.3 Support in the field (Comprehensive Questionnaire Part 3 Category 10)

VARIABLE	SCOTLAND	SLOVENIA	ARMENIA
Do the FHNs have mentors in the field	Yes	Yes	Yes
Mentor preparation	All mentors attended for a one day preparation course and also one day each semester	Lectures and practice	During advanced training courses the organizational issues of teaching clinical skills are considered
Peer support	Access to web CT hosted by the University. Study days have been arranged for FHNs to meet together	Support from stakeholders in the University of Maribor and also the WHO collaborating centre, Maribor	Although there is a Nurses Association in Armenia the nurses are under-using its important role. Ministry of Health and Association of Medical Doctors have offered to establish an association of Family Health Nurses with support from Ministry

7.3.4 Quality assurance (Comprehensive Questionnaire Part 3 Category 10)

VARIABLE	SCOTLAND	SLOVENIA	ARMENIA
Is the FHN project quality assured	Yes	Yes	Yes
Method of QA	Standard course review supervised by University Degree course board and Faculty teaching sub committee	Examinations, tests and questionnaires	Pre and post testing on each curriculum block of study. Also student questioning about quality of course
Does the project have external audit	The course has an external examiner who reports to the University Degree exam board	The University of Maribor professional body to approve curriculum	The FHN project has anonymous assessment carried out by the World Bank and also WHO

Tables 7.3.1, 7.3.2, 7.3.3 and 7.3.4. Finland, Tajikistan, Portugal and Moldova did not respond to this question, and this may have been because their level of implementation of the FHN programme was not sufficiently advanced to answer. Scotland, Slovenia and Armenia submitted good information showing the length of the training, the preparation of the teachers and also the quality assurance and audit methods. The length of the course ranged from 6 months or 12 months part-time to 45 weeks full time. In all three countries, the FHNs learnt how to use the WHO FHN assessment tool in their training.

7.3.5 Comparison of WHO Europe Multi-National Curriculum/In-Country Curricula (Comprehensive Part 3 Category 10)

VARIABLE	WHO Europe Curriculum	SCOTLAND	SLOVENIA	FINLAND	PORTUGAL (CHN only; FHN not yet implemented)
Programme length	*40 weeks full-time*	40 weeks	1 academic year	40 weeks	148 hours (CHN)
Level	*Post-registration*	Post-registration	Post-graduate	Post-registration	Post-graduate
Fieldwork	*yes*	yes	yes	yes	yes
Teaching methods	*Lecture, seminar, case-study, community profiling, reflective learning, health assessment*	Lecture, tutorial, group work, seminars, Learning portfolio, case study, computer learning, self-directed study	--	Lecture, tutorial, group work, seminars, Learning portfolio, case studies, computer learning	--
Content (modules)	*- Concepts, practice and theory* *- Working with families* *- Decision-making* *- Information management* *- Working with Families* *-Managing resource* *- Leadership and multi-disciplinary working*	Research, decision-making and evaluation. Working with families in the community. Communication Principles and practice of family health nursing.	Social-political issues. Informatics and research. Professional profile development. Nursing care. Diploma studies.	Orientation to family health nursing. Health promotion of Families. Networks of family health nursing. Community-based family health nursing. Developing competencies of nurse and PH nurse.	Theoretical basis for family health nursing. Family health nursing: from evaluation to intervention. Fieldwork within the context of practice. Family health nursing: a reflective analysis. (All within community nurse education framework)

Table 7.3.5 provides an overview of the education programme designed by WHO to educate nurses in the pilot countries for the role of Family Health Nurse as defined in HEALTH21 (WHO 1998), in comparison to those curricula submitted by participants (a full review is provided in the Appendix). Four countries submitted their curricula for evaluation. Comparison was challenging due to the differing nature of the material submitted. Likewise, the non-submission of curricula from other pilot countries means that only a limited comparison is possible. The first level of analysis was used to look at similarities and differences between the pilot country and multi-national curriculum in the key areas of programme length, content (teaching modules) and teaching methods. This is summarized in the table.

Central to all programmes was the concept of family. All submissions listed competencies similar to those specified in the multi-national curriculum. When the indicative content (syllabus) of the modules was considered, there was evidence of a strong influence from the WHO Europe curriculum. This was particularly evident in the areas of communication; decision-making; primary, secondary and tertiary care; family theory and practice; underlying theoretical concepts; research; and the interface between individuals, families and communities. Intergenerational care and the life cycle approach were clearly articulated in three out of the four curricula.

The recommendation from WHO Europe was that candidates should have a minimum of 2 years post qualifying experience – including community work – prior to undertaking the FHN education programme. All these countries do run the course at post post-graduate/registration level in line with WHO Europe thinking. The entry requirements and academic level of the FHN programmes is likely to be strongly influenced by the in-country nurse education regulatory system.

Fieldwork with an associated clinical assessment component was reported in three programmes (Portugal, Finland and Scotland). This theory/practice mix is seen as important in the preparation of Family Health Nurses. However, this assumes the presence of adequately skilled practitioners in the fieldwork area who can support and assess the student Family Health Nurse. As the Family Health Nurse is a new role, the reported use of experienced community nurses who had undertaken additional education to undertake this supervision role is promising. These nurses were supported in their supervisory role by nurse teachers.

The WHO Europe curriculum appeared to provide a useful framework for in-country programme development. However, limitations exist in terms of the number of countries who submitted details of their programmes and the type and amount of information supplied by the four pilot countries. Due to these limitations, it is not possible to determine accurately the extent to which the WHO Europe curriculum was used in all pilot countries. Member states remain at different states of readiness in their ability to organize, run and monitor competency-based programmes of education and this is reflected in the responses. Importantly, there are certain prerequisites to run such programmes, including government support, adequately prepared nurse teachers and practitioners, learning materials and a suitable teaching environment.

7.4 Local organization of the FHN pilot studies

7.4.1 Local organization of Family Health Nurse (Comprehensive Questionnaire Part 1 Category 1)

VARIABLE	SCOTLAND	SLOVENIA	ARMENIA	TAJIKISTAN	MOLDOVA
Names of Pilot Sites	Highland NHS Board , Western Isles NHS Board Orkney NHS Board, Lomond and Argyll NHS Board	Whole country	Shirak, Lori, Kotayk, Syunik, Armavir, Yerevan	Varzob, Dangara, Kulob and Ridaki	Chisinau, Territorial Medical Association, Family Health Centres 1,2,3 and 4
Is there a FHN implementation group and how many members	24 members	No	Yes - 8 members	27 members both national and international members e.g. World Health and Asian Development Bank	7 participants in 4 implementation groups 28 total
FHN implementation group terms of reference	Membership to reflect project geographical areas, provide a national guide to the study, To liaise with local implementation groups	Not applicable	All members of the Multi-disciplinary Group understand the basic ideas of project. They introduced the family medicine project. Planned project's introduction, learnt about WHO family health nurse concept, carried out workshops, trained FHNs, conducted research about progress of report and evaluated results	No formal terms of reference. There are semi-annual WHO agreements. Organized curriculum for pre and post qualification FHNs Legislation for FHN registration MoH requirements Introduced FHN into health centres as part of health reform	Co-ordination of FHN Pilot implementation process, giving consultations, presenting statistical data and managing a monthly evaluation

VARIABLE	SCOTLAND	SLOVENIA	ARMENIA	TAJIKISTAN	MOLDOVA
Implementation method	National Steering Group meets all day at central point in country with all four projects. Local implementation groups led by directors of nursing have staff representation and local stakeholders	N/A	Being introduced into most of region with much support from the local governmental bodies, health care departments and rural communities. The population appreciate the recent introduction of family medicine. There are working groups in two areas that have good support from all local stakeholders. Training supported by World Bank and WHO and started in the RA National Institute of Health Care and Basic College. The 3 year programme began in 2005. Project success is supported by positive attitudes of public to role of FHN concerning prevention of diseases and the care of patients	Initial focus on education Using Previous WHO/ World Bank health reform health centre pilot sites as FHN implementation pilot sites	In 4 areas project started with a pre-implementation assessment followed by education of FHNs. Education model was WHO curriculum adapting to match local conditions. Duties / responsibilities of FHN reviewed in accordance with WHO concept of FHN. A survey was done to assess public opinion for the new FHN concept: barriers and advantages were discussed at session.
Method of in-country evaluation	University led evaluation completed June 2003	None	Internal evaluation of family medicine, which includes family health nursing at the end of 2005	Yes but no details given	Yes but no details given
Number of qualified FHNs	31 (2003)	850	156 on previous training with 60 currently training on family nurse specialty. In 2006, 150 FHNs will qualify.	303	20 according to WHO program. 1500 trained on a shorter programme within the Department of Primary Health

Table 7.4.1 describes salient points about the FHN implementation process. Finland and Portugal did not respond to this part of the data collection: Portugal has not started its FHN programme yet. Four of the five respondents, Scotland, Armenia, Tajikistan and Moldova all had FHN pilot study project implementation groups with varying objectives. The implementation processes varied from being centrally directed to local delegation and decision-making. The responses demonstrated the considerable work that had been achieved to get a number of WHO defined FHNs trained and working in the field. The numbers varied from 31 in Scotland (at the end of 2003) and 60 in training in Armenia (2005) with 150 due to qualify through 2006; 303 in Tajikistan (2005, but it is not absolutely clear how many of these were trained according to WHO FHN definitions and criteria) and Moldova with 20 (2005). Slovenia has had a FHN for many years and did not report any new developments related to the WHO pilot study. The 156 mentioned by Armenia followed a 10 month course on a curriculum were not mapped to the WHO framework. It is assumed that the 60 nurses now in training and due to commence are on the WHO-based FHN course.

The details for FHN training relating to 2005 indicate that the FHN implementation programme has only just begun in these countries, indicating how long the start-up processes are for such developments. It also provides confirmation that many countries were unable to provide full data on some of the areas covered in the questionnaires. The commitments were undertaken in 2000, and it should be commended that in spite of the obvious delays, these countries are still pursuing their goal of FHN implementation and evaluation.

7.5 Employment costs

7.5.1 Funding the health system, the general practitioners, the employers of family health nurses, financing family health nurses (Comprehensive Questionnaire Part 2 Category 7 and Part 4 Category 12)

VARIABLE	SCOTLAND	SLOVENIA	FINLAND	ARMENIA	TAJIKISTAN	PORTUGAL	MOLDOVA
Health system funding	State funded from national insurance	76.7 % from national insurance 23.3% from private or medical insurance	State funded 92% from taxation 8% patients fees	State funded	98% state funded 2% private health and direct payment by patients	State funded- 80% from general taxation 20% from national insurance	--
How general practitioners are paid	State funding	67% by public funding 33% direct payments	85% public funding; 15% direct payments	Patients pay according to prices approved by head of medical centre	State funding	State funding	--
Employment of family health nurse	Community nursing services	Community health centres A few are self employed	Publicly funded health system	The state for FHNs working in public services and other funders for those working in privatised centres and European Centre of Health	Publicly funded community services for most family health nurses	Not applicable	Community services
Changes to financing of nurses following introduction of family health nurses	No changes	None	No changes	The FHN gets the same salary as the family doctors per capita for functions fulfilled this means their salary has doubled.	--	Not applicable	--

Table 7.5.1 Questions covering data on the funding of FHNs had a poor response, with much missing data. Nevertheless, the data shows that all countries appear to be funding the family health nurse from state funding, apart from a few privately funded nurses in Armenia and a number who are self-employed in Slovenia. Most family health nurses are employed by state employers, as are the general practitioners. No country reported much change in the financing of community services post the introduction of the FHN. Armenia however mentioned the dramatic increase in the salary of the family health nurses and that it was similar to the family doctors.

7.6 Family health nurse role and activities in each country

7.6.1 Providers view of family health nurse role and activities (Comprehensive Questionnaire Part 4 Category 11)

SCOTLAND	SLOVENIA	FINLAND	ARMENIA	PORTUGAL	MOLDOVA
Case load of total care of families providing acute care to health promotion leader nursing team with GP, Social workers and hospital	Mondays-Sundays and evenings Visit 6-8 families per day Covers population of 2300 Contact with other agencies as required: - team meetings - reports - personal contact - phone contact	Similar to general Nurse but more detailed individual work with patients and focus on the family Patient appointments Acute care-open access Medical care Lab referrals Telephone advice Team work doctors/nurses Book patients for doctor Assist doctor	Reception of patients 10-14 per day Health education twice a week - individuals and groups Home visits most of day : chronic patients, rehab, emergencies, treatments Social work /sick-nurse combined role Nursing documentation Work with teenagers Future fathers	Centered on families Ambulatory care in health Centres Health extensions and home visits Nursing visits, intervening according to diagnosis, prescribing treatments and therapeutic procedures Team visits to vulnerable Family users Schedule planned so Nurses visible and users know what to expect e.g. Mon. programmed nursing care/home visits. Tuesday team home Visits. Wed. Risk groups and home visits. Thursday vulnerable groups and Nursing visits, group work Home visits for health Promotion health care for dependent users Documentation Detecting problems and developing interventions Relevant health promotion to patient, family and carers School health Referral when necessary Management of material resources	Documentation; Blood pressures and temperatures; Weigh children; Provide medical assistance; Supervise pregnant woman; Deal with secretarial work; Health promotion;Vaccination/First aid Visit new born children; Visit invalid patients Patient counselling re: medical conditions Phone consultations; Home visits every day Health education for self care of chronic ill Collaborate with NGOs Home visits for children under one year Giving prescribed drugs; Follow up visits to patients Making accounts; Training people Home palliative care; Postnatal home visits Support of parents; Work with the doctor Work in manipulations Room - do manipulations at patients home Collect specimens from home Bedridden patients Work in diagnostic room; Make home visits Care for skin infections Supervise condition of sick children Do ECG's, Eye tests Cleaning manipulations room.

Table 7.6.1 provides information on the activities of the FHN as perceived by the FHNs themselves. Tajikistan did not respond to this question and have not been included in this table. Both Portugal and Moldova provided very many responses to this question and showed a wide range of activities. Scotland, which has had community nurses for many years and Slovenia, which has had a FHN role for nearly 50 years both provide a much more concise summary. The range of activities generally appear to fit the WHO definition of FHN (see Executive Summary) and include a family focus, all ages care, particular concern with vulnerable groups, acute care enabling early hospital discharge, health promotion and prevention, working with other members of primary care team, being lynch pin between family and general practitioner, managing documentation and resources. Moldova provided a detailed description of tasks that fall into to role of FHN, and was the only country to include 'cleaning' as an activity. Cleaning is not included in the FHN definition. Cleaning however was part of

nursing activities in many countries in the past. In very many countries, however this task has been handed over to others, so that the nurses can use their higher skills and focus on providing health care for patients.

7.6.2 Policy-makers (purchaser's) view of family health nurse role (Comprehensive Questionnaire Part 1 Category 2)

VARIABLE	SCOTLAND	SLOVENIA	ARMENIA	TAJIKISTAN	PORTUGAL	MOLDOVA
Purchasers view of FHN	Multi-skilled generalist nurse. Health resource for local community Combines roles of caring for sick with health promotion and prevention for whole family	Only nurse working with the family, in homes and local communities. Does triple role curative, promotion and preventive	Primary role working with individuals and families in their own homes. Provides: care for sick, health promotion and education, disease prevention, Social and psychological assistance Organization of home care Link between patient and doctor, substituting for doctor as necessary	Highly educated, high quality professional nurse working in the community with families. Provides nursing care, health education, disease prevention and intervenes with health problems	Professional integrated in primary health care team Responsible for global nursing care provided to defined group of families and community activities. Care provider with health promotion and prevention and clinic responsibility aimed at responding to needs of family members. Encourages independence Resource manager/organizer	Follows all the principles of the WHO FHN Nurse definition
Difference between CHN and FHN	The FHN is family focussed whereas CHN is individual focussed within family context. FHN follows the life course of families and the CHN intervenes at only discrete periods. FHN focuses on both direct and preventive care and CHN provides direct or preventive care.	The FHN is only nurse in the community	CHN and FHN have much in common but FHN provides higher skilled work and more concrete and responsible functions. FHN has direct access to family and works with sick and vulnerable and their families. The FHN promotes health and provides care	FHN works with the family. They have an increased scope of work and undertake disease prevention and health promotion irrespective of sex, or age in the families with whom they work.	The FHN provides global care to the same families, accompanying them through life's processes and assuming the role of case manager for the family.	The FHN is the only nurse working in the community

Table 7.6.2 indicates a remarkably consistent view across respondents as to the understanding of the FHN role from a policy and strategic perspective. There is an emphasis on the family focus throughout the life span, providing acute care as well as health promotion and prevention. Two countries, Slovenia and Moldova, do not have any nurses other than FHNs in the community, and did not identify differences between the FHNs and other community nurses. Finland did not respond to this question.

7.1 Organizational Issues: the Providers' views.

This analysis is concerned with two questions 10 and 11 in section 3 of the Standard Questionnaire. It examines the organizational issues surrounding the implementation of the Family Health Nurse (FHN). The questions are qualitative and so a thematic analysis has been carried out both intra- and inter-country. The section focuses on the change processes required and/or undertaken to support and develop the FHN role and function and are listed below:

Question 10

1. What changes do you believe have taken place in the Community Health Services following the introduction of the FHN?
2. What barriers do you believe that you have in your country, which need to be addressed to ensure the successful performance of the FHN?
3. What could still be done to facilitate the performance of the FHN?
4. What measures have been introduced to support the FHN in their new roles?

Question 11

Please add any further comments that you would like to make, regarding the whole study, comments on the questionnaire, or the FHN programme in general.

Responses to this section of the Standard Questionnaire were received from five countries, Scotland, Slovenia, Finland, Portugal and Moldova. The number returned for each country ranged from 23 (Finland) to 74 (Portugal). This means that the level of analysis for each country is different as it is dependent on the quantity and detail of information provided. Slovenia provided minimal responses to the questions on barriers and changes, presumably because their FHN-equivalent service has been well established for about 50 years: they were not included in the analysis.

7.7.1 Inter-country key theme comparisons

A thematic analysis has been completed for each question by country and is fully reported in the Appendix. Common key themes occurring across countries have been identified, allowing a degree of inter-country comparison; these are reported below in the following section (these tables will also be found in the Appendix). Inter-country comparisons should be made with some caution, as they need to be interpreted with regard to the different infrastructure and development of each nation's health services. Where no response is indicated for the theme, it indicates that the country did not identify this specifically – they may though have identified factors that where not shared with other countries and so are not presented in this theme analysis.

7.7.2 What changes do you believe have taken place in the Community Health Services following the introduction of the FHN? (Standard Question 10.1)

Theme	Scotland	Slovenia	Finland	Portugal	Moldova
Improved communications/collaboration-across teams, across agencies, patients, public, local/national	*		*	*	
Shift in practice from individualist care to holistic/population focused care - Cultural shift	*		*	*	*
Identifying and meeting previously unmet needs	*			*	
Improved data collection/knowledge of population needs			*	*	*
Increased responsibility, accountability, autonomy			*	*	

Table 7.7.2 shows a very encouraging response in that four countries Scotland, Finland, Portugal and Moldova recognized a shift in practice from individualistic care to holistic population based care and three countries (Finland, Portugal and Moldova) reported improved data collection and knowledge of population needs.

7.7.3 What barriers do you believe that you have in your country, which need to be addressed to ensure the successful performance of the FHN? (Standard Question 10.2)

Theme	Scotland	Slovenia	Finland	Portugal	Moldova
Case load size, workload, lack of time to practice FHN role	*			*	*
Mistrust/misunderstanding of FHN role – professional protectionism, professional resistance	*		*		
Need for better pay	*		*		
Lack of funds/resources to support development/implementation of the FHN/competing demands	*		*	*	*
Resistance to change/need for cultural change at all levels	*		*	*	
Lack of clarity/definition FHN role/function and associated poor recognition of FHN in practice	*		*	*	*
Shortages of staff		*	*	*	

Table 7.7.3 shows a number of challenges to be addressed in the management of change process when introducing a new role. Providers in four countries (Scotland, Finland, Portugal and Moldova) commented on the lack of funding to support the development, implementation and sustainability of the FHN. Four countries (Scotland, Finland, Portugal and Moldova) mentioned lack of in-country clarity of role function and associated poor recognition of FHN role. This is compounded by the mistrust and misunderstanding of FHN role mentioned in Scotland and

Finland. Three countries (Scotland, Finland and Portugal) emphasized the resistance to change, which is of course part of any change management programme, but it does need to be addressed.

7.7.4 What could still be done to facilitate the performance of the FHN? (Standard Question 10.3)

Theme	Scotland	Slovenia	Finland	Portugal	Moldova
FHNs require a distinct professional identity/role specification and associated support at all levels national/local	*		*	*	
Better publicity/knowledge of the FHN –all stakeholders and at all levels	*		*		*
Access to continuing professional education and development	*		*		*
Better pay/working conditions	*		*	*	*
Support for the development of the FHN role (all levels)	*		*		
Time to develop the role/do more public health work	*		*	*	
Need for the outcome of the evaluation project/further research into the FHN role	*		*	*	

In **Table 7.7.4**, four countries (Scotland, Finland, Portugal and Moldova) suggest that better pay and working conditions could assist the development of the FHN service. Three countries (Scotland, Finland and Portugal) mention the importance of allowing more time to develop the role fully and the need for an outcome evaluation and further research into the role of FHN. Three counties (Scotland, Finland and Moldova) ask for more continuing education.

7.7.5 What measures have been introduced to support the FHN in their new roles? (Standard Question 10.4)

Theme	Scotland	Slovenia	Finland	Portugal	Moldova
Good management support	*				*
Networking- including local, national and international support	*				*
Improved education and training and access to research				*	*
Access to IT facilities and other equipment				*	*

In **Table 7.7.5** Moldova reports considerable support has been given to support the FHN in their new role. Scotland also emphasizes the role of good management support and networking opportunities. Portugal emphasizes the need to develop a good research culture in nursing.

7.8 Role, Function and further development needs of FHNs

In Question 8 of the Standard questionnaire, the family health nurses themselves were asked to rate 48 tasks identified as being relevant to the family health nurse. The rating ranged from 1

(not important) up to 7 (very important). For each of the 48 questions they needed to make three responses:

- How important the task was for a community health nurse (if the country had community health nurses)
- How important the task was for a family health nurse
- How well the family health nurse performed the task.

The data collected was extensive, and a full detailed analysis from each country can be found in the Appendix.

7.8.1 Inter-country comparison

For the purposes of the inter-country evaluation, the countries have been compared on three variables:

- The importance of the task for the family health nurses
- The performance of the family health nurses on the task
- The training needs of the family health nurses. This variable is derived by subtracting the mean of the performance of the task from the mean importance of the task.

For practical purposes, and to aid presentation, only 10 tasks of the 48 were chosen for this inter-country evaluation report. These were identified as being characteristic of the FHN role (see Executive Summary), across a range of their activities, the population and family age ranges and care settings:

8.2 Health promotion for children 0 - 15 years

8.6 Disease prevention in people 16 - 65

8.8 Detecting disease early 16 - 65

8.10 Providing care for acutely ill children

8.13 Providing care for chronically sick and disabled children

8.17 Helping individuals deal with stress

8.18 Helping families cope with stress

8.25 Assessing health needs of whole family

8.41 Providing the first point of contact for patients

8.48 The family health nurses can substitute for the doctor

7.8.2 Explanation of how to interpret the following charts

The title of the figures reflect the question number in the Standard questionnaire: Figure 8.2 indicates Question 8.2. The figures include two bar charts (a and b) for the mean (average score) for each of the 10 tasks, showing the differences between those countries that responded to the questionnaire. In each bar chart the country column also shows the number of returns (N:). The upper and lower limits of confidence interval (CI) estimates, at 95% are noted on each bar.

The first bar charts (a) show the mean rating for both the importance of the task for the FHN and their performance for each country. The second bar chart (b) shows the difference in importance

and performance for each country on each of the 10 tasks. The difference between importance and performance is a critical assessment of the development needs that the FHNs require in a country. This can be written: Importance of a task – Performance on a task = Training needs. In some cases, the importance of the task is low, but the performance is high: Importance of a task – Performance on a task = Negative Training need (e.g. Finland in figures 8.6a and 8.6b).

All the bar charts are followed by one histogram (c) for each task. These histograms are another way of demonstrating the results of Importance of a task – Performance on a task = Training needs, which has already been shown in the second bar chart. Instead of the confidence interval, however, the normal distribution of the means for each country is shown on the Figure.

Tajikistan responded with only one completed questionnaire. It is possible that the translation instruction was not clear enough as the respondent rated every question as 7 (the highest scores) for both importance and performance. Whilst it is possible to rate every task as the utmost importance, it is impossible to score top marks for performance on every task, therefore these results are not presented.

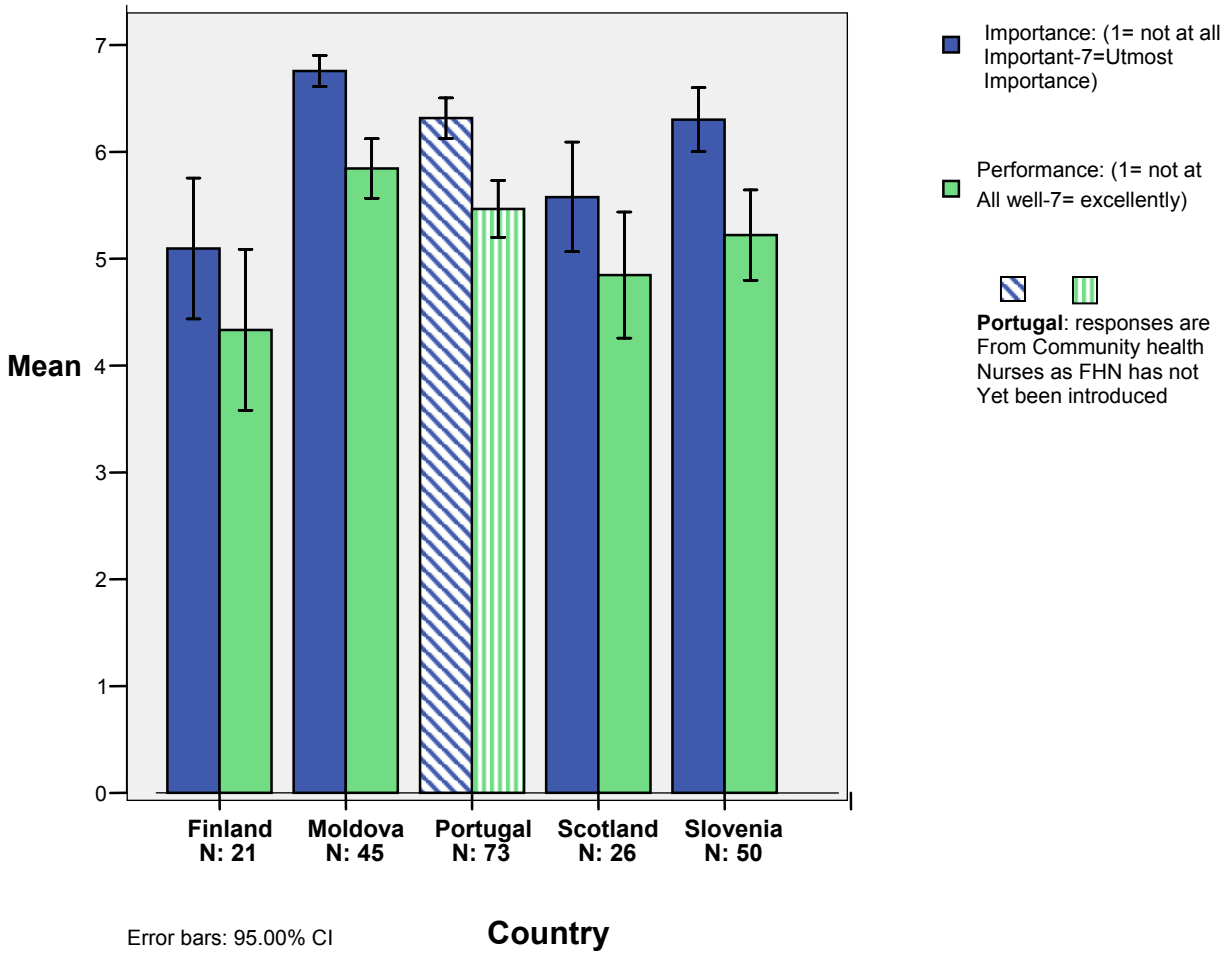
Despite the pictorial evidence in the bar charts and histograms, because of the stage of community health services development and the different contextual backgrounds it is impossible to compare directly the training needs of one country with another. In-country analyses of training needs are useful, and can be applied to all 48 tasks if required.

7.8.3 Discussion

The remarkable similarity between each country on the importance of tasks for the FHN suggests that, on paper at least, the FHN is carrying out a similar role in each country. Nevertheless, a few comments will be made on each set of Figures. Some suggestions are made in an attempt to explain the differences in response between countries. However, these results will need to be interpreted internally, in conjunction with in-country reporting, to identify the actual circumstances that apply within each implementation framework. Responses from Portugal are made from Community Nurses, and the FHN programme as not yet been implemented. However, it was decided to include these responses for comparative purposes.

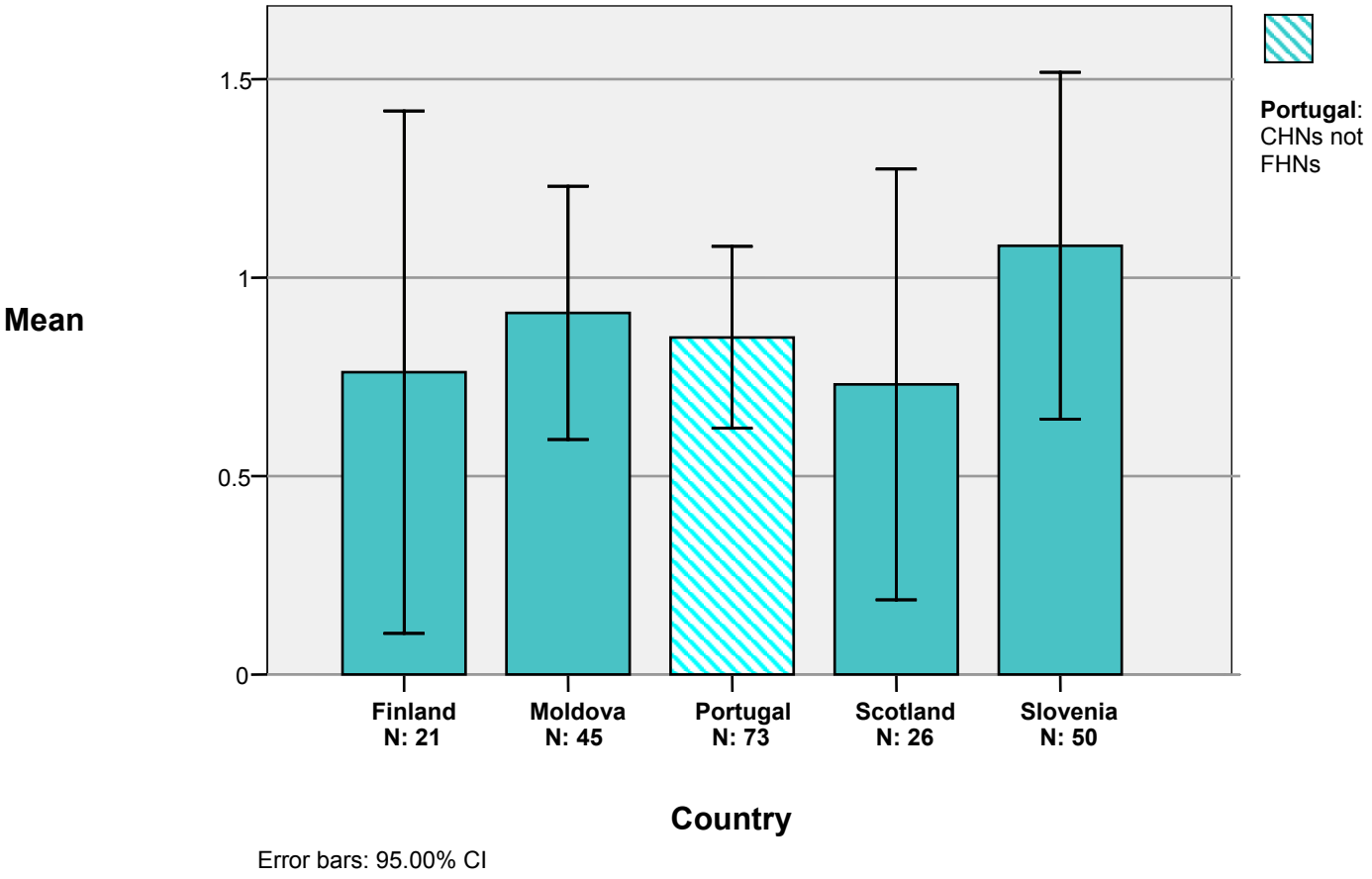
(NB the black vertical line indicates the range of responses. Figure numbers refer to the questionnaire number)

Figure 8.2a Difference in Importance and Performance of FHNs in Health Promotion for Children 0-15 years



In line with the emphasis of the WHO FHN concept, Figure 8.2a show that all countries consider *Health Promotion for Children 0-15 years* as very important, with Moldova and Slovenia considering it a very high priority activity.

Figure 8.2b Difference in Importance and Performance of FHNs in Health Promotion of Children 0-15 years



As indicated previously, *Health Promotion in Children 0-15 years* is considered a basic activity within the concept of the FHN. The difference between importance and performance should indicate a training need, and Slovenia appears to indicate the greatest training need, with Scotland the lowest training need on this task (but also see Table 8.8b).

Figure 8.2c Difference in Importance and Performance of FHNs in Health Promotion for Children 0-15 years

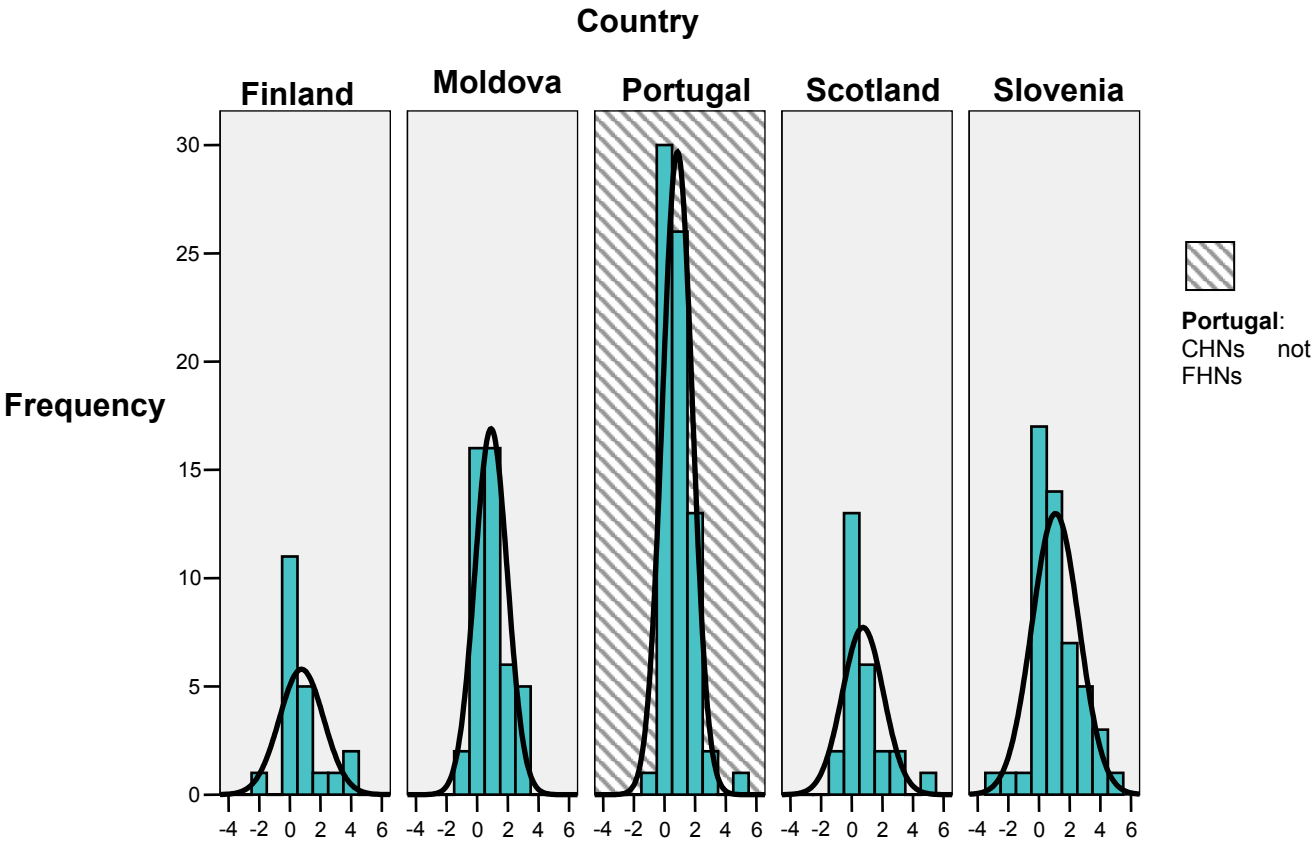
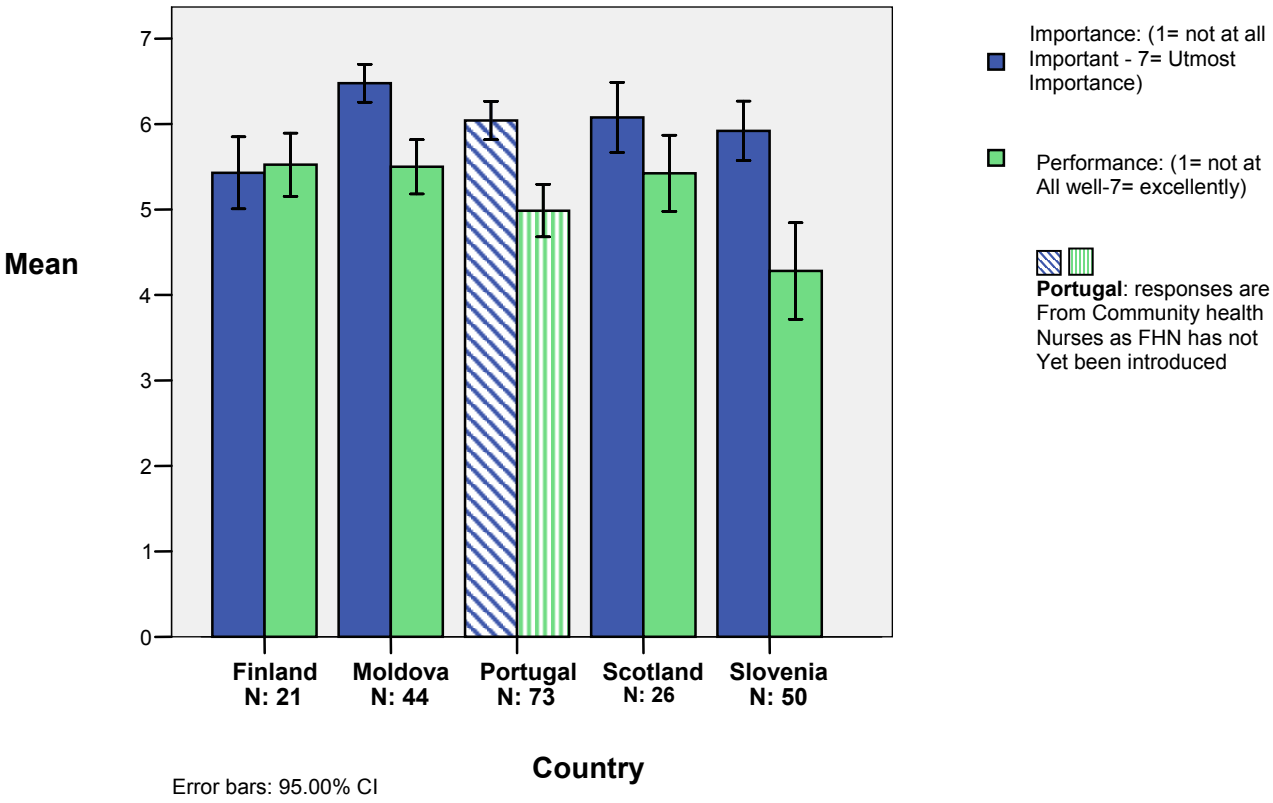


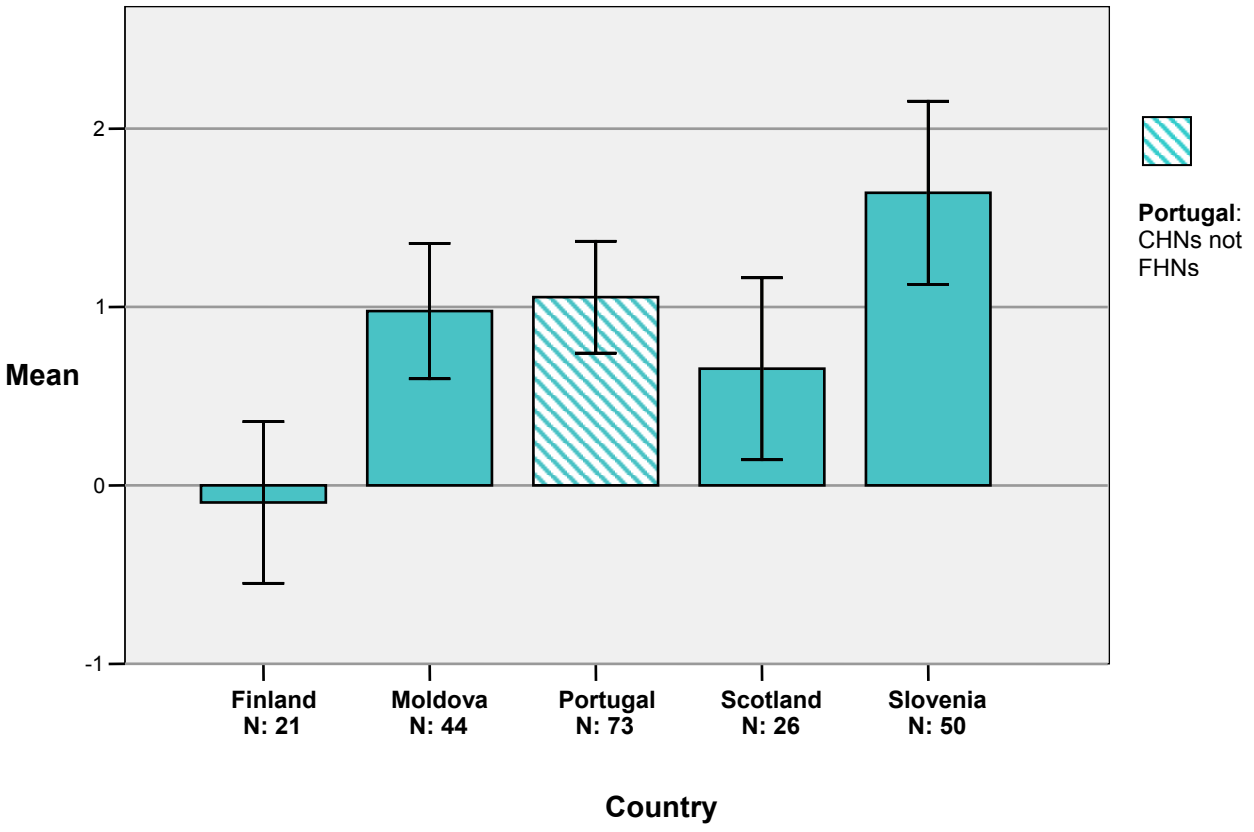
Figure 8.2c identifies the range of responses for the mean score differences between importance and performance of FHNs in *health promotion for children 0-15 years*. This is similar to Table 8.2b. In Table 8.2c the score of the difference between importance and performance is shown, and charted against the normal distribution curve. For example, in Portugal, the scores of nearly 30 respondents identified no difference between the importance and the performance on this task whilst the scores of approximately 25 respondents indicated a difference of one point on the scale, between importance and performance. One respondent indicated a greater performance level than importance level, by 1 point (indicated as -1) on the scale. This latter indicates FHNs possess more skills than are needed in relation to the importance of the task to an FHN. Another respondent's score indicated a difference between importance and performance of 5 points i.e. they rated importance five points higher than performance. This could indicate a need for updating of knowledge and skill or it may highlight an organizational blockage, which needs attention before the FHN is able to perform to the level required.

Figure 8.6a Difference in Importance and Performance of FHNs In Disease Prevention in people 16-65 years



In Figure 8.6a, again all countries identify *Disease prevention in people 16 – 65 years* as being very important to the role of the FHN. This is again in line with the emphasis on disease prevention within the WHO concept of the FHN.

Figure 8.6b Difference in Importance and Performance of FHNs in Disease Prevention in People 16-65 years



Finland recognised a slight negative training need on this issue, with performance being rated on average higher than importance (see 8.6a). As with 8.2, Slovenia had the greatest training need, which may reflect the time span between completing training to be a family health nurse (possibly some time ago as they have been running the FHN service for some time) and completing this questionnaire. If so, it reflects the need in all countries for continuous professional education programmes.

Figure 8.6c Difference in Importance and Performance of FHNs in Disease Prevention in People 16-65 years

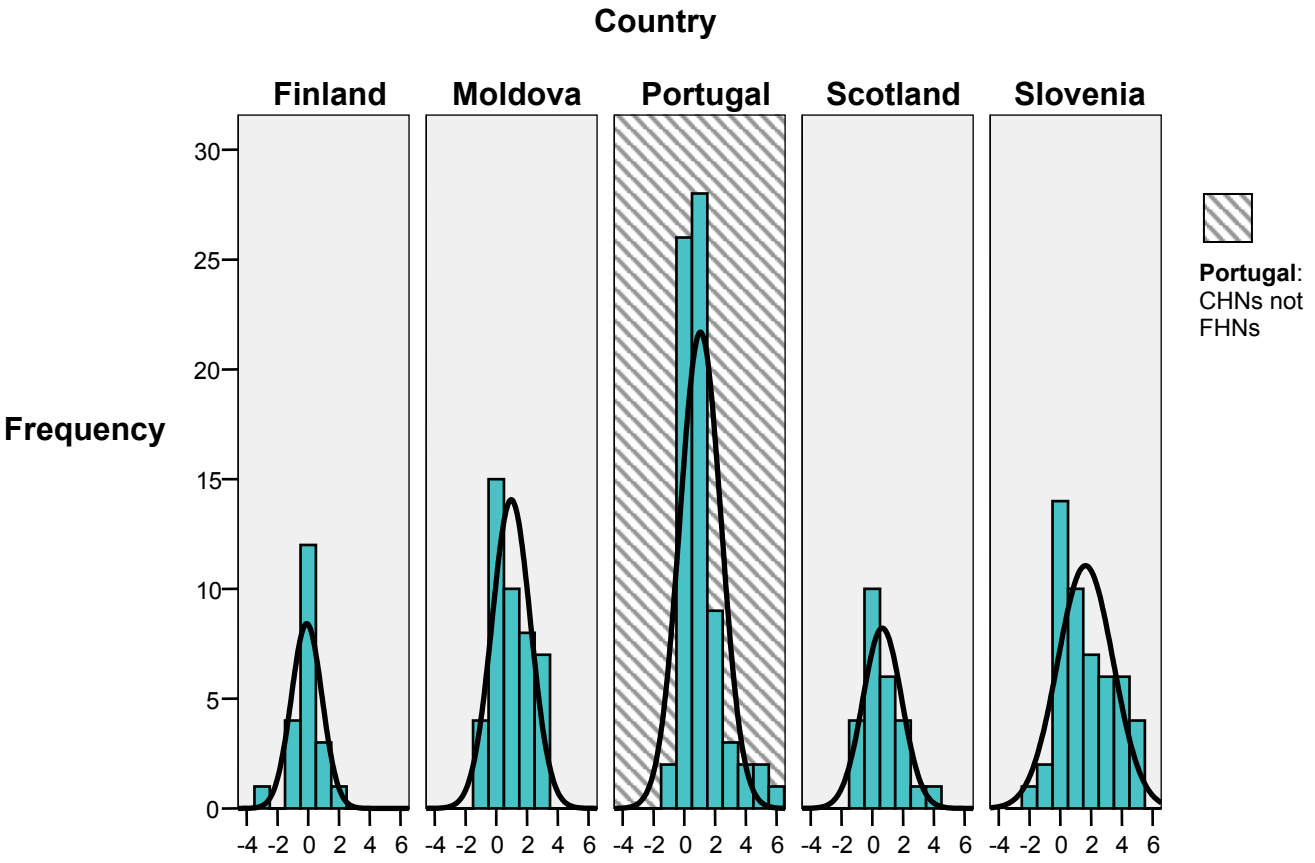
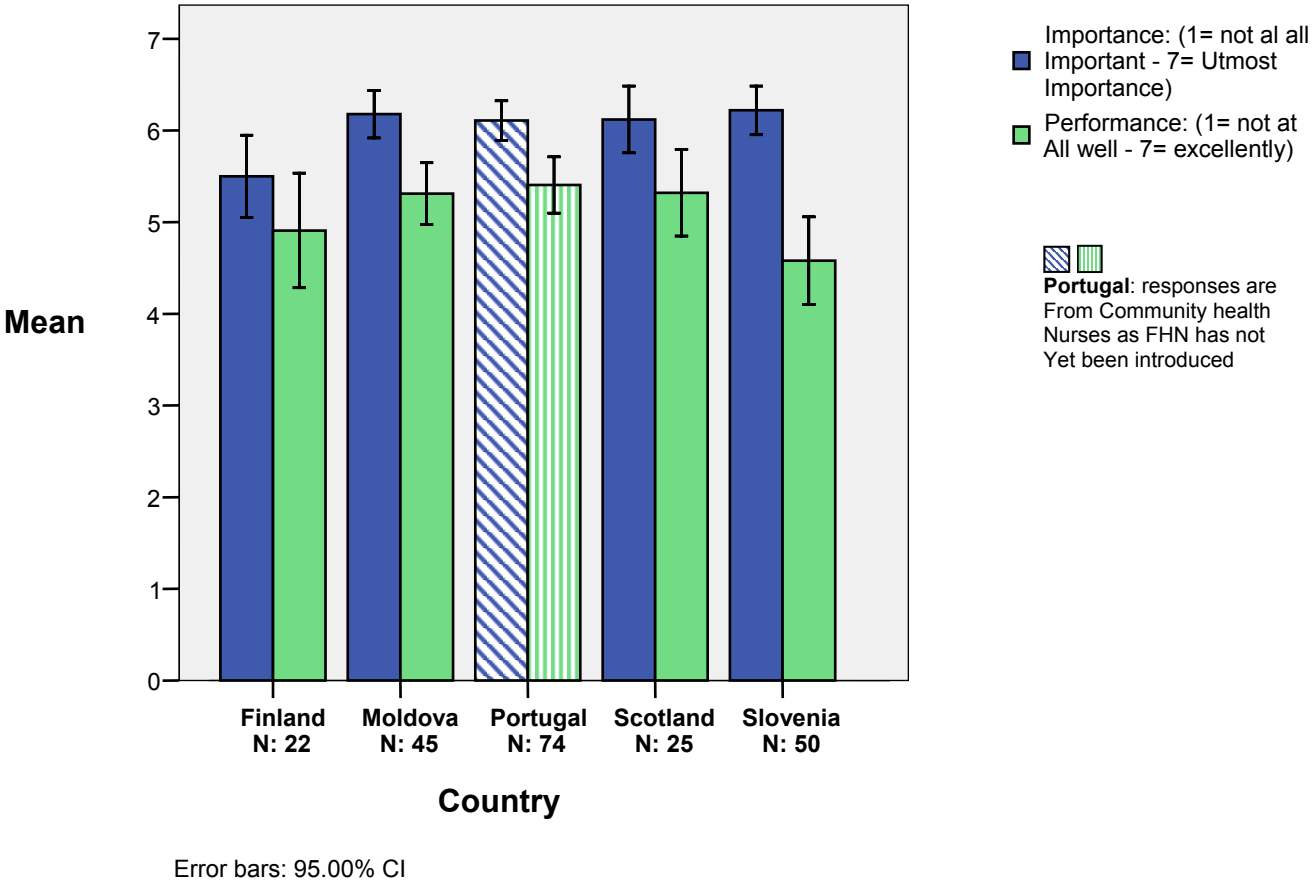


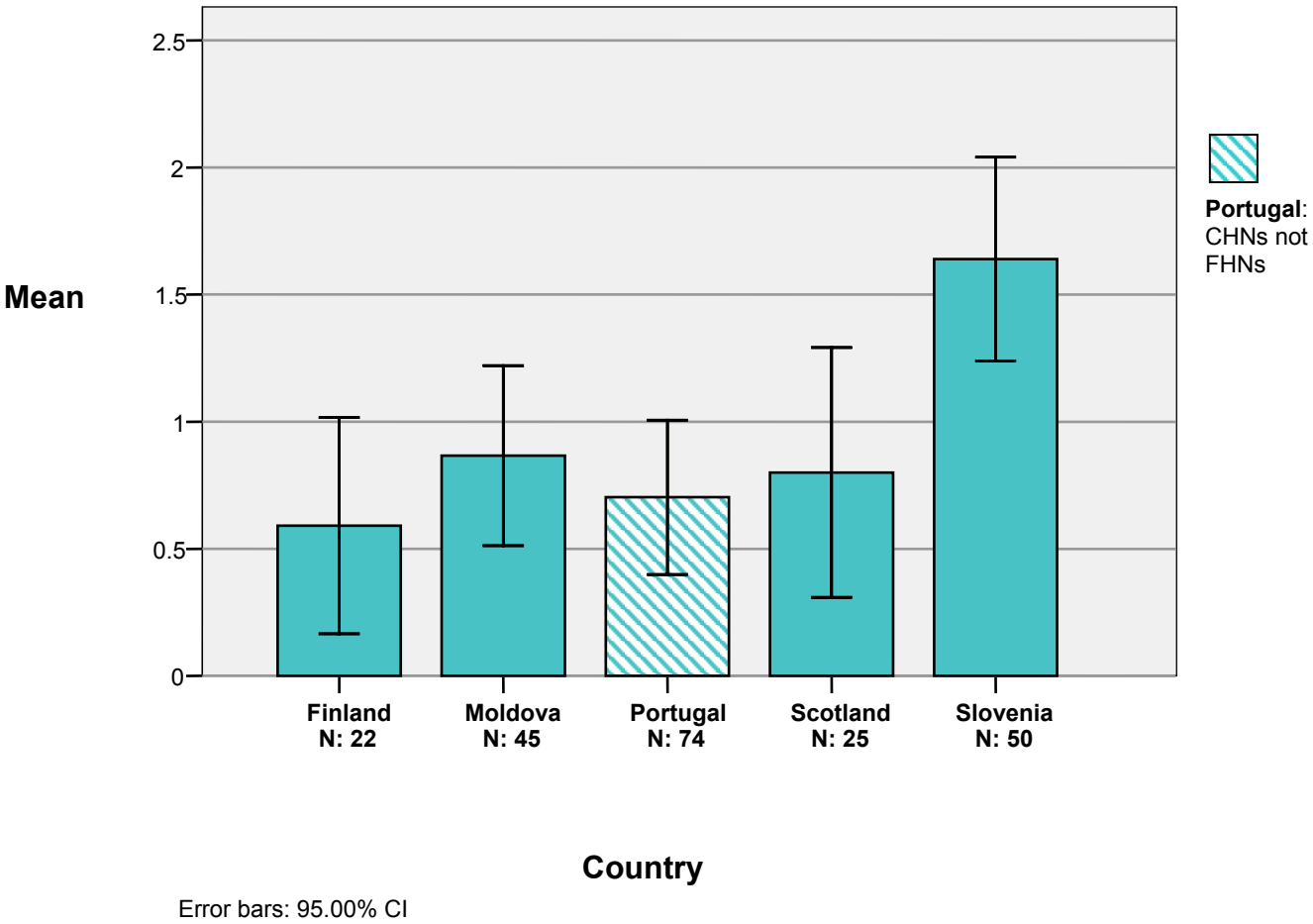
Figure 8.6c identifies the range of responses for the mean score differences between importance and performance of FHNs in *disease prevention in people between 16-65 years*. This is similar to Table 8.6b but shows the score of the difference between importance and performance charted against the normal distribution curve. For example, in Moldova, the scores of 15 respondents identified no difference between the importance and the performance on this task whilst the scores of approximately 7 respondents indicated a difference of 3 points on the scale (importance > performance). 4 respondents indicated a greater performance level than importance level, by 1 point (indicated as -1) on the scale, indicating FHNs possess more skills than are needed in relation to the importance of the task to an FHN. Importance might be scored lower in some tasks due to infrastructure/professional influences on the range of activities carried out by FHNs.

Figure 8.8a Difference in Importance and Performance of FHNs in Detecting Disease early for people 16-65 years



In Figure 8.8a countries showed little difference in their opinions of how important the task *Detecting Disease early for people 16-65 years,* but again Slovenia identified the greatest training need on the basis of their performance of this task. As with 8.2 (Health Promotion) and 8.6 (Disease Prevention), *Detecting Disease early* is a primary function of the FHN role.

Figure 8.8b Difference in Importance and Performance of FHNs in Detecting Disease early for people 16-65 years



Again, Slovenia identified the greatest training need. However, the difference between importance and performance, identified here as indicating training need, might in some areas instead indicate that this activity, whilst important to the role of the FHN from the viewpoint of the WHO definition, is not within the current capacity of those working in-country, as yet (e.g. for professional, organizational or legal reasons). Therefore, the performance will not as high as might be anticipated. If this were the case, countries are encouraged to re-visit all data to ascertain the reasons behind any discrepancy. It is especially recommended that countries investigate this aspect further for activities such as this; *Detecting Disease early,* as it is a primary function of the FHN.

Figure 8.8c Difference in Importance and Performance of FHNs in Detecting Disease early for people 16-65 years

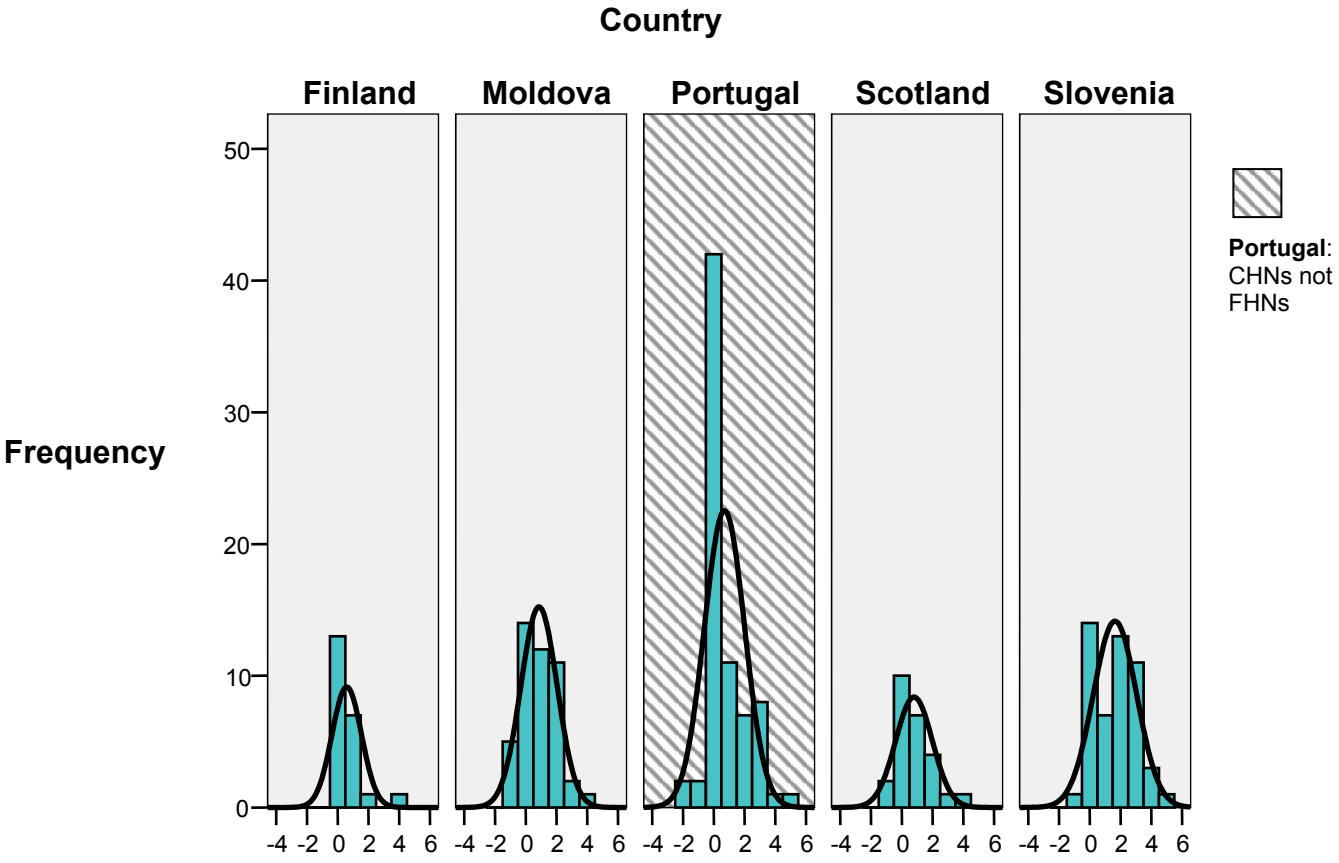
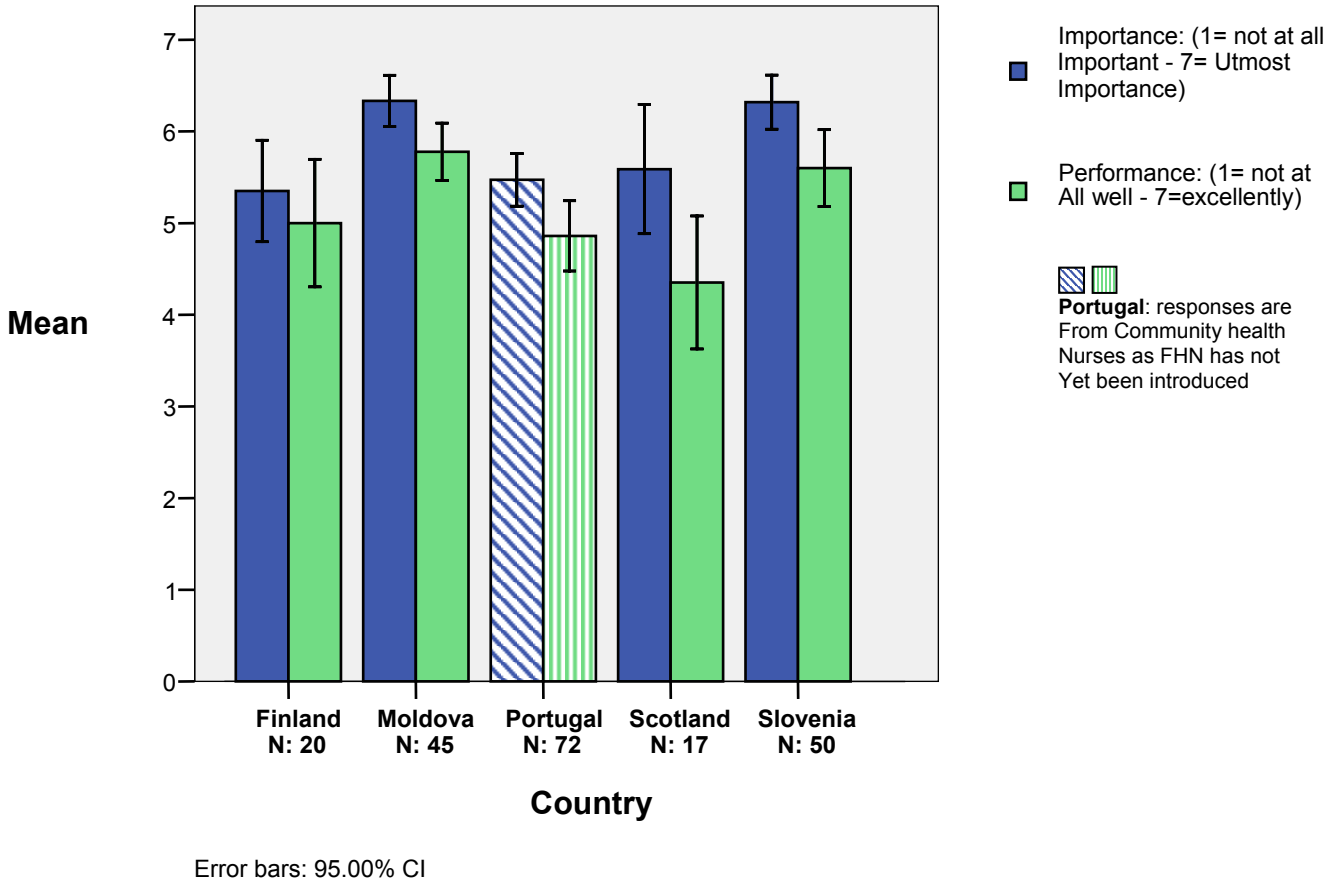


Figure 8.8c identifies the range of responses for the mean score differences between importance and performance of FHNs in *detecting disease early for people aged 16-65* and is similar to Table 8.8b. In this table however, the score of the difference between importance and performance is shown, and charted against the normal distribution curve. For example, in Scotland, the scores of 10 respondents identified no difference between the importance and the performance on this task whilst 1 respondent indicated a difference of 4 points between importance and performance (i.e. the importance of this task was 4 points higher than the performance rating given). As before, this could indicate a need to update knowledge and skill or it may highlight an organizational blockage, which needs attention before the FHN is able to perform to the level required. Approximately 3 respondents indicated a greater performance level than importance level, by 1 point (indicated as -1) on the scale. Again, this could indicate FHNs possess slightly higher skill levels than are needed in relation to the importance of the task or alternatively some organizational influence making this task less important, although the nurses do it well.

Figure 8.10a Difference in Importance and Performance of FHNs in Providing Care for Acutely Ill Children



Figures 8.10. All countries identified *Providing Care for Acutely ill Children* as being important, with Slovenia and Moldova viewing it as slightly more important than other countries.

Figure 8.10b Difference in Importance and Performance of FHNs in Providing Care for Acutely Ill Children

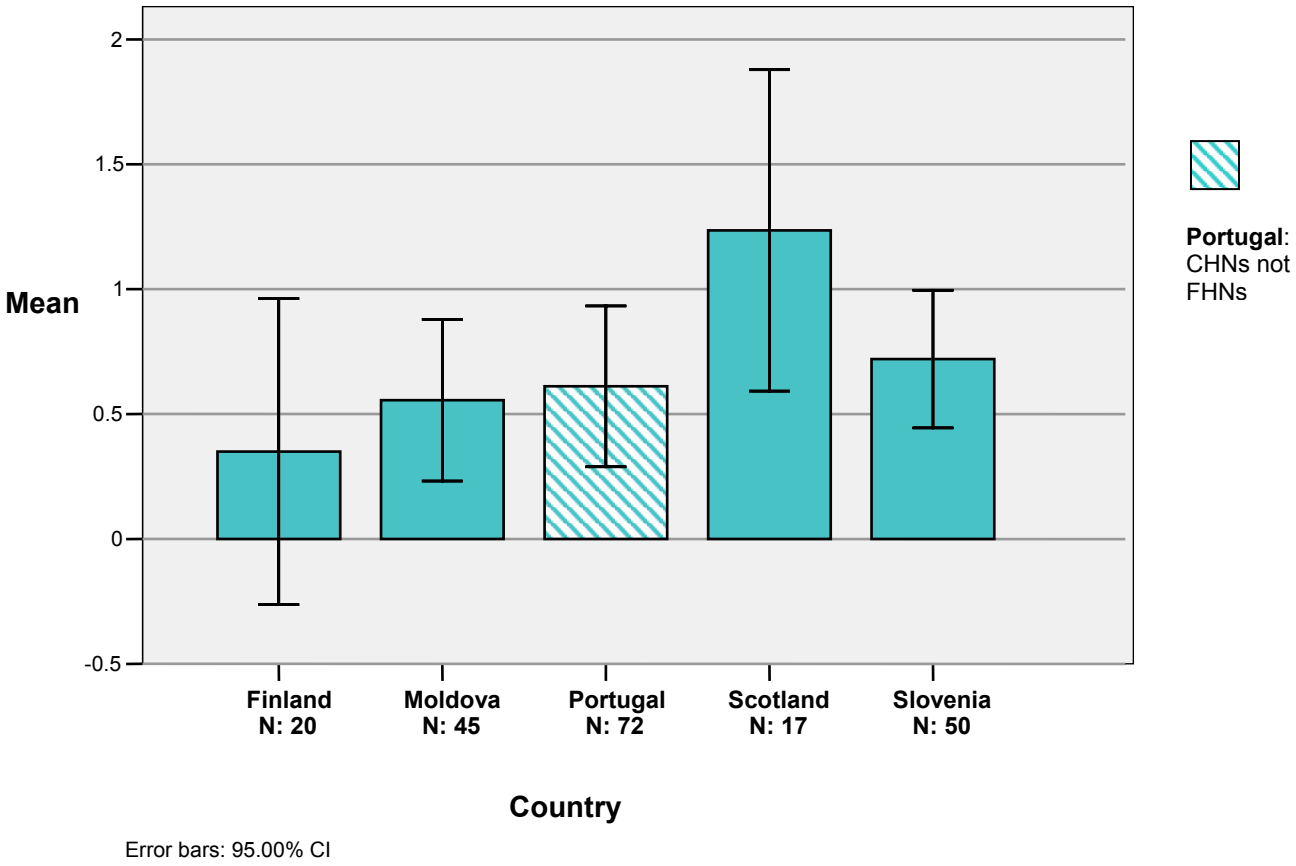


Figure 8.10b clearly shows that the Scottish FHNs recognised a greater training need than the other countries in this task. This might have a historical basis in that, until recently, acutely ill children were often cared for in the community by hospital outreach staff, or that the staff training as FHNs do not have a great deal of paediatric experience generally. The picture may be similar elsewhere and is again a factor that requires further investigation in-country.

Figure 8.10c Difference in Importance and Performance of FHNs in Providing Care for Acutely Ill Children

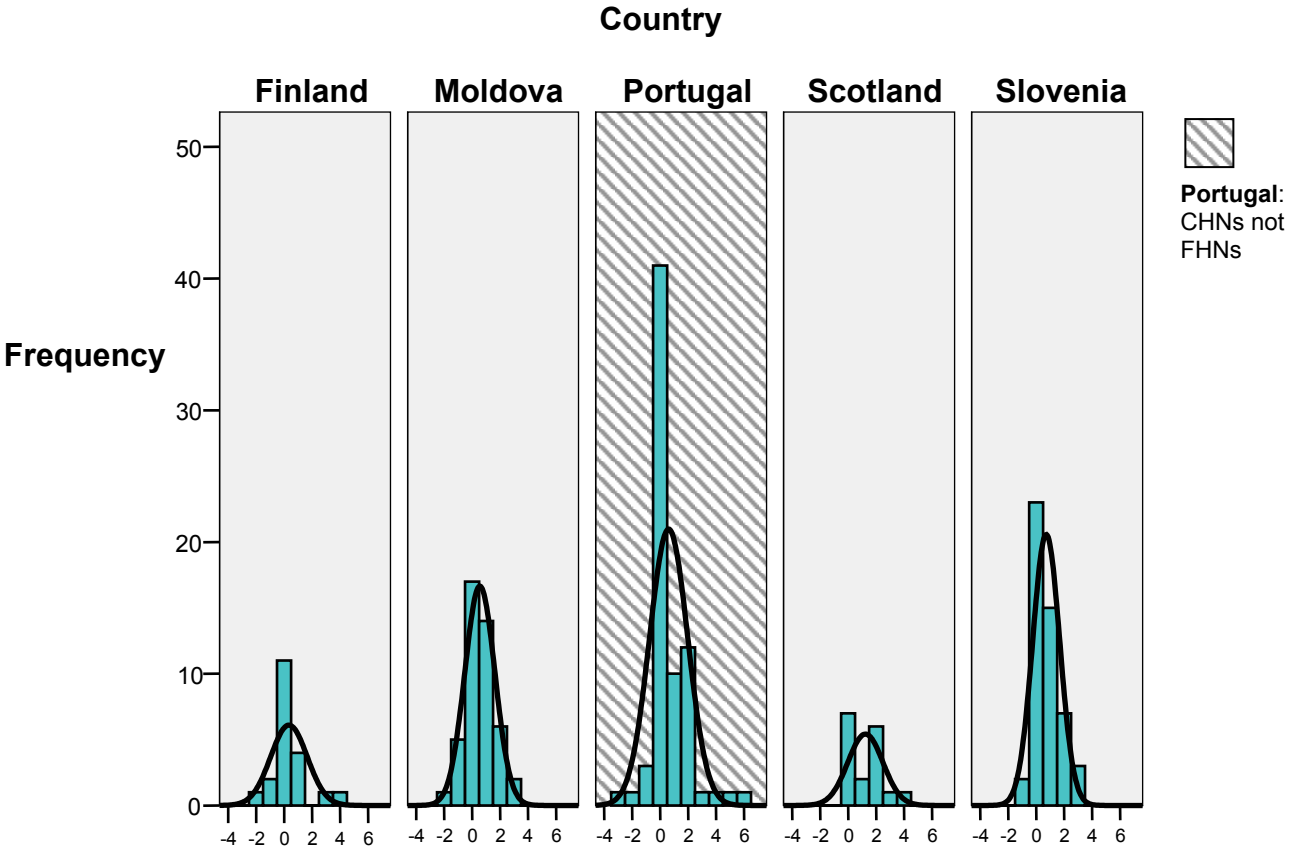
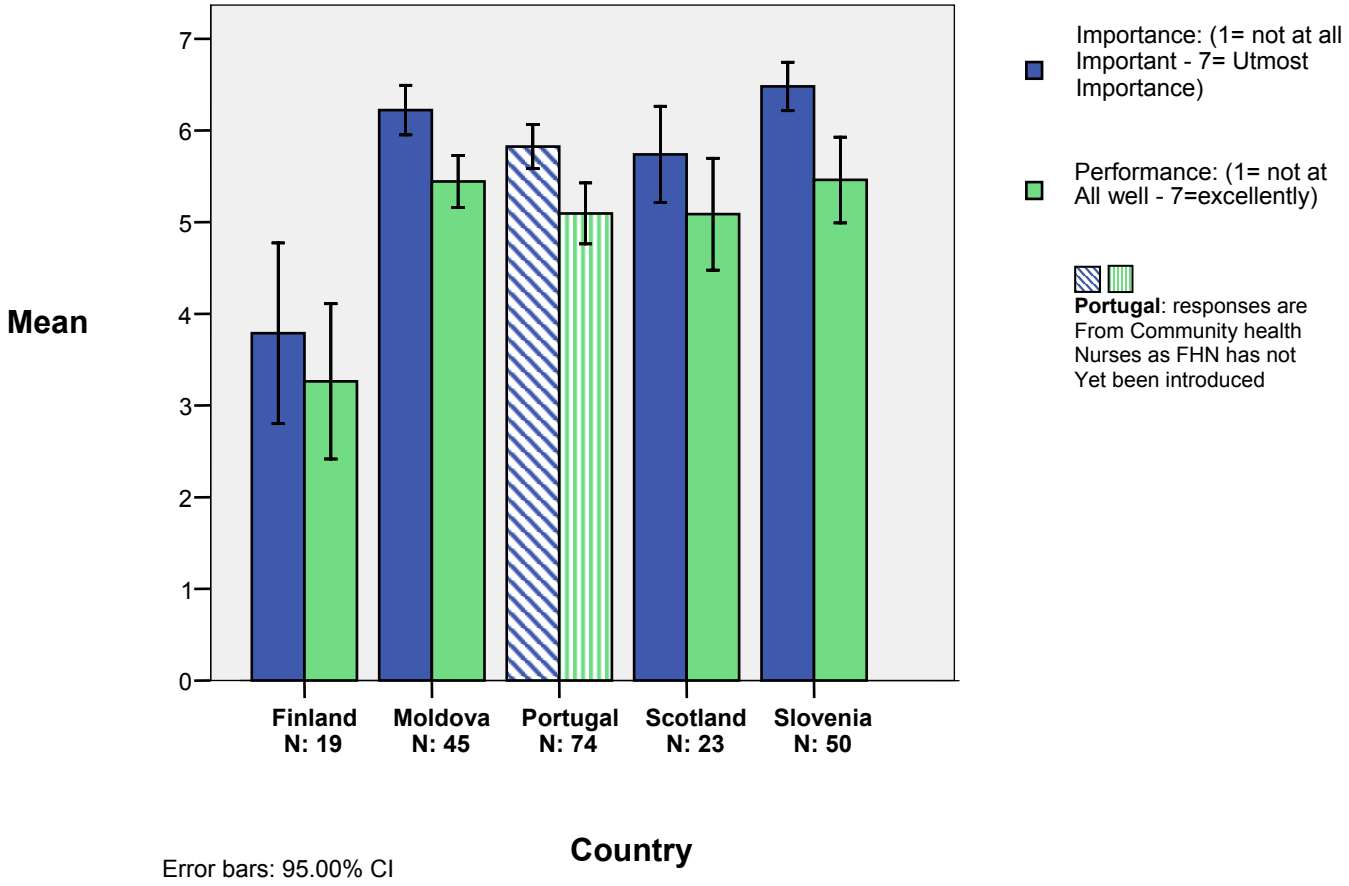


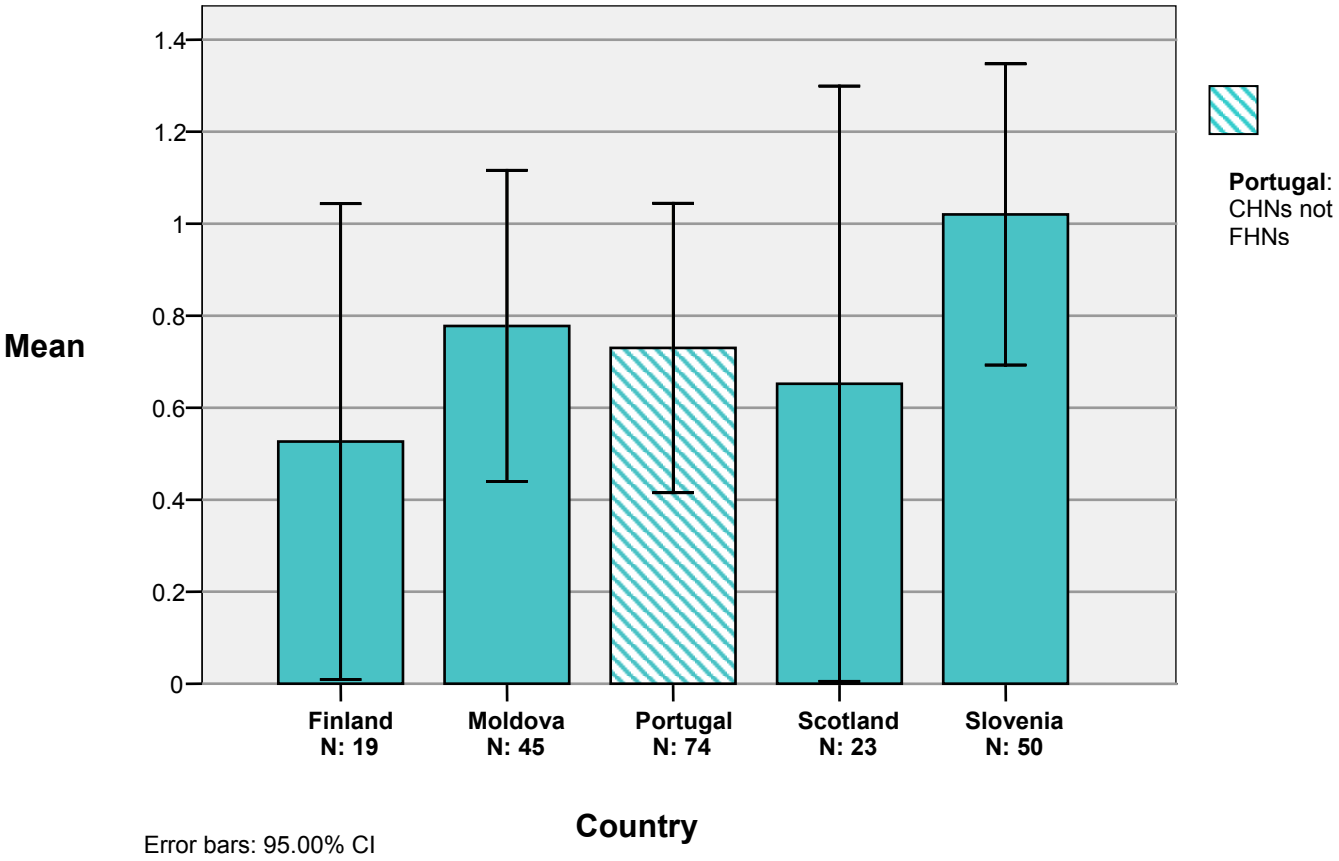
Figure 8.10c identifies the range of responses for the mean score differences between importance and performance of FHNs in *providing acute care for children*, showing the score of the difference between importance and performance charted against the normal distribution curve. For example, in Finland, 12 respondents identified no difference between the importance and the performance on this task whilst 1 respondent indicated a difference of 4 points on the scale, between importance and performance, indicating educational needs or organizational issue blocking the performance of this task. One respondent indicated a greater performance level than importance level by 2 points (indicated as -2) on the scale, indicating FHNs possess more skills than are needed in relation to the importance of the task to an FHN.

Figure 8.13a Difference in Importance and Performance of FHNs in Care for Chronically Sick and Disabled Children



Finland believes that *Care for the Chronically Sick and Disabled Children* in Figures 8.13 is far less important than other countries. Again, this may be because caring for such children is not a common function of FHNs in Finland. All the other countries do view this activity as highly important.

Figure 8.13b Difference in Importance and Performance of FHNs in Care for Chronically Sick and Disabled Children



Slovenia again indicated the greatest difference between performance and importance. This may be because it is not a function of the role of FHNs within Slovenia, although as it was identified as being important (in 8.13a) this seems unlikely. It seems more likely the case that it is recognition of a training need in this area. As mentioned previously, Slovenia has had FHN roles within community services for some time and it might be that these nurses completed their training sometime ago and require further continued professional development.

Figure 8.13c Difference in Importance and Performance of FHNs in Care for Chronically Sick and Disabled Children

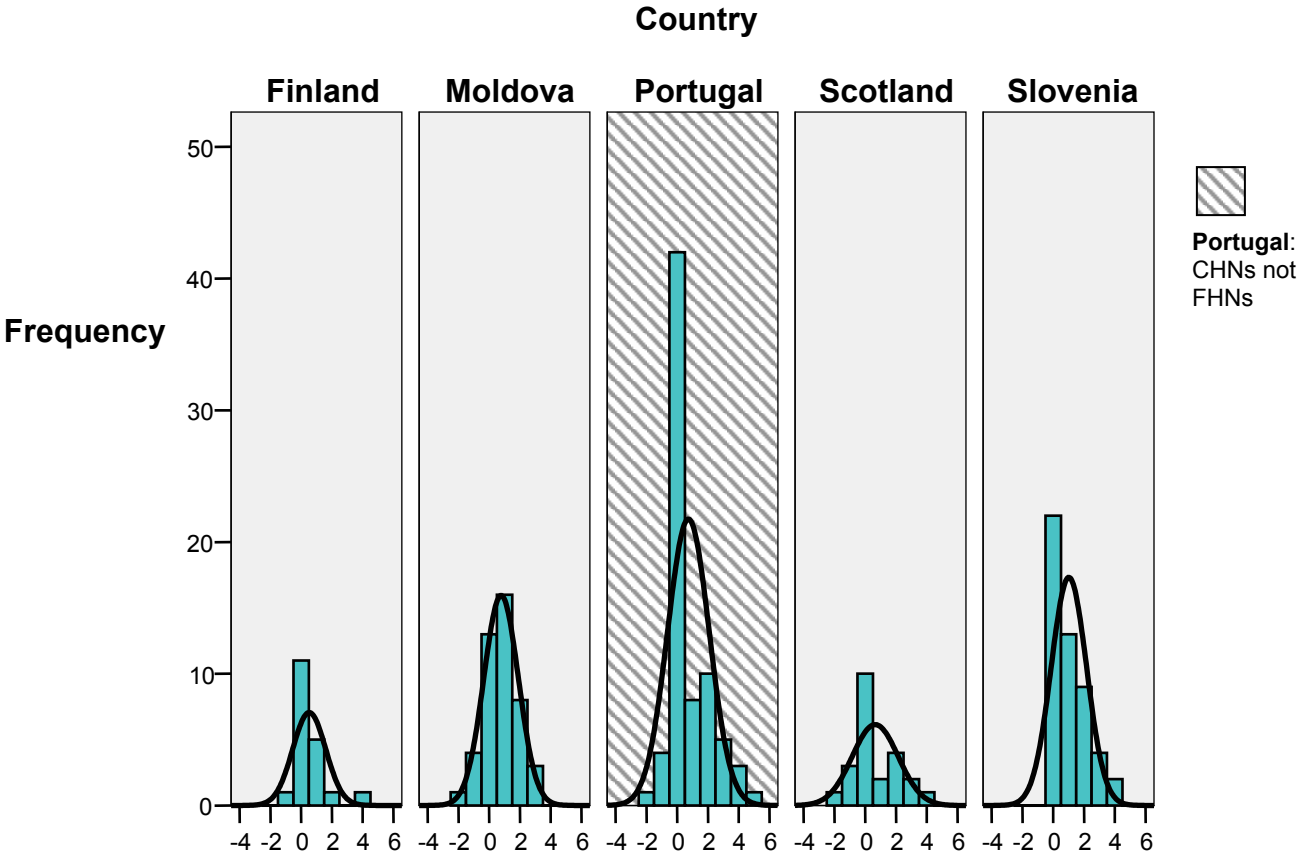
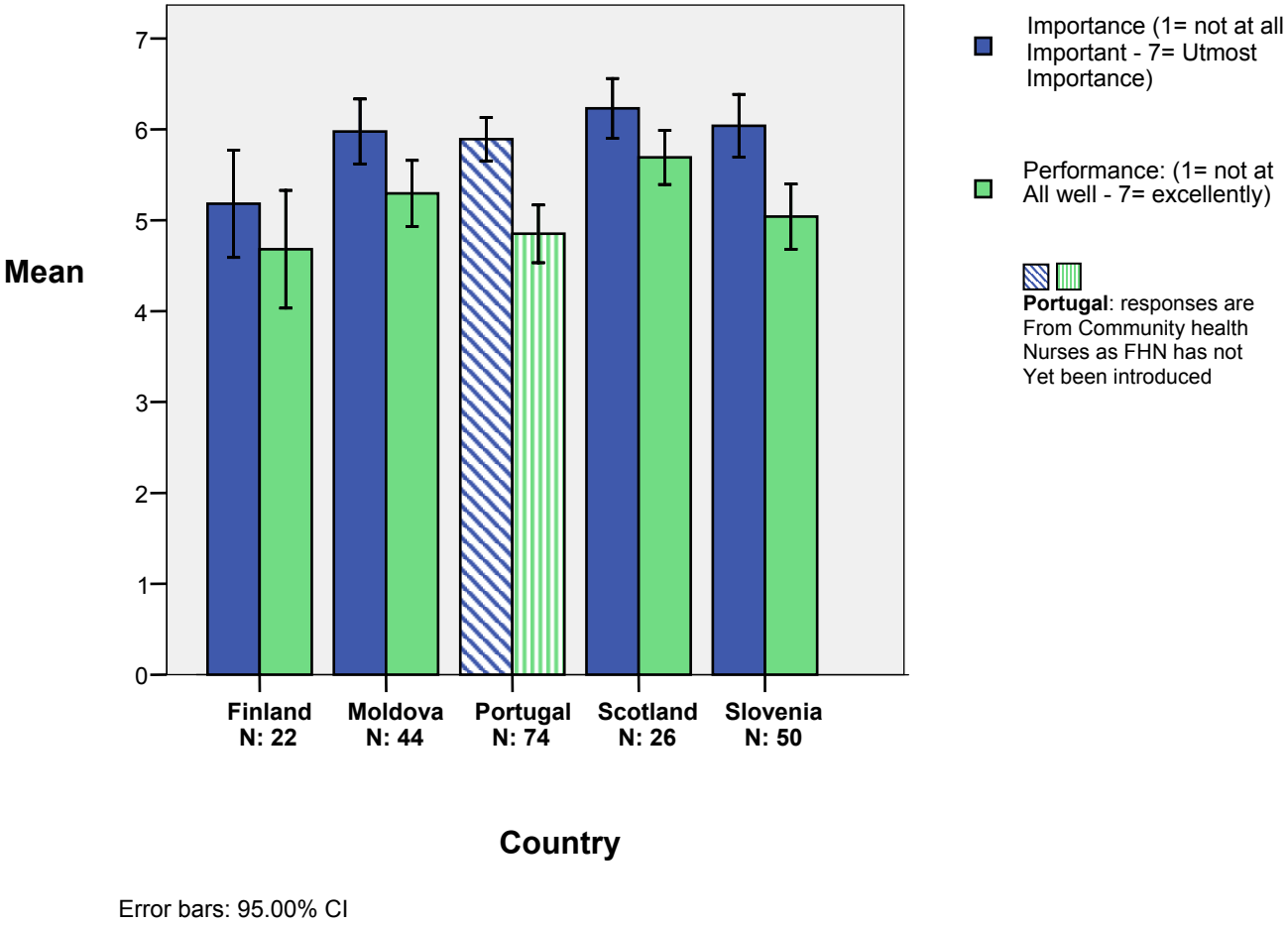


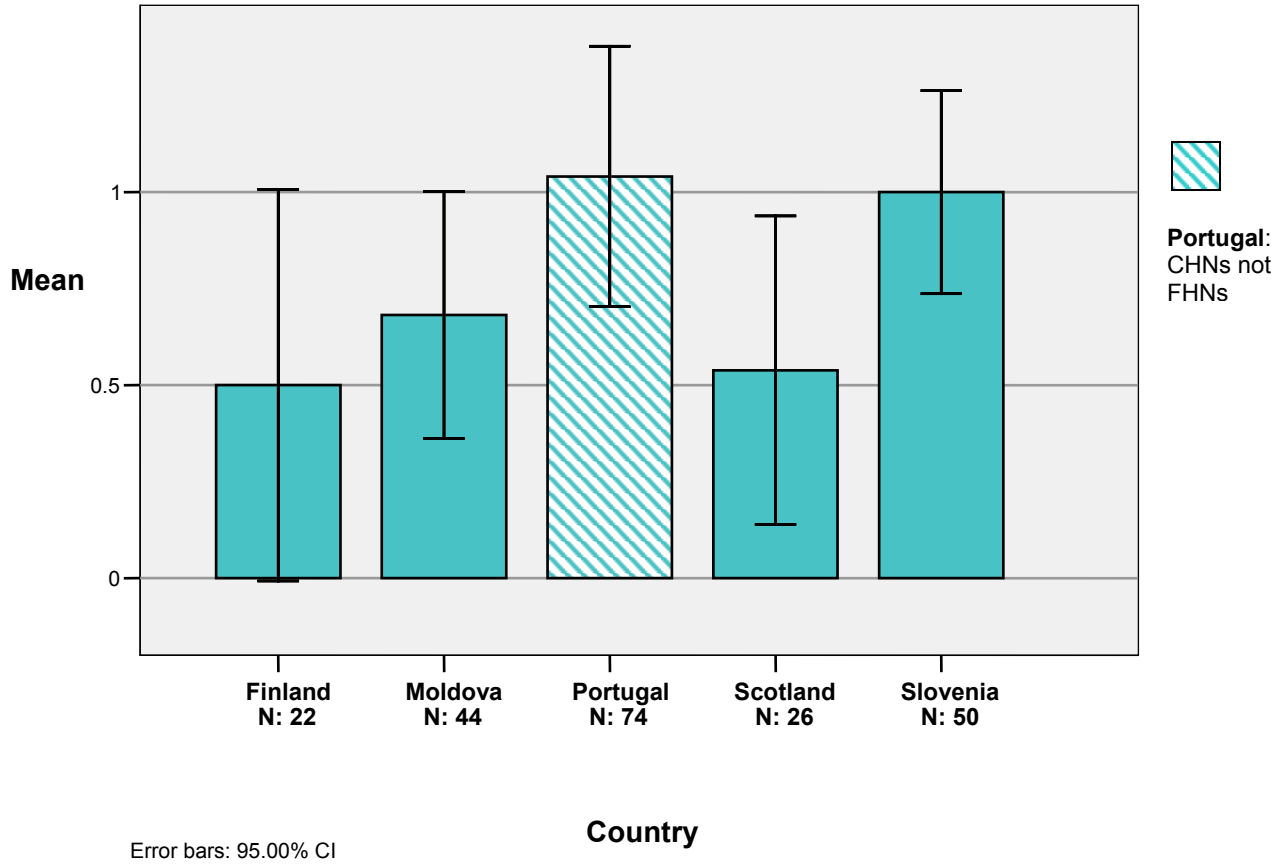
Figure 8.13c identifies the range of responses for the mean score differences between importance and performance of FHNs in *caring for chronically sick and disabled children*. In Slovenia, 22 respondents identified no difference between the importance and the performance on this task whilst 2 respondents indicated a difference of 4 points on the scale, between importance and performance. Unlike all other countries, no respondents indicated a negative relationship between importance and performance, whereby performance is rated higher than importance.

Figure 8.17a Difference in Importance and Performance of FHNs in Helping Individuals Cope with Stress



All countries have a similar high level of belief in the *Helping Individuals Cope with Stress* as shown in Figures 8.17 and those with FHNs working appear to perform this function relatively well.

Figure 8.17b Difference in Importance and Performance of FHNs in Helping Individuals Cope with Stress



Portugal and Slovenia reflect a greater training need in *Helping Individuals coping with stress*. It needs to be remembered that Portugal does not currently have FHNs and the questionnaires were completed by community health nurses, some of whom have completed a family health nursing module. Within the WHO concept of the FHN *coping with stress* is an area where the FHN is thought to have particular influence and so any discrepancy between importance and performance should be investigated.

Figure 8.17c Difference in Importance and Performance of FHNs in Helping Individuals Cope with Stress

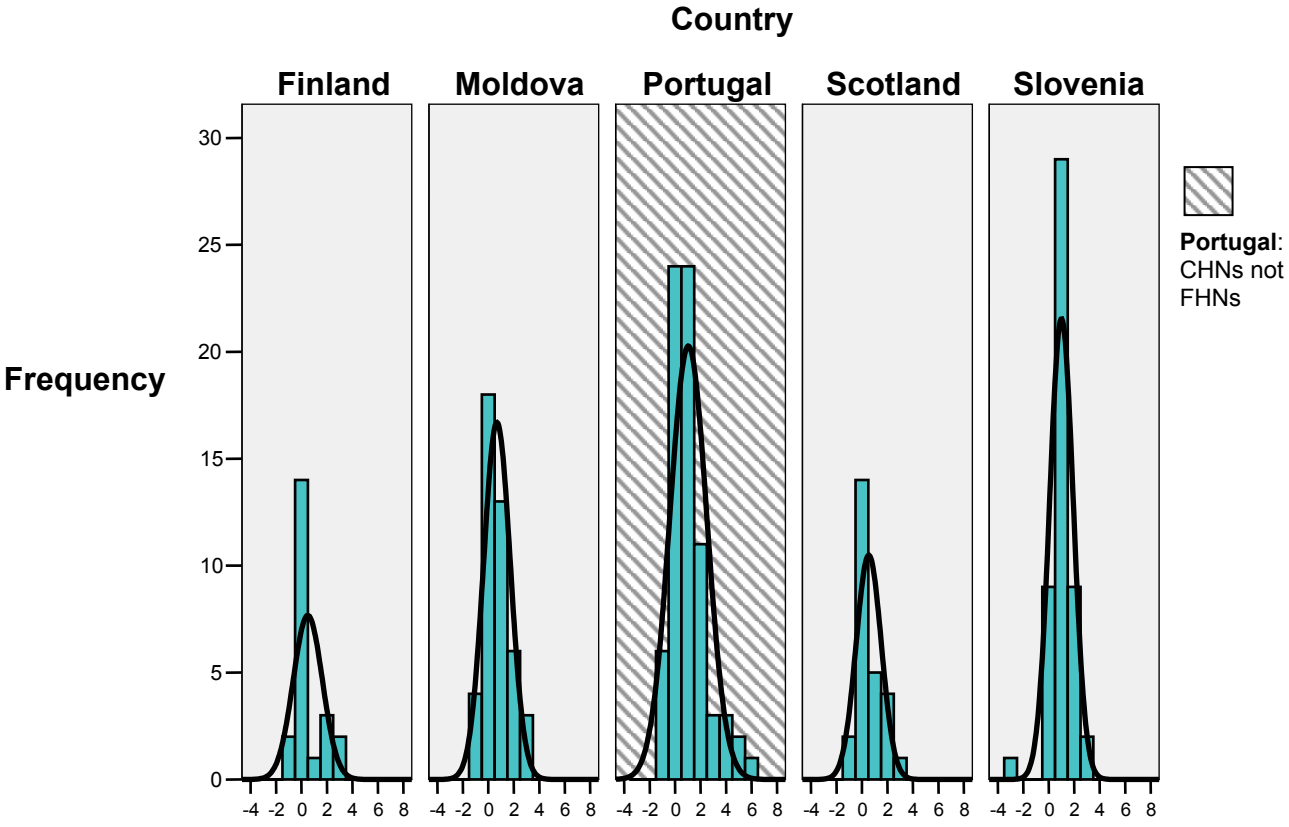
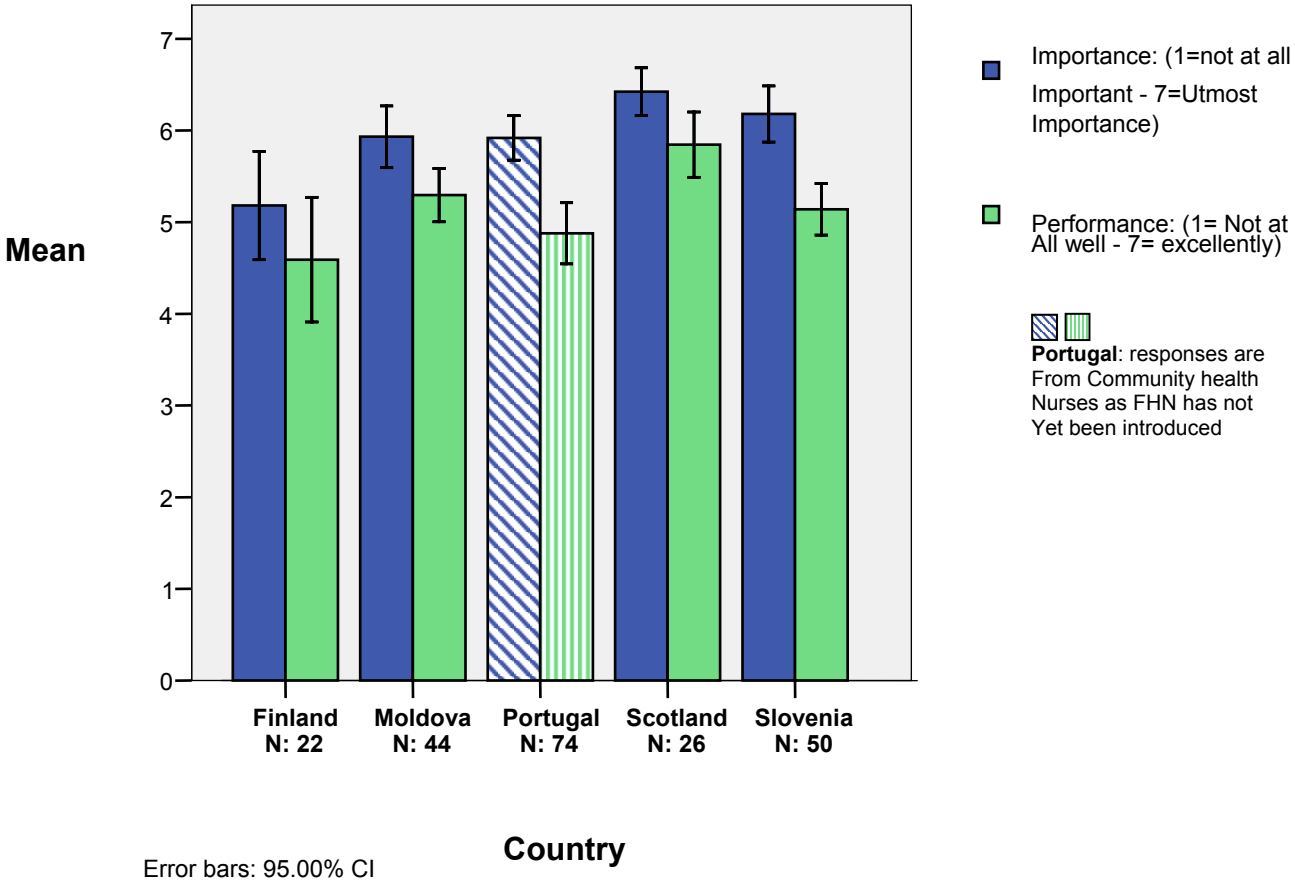


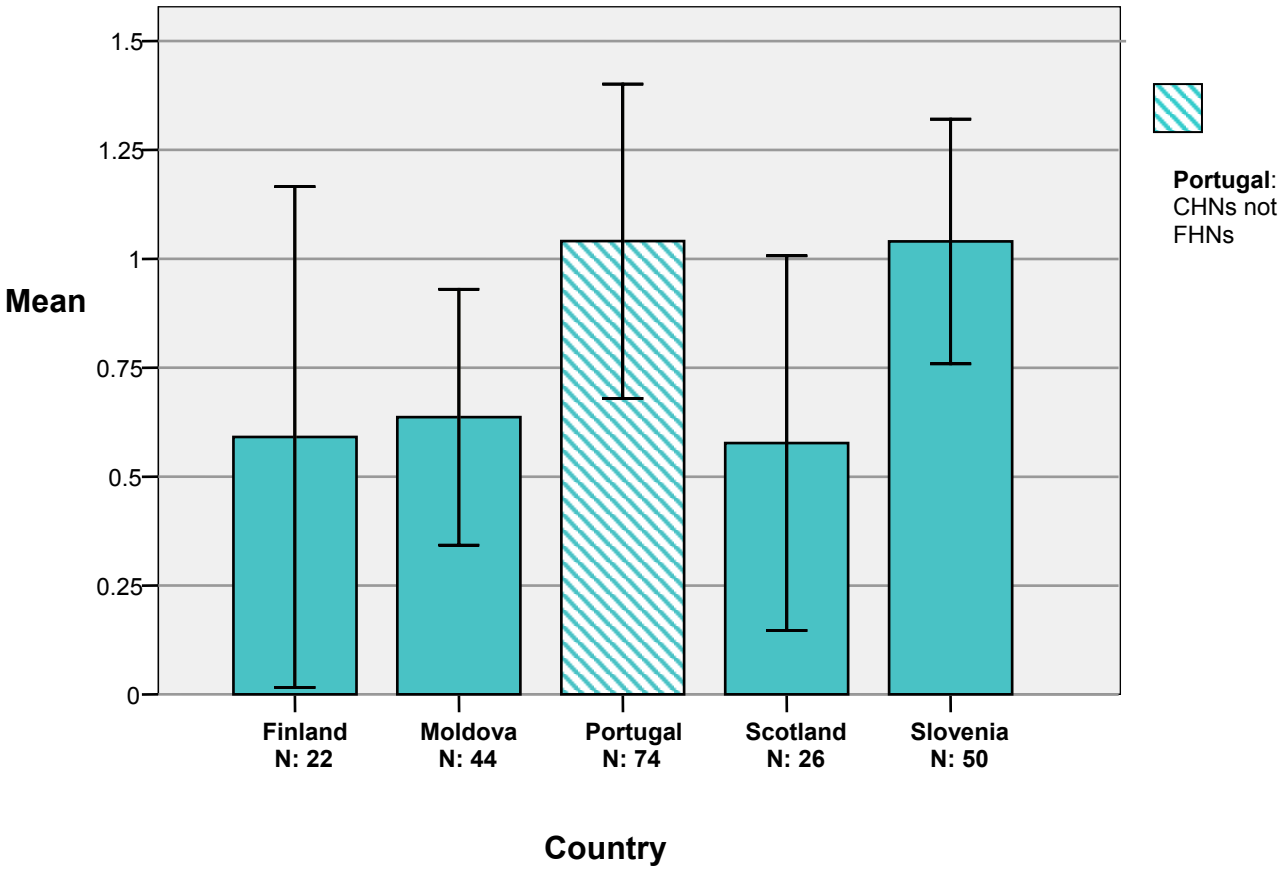
Figure 8.17c identifies the range of responses for the mean score differences between importance and performance of FHNs in *helping individuals cope with stress*. This is similar to Table 8.17b, though here the score of the difference between importance and performance is shown, and charted against the normal distribution curve. For example, in Portugal, the scores of 24 respondents identified no difference and 24 indicated a difference of just 1 point between the importance and the performance on this task, suggesting that the performance of the task in relation to its importance is good. However, 2 respondents indicated a difference of 6 points on the scale. Interestingly, 7 respondents also indicated a greater performance level than importance (performance > importance), by 1 point (indicated as -1) on the scale. In the case of Portugal, this large range in score differences between importance and performance of this task is likely to be associated with the fact that FHNs are not yet operational and there is uncertainty in the role definition.

Figure 8.18a Difference in Importance and Performance of FHNs in Helping Families Cope with Stress



All countries believe that *Helping Families Cope with Stress* is a very important role for FHNs, especially Scotland and Slovenia, both of whom have well-established FHN programmes with a strong emphasis on family-focussed nursing.

Figure 8.18b Difference in Importance and Performance of FHNs in Helping Families Cope with Stress



Portugal and Slovenia are the two countries that again recognise a greater training need. It must be remembered that Portugal does not have FHNs in the sense of the WHO model and therefore those activities that are family focussed are likely to be more problematic to them. FHNs in Finland, Scotland and Moldova appear to perform this function relatively well. Slovenia indicates a greater training need, with a gap between performance and the high rating for the importance of this activity.

Figure 8.18c Difference in Importance and Performance of FHNs in Helping Families Cope with Stress

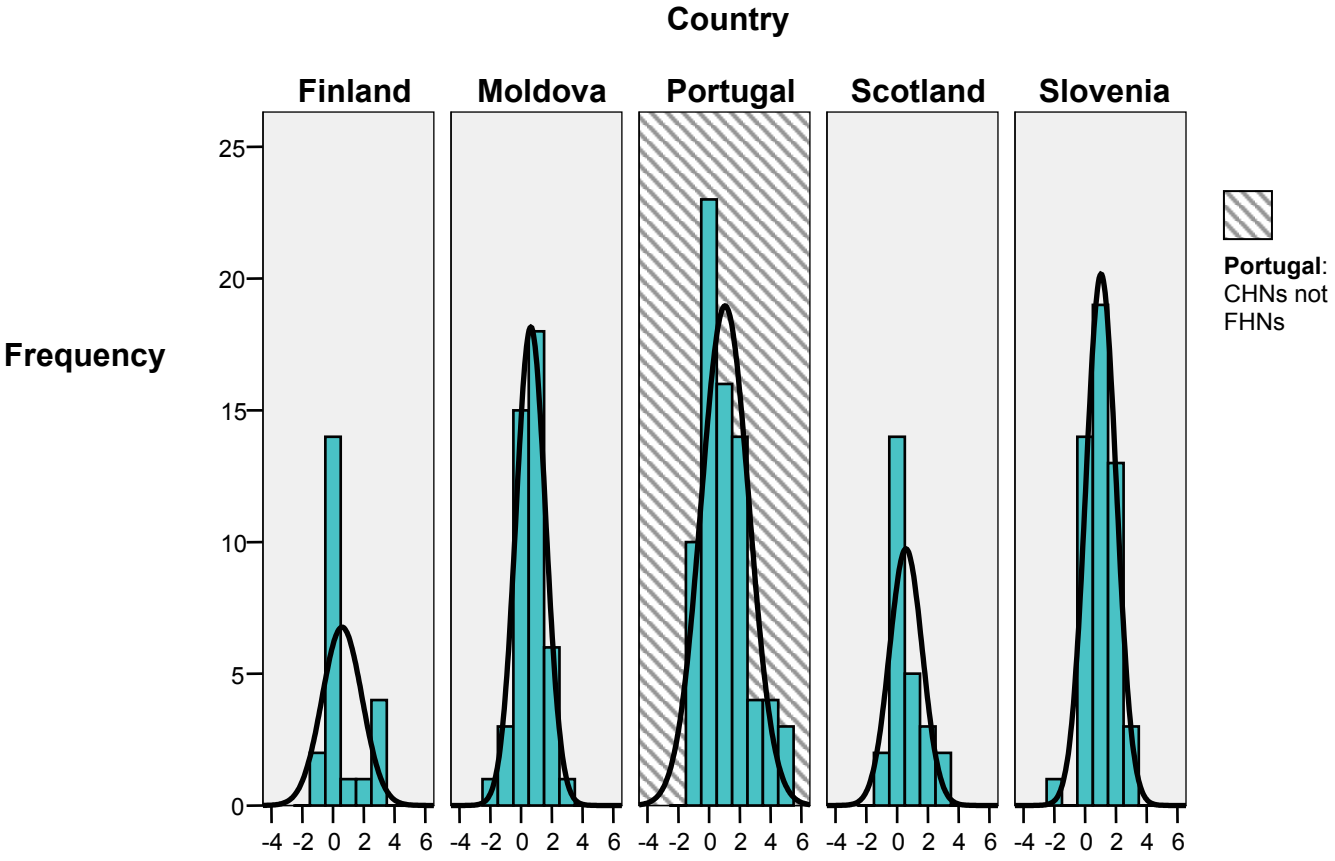
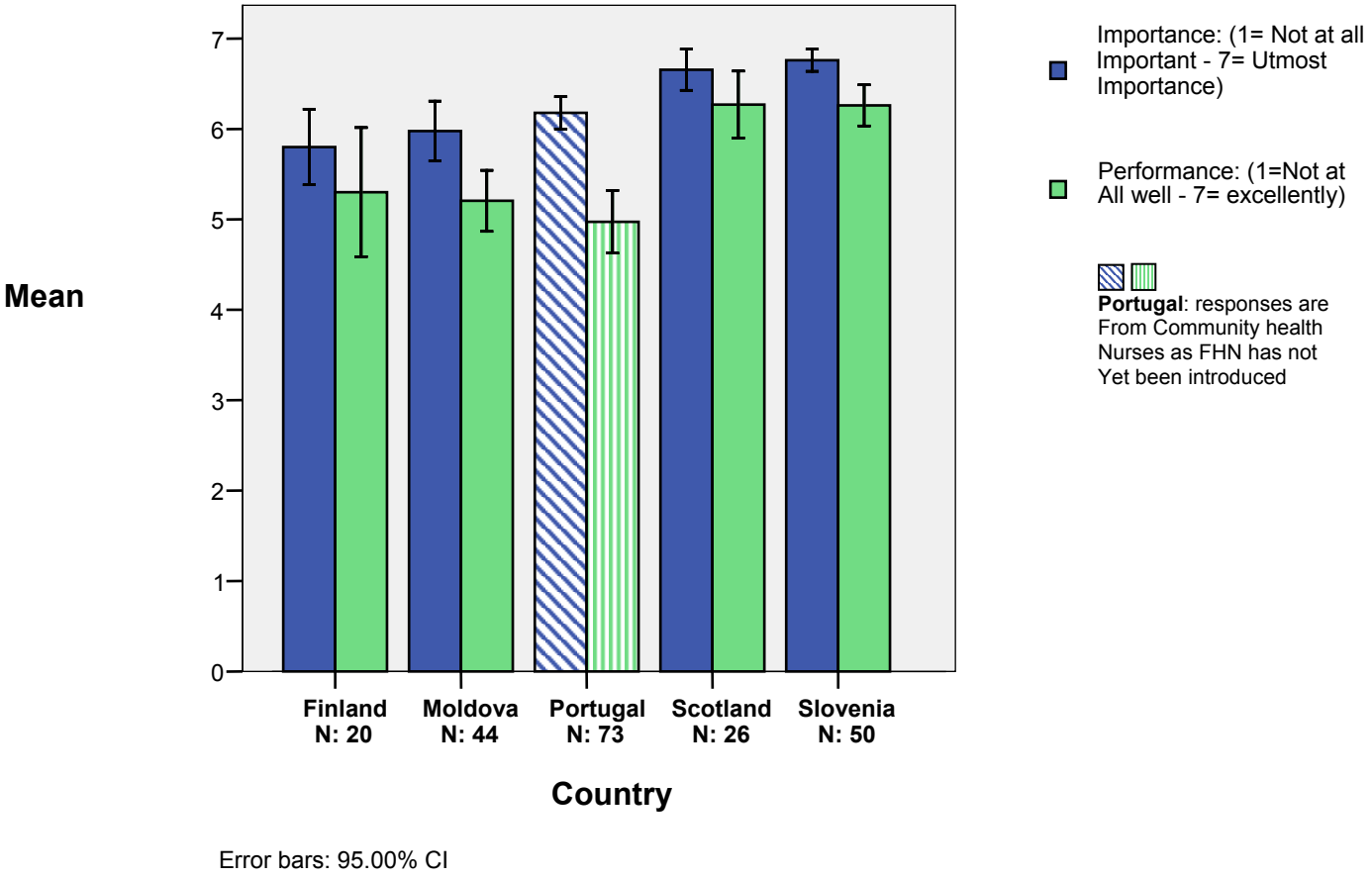


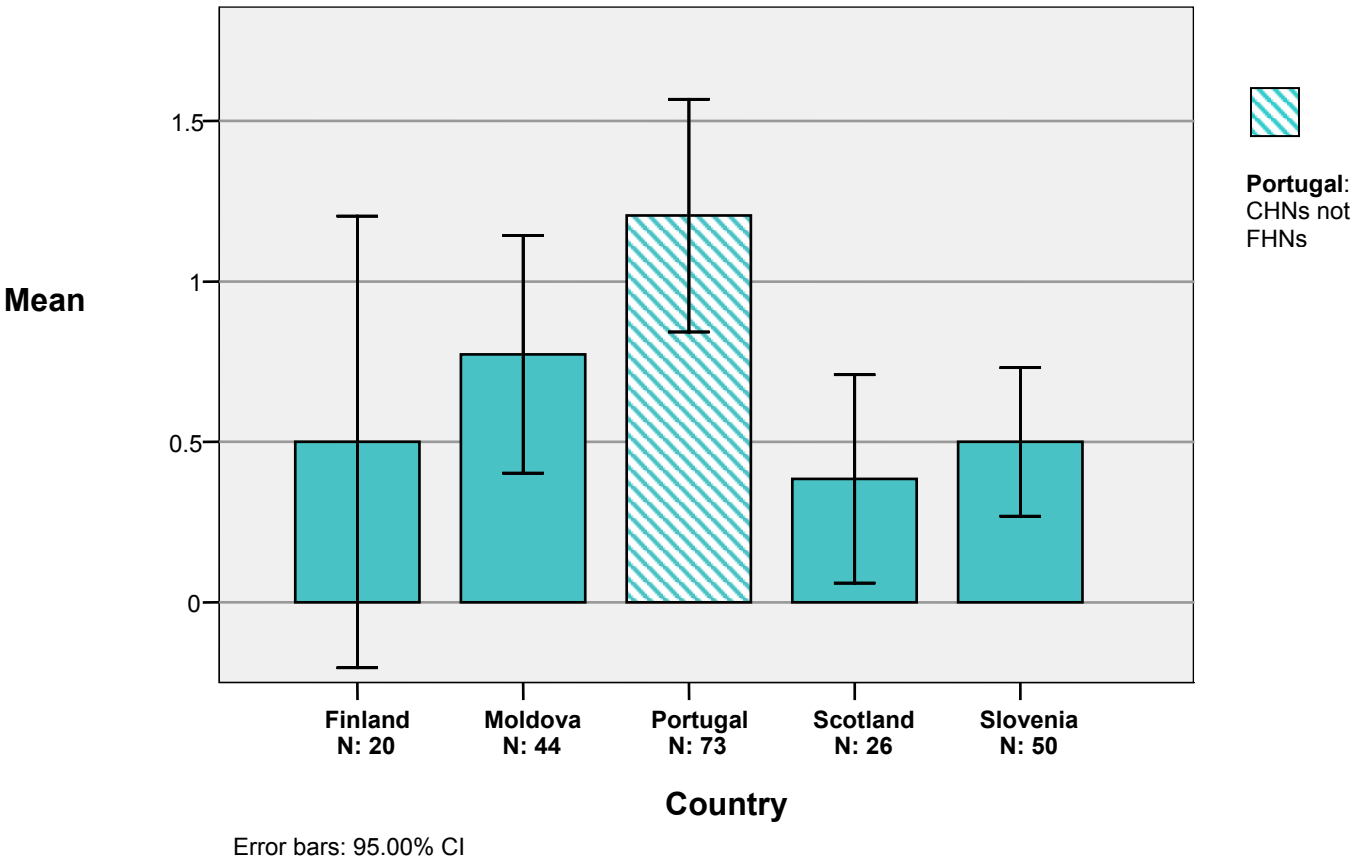
Figure 8.18c identifies the range of responses for the mean score differences between importance and performance of FHNs in *helping families cope with stress*. Helping families cope with stress is a vital function of the FHN, and any discrepancy between importance and performance in either direction on the scale, is worth investigating.

Figure 8.25a Difference in Importance and Performance of FHNs in Assessing Health Needs of Whole Family



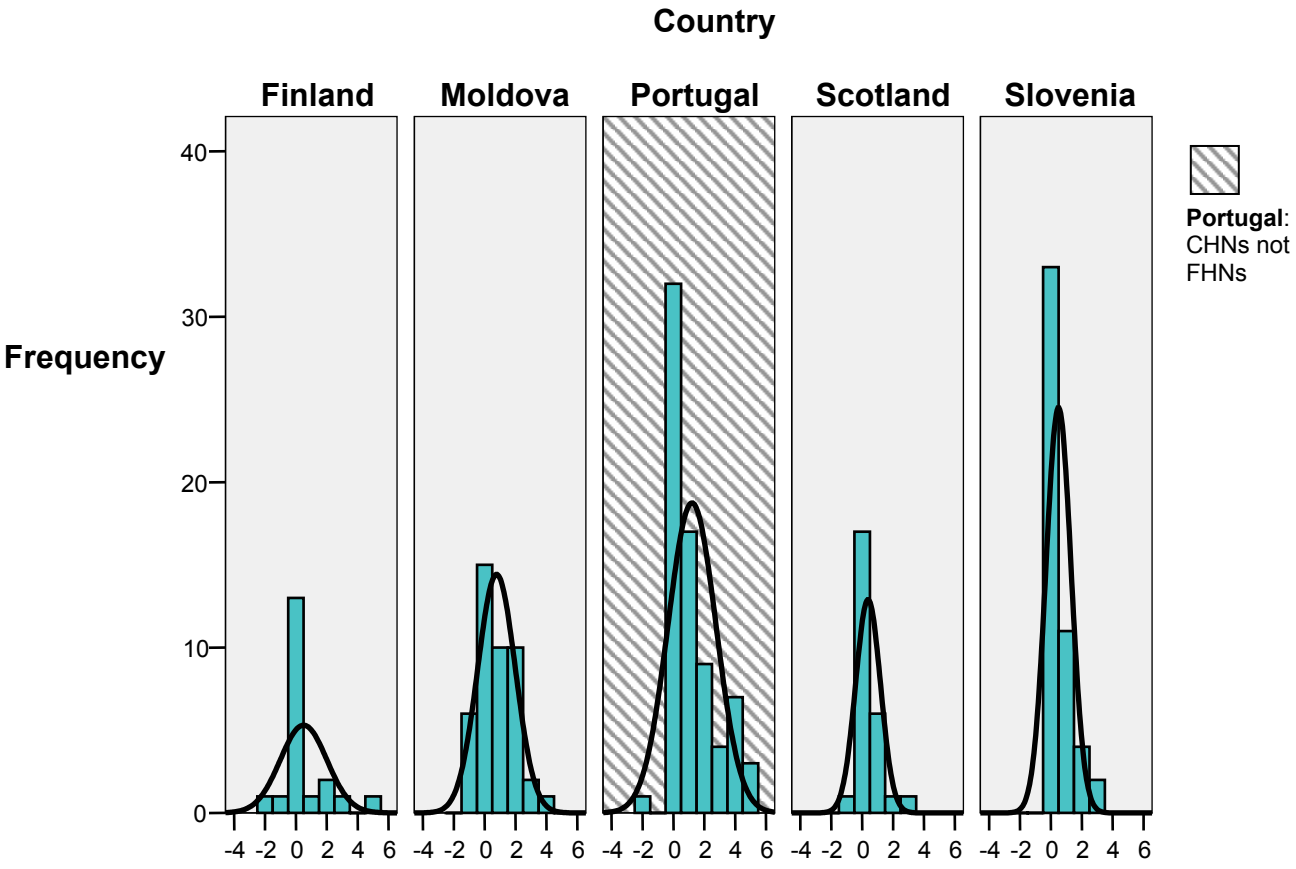
Assessing Health Needs of the Whole Family is considered a very important activity across all countries, again in line with the WHO FHN definition. As expected, Portugal records a lower performance level than other countries, due to their current lower level of family focussed training.

Figure 8.25b Difference in Importance and Performance of FHNs in Assessing Health Needs of Whole Family



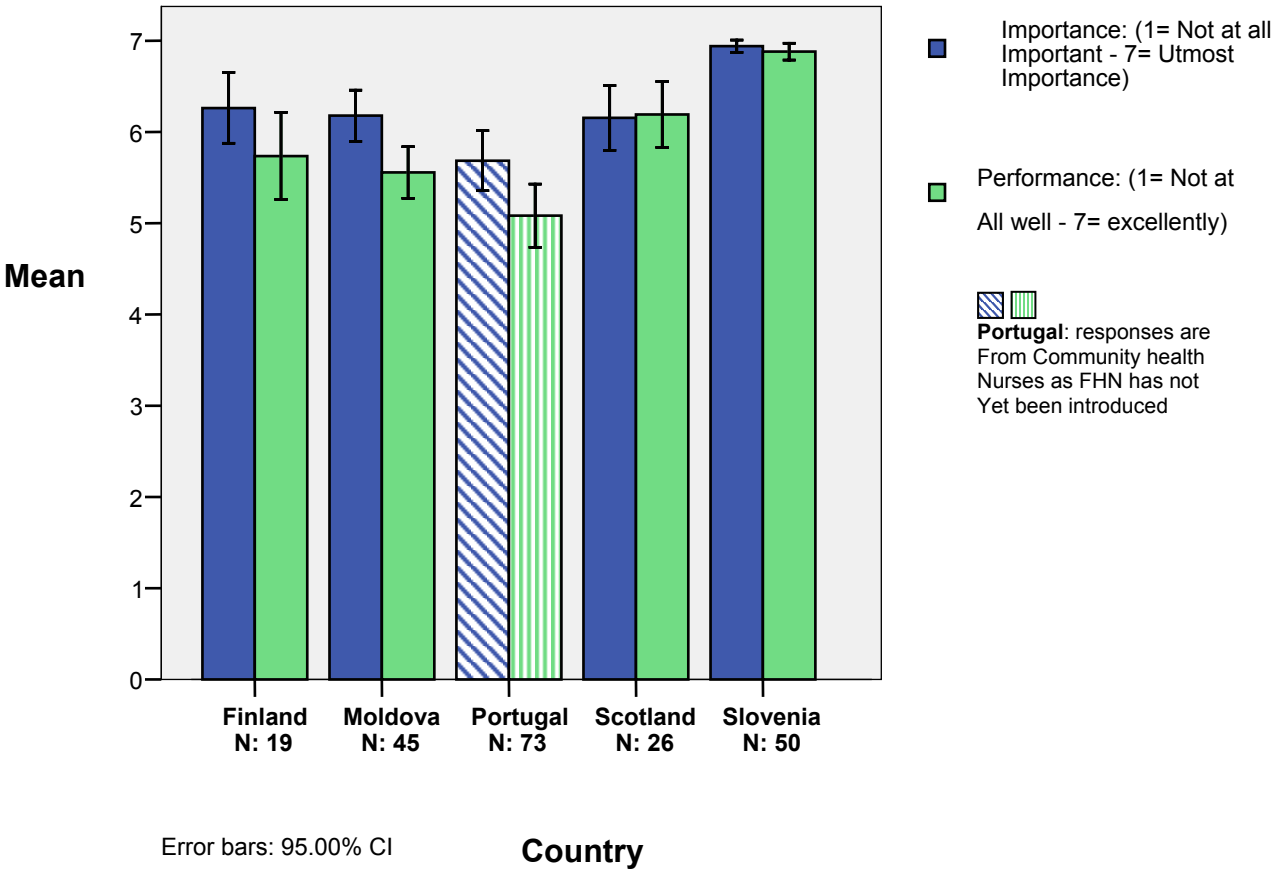
All countries except Portugal indicate that the performance of this activity is also relatively good. Portugal demonstrates a much greater training need than other countries and Scotland has the lowest training need. Again, this probably reflects the fact that Portugal has not yet implemented their FHN programme, and so assessing family needs is still a new approach. It may also reflect the need for public education. Elsewhere in the questionnaire, Portugal had noted that public health and health promotion services are not generally well utilized in the country. This task is a main requirement within the WHO definition of the FHN.

Figure 8.25c Difference in Importance and Performance of FHNs in Assessing Health Needs of Whole Family



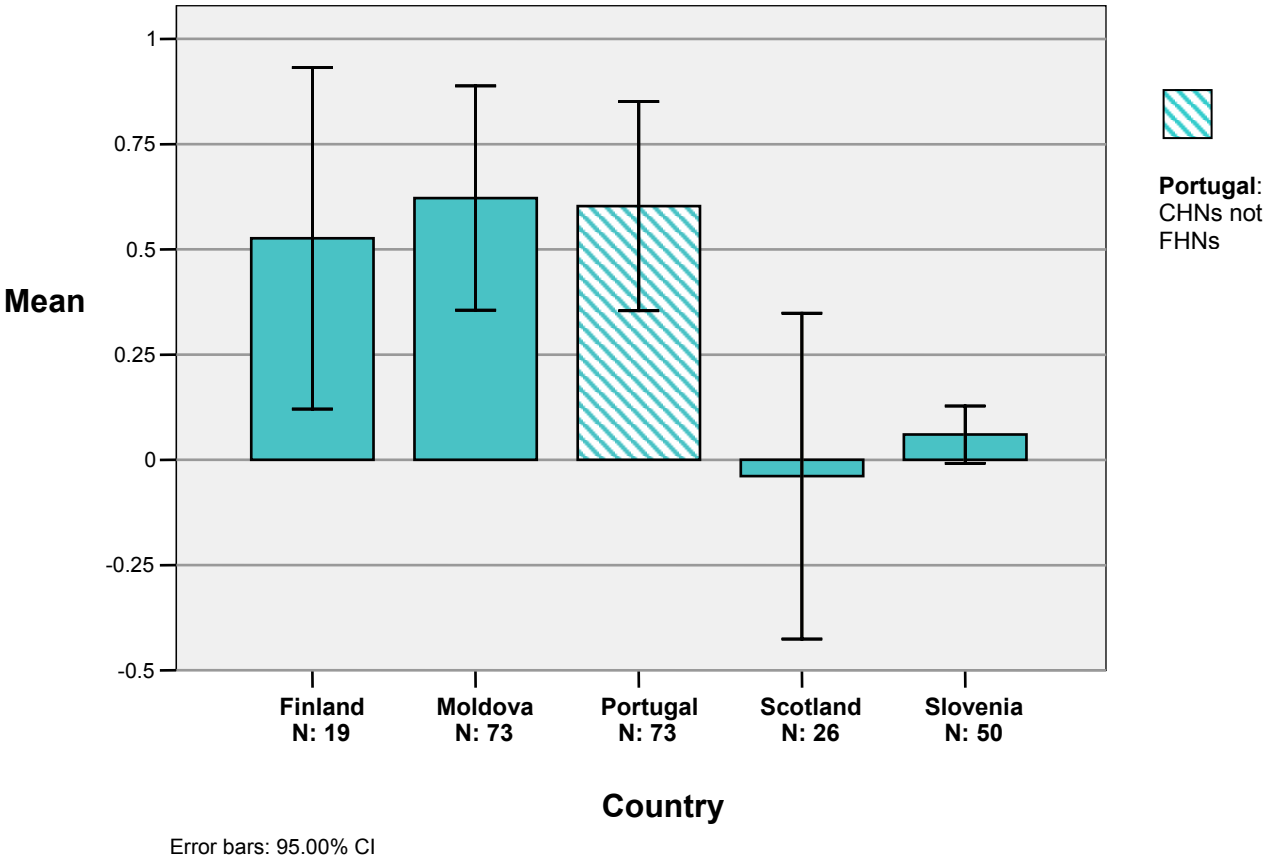
Assessing family health needs is a basic function of the FHN and figure 8.25c identifies the range of responses for the mean score differences between importance and performance of FHNs for this task. Portugal has not implemented the FHN model yet, and so it was not surprising that the family health needs assessment activity produced a wide range of responses. Moldova also produced some inconsistency, which might indicate some work is required on family health needs assessment activities within their FHN implementation. The vast majority of respondents from Finland identified no difference between importance and performance, indicating that FHNs were generally happy with their performance in this area.

Figure 8.41a Difference in Importance and Performance of FHNs in Providing First Point of Contact for Patients



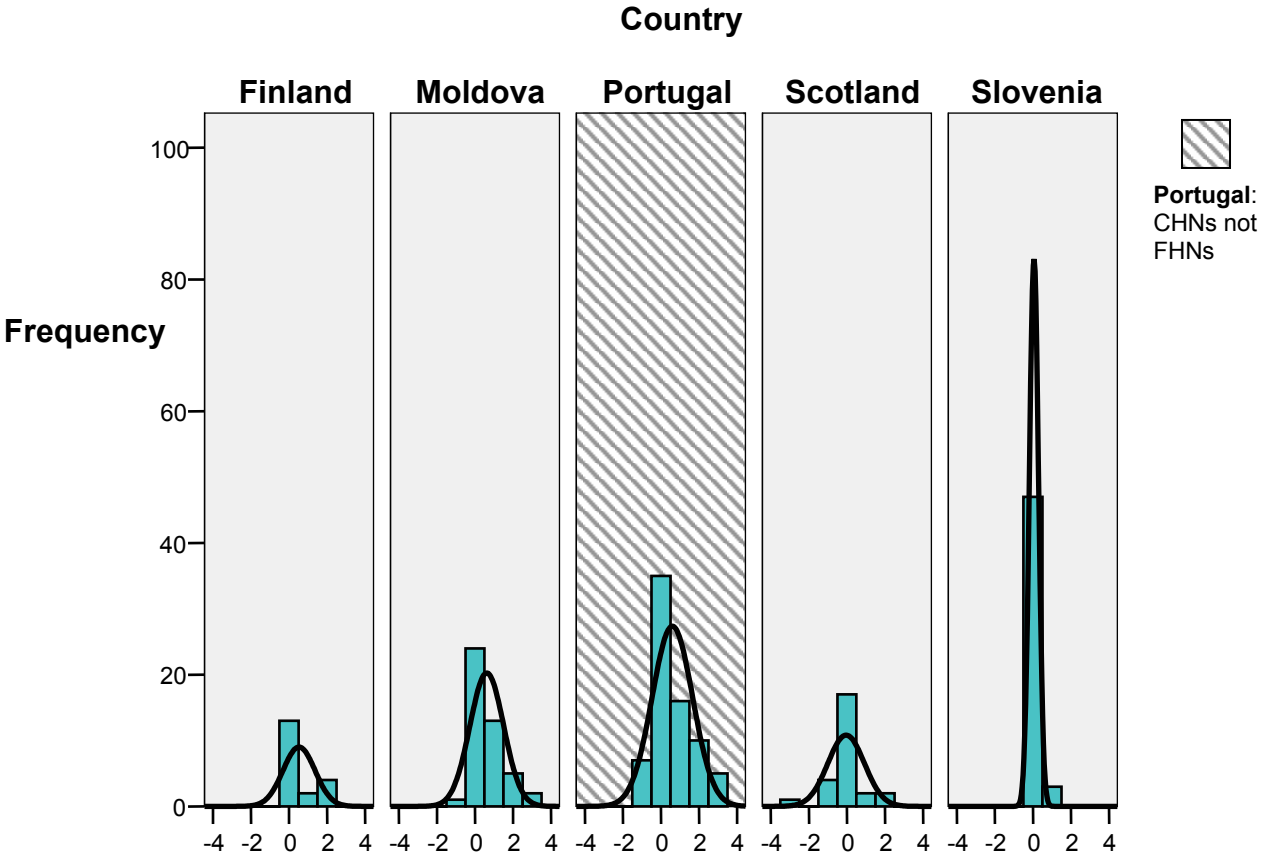
Providing the first point of contact for Patients is a basic activity for the role of an FHN. Slovenia especially shows that it is of crucial importance and both they and Scotland appear to perform this task very well indeed.

Figure 8.41b Difference in Importance and Performance of FHNs in Providing First Point of Contact for Patients



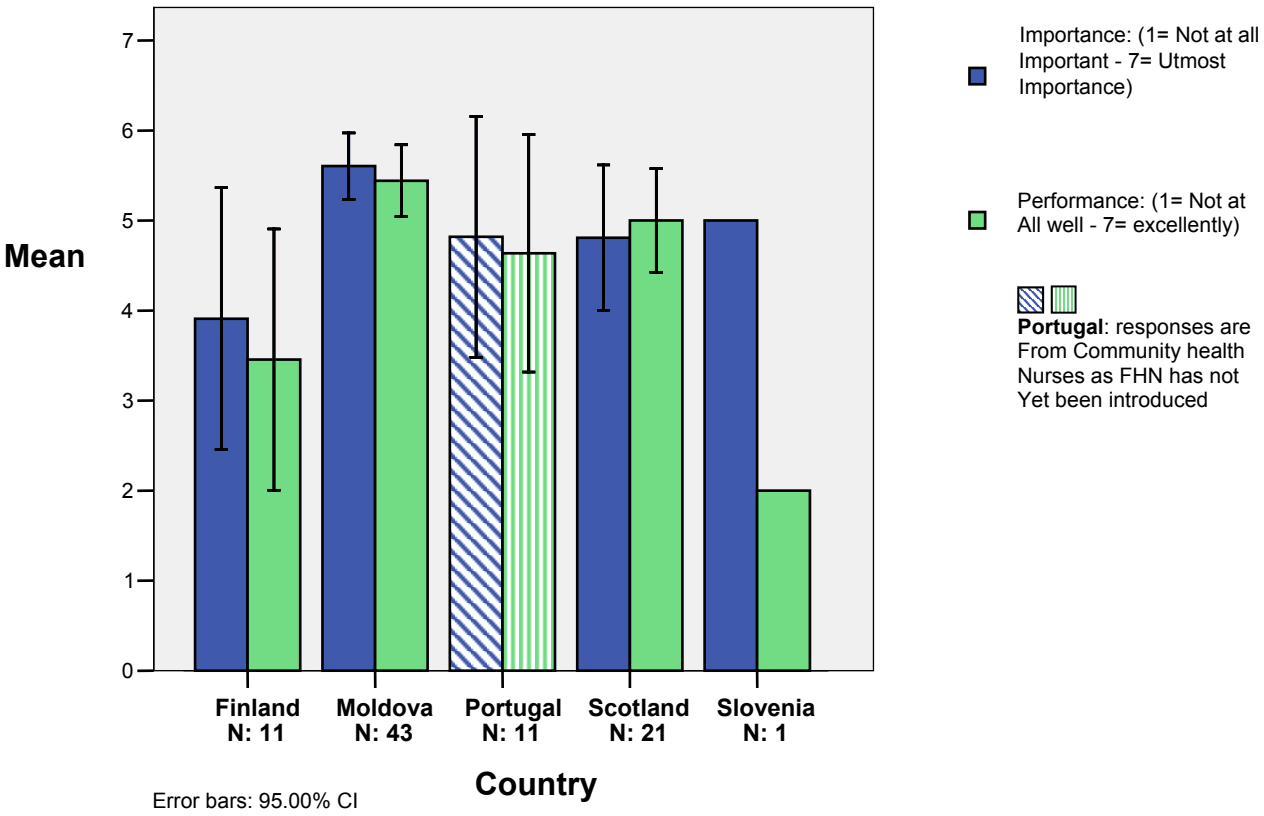
Scotland indicates a negative training need and Slovenia a very small positive training need. This function is one of the major aspects identified in the original WHO vision of the FHN and it is encouraging that these two countries, which have the most well established FHN programmes, appear to recognise the importance of this activity and to perform it well.

Figure 8.41c Difference in Importance and Performance of FHNs in Providing First Point of Contact for Patients



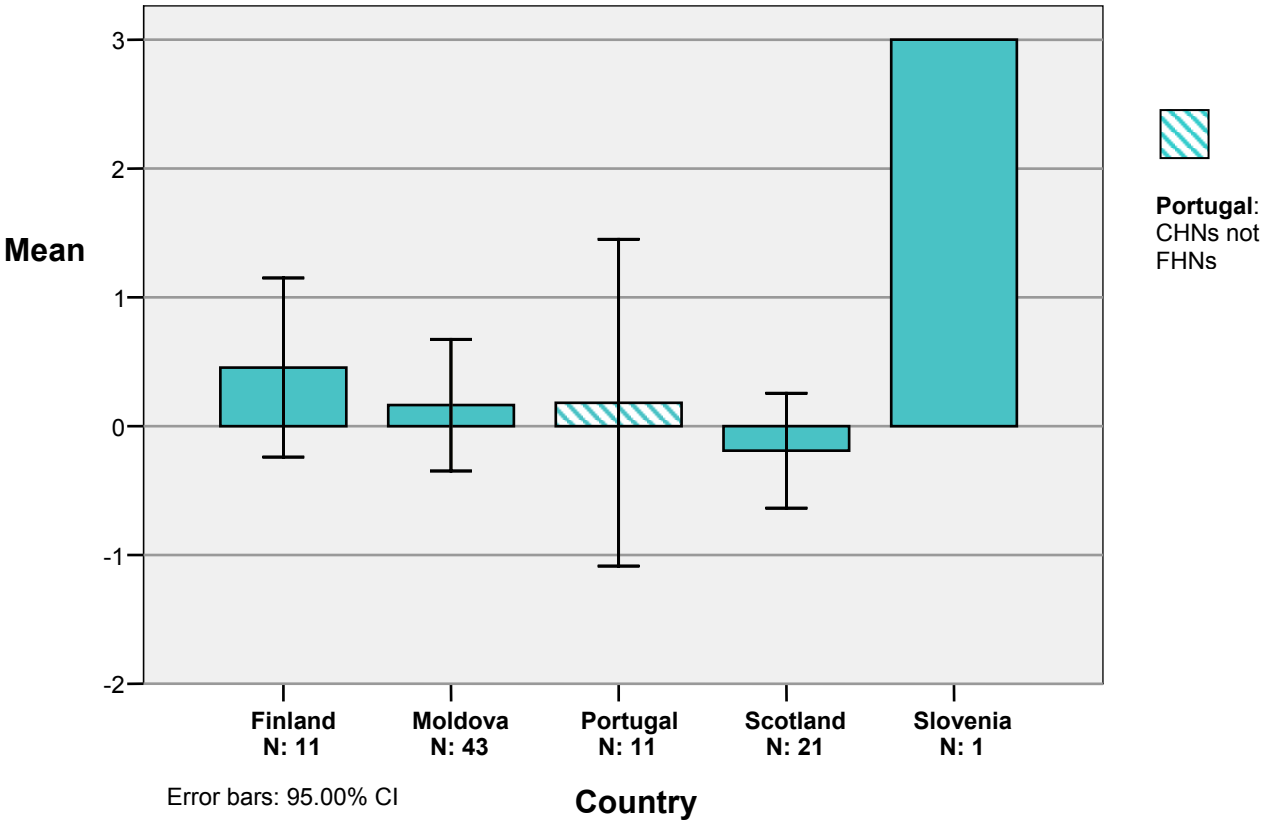
Providing a first point of contact is again a basic activity for the FHN according to the WHO definition. Respondents from Slovenia show a great level of consistency in their assessment of difference between importance and performance – the vast majority of respondents indicate no difference at all, with approximately 4 indicating a small 1 point difference. It would appear that this function is performed well in Slovenia. In addition, Scotland and Finland showed good consistency on this task, and this is probably a reflection of the fact that these three countries have a well-established FHN programme based closely on the WHO concept.

Figure 8.48a Difference in Importance and Performance of FHNs in Substituting for the family Physician/GP



Appropriate *Substitution for the family doctor,* is an activity explicitly identified in the WHO FHN definition. Finland shows that this activity is far less important than in other countries, although it was generally less important than many of the other activities across all countries. All countries except Slovenia felt they performed the activity relatively well, even though it was not necessarily as important an activity as others.

Figure 8.48b Difference in Importance and Performance of FHNs in Substituting for the Family Physician/GP



Substitution for the family doctor is rated as less important than many other activities. Interestingly, Slovenia again demonstrates a large disparity between importance and performance. Finland, Moldova and Portugal all identify an apparently small training need. Finland and Portugal identified this activity as less important than other activities. In contrast, Scotland identified a negative training need in this task.

Substitution for the family doctor has proved a contentious issue in all of the training workshops through the multi-national FHN evaluation phase, and so in the case of Substitution, the responses might reflect something other than a direct training need. Substitution for Doctors is an activity that FHNs are not necessarily encouraged or permitted to do in many countries, despite it being fundamental to the WHO FHN concept. It is likely in this case that it is identified as less important and / or less well performed for this reason.

In contrast, Scotland has a well established FHN model based closely on the WHO model, and has had substitution in some activities (e.g. nurse practitioners, nurse prescribers) for family doctors for some time, especially in rural areas where there are fewer doctors available. Relative success in this activity may also be a reflection of positive public attitudes in Scotland to nurse substitution.

Figure 8.48c Difference in Importance and Performance of FHNs in Substituting For the Family Physician/GP

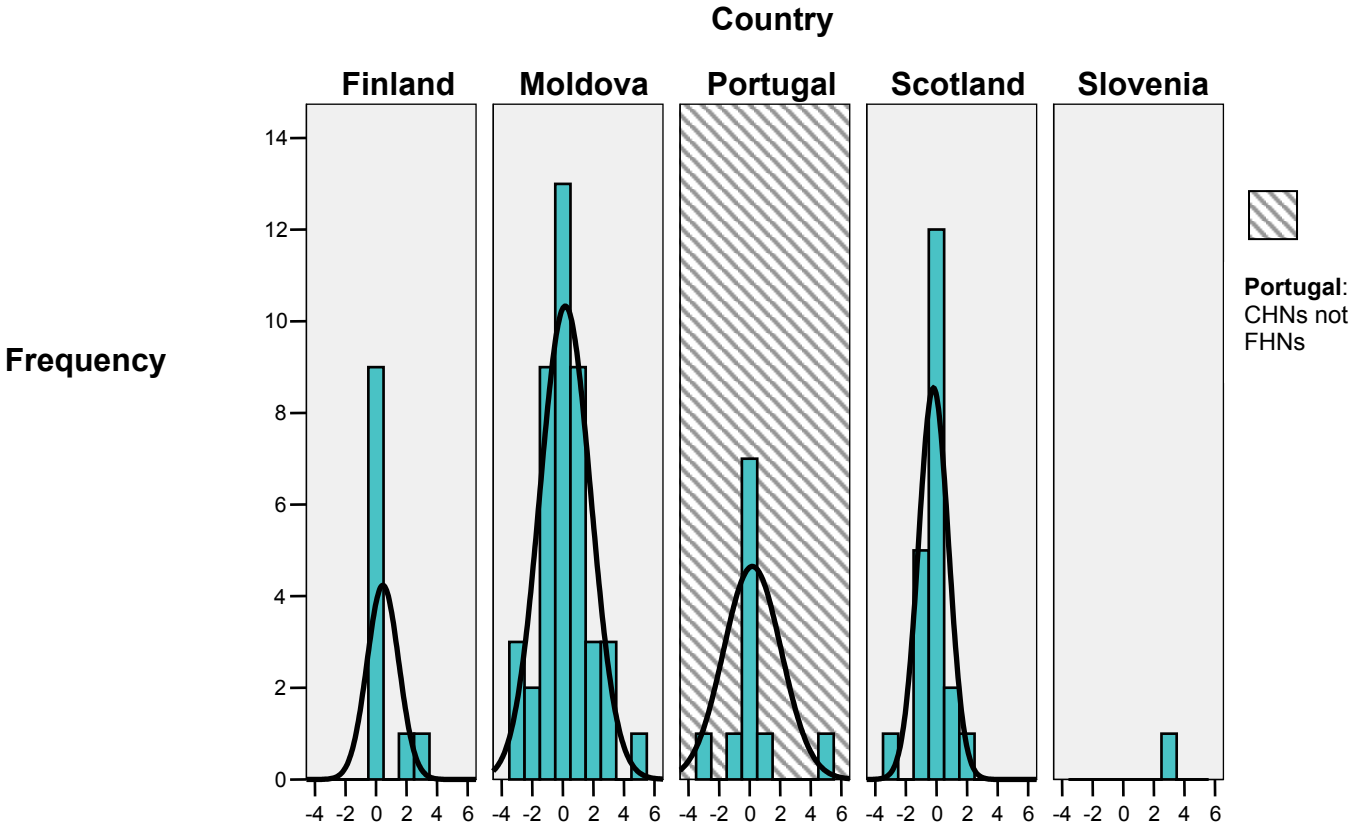


Figure 8.48c identifies the range of responses for the mean score differences between importance and performance of FHNs in *substituting for family doctors*. Again, this is an important task according the WHO vision of the FHN, although in many countries it has proved a contentious issue. Moldova shows a wide range of responses on this issue, with 13 respondents indicating no difference between importance and performance, and 9 respondents each for 1 point difference (importance > performance) and -1 point difference (performance > importance), plus a number of other response ranges between +5 and -3. This might indicate some uncertainty as to this task that requires further investigation. Very few respondents from Slovenia answered this question, which again might indicate some uncertainty regarding this task. Respondents from both Finland and Scotland appear relatively happy with their performance of this role in relation to its perceived level of importance.

8. Discussion and Recommendations

The data received was varied and complex, due in part to different development cycles, to the lack of data received from some areas and the inability of other countries to participate. External factors were important. No data was received from Kyrgyzstan, but the country underwent a major political upheaval during this time, and it is understandable that priorities would have been elsewhere. Armenia made mention of national difficulties outstanding from the earthquake in 2000, and this again would have influenced local circumstances and response to change in the subsequent years. Wider issues do affect progress and achievements, and need to be borne in mind when assessing outcomes.

The regional comparisons that were planned originally have not been possible due to the range of countries taking part.

8.1 Emerging Themes

8.1.1 Context

It is important to highlight how the in-country starting points influence the response to questions about the FHN implementation, in order to provide a realistic interpretation of the findings. Comparisons of country implementation activities and development need to be done in light of their individual circumstances and the point they are at in a change cycle.

The countries participating in the multi-national study were all at very different stages when the FHN implementation programme was initiated by WHO, and during the data collection phase of the WHO FHN multi-national evaluation. They vary considerably, in terms for example, of population size and health and social care priorities, such as access to clean water and household infrastructures (see Chapter 7). This highlights the very different systems into which the FHN model is being implemented. In addition, it is clear that on the basis of their community health nursing services, let alone their wider health system, participants were all at different points in the change lifecycle:

Scotland has 16 different types of nurse working in the community and has had nurses working in the community for 100 years. They started their FHN pilot implementation in 2001 and this was completed in 2003. During 2005 they moved into the second phase of implementation.

Slovenia has had a version of the family health nurse for over 50 years and believes that their model underpinned the WHO definition of the Family Health Nurse. They currently have a very active family health nurse service have adapted their FHN curriculum to the WHO FHN curriculum.

Finland has a well-developed health system, with an established community nursing service, on which the FHN model is building. Their first FHNs graduated during 2003.

Armenia has had a basic FHN programme since 2002. 60 nurses have completed the WHO curriculum-based training and 60 are in training during 2005, with 150 due to undergo training through 2006. An in-country evaluation was planned for the end of 2005.

Portugal has an active community health nurse service and over 50 of these nurses have completed a family nursing course (not based on the WHO curriculum). The country is gradually moving towards a FHN model but has not formally implemented it at this stage. They joined the multi-national evaluation in its latter stages, in order to gain experience and advance research in this area.

Tajikistan has some non-WHO curriculum trained community nurses working and 300 FHNs. It is now concentrating on strengthening the education programmes, having had assistance from Scotland in adapting the WHO curriculum. Over 1000 FHNs are now in training and an in-country evaluation is planned during 2006-2007.

Moldova has 1500 FHNs trained via a short educational programme. They have no other community nurses. 20 FHNs have now been trained according to the WHO curriculum, graduating in 2003 and 87 are in training. An in-country evaluation is planned.

The reasons countries took part in the project were varied and overlapping (Results Table 1.3). For some it was to develop new approaches to rural services or share experiences. For others it was because the family approach matched their health priorities, and for others it was the opportunity to take part in a wider WHO project. These underlying issues will have influenced how the implementation was managed and to what extent it was supported.

8.1.2 Funding

One of the major issues arising from the results was concerns about the long term funding for the FHN service. Funding issues are one of the main obstacles to success in developing PHC services (Hall & Taylor 2003). The FHN implementation phase was funded by the in-country national health budget, and in most countries, no additional external funding was provided for this development. Some of the Central European countries obtained support from external agencies e.g. the World Bank and NGOs. WHO in-country budgets provided some limited support. The progress made indicates the level of commitment to the project from governments and health professionals. However, financial support beyond the implementation stage was much less certain across all countries.

Most FHNs were employed within the existing or newly developing community services, and again rarely were additional funds available. Salaries in relation to new levels of responsibility and ways of working were a common obstacle across all countries, where low salaries were seen as a barrier to recruitment and retention of FHNs. Armenia was the only country to indicate any real improvement in salaries for FHNs. Here, some FHNs were on salaries similar to family doctors, indicating a large shift.

Health insurance issues were identified in several countries. Slovenia noted that better recognition of the potential of FHNs from insurance companies would be helpful, as currently their extended role was not sufficiently recognised

8.1.3 Professional definitions and perceptions of FHNs

The influence of socio--cultural issues was highlighted throughout the evaluation. These include the effect of public perceptions of nursing activity on the ability of FHNs to act as independent and interdependent professionals. As with any change, resistance from users will be a major impediment to its success, and user expectations have to be managed through public education and discussions. In Portugal, public health nurses have been severely under-utilized because

people tend not to access the health system until they are ill and need a doctor. The utilization of nurses aiming to promote healthy lifestyles and reduce behavioural risks is a big cultural shift. This issue applies across all participating countries.

Misunderstandings from the public as to the role and responsibilities of the FHN are widespread, regardless of their level of activity. The multiple responsibilities that the FHNs have for public health and health promotion, as well as caring activities can cause confusion to users and other health professionals. The focus on a multi-skilled, generalist role, as opposed to the specialist systems characteristic of many health systems does pose difficulties. Responses indicate public confusion as to different nurse responsibilities in Scotland, where there are many specialist nurses working in the community and where role definitions have been problematic for many FHNs. In Slovenia this is less of a problem as there are only FHNs working in the community. However, in general the concept of multi-skilled nurses working across public health and care functions has proved an issue across all countries, indicating the need for awareness raising and education.

The extent to which nurses should substitute for doctors where appropriate was another area of contention. In Scotland, nurses have to some degree substituted for doctors for some time. The experience of nurse practitioners and nurse prescribing have promoted acceptance of nurses as taking on some traditionally 'doctoring' roles. In other countries, nursing substitution for doctors is not yet fully accepted, despite it being within the role definition of the WHO FHN. This issue is another area where users will have to be made aware of the potential of FHNs and other nurses, and the benefits and safeguards involved in the expansion of their professional roles

The response from other health professionals is also important, as professional protectionism proved a major obstacle to the functioning of the FHNs within their new role. Nurses from all countries noted some resistance from doctors about their role, and from other health professionals, especially other nurses. This may be due to fear of the impact of changes on their own roles and job security. The passage of time and experience of working with FHNs might be all that is required for these issues to start falling away. However, high level support and raising awareness will be crucial to promote the FHN development during this time.

The approach to the family as the unit of health care is also a factor requiring some degree of perceptual shift. Traditionally, individuals were the focus for health interventions. The focus of the FHN on the family is a challenge to the users, the nursing profession and other health professions.

8.1.4 Education of FHNs

The WHO curriculum identifies core competencies and training requirements. During the initial implementation phase, some countries have used the curriculum in full whilst others have used it as a guidance document and adapted it to local circumstances, whilst attempting to maintain standards. It has been difficult to compare absolute educational and professional developments. As discussed elsewhere, variations on levels of basic education, nursing education, health organization and needs and inter-professional relationships all affect the day-to-day functioning of the FHN role in each country.

8.1.5 Research and ICT

Participating in research and access to research outcomes was a major factor identified throughout the project as well as in the workshops. Simply participating in large-scale project

was in itself a major outcome for countries that had not been exposed to such activity before. Portugal and Moldova were amongst several countries who mentioned the lack of a research culture in their nursing system, and inadequate access to the necessary expertise and ICT infrastructures to develop one. The evidence base in nursing generally is poor, and quality research needs to become part of nursing education and practice.

8.1.6 Networks and Partnerships

Another major theme is the development of networks and partnerships between participants. The workshops were very interactive and feedback indicated that the sharing of experiences and discussion of problems and potential solutions was hugely beneficial. Partnerships that have developed from the cross-national FHN initiative, such as that between Scotland and Tajikistan, are as important an output as any gain in knowledge.

8.1.7 FHN Role Definition

Details about the reality and perceptions of role of the FHN in each country are shown in Chapter 7. The 48 tasks identified in the Standard Questionnaire were drawn from the WHO FHN definition and curriculum. The similarity between countries on the core activities of the role suggests that FHNs are carrying out similar functions, according to the WHO definition. There are variations in what is considered more important in one country than another, and these may be related to structural and process considerations. These have been commented on in the results section.

In those countries that have community health nurses (e.g. Scotland), the role of the FHN is an expanded CHN role. These countries indicated that the FHN has a more holistic role than CHNs, focussing on the family and carrying out multiple tasks for all age groups, covering, health promotion, disease prevention and curative care. All countries included counselling individuals and families in stressful situations as an important task. As the FHN is a new role in most countries the evaluation included a question about how well the FHNs though they were performing on 48 tasks. Again, there was remarkable similarity with some key difference between countries that were discussed in Chapter Seven. In any professional role, continuous education is important. For the FHN this is even more the case, as they lead an isolated professional life working on their own in patients' homes for a considerable part of their daily work. They also have a very wide-ranging role, which requires considerable knowledge and will require regular updating.

The findings from this evaluation, both those in the body of the report, the Appendices and the wider data responses available electronically on CD, can assist individual countries design appropriate continuous education modules which address the training needs (Importance – performance = training need).

8.2 Project Successes

8.2.1 Country involvement

Seven countries took part in the multi-national evaluation itself, and 12 participated in the wider processes of the study, participating in the interactive workshops and providing data through the early stages. Several other countries dropped out due to lack of ministerial support or external factors that prohibited their participation, although many of these have implemented their own FHN programme.

8.2.2 Stages of development

Those who did participate in this final evaluation showed great commitment and enthusiasm, especially with regard to there being no funding provision or dedicated research infrastructure. Many have not yet fully implemented their FHN programmes, either having just started their programme or planning to start very soon. Some have developed a fully functional FHN programme and have moved onto the next stage.

8.2.3 Definition and activities

The definition and activities of FHN do vary slightly across participating countries as each has implemented it within the context of existing circumstances. However, the core concepts and functions are consistent. Regardless of the level and type of implementation, the belief in the potential of the FHN is very strong. There is a commitment to a skilled generalist role – a 'specialist-generalist' for the community environment, with a focus on the family. This belief comes from both the providers and the policy-makers, indicating a level of commitment for change in spite of the challenges faced. The benefits and potential of the FHN role are clear to those who have experienced it in policy and in practice. It is striking that, for a profession used to not being heard and not being part of the decision-making process, the call for FHNs came from within nursing and the FHN has come to fruition in a number of countries with Government and important stakeholder support.

8.2.4 Action research

The WHO FHN multi-national study was pursued along the lines of an action research process, in that it was viewed as a learning process researching *with* participants rather than conducting research on them. The knowledge and experiences shared through the workshops was very exciting and beneficial to all concerned. The workshops, essential for success, were resource intensive and fully dependant on the generosity of the organizers.

8.3 Project Challenges

8.3.1 Time lags and response of participating countries

As discussed elsewhere, the process of international research is complex and fraught with difficulties, which should not be underestimated. The WHO FHN multi-national study operated on several levels and there were external and internal influences that can be seen to have contributed negatively to the outcome. The data collection process and the analysis of complex data were compounded by its late receipt by the research team. In this project, there was additional pressure on participants to translate the tools and guidelines.

The research team were originally commissioned by WHO to conduct the research in 2003, as it was anticipated that the FHN implementation pilots would be well underway by then. In the event, the implementation took much longer in some regions and indeed some countries are still at the very early stages. The data collection was delayed until 2005, in order to allow for the delays in service introductions, but even then, many countries were not as ready as would have been desired. However, it was decided that some evaluation had to take place in order to complete the initial stage of the project and move onto the next stage. The changing timescales demanded new approaches and constant re-adjustments to working schedules. Changes of this

scale are perhaps unrealistic in the timescale originally envisaged, especially for countries where professional nursing as a whole was not highly developed.

The planned intra-regional study was abandoned due to the lack of sufficient suitable countries within each region.

8.3.2 Public Health Timescales

Public health and health promotion are both initiatives where development and outcomes require a long-term perspective. The rapid introduction of the FHN, with its innovative concept of multi-skilled generalist with public health/health promotion functions, as well as specialist care functions, challenges on several levels. It challenges the established perceptions of the role of nurses as health professionals and the barriers between and across the range of health professionals. Ensuring such innovations are accepted and beneficial demands both time and information. There is a tension between implementing services effectively and implementing them rapidly.

8.3.3 Implementing a new nursing services: a case of change management

The implementation of a new community nursing service, which is at the heart of the WHO FHN programme, is initiating a process of change within already dynamic environments. According to Bainbridge *"Change is no longer an irregular outing, an inconvenient upheaval to be undertaken once every ten years. Change is something we have to learn to live with, to structure and to manage. Change is here to stay, and the winners will be the ones who cope with it."* (Bainbridge 1996). Demands arising from developments in technology, legislation, political and social events, globalization, and increased expectation from users, are forcing a change agenda on all health care systems. In order to adapt, systems and organizations have to address multiple operational and procedural factors. The workforce has to be prepared in order to have the skills and knowledge to take on new roles and responsibilities. Social and cultural understandings need to be reshaped to accept and support the introduction of new practices. Infrastructures, reward systems, appraisal processes and roles need redefinition. Leadership practice and management procedures have to adjust, and new ways of working with stakeholders need to be cultivated. Technological advances and capabilities must be introduced, and preparation of the workforce to work with the new IT structures is needed. Importantly, change is a process that unfolds over time, and where a development in one area influences the activity of another. It requires a holistic approach in order to encourage positive outcomes at all levels of activity. Change is a process that engenders fear and uncertainty amongst those exposed, and this needs to be dealt with sensitively in order for it to be a success (ibid, Nadler 1998).

Bainbridge outlined a five-step process of redesign for systems undergoing planned change:

1. The design stage to determine overall requirements
2. The definition stage where the design is specified and documentation of the design stage requirements occurs
3. The development stage, where new capabilities are cultivated through training, education and restructuring
4. The dismantling stage, where redundant parts of the organization are removed or converted into new capabilities
5. The deployment stage, where new capabilities are introduced into the new organizational environment, both internally and externally.

The FHN implementation can probably be viewed as part of the development stage, whereby new capabilities are being developed through training, education and restructuring. It follows therefore, that the subsequent stages need to be pursued in order to complete the change process, and ensure a sustainable outcome.

To be lasting, change must be made through all of layers of an organization, and within the 'players' themselves. It can be an uncomfortable experience, but each member of an organization must be committed to ensure success. Resistance to change is a major barrier; "*Because resistance is so common, learning to overcome it is crucial to managing change at every level*," (Nadler 1998 p. 84). The development or 'transition' stage, where the change process is instigated, must be handled carefully.

The multi-national evaluation of the WHO FHN implementation programmes across Europe has identified many issues pertinent to a change management agenda. The evaluation aimed to assess the implementation of the FHN concept within different health care systems in Europe. The wider context for this implementation is one of fundamental health care reform, in the face of complex health problems, across the region. Nurses and midwives are increasingly being seen as a key resource in these health reform strategies. They form the largest group of health care professionals and work in a wide range of settings. As such, nurses have been identified as having the potential to make a major contribution to the achievements of targets for the 21st century. The shift in health provision in many systems is one of moving from state and professional control to increasing public participation, voluntary and non-government support services and a widening of the scope and activity of health interventions and professional practice.

The FHN model has been promoted as one approach to strengthening the contribution of nursing and midwifery in Europe. The FHN role constitutes a major change within community health nursing, across all countries regardless of their starting point. The countries that have taken part in the multi-national study are all at different stages in the lifecycle of health system change. Each country has a different health service history, and they vary in their approach to the provision of community health services. In addition, each country has adapted the WHO Family Health Nurse definition differently to meet their political and financial circumstances, as well as their health service frameworks. It is clear therefore, that this research could not aim to present a direct like-for-like comparison, but instead tried to highlight comparative themes.

8.3.4 Sustainability

A well designed and managed implementation plan is important for health service interventions, as is long-term sustainability with ongoing research and evaluation. Countries require dedicated funding to initiate innovations on this scale, and the danger is that having implemented the FHN service, the sustainable funding for an ongoing service is not forthcoming. Repeat evaluations are recommended to ensure this does not occur. In addition, recognition that such interventions take time must be mirrored by an acceptance that the evaluation of those interventions also requires time. The biennial system of WHO activity results in a short-term perspective in some areas that do require longer-term activity. The output from this current project is due in the main to the good will and commitment from participants, often within their existing roles without additional resources. The project management demanded flexibility across an extended timescale, and might not have been possible under different circumstances.

8.3.5 Systems view

A systems view of health and welfare is required, as any change in one area will affect others, often in unexpected ways. One issue, which influenced heavily on the project management, was the personnel changes in the nursing directorate at WHO. Through the lifetime of the project, there were three nurse advisors working on it, and, though unavoidable, this caused some disruption to the processes and communication. Having said this, the input from all nursing advisors through the project was staunch and unfailing at every stage.

The results of the multi-country evaluation indicate that the processes of revolution in the form of health systems reform were competing with slower change mechanisms in reaching the full potential of FHN within existing and developing health services. There was some evidence of policy versus practice discrepancy, with different perceptions and understanding of providers and policy makers about the same issues. There is a time lag between policy and practice innovation and this requires a need for flexibility and negotiation. There is a developing research basis for the FHN policy – and there is evidence for the success of the implementation.

8.4 Recommendations

1. An ongoing evaluation of the change process is essential, to assess how countries progress with the next stage and the sustainability of the FHN programme. The implementation of a new initiative is just the first step, and subsequent activity is required to ensure any changes are sustained. The underlying context within which the FHN is implemented will influence the degree and rate of change; all countries must be encouraged to complete their own change cycle. Country progress reports should be encouraged at annual meetings of European Chief Nurses.
2. Funding issues must be addressed in order to establish a sustainable service. Recruitment and retention of nurses is problematic across all countries, and the development of a new role, with wide responsibilities in a period of transition, coupled with perceived low salaries, will cause barriers to the FHN programmes reaching their full potential.
3. The role and responsibilities of FHNs need to be reiterated and disseminated widely. The public and other health professionals both show some confusion as to perceptions of what the role is and how it differs from, and affects others.
4. All countries should scrutinise the findings and make their own decisions about adaptation of their current FHN role, future FHN training needs and continuous education.
5. The research base of nursing and primary care both need to be strengthened. The FHN role demands a wide knowledge base and access to good research on which to build evidence-based practice is essential for its professional development. In light of the technological basis of research information management, a reliable ICT infrastructure is required for this purpose. Participation in other projects would provide good experience for those countries that have not developed a strong research culture internally.
6. The existing links between countries that have developed out of the FHN study should be strengthened and new ones encouraged. Networking and inter-country participation meetings must be seen as an end in itself in international collaboration. It requires resources such as dedicated funding and strategic support

9. Conclusions

The picture to be drawn from the WHO FHN Multi-national study is one of system complexity, where one innovation or activity has consequences elsewhere. Some of these consequences could be anticipated and others could not. The initial implementation of the programme has commenced in many countries across Europe, some of whom participated in the evaluation. Having started on the initial implementation, there is general concern regarding the sustainability of what has developed into an exciting and innovative service.

WHO developed the concept of the role, guidelines for its implementation and a curriculum with which to train nurses as FHNs. The countries were encouraged to participate in the in-country implementations and the multi-country study. Within each country a complicated interaction of policy and practice had developed, influenced by local historical and socio-economic circumstances. As such, direct comparison is problematic, and this report has attempted to identify streams of differences and similarities, which we hope will be of use to nurses and policy-makers.

The most important outputs: the initial implementation processes, the need for sustainability of the FHN role in practice, the need for ongoing research and evaluation to monitor progress, and the importance of FHN education and networking, are clear. The interaction between policy, practice and public perception, as with much health system activity, and its influence on the development of the FHN, is less clear and requires further investigation.

What is also less clear is how and when the themes identified operate. For example, whether the responses given by a country in the evaluation relates to requirements for introduction of the FHN (e.g. Portugal) or occurs because of the FHN implementation (e.g. Scotland) is largely dependent on where the country is or perceives they are in the change and development cycle. Therefore, for example, some countries identified research and IT support as being required for change, others identified it as an outcome of the changes being implemented. The response to questions showed a considerable re-visiting of material within / across respondents and countries, showing that the changes and developments are dynamic, ongoing and evolutionary in nature. It shows that different respondents often see the same issues as both beneficial to the implementation of the FHN and also as barriers to the development and future of the FHN, depending on their status within the cycle of change.

The outcomes suggest that some aspects of the FHN implementation have been acted upon in-country by ‘key movers’ of the model. However, the wider picture has not been sufficiently addressed or disseminated. Importantly, a major message is that longer term consequences and outcomes have not been addressed, or communicated to the providers. Where decisions have been made and disseminated, they are primarily about the initial investments of time and money to instigate change. The necessary commitment required to maintain and sustain the changes are less clear and cause immense concern to those ‘on the ground’. Respondents were concerned that the implementation of the new nursing model is being mistaken for the completion of the change process. Long-term commitment is required to achieve changes in individual, organizational and societal values. Only when this is addressed will the FHN role really achieve its full potential.

10. References

Baker, T.L. (1994), *Doing Social Research* (2nd Edn.), New York: McGraw-Hill Inc.

Bainbridge, C. (1996). Designing for change: A practical guide for business transformation. New York: John Wiley.

Baistow K 2000 Cross-national research: What can we learn from Inter-country comparisons? *Social Work in Europe* 2000: 7(3); 8-13

Crosswaite, C. and Curtice, L. (1994), Disseminating research results-the challenge of bridging the gap between health research and health action. *Health Promotion International* 9: 289.

Dean, S et al 2005. The challenges of cross-national research in primary health care across Europe. *Family Practice* 2005:22; 341-346

De Vaus, D.A. (1993), *Surveys in Social Research* (3rd edn.), London: UCL Press.

Edgecombe G (2001). '*Public Health Nursing: Past and Future: A review of the Literature'*, WHO Europe.

Hall and Taylor 2003. Health for all beyond 2000: the demise of the Alma Ata Declaration and primary health care in developing countries. *Medical Journal of Australia:* 2003; 178, 17-20.

Hantrias L & Mangen S 1996. *Cross-national Research Methods*. Pinter: London

Jurgens, E 2004 '*Priority Programmes: synergy or antagonism*?' Report on the symposium held by **GEO**, standing committee for Health and Development of the NVTG
www.share-net.nl/assets/images/Final_report_Priority_Programmes_6_dec_2004__15_jan_05_.doc
Last accessed January 30 2006

Kekki P 2004. 'Primary health care and the Millennium Development Goals: issues for discussion'. WHO 2004
http://www.who.int/chronic_conditions/primary_health_care/en/mdgs_final.pdf
Last accessed January 30 2006

McHugh, M. & Cotroneo, M. 1999 *Family Health Nurse Concept: What The Literature offers for WHO Europe* (Unpublished document)

Murray & Frenk 2001 World Health Report 2000: a step towards evidence-based health policy. *The Lancet* 357 (May 26).

Nadler, D. A. (1998).*'Champions of change'* San Francisco: Jossey-Bass.

NAP 2001. Cross-national research to help countries prepare for an aging population. National Academic Press. Washington.
http://fermat.nap.edu/books/0309074215/html/index.html
Last accessed 6th February 2006
Ollenshlager, G et al, 2004. 'Improving the quality of health care: using international collaboration to inform guideline programmes'. *Quality and Safety in Health Care* 13 (455-469)

PAHO 2003. *Celebrating 25 years of the Alma Ata Declaration*. WHO Europe
http://www.paho.org/english/dd/pin/alma_brochure.pdf
Last accessed January 30 2006

Polit, D.F., Beck, C.T. and Hungler, B.P. (2001), *Essentials of Nursing Research: Methods, Appraisal and Utilization*. 5th Ed., Philadelphia: Lippincott Williams & Wilkins

Prescott, P.A. and Soeken, K.L. (1999), The potential uses of pilot work. *Nursing Research* 38: 60-62.

Redmond M 2003. Cultural and ethical challenges in cross-national research. *International Journal of Qualitative Methods* 2003: 2(4)

UN 2000 Millennium report of the Secretary-General of the United Nations. WHO Europe.
http://www.un.org/millennium/sg/report/index.html
Last accessed January 30 2006

Saltman R et al 2006. *Primary Care in the Driver's Seat? Organizational Reform in European Primary Care.* European Observatory on Health Systems and Policies Series. Open University Press. Maidenhead, England.

Scottish Executive 2003. Evaluating Family Health Nursing Through Education and Practice. Scottish Executive.
http://www.scotland.gov.uk/cru/resfinds/efht.pdf
Last accessed 6th February 2006.

van Teijlingen et al. 2001 The Importance of Pilot Studies. *Social Research Update.*Issue 35 Winter 2001
http://www.soc.surrey.ac.uk/sru/SRU35.pdf
Last accesses February 6th 2006.

World Bank 2004. The Millennium Development Goals for Health: Rising to the Challenges. World Bank
http://www-wds.worldbank.org/servlet/WDS_IBank_Servlet?pcont=details&eid=000009486_20040715130626
Last accessed February 6th 2006.

WHO 1978 *Declaration of Alma Ata*. WHO Europe.
http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf
Last accessed January 30 2006

WHO 1988 *Vienna Declaration*. WHO Europe.
http://www.euro.who.int/AboutWHO/Policy/20010828_1
Last accessed January 30 2006

WHO 1998 'HEALTH21: Health for all in the 21st Century' WHO Europe.
http://www.euro.who.int/document/HEALTH21/wa540ga199heeng.pdf
Last accessed January 30 2006

WHO 2000a 'Munich Declaration: Nurses and Midwives: A force for health' WHO Europe.
http://www.euro.who.int/eprise/main/WHO/AboutWHO/Policy/20010828_4
Last accessed January 30 2006

WHO 2000b 'The Family Health Nurse: context, conceptual framework and curriculum'. WHO Europe.
http://www.see-educoop.net/education_in/pdf/family_health_nurse-oth-enl-t06.pdf
Last accessed January 30 2006

WHO 2000c 'Financing and Structural Arrangements for the Family Health Nurse' A report of the meeting in Barcelona. WHO Europe.
http://www.euro.who.int/document/e71498.pdf

Last accessed January 30 2006

WHO 2001a Second WHO Ministerial Conference on Nursing and Midwifery in Europe. WHO Europe.
http://www.euro.who.int/document/e73039.pdf
Last accessed January 30 2006

WHO/PAHO 2003 Global Meeting on Future Strategic Directions for Primary Health Care.
http://www.who.int/chronic_conditions/primary_health_care/en/human_resources_en.pdf.
Last accessed January 30 2006

WHO 2003a WHO Family Health Nurse Multinational Study. Report of the Madrid Meeting. WHO Europe.
http://www.euro.who.int/document/e79369.pdf
Last accessed January 30 2006

WHO 2003b Government Chief Nurse Meeting. Report of the Madrid Meeting.
WHO Europe.
http://www.euro.who.int/document/e81508.pdf
Last accessed January 30 2006

WHO 2003c *Primary Health Care: A Framework for Future Strategic Directions.* WHO.
http://www.who.int/chronic_conditions/primary_health_care/en/phc_report_oct03.pdf
Last accessed January 30 2006

WHO 2004a 'What are the advantages and disadvantages of restructuring a health care system to be more focused on primary care services?'. Health Evidence Network. WHO Europe.
http://www.euro.who.int/document/e82997.pdf
Last accessed January 30 2006

WHO 2004b *Munich Declaration: Nurses and Midwives: a Force for Health. Analysis of implementation of the Munich Declaration*. WHO Europe
http://www.euro.who.int/document/e86640.pdf
Last accessed January 30 2006

WHO 2004c The World Health Report 2004: *Changing History*
http://www.who.int/whr/2004/en/report04_en.pdf
Last accessed February 6th 2006.
WHO 2005a. *Health and the Millennium Development Goals.*
http://www.who.int/mdg/publications/MDG_Report_revised.pdf
Last accessed January 30 2006

WHO 2005b WHO Family Health Nurse Multinational Study. Report of the Glasgow Meeting. WHO Europe.

Whyte LA (2000*) Community nursing and midwifery in Europe: Analysis* Nursing and Midwifery Unit, WHO Europe

Wright, L.M., & Leahey, M. 2000. *Nurses and families: A guide to family assessment and intervention* (3rd ed.), Philadelphia: F.A. Davis

Implementation of Family Health Nurse Project Inter-Country Evaluation

Annex 1. The Comprehensive Questionnaire: Part One

Part One is addressed to the FHN Co-ordinator and it contains categories 1-2.

Guidelines for Part One

Category 1. Organisation of the Family Health Nurse (FHN) Study

The purpose **of this category is to find out how the FHN is being organised in each country participating in the European study.**

Questions 1.1 – 1.3 **Please state who is completing this part of the Comprehensive Questionnaire, and whether or not this is the same person as your country's FHN Coordinator.**

Questions 1.4 – 1.10 **This set of questions asks where in your country the FHN sites are located, and then asks for details about the formation and the actions of the multi-disciplinary implementation Group.**

Questions 1.11 – 1.15 **This set of questions asks for details about how the FHN project is being implemented and evaluated in your country.**

Category 2. The Introduction of the Family Health Nurse

The Overall purpose of the category is to find out how the FHN is being introduced in your country and how much it is going to cost the health service.

Questions 2.1 – 2.2 **These questions ask you to describe how the Concept of the Family Health Nurse (as described by WHO) has been modified and interpreted to suit the conditions in your country in regard to the nature and stage of development of your health service.**

Questions 2.3 – 2.4 **These questions ask you about the numbers of FHNs you have in your country.**

Questions 2.5 **Most countries in Europe have had a community nursing service for a number of years. Therefore, you are asked to explain how the new concept of the FHN (as described by WHO) differs from the existing roles in community nursing in your country. If you answer 'yes' to question 2.5 then please move on to answer questions 2.5.1 and 2.5.2. In order to properly evaluate the WHO-FHN role, it is important to be able to tell the difference between this new role, and any previous or still existing community nurse role in your country.**

Question 2.6 **This question is in the form of a chart, which asks you to fill in the specific costs of introducing the FHN against the items listed.**

If you are not the FHN Co-ordinator, please return this part of the questionnaire to your FHN Co-ordinator as directed in the accompanying letter.

On behalf of WHO European Region, we thank you for your co-operation. We very much appreciate the time and effort you have contributed to the success of this study.

Comprehensive Questionnaire: Part One

If a question cannot be completed please explain why in the space for the answer.

Category 1: Organisation of the Family Health Nurse (FHN) Study:

1.1 **Job Title of person/s completing Questionnaire:**

1.2 **Name of Family Health Nurse (FHN) Project Co-ordinator:**

1.3 **Job Title of FHN Co-ordinator:**

1.4 **Please name the Health District(s) or Area(s) of each FHN site in your country:**

1.5 **How many participants are there in the multi-disciplinary Implementation Group?**

1.6. Please list the members of the National FHN Implementation Multi-disciplinary Group		
Representatives from	Number of Members	Actual Job Title/s
Ministry of Health		
Regional Community Nursing Director or equivalent		
Local Community Nursing Director or equivalent		
Family Doctor		
Representative of University Nursing Department or equivalent		
A patient or Lay Person		
A person with skills for the research/ evaluation of health care innovations		
An expert in health economics or health insurance		
Other members		

1.7 **On what date was the Multidisciplinary Group first convened?**

Day Month Year

1.8 **How many times has the group met?**

1.9 **What are the Terms of Reference of the National FHN Implementation multidisciplinary group? Please record below.**

1.10 **Please list the Job Titles of the major Stakeholders supporting the FHN Project, other than those included in the list of Implementation Group members (1.6)**

1.11 **How is the Family Health Nurse Implementation being carried out in your country e.g. through Geographical Implementation Groups?**

1.12 **Are you doing an in-country evaluation of the FHN Site/s?**

Yes **No** (please circle the one that applies)

If you answered 'Yes' to question 1.12, when will you have your results?

If you answered Yes to 1.12, and have already completed this evaluation, please return a copy of your in-country evaluation results with these completed questionnaires to WHO Europe.

In-country evaluation attached: **Yes** **No**

1.13 **How many qualified FHNs are** currently working **in your country?**

1.14 **What date did the first FHN start working in the community?**

Date Month Year

1.15. Who employs the Family Health Nurses? **(Please list all employers)**	
The employers of Family Health Nurses	Number of nurses
Publicly funded agencies • **Hospitals** • **Community Services** • **Doctors** • **Others - please explain**	
Privately funded agencies • **Hospitals** • **Community Services** • **Doctors** • **Others - please explain**	

Self employed	

Category 2. The Introduction Of The Family Health Nurse

2.1 **On what date did you start preparing nurses for their role in the Family Health Nurse Project?**

Date Month Year

2.2 **Please define the concept of the Family Health Nurse within** your **country.**

2.3 **Please explain how it differs from the role of the other nurses who work in the community.**

2.4 **How many Family Health Nurses in total have been prepared for their new roles in** your **country?**

2.4.1 **The number of** qualified **FHNs:**

2.4.2 **The number of FHNs who are** in training:

2.5 **Has your country had a Family Health Nurse role before the introduction of the Family Health Nurse Project?**

Yes **No** (please circle as appropriate)

2. 51 **If you answered 'Yes' to 2.5, please say when and where the FHN role was in place.**

2. 52 **Please give an outline description of the role and include the main responsibilities so that we may see differences between existing FHN roles in your country and the new WHO FHN role that is now being evaluated across Europe.**

2.6 What is the financial cost of the introduction of FHN	
Item 2. 61 Academic Costs	Cost
FHN Course **Student Fees** **Student Bursaries** **Practical field work costs** **Student Transport** **Course accommodation costs** **Course admin costs**	
Preparation of FHN Teachers	
Ongoing costs for FHN teachers	
Preparation of Mentors	
Ongoing costs of mentors	
2. 62 Service Costs	
Salaries of FHNs in field	
Transport of FHNs in field	
Equipment for FHNs in field	
FHN Peer Group Support	
FHN Management costs	
FHN accommodation in field	
FHN administration	
Other costs	

TOTAL COST	

Annex 2. The Comprehensive Questionnaire Part Two:

The National Social, Economic and Policy Context of the Family Health Nurse

Part two is addressed to various senior managers in the Government's Health Department, and contains categories 3 – 7 as follows:

Guidelines for Part Two

Category 3. Country Information

Category 4. Policy Context for the Introduction of the FHN

Category 5. Nursing Preparation

Category 6. Midwifery and Obstetrics

Category 7. The Health System

Category 8. Community Nursing (not including FHNs)

Category 9. Equity and Access to Health Care

Each of these 7 categories has their own guideline. Therefore the different categories can be sent simultaneously to the government department, manager or officer that is most able to provide the information required by the questions.

Guidelines for Category 3: Country Information

The purpose **of this category is to document the epidemiological and socio-economic details of your country. In order to carry out a comparative evaluation of the introduction of the FHN across a number of European countries, it is necessary to know the epidemiological and socio-economic situation of your country as a whole and of each region or province in which the FHN is being evaluated.**

The first question, 3.1 **requires you to name each area in your country in which the FHN project is taking place.**

The rest of the questions in this category (3.2 – 3.16) are placed in a table. **You should first fill in the names of each of your FHN sites in the column headed *FHN Provinces or Regions,* and check that they match your answer to 3.1. You should then give as many answers as you have FHN sites for each of the questions from 3.2 to 3.20. The first answer should be written in the column headed '**National' **and then the answers for each of the FHN sites should be written into the appropriate column. This is illustrated in the example table.**

Example

Information	National	FHN Provinces or Regions[1]			
		Area 1	Area 2	Area 3	Area 4
3.2. Total Population	***Write in the total population for your country***	***Write in the population for this area***	***Write in the population for this area***	***Write in the population for this area***	***Write in the population for this area***
3.3. Annual Birth Rate and so on….	***Write in the annual birth rate for your country***	***Write in the annual birth-rate for this area***	***Write in the annual birth--rate for this area***	***Write in the annual birth-rate for this area***	***Write in the annual birth-rate for this area***

In cases where you do not know the answer to any of these questions, please try and find out by asking someone else working in the relevant government department. If it is not possible to find an answer to any question, please write in the space in the table that the information is not available to demonstrate that the question has not simply been overlooked.

Please return this questionnaire to your FHN Co-ordinator as directed in the accompanying letter of introduction.

The Comprehensive Questionnaire Part Two:

Category 3. Country Information

3.1**.Please name the Province/s or Region/s in which each F H N project is taking place?**

Province/Region- Area 1: **Province/Region- Area 2:**

[1] See Question 2.2 and please complete one column for each Health Area or District.

Province/Region- Area 3: **Province/Region- Area 4:**

Information	National	FHN Provinces or Regions[2]			
		Area 1	Area 2	Area 3	Area 4
3.2 **Total Population**					
3.3 **Annual Birth Rate**					
3.4 **Population numbers:**					
0-5 years					
6-15					
16- 18					
19-65					
66-90					
Over 90					
3.5**. Infant mortality rate**					
3.6**. Maternal Mortality Rate**					
Information	National	FHN Project Areas/ or Districts[3]			
		Area 1	Area 2	Area 3	Area 4
3.7. **What proportion of the GDP is spent on health care?**					

[2] See Question 2.2 and please complete one column for each Health Area or District.
[3] See Question 2.2 and please complete one column for each Health Area or District.

3.8.**What are the top 10 health priorities?**	**1.** **2.** **3.** **4.** **5.** **6.** **7.** **8.** **9.** **10.**	**1.** **2.** **3.** **4.** **5.** **6.** **7.** **8.** **9.** **10.**	**1.** **2.** **3.** **4.** **5.** **6.** **7.** **8.** **9.** **10.**	**1.** **2.** **3.** **4.** **5.** **6.** **7.** **8.** **9.** **10.**	**1.** **2.** **3.** **4.** **5.** **6.** **7.** **8.** **9.** **10.**

Information	National	FHN Project Areas/ or Districts[4]			
		Area 1	Area 2	Area 3	Area 4
3.9 **Is there easy access to essential drugs when needed?**					

[4] See Question 2.2 and please complete one column for each Health Area or District.

3.10 **Total number of children in other forms of residential care**					
3.11 **The Unemployment rate**					
3.12 **The percentage of single parents**					
3.13 **The percentage of Single Person Households**					
3.14 **What are the main types of employment**					
3.15 **What proportions of the population do not have access to clean water?**					
3.16 **Type of Housing:** **What Proportion is rented?** **What proportion is owner occupied?**					

Guidelines for Category 4: Policy Context for the Introduction of the FHN

The purpose **of this category is to understand the background and policy context of the current healthcare system in your country in order to see how the introduction of the FHN relates to this. In other words, why and how has the FHN come to be in your country at this time?**

Question 4.1 **is asking for general information. Please give the main objectives of your healthcare system as a whole over the last 5 years. You are advised to think about what your healthcare system has been trying to do, its main focus of attention and priority, and in which direction it is moving.**

Question 4.2 **is asking for more specific information in relation to the FHN. Please refer back to your answer in 4.1 and identify which of the policy objectives, focus points or priorities have influenced the FHN study in your country. If you think that it was influenced by policies, priorities, or even events that are not part of the general healthcare policy in your country as given in 4.1, please say so and explain your answer.**

Question 4.3 **is still seeking specific information in relation to the FHN by asking you for the *official reason* why your country applied to participate in the WHO FHN study. Such information will be available in your country's formal written application to WHO, and you could either transfer the information in answer to this question, or you could attach a copy of the application form to the questionnaire.**

Question 4.4 **is asking you for your *personal views* as to why you think that your country applied to participate in the WHO – FHN study. Please explain why you think that your country needs to have a FHN service. You are advised to think along the lines of what will the FHN do for your country's healthcare system, in terms of meeting the needs of patients and families.**

Please return this questionnaire to your FHN Co-ordinator as directed in the accompanying letter of introduction.

On behalf of WHO European Region, we thank you for you co-operation. We very much appreciate the time and effort you have contributed to the success of this study.

The Comprehensive Questionnaire Part Two:

Category 4. Policy context for introduction of FHN

4.1 **Over the period of the last 8 years (since 1997) what have the main health policy objectives been in your country?**

4.2 **Which of the health policy objectives mentioned in 4.1 above have influenced the introduction of the FHN in your country?**

4.3 **Why did your country apply to participate in the WHO FHN Study?**

4.4 **Why do you think that your country needs the FHN service?**

Guidelines for Category 5: Nursing Preparation

The purpose **of this category is to gather information about the basic and post-basic preparation of general nurses and of community nurses.**

It is important to note **that some questions exclude the FHN while other questions include the FHN.**

Questions 5.1 to 5.4 **are asking for general information about how nurses are prepared in your country** excluding the FHN**.**

Questions 5.5 to 5.7 **are asking for information about how community nurses are prepared** excluding the FHN**.**

Questions 5.8 and 5.10 **are asking for information about the number and gender of nurses in your country and these** include the FHN**. However, please note that Q**uestion 5.9 **is asking for the total number of nurses working in the community *before* the FHN was introduced.**

Please return this questionnaire to your FHN Co-ordinator as directed in the accompanying letter of introduction. On behalf of WHO European Region, we thank you for you co-operation. We very much appreciate the time and effort that you have contributed to the success of this study.

Category 5. Nursing preparation

5.1. Average School-leaving age in your country

.

5.2 The level of minimum basic nursing qualification studies	
Basic Qualification	% of total nurses with level of qualification indicated
Certificate	
Diploma	
Degree	
TOTAL qualified nurses	

5.3 Normal academic entry requirements for nursing qualification studies	
Basic Qualification	Normal entry requirements Number of years schooling and minimum age
Certificate	
Diploma	
Degree	

5.4 The length of basic nursing education	
Qualification	Length of study for qualification (number of years)
Certificate	
Diploma	
Degree	

5.5 **Is there a specific educational preparation for nurses (who are** not **Family Health Nurses) to work in the community?**

Yes **No** (please circle the answer that applies)

If you answered 'Yes' **to Question 5.5 please complete Question 5.6 and continue to answer all questions.**

If you answered 'No' **to Question 5.5 please go straight to Question 5.7 and then continue to answer all questions.**

5.6. Educational preparation to work as a nurse in the community (not FHNs) (please complete the questions)		
Level of education	Yes /No	Not required
Certificate		
Diploma		
Degree		
Other please explain		

5.7 **Are community nurses (**Not **FHN's) required to have any other experience apart from the education noted above before appointment? Please comment.**

5.8. What is the total population and gender of all nurses (including FHNs) working in the country? (Both hospitals and community)		
Number of female nurses	Number of male nurses	Total of all nurses

5.9. What was the country's total population of nurses working in the community *before* the FHN was introduced?		
Number of female nurses	Number of male nurses	Total of all community nurses

5.10. What is the country's total population of nurses working in the community including the FHN?		
Number of female nurses	Number of male nurses	Total of all community nurses

Guidelines for Category 6: Midwifery and Obstetric Nursing Care

The purpose **of this category is to gather information about midwifery and obstetrics. Since these services are related to the role of the FHN, this information will add to the general background in which the FHN is being developed in your country.**

Question 6.1 **is straightforward in asking you to provide some general information about the midwifery and obstetric services in your country.**

Question 6.2 **is trying to find out how many, and what kind of health care practitioners are contributing to provision of the maternity and obstetric services. Please look carefully at the table for question 6.2. The rows represent the different types of maternity or obstetric care, while the columns represent the different types of practitioners that provide the care.**

For example, in row 1 you should 'tick' which practitioners, obstetrician, family doctor, midwife etc. provide antenatal care. The same applies to the other rows. In the columns headed 'health professional' and 'non-health professional' please write in the exact title of the practitioner providing the care and include non-qualified midwives. In respect of other health professionals, these could include qualified nurses working in maternity/obstetric care who are not qualified midwives.

Please return this questionnaire to your FHN Co-ordinator as directed in the accompanying letter of introduction.

On behalf of WHO European Region, we thank you for you co-operation. We very much appreciate the time and effort that you have contributed to the success of this study.

The Comprehensive Questionnaire Part Two:

Category 6. Midwifery and Obstetrics

6.1. Location of all births in the country	Number of Births
Number born at home	
Number born in polyclinics, hospitals, nursing homes	
Do you have midwives?	
Do they work in the community?	

6.2. Who else provides maternity or obstetric care?					
Type of care	Obstetrician	Family Doctor	Midwife	Other Health Professional	Non - Professional Workers
Antenatal care					
Deliveries					
Postnatal care (Hospital-based)					
Postnatal care community/ surgery or polyclinics					
Postnatal care in own or family homes					

Guidelines for Category 7: The Health System

The purpose **of this category is to understand how the health system is structured and functions in your country. Health systems vary among the countries of Europe where the FHN is being studied. It is very important that the FHN is evaluated within the right context so as to make a realistic and useful cross-country comparison.**

Question 7.1 **Please explain the services that each of the healthcare facilities are actually providing. Each row in the table represents a particular healthcare facility, acute hospital, small hospital, nursing home, etc, while each column represents a particular type of healthcare service that could be provided by a particular facility. For example, follow along row 1 and tick in the boxes as appropriate to indicate whether the large acute hospitals provide surgery, medicine, etc.**

There will be a marked variation of service provision both within and between countries. Not all facilities of the same type will provide the same services. For example, not all large hospitals will provide accident & emergency, or rehabilitation, and some small hospitals may provide surgery while others do not. If this is the case, you should tick the boxes according to the most usual pattern. If for example, most large hospitals provide accident & emergency, then you should tick the box, and then make a note of the variation in the last column head 'COMMENT'.

In regard to hospitals there may be differences between those that provide mostly acute services and those that provide continuing or long-term care, which may be called 'cottage' or 'community' hospitals. Further, it is possible that 100-bed hospital is not considered large in your country, or that those hospitals providing continuing/long-term care have more than a 100 beds. If this is the case, or there are other variations in your country, please make a note of this in the last box of column 1 under 'other', and in the column headed 'COMMENT' as you think to be the most appropriate one to use for what you have to say.

Question 7.2 **The broad categories of how healthcare systems are funded in Europe are as follows:**

- **State Funded Health System: mainly from general taxation**
- **State Funded Health System: mainly from national insurance**
- **Private Health/Medical Insurance**
- **Direct Payment by Patients**

Please say how your health service is predominantly funded. If it does not fit into these categories, then please explain in the column for 'other methods of funding' how your health service is funded. Please give the total cost of your health service in the last row.

Question 7.3 **Please state the proportion of the Gross Domestic Product (GDP) that your country spends on healthcare. Most countries publish the percentages of GDP spent on healthcare along with that spent on other this such as defence, transport etc.**

Question 7.4 **Please say how general practitioners or family physicians are paid in your country**

Question 7.5 **Please give the total number of general practitioners or family physicians.**

Please return this questionnaire to your FHN Co-ordinator as directed in the accompanying letter of introduction.

The Comprehensive Questionnaire Part Two:

Category 7. The Health System

7.1. What kind of health services do each of the healthcare facilities in your country provide?
In table 12, please place a tick in the boxes that match services to facilities and list other services and facilities you have in your country that are not listed in the 'other' columns.

HEALTH-CARE FACILITY	Surgery	Medicine	Obstetrics	Rehabilitation	Mental Health	Accident & Emergency	Other Services Provided (Please specify)	COMMENT **Please make a note in this column if the services in your country do not fit the pattern in this table.**
Large Acute Hospitals: >100 beds								
Small Hospitals: <100 beds								
Residential Institutions e.g. nursing homes, long-stay etc.								
Healthcare Clinics								
Polyclinics								
Home Visiting Services								
General Practitioners or Family Doctors								
Other healthcare facilities: Please specify								

7.2. How is your health service funded?	
Type of Funding	What proportion of your health service is funded in this way?
State Funded Health System: mainly from general taxation	
State Funded Health System: mainly from national insurance	
Private Health/Medical Insurance	
Direct Payment by Patients	
Other Methods: please explain	
Total Cost of Health Care Service	

7.3 What proportion of your Gross Domestic Product (GDP) is spent on health care?

7.4. How are General Practitioners or Family Physicians Paid?	
Type of payment	Number of General Practitioners or Family Physicians paid in this way
State (i.e. paid by public funding from taxation or national insurance)	
Private Medical/Health Insurance	
Paid Directly by the Patients	
Other forms of Payment: please specify	

7.5 What is the total number of General Practitioners or Family Physicians that work in your country?

Guidelines for Category 8: Community Health Nursing (Excluding FHNs)

The Purpose **of this category is to gather information about the way in which the community nursing service works in your country. In order to fully understand the impact of the introduction of the FHN and how it will fit in with the existing services. Please note, however, that this category does not seek information about the concept of the FHN itself; or about the policy and practice of the FHNs as they are being introduced in the present.**

Question 8.1 **Not all countries have community nurses, so if you answer 'No' to this question then you need go no further with this category. If you answer 'Yes', then please continue with the rest of the questions.**

Question 8.2 **The following types of community nurses are common in most countries that have a community nursing service:**

- **General Nurse This is a qualified nurse who provides mainly curative type care to people in his or her own homes and in local clinics. Other names include:**
  - **Visiting nurses**
  - **District nurses**
  - **Home nurses**
- **Public Health Nurse This is a qualified nurse who provides mainly preventive type care for people in their own homes, local clinics, schools and in public health offices. Also, they are concerned with maternal and child health (MCH), epidemiology and health promotion. Other names include:**
  - **MCH nurse**
  - **Health Visitor**
  - **School nurse**
- **Generic or Combined Duties Nurse This is a qualified nurse who combines the practices the general nurse and the public health nurse in equal measure in the same role.**
- **Specialist Nurse This is a qualified nurse who provides specialist care to people in their own homes, in local clinics and also in acute healthcare facilities such as hospitals. They often work across the boundary between primary and secondary care and can be employed by either sector. In addition, they provide a resource of specialist knowledge to other nurses working in the community. Their specialism may be based on a disease entity such as cancer or diabetes, on a care area such as a paediatrics, or on a particular practice such as the care of stomas. Specialist nurses include:**
  - **Home care paediatric nurse**
  - **Diabetic care nurse**
  - **Cancer care nurse**
  - **Parkinson's disease or other particular diseases such as strokes**
  - **Stoma care nurse**
  - **Continence advisor**
  - **Rehabilitation nurse**

Question 8.2 **is to identify the different types of community nurses. In column 2 of the table please record the exact titles of the nurses you have working in your country against the general types given in column 1. And then, in column 3, please write in the numbers of each type against the title.**

Question 8.3 **Please state who employs the different types of community nurses. The possible employers have been divided into three categories; publicly funded agencies, privately funded agencies and self-employed, which are listed in column 1. Please write in the titles of the community nurses you have identified in question 8.2 against the correct employer in column 2 of question 8.3.**

Question 8.4 **asks you to say whether or not you have any information about users' views.**

Question 8.5 **If you answered 'yes' to question 8.4, describe what this information consists of by making a list of the type, title and dates of reports in the table provided.**

Question 8.6 **Please give a summary of the results of the information (with reference sources) that explains what patients and users think about their community nursing services in the table provided.**

Please note, questions 8.4 – 8.6 are requesting information that does NOT **include the FHNs.**

Please return this questionnaire to your FHN Co-ordinator as directed in the accompanying letter of introduction.

On behalf of WHO European Region, we thank you for you co-operation. We very much appreciate the time and effort that you have contributed to the success of this study.

The Comprehensive Questionnaire Part Two:

Category 8. Community Health Nursing (excluding FHNs)

8.1. Do you have nurses (not including FHNs) who work in the community?

Yes **No** (please circle the answer that applies)

8.2. How many Nurses work in the community?
(Please complete all titles and numbers according to the guidelines on page 17)

Types of Community Nurses	Actual Titles of Community Nurses of Each Type	Number of Nurses of this Title.
General Nurses		
Public Health Nurses		
Generic or Combined Duties		
Specialist Nurses		

8.3. Who employs the community nurses who work in the community (not including FHNs)? **(Please fill in the titles of the community nurses you have identified in Question 8.2 in Column 2 against the possible employers in column according to the guidelines)**	
The Employers of Community Nurses	Titles of Community Nurses Employed
Publicly Funded Agencies • **Hospitals** • **Community Services** • **Doctors** • **Other (please specify)**	
Privately Funded Agencies • **Hospitals** • **Community Services** • **Doctors** • **Other (please specify)**	
Self Employed	

8.4. Do you have information about how patients and users view the community nursing services (not including FHNs)?

Yes **No** (please circle the answer that applies)

8.5 If you answered 'yes' to question 8.4, please make a list of what the information consists of. This should include the type, e.g. a research report, survey, review etc, and its title and date**.**		
Type of Information	Title	Date

8.6 Please summarise the views of what patients and users think about their community nursing services. *Please note that does not include the FHNs*.		
Summary of Patients/Users Views of the Community Nursing Services	References of the Source of the Views Given	Date of the Reference

Guidelines for Category 9: Equity and Access to Health Care

The purpose **in this category is to obtain information about the extent and nature of variations in access and equity in healthcare provision. Previous research has shown that health inequalities exist in most countries in Europe, including those with the most developed healthcare systems. As the FHN develops across Europe, it will become important to evaluate it in terms of how the introduction of the FHN affects health inequalities.**

Questions 9.1 – 9.2 **are first asking you to say whether or not there is unequal access to healthcare in your country, and then to explain how access is unequal, which services are affected and where in the country this happens.**

Questions 9.3 – 9.4 **are asking the same thing but in respect of unequal provision of healthcare.**

Questions 9.5 – 9.6 **is asking you to say whether or not people may access the community nursing service directly themselves, or whether they have to be referred by another agency or professional. In other words, is there direct public access to community nurses or are they guarded by a professional gatekeeper such as a hospital, a general practitioner or a social worker?**

Please return this questionnaire to your FHN Co-ordinator as directed in the accompanying letter of introduction.

On behalf of WHO European Region, we thank you for you co-operation. We very much appreciate the time and effort that you have contributed to the success of this study.

The Comprehensive Questionnaire Part Two:

Category 9. Equity and Access to Health Care

9.1 **Does everyone in your country have equal access to all services that are provided?**

Yes **No** (please circle the answer that applies)

9.2 **If you have answered 'Yes' to question 9.1, please explain what kind of unequal access takes place and include where this is in the country, and which services are affected.**

9.3 **Are the community health and primary care services provided on an equitable basis throughout your Country?**

Yes **No** (please circle the answer that applies)

9.4 **If you answered 'yes' to question 9.3, please explain what sort of variations in service provision take place, and where these are the country.**

9.5 **Can members of the public without reference to any other person, gain direct access community nurses (not FHNs) in order to obtain the care they need?**

Yes **No** (please circle the answer that applies)

9.6 **If you have answered 'no' to question 9.5, who are the gatekeepers to the community nursing service?**

9.7 **Are any of the areas you have named in the previous questions in category 9 as being places where health inequalities exist the same as those areas that have been listed as the sites of the FHN in answer to questions 3.1?**

Yes **No** (please circle the answer that applies)

9.8 **If you have answered 'yes' to question 9.7, please list the areas that are both a site for health inequalities and for the FHN studies.**

Annex 3. The Comprehensive Questionnaire: Part Three

The Educational Preparation of Family Health Nurses (FHN)

Part three is addressed to the directors and teachers in academic departments that carrying out the training and education of family health nurses according to the specifications and guidance of the WHO European Regional Office in Copenhagen
This part contains only one category:

Guidelines for Part Three

Category 10: Educational Preparation of FHNs.

Question 10.1 **is asking you to record how candidates are selected to take the FHN course.**

Question 10.2-10.3 **is asking you to provide details of the numbers of FHNs trained and the type of course they undertake.**

Questions 10.4 – 10.6 **This set of questions is asking you about the number and nature of practical placement as part of FHN preparation, and about any inputs that contribute to, but are not part of, the academic preparation.**

Question 10.7 **requires a simple yes/no answer regarding the use of the FHN assessment tool in the preparation of FHNs.**

Questions 10.8 – 10.13 **This set of questions is asking you to explain the use of fieldwork mentors in the preparation of FHNs.**

Questions 10.14 – 10.17 T**his final set of questions is asking you to explain the methods of quality control and audit that have been set up to assess the quality and effectiveness of the preparation for FHNs.**

Curriculum for the Preparation of FHNs.

Questions about the details of your written curriculum for preparing FHNs (and about how this varies from standard curriculum written by the WHO European Regional office) have been omitted on the expectation that you could provide a copy of your curriculum. Therefore, *please could you attach a copy of your country's FHN curriculum to this questionnaire when you have completed it*, and then return both to you national FHN Coordinator. This will spare you from having to give lengthy answers to questions about details that are already documented.

Please return this questionnaire to your FHN Co-ordinator as directed in the accompanying letter of introduction.

On behalf of WHO European Region, we thank you for you co-operation. We very much appreciate the time and effort that you have contributed to the success of this study.

The Comprehensive Questionnaire Part Three:

Category 10. Educational Preparation of FHNs.

10.1 **What are the admission criteria for the FHN training Course? Please explain and give details**

10.2. What kind of educational preparation do FHNs have for their new roles?			
Type of Course	Number of Courses	Duration of course	Number of FHNs trained
Full time			
Part-time			
Long distance			
Other types (Please record and explain)			

10.3 **Did the FHNs receive other preparation for their new role apart from educational courses?**

Yes **No** (please circle the answer that applies)

10.4 **Please explain what preparation the FHNs received for their new role apart from educational courses. Please summarise below.**

10.5 **Do the FHN students undertake practical work in the community while on the FHN Course?**

Yes **No** (please circle the answer that applies)

10.6 **Please provide details of the practical work in the FHN Course.**

10.7 **Have your FHNs been trained in the use of the FHN assessment tool?**

Yes **No** (please circle the answer that applies)

10.8 **How are the teachers being prepared to teach the academic and practical aspects of the FHN Course? Please explain below.**

10.9 **Do the FHNs have mentors in the field?**

Yes **No** (please circle the answer that applies)

If you answered yes **go to the next question. If you answered** No **please go to Question 10.13.**

10.10 **Do FHN students have learning objectives for their clinical experience in the field?**

Yes **No** (please circle the answer that applies)

10.11 **Have the mentors been taught about the expected role of the FHN?**

Yes **No** (please circle the answer that applies)

10.12 **How were the mentors prepared for their role?**

10.13 **What structures have been set up for peer group support for the FHN? Please explain.**

10.14 **Do the FHN Courses have quality control measures?**

Yes **No** (please circle the answer that applies)

If you answered Yes **go to the next question, if you answered** No **please go to question 10.16**

10.15 **Please explain the FHN Educational Course quality control measures.**

10.16 **Have you introduced an external Audit System for your FHN Course?**

Yes **No** (please circle the answer that applies)

10.17 If you answered '**Yes'** to the last question please explain the FHN Course External Auditors audit?

Please do not forget to attach a copy of your

FHN curriculum to this completed questionnaire – thank you.

Annex 4. The Comprehensive Questionnaire: Part Four

The Role, Responsibilities and Effectiveness of the Family Health Nurse

Part Four is addressed to the directors of nursing of the FHN sites with the request that they lead a team of the FHNs in post and other stakeholders for the purposes of completing this questionnaire.

This final part of the comprehensive questionnaire gathers information about how the FHN role is developing. This is necessary information to the success of the inter-country evaluation. It consists of 3 categories as shown below.

Guidelines for Part Four

Part Four Categories:

Category 11. **The Work of the Family Health Nurse**

Category 12**. Changes to the Healthcare System Caused by Introducing the FHN**

Category 13. **The Effectiveness of the Family Health Nurse**

Each category contains a range of questions that require contributions from varied local stakeholders. Directors of nursing are advised to complete the bulk of the questionnaire with the FHNs in post, **either individually or as a group, and then to seek the opinion of other stakeholders as appropriate to each question. In practical terms, the local FHN implementation group can probably complete the questionnaire during one, or a series, of its regular meetings.**

Category 11. The Work of the Family Health Nurse

Question 11.1 – 11.3 **The director of nursing should complete these questions, about how the FHN is working in daily practice, with the assistance of the FHNs in post.**

Question 11.4 **in answering this question, about how others view the role of the FHN, the director of nursing should seek the views of 'significant others', whose perceptions and views of the FHN role are important to its evaluation and development. There is a space in the last row for you to add others that are 'significant' in your area. Please fill in the views held by the significant others in column 2 of the table provided.**

Question 11.5 **Please explain how you actually obtained the information you have provided in answer to question 11.4**

Question 11.6 **simply asks you to say whether or not you have any information about patients' and users' views about the new concept of the FHN.**

Question 11.7 **If you answered 'yes' to question 11.6, describe what this information consists of by making a list of the type, title and dates of reports in the table provided.**

Question 11.8 **Please give a summary of the results of the information (with reference sources) that explains what patients and users think about the new concept of the FHN in the table provided.**

Question 11.9 **is a simple yes/no question best answered by the directors of nursing after checking the reality with the FHNs. It is about whether patients and users have direct access to the FHNs or whether they have to be referred through a 'gatekeeper'.**

Category 12. Changes to the Healthcare System Caused by Introducing the FHN

Question 21.1 **This is the only question in this category. It will need to be answered by the director of nursing in consultation with the FHNs and the local stakeholders. It concerns the changes to the health system that have occurred as a result of the introduction of the FHN. Column 1 lists the changes that may have occurred, while the last row has been left free for you to add in any other changes that have occurred to the health system in your area. Please would you explain each change that has occurred in column 2 against the change listed in column 1.**

Category 13. The Effectiveness of the Family Health Nurse

In this category, information about how effective the FHN has been, or is likely to be, in addressing health inequalities is required. In addition, information about how the introduction of the FHN has specifically affected the health of patients and families is sought.

The questions here are best answered by the directors of nursing in consultation with the FHNs.

Question 13.1 **first asks you to state whether or not you collect information about the effects of the FHN on the health of families. If you do collect such information, the following questions ask you to describe the information collected, with explanations as to why and how this is expected to measure the effectiveness of the FHN.**

Question 13.2 **is about how the FHN has affected equality of access to services.**

Question 13.3 **is about how the FHN has affected the quality of services.**

Question 13.4 **in this final question please summarise all the information you have collected so far about the introduction of the FHN in order to provide an overall picture of how the FHN is developing in your area, which should include the effects on the local services.**

Please return this part of the questionnaire to your FHN Co-ordinator as directed in the accompanying letter of introduction.

On behalf of WHO European Region, we thank you for you co-operation. We very much appreciate the time and effort that you have contributed to the success of this study.

The Comprehensive Questionnaire Part Four:

Category 11. The work of the FHN

11.1. Please describe the work of the Family Health Nurse in a typical week
(Include interactions with other health and social care professionals and other community based support services and with the community itself)

11.2**.**Please summarise the agencies to which an FHN could refer a patient directly

11.3 How does the new FHN service fit or connect with existing services? Please explain**.**

11.4 How do others view the role of the FHN?	
Others	Views (please summarise)
Other community nurses	
Family Doctors	
Hospital Doctors	
Community based support services Social Services **Voluntary organisations** **Others**	

11.5 How did you get the information in Question 11.4?

11.6 Do you have information about how the users (families and Patients) view the FHNs?

Yes **No** (please circle the answer that applies)

11.7 If you answered 'yes' to question 11.6, please make a list of what the information consists of.

This should include the type, e.g. a research report, survey, review etc, and its title and date**.**		
Type of Information	Title	Date

11.8 Please summarise the views of what patients and users think about the new concept of the FHN.

Summary of Patients/Users Views of the Family Health Nurse	References of the Source of the Views Given	Date of the Reference

11.9 Do users have direct access to the FHN?

Yes **No** (please circle the answer that applies)

Category 12: Changes to Health System

12.1 What changes have been made to existing community nursing services Following the introduction of FHNs?	
Changes	Explanation
Range of Nursing Services provided	
Access to Nursing Services	
Financing of Nursing Services	
Impact on other services: **Medicine** **Midwifery** **Others**	

Category 13: FHN Effectiveness

13.1 Do you collect information about changes in health status of families following FHN intervention?

Yes **No** (please circle the one that applies)

If Yes **Please explain in the following questions:**

13.1:1 What kind of information do you collect about changes in health status of families following FHN intervention?

13.1:2 Why do you collect this kind of information?

13.1:3 How do you use this to measure the effectiveness of the FHN?

13.2 Do you have evidence of easier access to healthcare for families and patients following the introduction of the FHN?

Yes **No** (please circle the one that applies)

13.2:1 If you answered 'Yes' to question 13.2, please explain what kind of evidence you have and how this demonstrates that the FHN is making it easier for families and patients to access healthcare.

13.3 Are you collecting information about the quality of the FHN Service?

Yes **No** (please circle the one that applies)

If Yes **Please explain in the following questions:**

13.3:1 What kind of information do you collect about the quality of the FHN service?

13.3:2 Why do you collect this kind of information?

13.3:3 How do you use this to ensure and/or measure the quality of the FHN service?

13.4 In order to give an overall picture on quality, please summarise the results of all your information about the quality of the FHN service

Annex 5. The Standard Questionnaire

This questionnaire consists of three parts, which should all be completed by each respondent. The appropriate guidelines for each part immediately precede each Part. Please read and follow the instructions carefully.

Guidelines for Part One: Organisation of the Family Health Nurse (FHN)

This first part of this questionnaire collects data about how the FHN is being set up in your country. In order to evaluate this, information needs to be gathered to distinguish between the community nurses who already exist **in your country and the FHNs who have been** recently appointed **as part of WHO's new model for community nursing. Participating countries have different job titles for the same, or similar, types of community nurses. Therefore four categories of community nurses have been devised to include most types:**

- General Nurse. **This is a qualified nurse who provides** mainly curative type **care to people in their own homes and in local clinics. Other names might include:**
  - **Visiting nurses**
  - **District nurses**
  - **Home nurses**
- Public Health Nurse. **This is a qualified nurse who provides** mainly preventive type **care for people in their own homes, local clinics, schools and in public health offices. Also, they are concerned with maternal and child health (MCH), epidemiology and health promotion. Other names for these nurses might include:**
  - **MCH nurses**
  - **Health Visitors**
  - **School nurses**
- Generic or Combined Duties Nurse. **This is a qualified nurse who** combines the practices **of the general nurse and the public health nurse in equal measure** within the single role**.**
- Specialist Nurse**. This is a qualified nurse who provides** specialist care **to people in their own homes, in local clinics and also in acute healthcare facilities such as hospitals. They often work across the boundary between primary and secondary care and can be employed by either sector. In addition, they provide a resource of specialist knowledge to other nurses working in the community. Their specialism may be based on a disease entity such as cancer or diabetes, on a care area such as a paediatrics, or on a particular practice such as the care of stomas. Specialist nurses include:**
  - **Home care paediatric nurse**
  - **Diabetic care nurse**
  - **Cancer care nurse**
  - **Parkinson's disease or other particular diseases such as strokes**
  - **Stoma care nurse**
  - **Continence advisor**
  - **Rehabilitation nurse**

Questions 1 - 2. **These two questions ask for identifying details. These are general in nature and cannot identify you individually.**

Questions 3 - 4. **These require your own personal views of the role of and need for the FHN in your country.**

Questions 5 - 6. **These ask whether you country has other community nurses who are not FHNs. If you do have them please record how many different types of community nurse you have.**

Question 7. If you answered yes to Q 5-6 **please record, in column 3, the actual Job Titles of the community nurses you have working in your area, against the general categories we have described above (see example below). Column 1 contains the code for each category of nurse (you will need to refer to this in order to answer Question 8 in part 2).**

If you have answered no to Q 5-6 then please continue to Part 2.

Category Code for Community Nurses	Category of Types of Community Nurses	*Examples* of Actual Titles of Community Nurses in each Category Working in Your Area
A1	**General Nurse**	***District nurse***
A2	**Public Health Nurse**	***Health visitor***
A3	**Generic or Combined Duties Nurse**	***Generic home care nurse***
A4	**Specialist Community Nurse**	***Diabetic advisor***

Please answer all questions as honestly as possible to enable a complete picture of the work of the FHN in your country.

Part 1: Organisation of the Family Health Nurse (FHN)

1**. Name of Country and region.**

2**.Your job title.**

3**. Do you think that you country needs the F H N? (Circle the answer that applies)** Yes No

Please elaborate below on your answer to Question 3

4. **Do you in principle personally believe in the concept of the FHN, for your country?**

(Circle the answer that applies) Yes No

Please elaborate below on your answer to Q 4.

5. **Do you have nurses (not including FHNs) who work in the community?**

(Circle the answer that applies) Yes No

6. **How many types of community nurses, (i.e. who are not FHNs), work in your area? Please list them.**

7. **Columns 1 and 2 below already contain codes for the four categories of community nurse. In column 3, please fill in the** actual titles **of community[5] nurses working in your area, (i.e. those who are** not FHNs**), against the correct Code and Category in columns 1 and 2.**

1	2	3
Category Code for Community Nurses	Category of Types of Community Nurses	Actual Titles of Community Nurses in each Category Working in Your Area
A1	General Nurse	
A2	Public Health Nurse	
A3	Generic or Combined Duties Nurse	
A4	Specialist Nurse	

[5] [5] A1 **General Community Nurse** (mainly concerned with **curative** work e.g. District Nurse and General Practice Nurse); A2. **Public Health Nurse** (mainly concerned with **health promotion and prevention** e.g. Health Visitor and School Nurse); A3. **Generic Community Nurse** (nurses who do **both curative and preventive** work but who are not called FHN nurses) and A4 **Specialist Nurses.** (See earlier guidelines on page 1 for more information).

Please continue to Part 2

Guidelines for Part 2: The Role and Practice of FHNs

This second part of this questionnaire is constructed to collect information about how the role and performance of the new FHNs differs **from that of the community nurses who already exist in your area.**

As a means of carrying out their jobs effectively, existing community nurses and the new FHNs perform a range of similar activities. Some of these activities will be more vital to certain community nursing roles than to others, while the successful performance **of some activities is vital to the** effectiveness **of certain roles. For the purposes of the inter-country FHN evaluation we need 4 sets of information under this general heading of 'Role and Practice of FHNs'.**

In general, from your perspective, we would like to know whether:

- **Any one of the existing community nurses (not FHNs) carry out these activities? This should be recorded in Column A.**
- **How important are these activities to the successful performance of (non-FHN) community nurses? This should be recorded in Column B.**
- **How important are these activities to the successful performance of the new FHNs? This should be recorded in Column C.**
- **How well can new role of the FHN perform certain activities? This should be recorded in Column D.**

Question 8 **consists of a table with 5 columns and 48 rows.**

Column 1. **This column is the Activities Column, and lists 48 possible activities for community nurses of all kinds, one activity in each row. The next four columns are labelled** A.B.C**. and** D

Column A. **In order to evaluate the new FHN role within the context of existing community nurse roles we are asking you to identify one of your existing community nurses,** one of those you identified in your answer to Question 7, in Part One. Choose one that has a role that most resembles that of the FHN and carries out many of the 48 activities**. Record this nurse under categories A1, or A2, or A3, or A4, as identified in Question 7.** For example**, looking at the Activities 1-48, if a general community nurse you listed in question 7 carries out most of the activities 1-48 and is most like the FHN place A1 in column A, as shown in the example below.**

Column B. **This column relates to existing community nurses. Answer all the questions in Column B for the nurse that you chose in Column A. Please** rate the importance **of each of the listed activities to the** successful performance of the existing (non-FHN) community nurse that you have recorded in Column A **on a scale of 1–7.**

Column C. **This column relates to FHNs. Please** rate the importance **of each of the listed activities to the** successful performance of the new FHN **role using the same 1 – 7 scale. This is illustrated in the example below.**

Column D. **This column relates to FHNs. Please** rate how well a FHN can perform **each of the listed activities using the same 1 – 7 scale. This is illustrated in the example below.**

In summary: ***Each activity is rated in three ways by writing the appropriate scale number (1 or 2 or 3 or 4 or 5 or 6 or 7) in each box. The first rating (in Column B) concerns the importance of this activity for the successful performance of the nurse whose Code you put in Column A: i.e. who works in the***

community in ways similar to the FHN, but who does not work as an FHN. The second rating (in Column C) concerns the importance of this activity for the successful performance of those who are working in the role of the FHN. The third rating (in Column D) is concerned with how well you believe FHNs in your country are able to perform this activity under normal circumstances.

If you do not have any nurses at all working in community health in your country apart from FHNs do not fill in Column A and B but do complete Column C and D.

Example of Activities and answers in Columns A, B, C and D

Please note: ***the figures given in this example are only to show you how to complete the table; they should not be used as an indication as to what your actual scores should be.***

ACTIVITIES (Column 1.)	A	B	C	D
1. Establish a relationship with patients	**A1**	**6**	**2**	**1**
2. Health promotion for children 1-15 years	**A3**	**5**	**6**	**5**
3. Health promotion for people 16-65 years	**A4**	**2**	**4**	**7**
4. ***and so on to 49***				

Question 9. **The last activity (number 48) listed Question 8 is 'substitute for family physician'. Question 9 is asking you to expand on your answer and to explain the ways in which each type of community nurse substitutes for family doctors. You should write your answers in column 3 against each type of nurse that you recorded in Question 7. For example, in Row 1, write down how the general community nurse (A1) substitutes for the work of the family doctor, and then so on in each row for each type of nurse.**

Part 2: **The Role and Practice of FHNs**

8. **As explained in the guidelines, in order to perform their jobs effectively, community nurses who are not FHNs, and the FHNs themselves, perform certain activities. In the tables that follow is a range of such activities, with instructions for each column in the boxes above. Firstly, please look at each activity and decide whether a particular type of (non-FHN) nurse carries out this activity. Please write down the code (e.g.A1) for one of these nurses – (see guidelines page 5) next to each activity in Column A. Then continue to complete Columns B then C and finally D.**

Please note: **The questionnaire is probably easier to complete if you go through the activities 1 to 48 completing Column A fully, before moving onto Column B and then Column C and D.**

D. How well can a FHN perform this activity under normal circumstances?
Ratings**:** 1 **not at all well,** 2 **a little,** 3 **quite well,**
4 **well,** 5 **very well,** 6 **extremely well,** 7 **excellently**

C. How important is this activity to the successful performance of FHNs?
Ratings**:** 1 **not at all important,** 2 **a little important,** 3 **a little more important,**
4 **more important,** 5 **very important,** 6 **extremely important,** 7 **utmost importance**

B. How important is this activity to the successful performance of (non-FHN) nurses working in the community? Please only refer to those types (codes) that you have named in Column A.
Ratings**:** 1 **not at all important,** 2 **a little important,** 3 **a little more important,**
4 more important, 5 **very important,** 6 **extremely important,** 7 **utmost importance**

A. Do any of the nurses that you mentioned in Part One: Question 6-7 carry out this activity?
If yes please write the **code** of **one** of these nurses in the **Column A** against all the activities. **Codes**: **A1**. General Community Nurse (mainly concerned with curative work e.g. District Nurse and General Practice Nurse) and **A2**. Public Health Nurse (mainly concerned with health promotion and prevention e.g. Health Visitor and School nurse) and **A3**. Generic Community Nurse (nurses who do both curative and preventive), and **A4** Specialist Community Nurses

Activities Column	A	B	C	D
1. Establish a relationship with patients				
2. Health promotion for Children 0-15 years				
3. Health promotion for people 16 – 65 years				
4. Health promotion for people over 65 years				
5. Actions to prevent disease for children 0-15 years (e.g. immunisation)				
6. Actions to prevent disease in people 16-65 years (e.g. cholesterol testing)				

D. How well can a FHN perform this activity under normal circumstances?
Ratings**:** 1 **not at all well,** 2 **a little,** 3 **quite well,**
4 **well,** 5 **very well,** 6 **extremely well,** 7 **excellently**

C. How important is this activity to the successful performance of FHNs?
Ratings**:** 1 **not at all important,** 2 **a little important,** 3 **a little more important,**
4 **more important,** 5 **very important,** 6 **extremely important,** 7 **utmost importance**

B. How important is this activity to the successful performance of nurses (who are not FHNs) working in the community?
Please only refer to those types (codes) that you have named in Column A
Ratings**:** 1 **not at all important,** 2 **a little important,** 3 **a little more important,**
4 more important, 5 **very important,** 6 **extremely important,** 7 **utmost importance**

A. Do any of the nurses that you mentioned in Part One: Question 6-7 carry out this activity?
If yes please write the **code** of **one** of these nurses in the **Column A** against all activities. **Codes**: **A1**. General Community Nurse (mainly concerned with curative work e.g. District Nurse and General Practice Nurse) and **A2**. Public Health Nurse (mainly concerned with health promotion and prevention e.g. Health Visitor and School nurse) and **A3**. Generic Community Nurse (nurses who do both curative and preventive), and **A4** Specialist Community Nurses

Activities Column	A	B	C	D
7. Actions to prevent disease in people over 65 years (e.g. Blood pressure monitoring)				
8. Detect disease early for people 16-65 years (e.g. antenatal screening)				
9. Detect disease early for people over 65 years (e.g. Diabetes)				
10. Provide care for acutely ill children (e.g. head injury)				
11. Provide care for acutely ill people 16-65 years (e.g. post surgery)				
12. Provide care for acutely ill people over 65 years (e.g. heart failure)				
13. Provide care for chronically sick and disabled children 0-15years (e.g. leukaemia)				
14. Provide care for chronically sick and disabled people 16-65 years (e.g. AIDS and muscular dystrophy)				
15. Provide care for chronically sick and disabled people over 65 years (e.g. terminally ill with carcinoma, Alzheimer's and Parkinson's)				
16. Help families cope with acute and chronic illness				

D. How well can a FHN perform this activity under normal circumstances?
Ratings**:** 1 **not at all well,** 2 **a little,** 3 **quite well,**
4 **well,** 5 **very well,** 6 **extremely well,** 7 **excellently**

C. How important is this activity to the successful performance of FHNs?
Ratings**:** 1 **not at all important,** 2 **a little important,** 3 **a little more important,**
4 **more important,** 5 **very important,** 6 **extremely important,** 7 **utmost importance**

B. How important is this activity to the successful performance of nurses (who are not FHNs) working in the community?
Please only refer to those types (codes) that you have named in Column A
Ratings**:** 1 **not at all important,** 2 **a little important,** 3 **a little more important,**
4 more important, 5 **very important,** 6 **extremely important,** 7 **utmost importance**

A. Do any of the nurses that you mentioned in Part One: Question 6-7 carry out this activity?
If yes please write the **code** of **one** of these nurses in the **Column A** against all activities **Codes**: **A1**. General Community Nurse (mainly concerned with curative work e.g. District Nurse and General Practice Nurse) and **A2**. Public Health Nurse (mainly concerned with health promotion and prevention e.g. Health Visitor and School nurse) and **A3**. Generic Community Nurse (nurses who do both curative and preventive), and **A4** Specialist Community Nurses

Activities Column	A	B	C	D
17. Help individuals cope with stress				
18. Help families cope with stress				
19. Understand and support families as care givers				
20. Understand how families define their identity, roles and functions				
21. Provide care for individuals in their own homes				
22. Understand impact of public health issues on families				
23. Understand impact of social and economic issues on families				
24. Assess the health needs of individuals				
25. Assess the health of the whole family				
26. Understand the potential of other agencies to provide care in the community				

D. How well can a FHN perform this activity under normal circumstances?
Ratings**:** 1 **not at all well,** 2 **a little,** 3 **quite well,**
4 **well,** 5 **very well,** 6 **extremely well,** 7 **excellently**

C. How important is this activity to the successful performance of FHNs?
Ratings**:** 1 **not at all important,** 2 **a little important,** 3 **a little more important,**
4 **more important,** 5 **very important,** 6 **extremely important,** 7 **utmost importance**

B. How important is this activity to the successful performance of nurses (who are not FHNs) working in the community?
Please only refer to those types (codes) that you have named in Column A
Ratings**:** 1 **not at all important,** 2 **a little important,** 3 **a little more important,**
4 more important, 5 **very important,** 6 **extremely important,** 7 **utmost importance**

A. Do any of the nurses that you mentioned in Part One: Question 6-7 carry out this activity?
If yes please write the **code** of **one** of these nurses in the **Column A** against all activities. **Codes**: **A1**. General Community Nurse (mainly concerned with curative work e.g. District Nurse and General Practice Nurse) and **A2**. Public Health Nurse (mainly concerned with health promotion and prevention e.g. Health Visitor and School nurse) and **A3**. Generic Community Nurse (nurses who do both curative and preventive), and **A4** Specialist Community Nurses

Activities Column	A	B	C	D
27. Understand the scope of community resources to assist individuals and families with their health and social needs				
28. Act as liaison between the family and greater health care at large				
29. Assist with early hospital discharge by providing follow-up care at home				
30. Act as co-ordinator between family physician and individuals/families				
31. Treating patients				
32. Fully accountable for planning and organising care				
33. Show colleagues and students how to do things				
34. Fully accountable for making decisions about an individual or families' care				
35. Able to explain and communicate all aspects of health care clearly to patients and their families				
36. Act as a leader in the community				

D. How well can a FHN perform this activity under normal circumstances?
Ratings**:** 1 **not at all well,** 2 **a little,** 3 **quite well,**
4 **well,** 5 **very well,** 6 **extremely well,** 7 **excellently**

C. How important is this activity to the successful performance of FHNs?
Ratings**:** 1 **not at all important,** 2 **a little important,** 3 **a little more important,**
4 **more important,** 5 **very important,** 6 **extremely important,** 7 **utmost importance**

B. How important is this activity to the successful performance of nurses (who are not FHNs) working in the community?
Please only refer to those types (codes) that you have named in Column A
Ratings**:** 1 **not at all important,** 2 **a little important,** 3 **a little more important,**
4 more important, 5 **very important,** 6 **extremely important,** 7 **utmost importance**

A. Do any of the nurses that you mentioned in Part One: Question 6-7 carry out this activity?
If yes please write the **code** of **one** of these nurses in the **Column A** against all activities. **Codes**: **A1**. General Community Nurse (mainly concerned with curative work e.g. District Nurse and General Practice Nurse) and **A2**. Public Health Nurse (mainly concerned with health promotion and prevention e.g. Health Visitor and School nurse) and **A3**. Generic Community Nurse (nurses who do both curative and preventive), and **A4** Specialist Community Nurses

Activities Column	A	B	C	D
37. Work as a member of a health care team				
38. Undertake administrative duties (e.g. keep records, write reports)				
39. Get on with professional colleagues				

40. Act as a manager of care				
41. Provide the first point of contact for patients in the community without reference to other professionals				
42. Provide health care at critical points and life events in individual/families lives				
43. Provide health care based on the latest research evidence				
44. Collect, collate and analyse relevant data about own work				
45. Organise own time effectively				
46. Provide feedback to colleagues				
47. Appraise own performance				
48. Substitute for the family physician or general practitioner				

Question 9**. See guideline page 6.**

9. Category Code for Community Nurses	Types of Community Nurses	Please describe the ways in which each Type of Community Nurse substitutes for Family Doctors.
A1	**General Nurse**	
A2	**Public Health Nurse**	
A3	**Generic or combined duty nurse**	
A4	**Specialist Community Nurse**	
FHN	**Family Health Nurse**	

Please continue to Part 3

Guidelines for Part 3: Organisational Issues

This third part is constructed to collect data about how the FHN is being introduced and supported in your area, and about how the new role is affecting the existing community health services. This part has two questions.

Question 10. **This is a series of four comments boxes. Please complete each box in your own words according to your own opinions and experience. If you wish to say more in any box than the space allows, please continue on the back of the page using the same box number as a reference.**

Question 11. **In this final question, please make any further comment about this whole study, including comment on this questionnaire, and add anything else you would like to say about the new FHN model of community nursing. If necessary, please continue on the back of the page.**

Part 3: Organisational Issues

10. Please complete each box with as many points as you can.

Box 1. What changes do you believe have taken place in the Community Health Services following the introduction of the FHNs?

Box 2. What barriers do you believe that you have in your country, which need to be addressed to ensure the successful performance of the FHN?

Box 3. What could still be done to facilitate the performance of the FHN?

Box 4. What measures have been introduced to support the FHN in their new roles?

11. Please add any further comments that you would like to make, regarding the whole study, comments on this questionnaire, or the FHN programme in general. Please continue on the back page if required.

National Stakeholders please return this questionnaire to your FHN Co-ordinator.
FHNs and local Stakeholders please return to your local Director of Nursing, as directed.

On behalf of WHO European Region, we thank you for you co-operation. We very much appreciate the time and effort that you have contributed to the success of this study.

Annex 6. 2003 Summary (summarised from 2003 Slovenia Workshop)

	1. Armenia	2. Finland	3. Kyrgystan
Reasons for participation in international FHN study:	National health reforms priority is primary care	Aim to develop community services. Good previous experience with WHO multi-studies	Match developments in national health plans, encompassing 'family health nurse' role'
Agreement with WHO FHN definition?	Yes but issues with concept of nurse-doctor substitution	Yes	Yes but some variation in substitution level of doctors by nurses
Agreement with WHO Curriculum?	Yes. Need to map current skills to WHO curriculum and identify gaps	Helsinki graduates (12/03) WHO curriculum. Espoo (03/03) curriculum adapted. FHN employment varies in areas.	Yes. Developed 2000/2001
Implementation & Planning groups:	Dir. Parliament for Health Service, Chief Nurse, Nursing & Midwifery Assoc., National.Inst. Health Protection & Primary Care & Health Education, Chief Regional Nurse.	National Steering Group: Chief nurse, Education Ministry, Nursing & Midwifery Assoc., Polytechnics, Health Centres, Nursing Research Institute.	(National) Health Minister, Chief Nurse, Minister of Education, Family Group Practices Assoc., National Health Insurance Fund. (Local) Family Doctor, regional Chief Nurse, Felsher, NGO, Public.
Funding:	Uncertain. None from ministry - technical help only. Possibly World Bank	Full funding by Min. Education who funds training costs. Health centres support students and employ them afterwards.	Money from WHO Europe.
Location of pilot sites:	Rural areas	Urban (Helsinki) Urban/Rural (Espoo)	Urban and rural in Family Group Practices.
Selection of nurses:	District nurses with established careers. 15-20 in total	Helsinki: 8 (2003). Espoo: 20 & both with further intake. Community, public health, midwives.	Family Medical Nurses convert to FHN. 10 in each area.
Problems identified:	Financial support. General support for concept of family	Recruitment of students to new service	Management by Minister. Local physicians need to

	health nursing.		change perceptions.
	1. Armenia	**2. Finland**	**3. Kyrgystan**
Solutions identified:	Sponsors to be sought: religious bodies; Armenian groups in US; seek support from WHO Liaison Officer	More pro-active recruitment	Define role and highlight benefits colleagues/patients. Use evidence from other countries
Education:			
Structure of training:	116 community nurses currently funded by World Bank / 10 month FHN training (2003). Some of these will enter pilot study.	Basic 40 weeks with full & part time training options	Full time 3 months in education centre. This covers theoretical training only. Practical training still not clear.
Subjects included:	Fundamentals of nursing/physiology/ sociology/ inter-personal relations/ psychology/manage-ment & leadership	As WHO curriculum with adaptation in Espoo only	As WHO curriculum
Education providers:	National Institute for Health	Polytechnics	Basic training by medical vocational schools. FHN training: Continuing Education Institute
Educator preparation:	Workshops for FHN trainers employed through FHN Chair at NI Health, qualified FHN teacher	Existing nurse teachers Masters qualification, family nurse experience	10-month course for FHN educator qualification, aided by WHO consultants.
Practice Assessor preparation?	As above	Workshops on FHN concept/training requirements	Drawn from family medicine programme. Physicians and nurses in primary care centres. Some patient feedback.
Student assessment:	Commission of representatives of Public & Health Institutions/NGO's, family medicine specialists/FHNs. 2 phases – practical testing/theoretical examination	Following the existing polytechnic protocols: structured questions; essays prior and during course; practical assessments; portfolios; case studies; feedback from community nurses and possibly families	Situational problem solving. Still require consultancy input with assessment protocols.

	4. Lithuania	5. Moldova
Reasons for participation in international FHN study:	Previous experience of WHO projects. Strengthening nursing influence. Already have nurses with autonomy (Red Cross).	Doctor support concept. In line with reforms. Regulation underway to support FHN role.
Agreement with WHO FHN definition?	Yes but interpretation of initial contact and referral by FHNs needs addressing	Yes but some work needed on concept of autonomy. Some medicines are nurse prescribed.
Agreement with WHO Curriculum?	Yes but needs more debate	Yes. Have identified training gaps.
Implementation & Planning groups:	(Head) Minister, Chief Nurse, Health Minister, Nursing & Midwifery Assoc. Medical Directors. (Local) Physician, Nurse, Manager, Aid Agency, and Patients.	Directed by Minister. Primary Care head, Minister for Professional Training, Director of Family Medicine. Local group meet weekly.
Funding:	From existing budgets.	State budget for theoretical training in first year of project. No extra to pay FHN salaries.
Location of pilot sites:	One rural, one urban.	Not yet identified.
Selection of nurses:	Community nurses (October 2003). Red Cross nurses already have autonomy.	Not yet identified.
Problems identified:	Releasing nurses from current work for training. Especially in rural areas.	Very positive response but ongoing funding not yet clarified. Fieldwork training not funded.
Solutions identified:	Distance & evening training options	Additional funds to be sought e.g. from employment budgets
Identification of Project Officer. Start of pilot programmes:	Selection Oct 2003	First graduates due in December 2003
Education:		
Structure of training:	Distance and evening learning. No formal timescale. Emphasis on community and FHN included in basic training.	40 week course, but would like one year.
Subjects included:	As WHO curriculum. Needs further discussion with college directors	As WHO curriculum once training needs have been identified.
Education providers:	Existing college system, nurse teachers and guest lecturers, clinic nurses.	School of Continuing Education for Nursing (CEU).
Educator preparation:	Existing community tutors. Further discussion with college directors.	Teachers in CEU who receive additional training to deliver FHN training.
Practice Assessor preparation?	Existing community tutors. Further discussion with college directors.	Assessor currently in health centres, with additional training for FHN course.
Student assessment:	Theoretical and practical examinations.	Pre and post testing and practical exam. Diploma paper presentation with research and self-evaluation. Tutor feedback.

	6. Slovenia	7. Tajikistan
Reasons for participation in international FHN study:	See it as supporting service development	Supporting Munich Declaration. Supported by public.
Agreement with WHO FHN definition?	Yes. Already doing this but not fully autonomous in WHO sense.	Yes but lead doctors find issue with autonomy.
Agreement with WHO Curriculum?	Yes	Yes. Have adapted to meet our needs assessment, with WHO input.
Implementation & Planning groups:	Minister, Chief Nurse, Minster of Education, Nursing & Midwifery Assoc., Medical Leaders. (Local) 5 senior nurses and Tatjana Gec.	Head: Minister of health. Nursing & Midwifery Assoc., Chair of Family Medical Institute. No local group.
Funding:	Both course and student support funded by existing funding through health centres.	Relying on international agencies, Aga Khan Foundation, World Bank.
Location of pilot sites:	Urban - Maribor	Rural – not yet identified.
Selection of nurses:	21 selected from community nurses.	10 nurses/midwives selected by Chief Doctor in rural areas.
Problems identified:	None	Poor equipment in rural areas. Low salaries. Issues relating to autonomy in nursing.
Solutions identified:	None	Requires additional funding. Need to change perceptions of doctors.
Identification of Project Officer. **Start of pilot programmes:**	Tatjana Gec. Ran 'own' pilot in 2002-2003. Community nursing programming 2004.	Identified by Ministerial Office. Revised training program running since 2001
Education:		
Structure of training:	New part-time 1-year university program.	6-month postgraduate diploma. Aim to have 1-year diploma from 2006.
Subjects included:	As WHO curriculum	Adapted to WHO curriculum after needs assessment process.
Education providers:	University level training	Institute for Postgraduate Training
Educator preparation:	Existing senior community nurses having monthly preparatory meetings. Multi-disciplinary university staff input.	Undergo 11-month programme funded by international agencies.
Practice Assessor preparation?	As above.	Current staff in clinic to assess FHNs. Post-graduate trainer funded by Chair of Family Medicine.
Student assessment:	Each student has a mentor. Assessment is through case studies, essays, examination.	No detail currently available.

Annex 7. 2005 Summary (from Glasgow workshop)

	Armenia	Finland	Kyrgyzstan	Lithuania	Portugal	Moldova	Slovenia	Spain	Tajikistan	Scotland
Link worker	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
FHN course Teachers Trained?	Yes	Yes	Yes	Yes No special training	Yes No special Training	Yes Danish assistance	Yes	No special training for FHN	Yes	Yes
How many FHN teachers trained	22	3 Plus 3	16 + (82 before 2003)	9	0	20	8	0	25	3+3
Date first intake FHN Course (WHO Definition)	2001	2002	2003	2005	(Similar course 2001)	2003	1986 - 2000	Not yet 2006	2000	2001
How many FHNs qualified?	156 +	43	In 2005 WHO course 2800 short course	2005	25 (Similar course)	15 (WHO FHN) 700 short course	850 Community nurses 770/850 FHN	FHN not yet	180 FHN	31
Future training Start date	N/A	N/A	N/A	2005?	N/A	N/A	N/A	2006?	N/A	N/A
Preparation of service for introduction of FHNs?	See Challenges, Solutions and Preparation for FHNs 2005: Appendix 5									
Any trained FHNs already working?	Yes	Yes	Yes	No	N/A	Yes	Yes	No	Yes	Yes
How many trained FHNs working?	Not detailed									
Date of first FHN working in country?	Not detailed									

Challenges, Solutions and Preparation for FHNs 2005: Country Summary

Armenia

Challenges:

- Lack of legal framework for FHNs.
- Insufficient government-level support for nursing generally.
- Lack of financial resources and no addition funds
- Lack of awareness or understanding of 'family medicine' and 'family health nursing"
- Misunderstandings among colleagues of FHN role and lack of support from non-nursing professionals
- Inadequate knowledge of evaluation processes for evidence gathering
- Managers are mostly physicians not nurses

Solutions:

- Introduce FHN amendments into the health care laws
- Gain support from Minister of Health and international agencies for FHN
- World Bank funding available from 2005
- FHNs promoting change in behaviour and increasing awareness
- Promote research work from other countries, encourage national research
- Provide better salaries; raise profile of all nurses, including FHNs.
- Raise public awareness of the role and its importance

Preparation for FHN Implementation:

- Increasing government knowledge about the role
- Highlighting the international nature of the study
- Raise the profile of nursing (and FHN) among health staff
- Prepare physician managers for managing FHNs

Finland

Challenges:

- Recruitment at the beginning
- Length of the FHN training course compared with many others
- Not all doctors support FHN role; issues e.g. division of work between doctors and nurses
- Unclear perceptions of the concept of the FHN and 'family nursing'.

Solutions:

- 2 employers recruited students directly, giving crucial support to the programme
- Increasing the involvement of physicians in planning the new service developments
- Wider discussions about concept of FHN, providing evidence to support the role

Preparation for FHN Implementation:

- Encourage 'ownership' by those involved: Directors of Nursing, students, teaching, other health staff, physicians
- Opted to participate in study - proactive approach to new developments
- Encourage student assignments on role development and disseminate these ideas to

working community

Kyrgyzstan

Challenges:

- Lack of understanding of the FHN role
- Absence of clear Terms of Reference
- Lack of funding from health budget
- Currently limited opportunities for FHNs after their training
- Inadequate resources and lack of priority for FHN
- Little coordination between education and practice

Solutions:

- Raising awareness through media sources
- Develop new Terms of Reference and documents for staff to work from
- Identify new sustainable funding opportunities
- Build nursing capacity within the health system
- Raise profile by active involvement of FHNs in decision-making
- Establish a coordination council to manage nursing issues, including education

Preparation for FHN Implementation:

- Prepare Terms of Reference to identify roles and responsibilities of FHN and identify potential 'added value'
- Disseminate to the media the concept of the 'family health nurse '

Lithuania

Challenges:

- The current regulatory framework is not adapted to FHN activity
- Lack of finances for teaching
- The duration of FHN course is longer than many others
- Still need support from external bodies/consultants
- Problems understanding the concept of the FHN

Solutions:

- To implement changes in professional standards to include FHN curriculum into the formal education programme
- Seek additional sources of funding and assistance from other WHO project sites
- Discussion of service and strategy with stakeholders and provision of evidence to support FHN concept

Preparation for FHN Implementation:

- Gaining Ministerial support
- Regulatory and legislative changes to accommodate FHN

Moldova

Challenges:

- Lack of legislation identifying responsibility of FHNs
- Lack of finance
- Lack of experience in research, especially nursing research
- Problems with training the FHN trainers

- Inadequate formal information resources

Solutions:
- Raise profile and legally formalise the FHN role
- Identification of potential resources e.g. SOROS Foundation/CARITAS-Moldova
- Invite assistance from international experts and researchers
- Obtain assistance with FHN trainers e.g. agreement from Danish NGO to provide help with FHN training
- Professional FHN manual published (although information infrastructure not in place)

Preparation for FHN Implementation:
- Build the capacity of **all** nursing speciality, including FHN role
- Promote the need for a research agenda across the health system
- Make links with international groups

Portugal

Challenges:
- Getting government support nationally and health centre support locally
- Raising interest from schools of nursing
- Adapting the WHO Curriculum
- Training the teachers
- Encouraging community health activity in family environments
- Funding the implementation of the FHN nationally

Solutions:
- WHO support and disseminate the results of this study to get the necessary support
- Gain commitment from senior nurses
- Focus on FHN training to emphasis the family in community health provide evidence for this approach
- Seek to obtain funding and services strategy based on strong evidence

Preparation for FHN Implementation:
- Raise the national profile of nursing generally
- Indicate potential health gains based on available evidence
- Involve the existing community nurses and build on this structure

Scotland

Challenges:
- Policy reforms elsewhere, especially in nursing and midwifery, are impacting on developments with FHN
- Introducing the new role within a well established existing system of community nursing, and defining its ‘added value’
- Developing the necessary education and support infrastructure
- Sustaining the role after training phase, providing sustainability

Solutions:

- Ensuring nurses are at the heart of the policy reforms
- Gaining commitment from Chief Nursing Officer and forming partnerships with education and service communities
- Articulating aspects of difference and value of the FHN through in-country/inter-country evidence Quality assurance processes
- Provision of mentoring support in practice
- Challenging pre-conceived ideas and emphasising that this is a new role not a replacement role. Developing change management practices.
- Continuing the FHN support arrangements after the end of the training period.

Preparation for FHN Implementation:

- Provide a project website, conduct road shows and disseminate activity through conferences, publications etc.
- The implementation group, chaired by the Chief Nursing Officer, includes educators, practitioners, other health professionals and community health councils.
- Local groups are chaired by senior nurses
- Development of a joint community and workforce engagement strategy to provide information and promote partnerships

Slovenia

Challenges:

- Recruiting the required number of nurses
- Providing definitive concept of FHN
- Impacts on the Higher education system
- Financial implications of a new system
- Obtaining the necessary levels of cooperation between all parties (both in-country and for inter-country study)

Solutions:

- Dissemination of information to community nurses to encourage applications
- Highlighting the focal role of FHN, based on available evidence
- Emphasis on higher education demands of role and high level of knowledge & expertise
- Share experiences with others, especially international experience
- Prepare unify guidelines and principles

Preparation for FHN Implementation:

- Needed to develop specialized education programme in advance
- Ensure supporting legislation and identify evidence to support implementations

Spain

Did not provide details as no plans to implement yet

Tajikistan

Challenges:

- Lack of inter-sectoral cooperation and support from doctors and other professionals
- Poor coordination with stakeholders
- Lack of understanding of FHN concept within community, and by educators
- Insufficient information and learning resources on nursing issues
- Legal and regulatory frameworks do not support nursing sufficiently and this will impact on FHN development

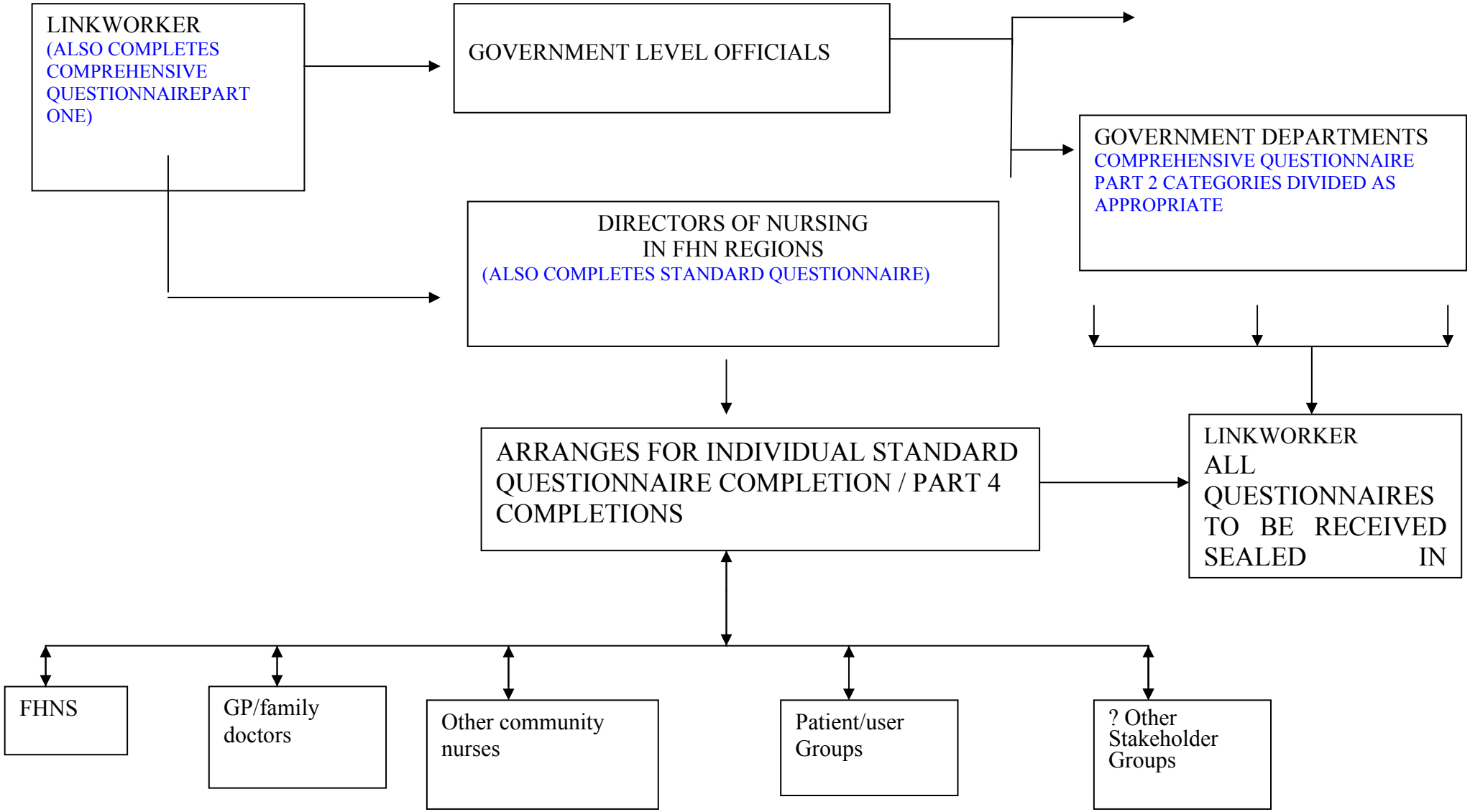
Solutions:

- Increase the involvement of all stakeholders in developments
- Develop a clear definition of the FHN role
- Establish coordination council to support developments in nursing
- Increase pubic awareness and provide evidence
- Train more nurse teachers and developing teaching resources
- Identify funding to enable research infrastructure development, e.g. from NGOs.
- Set up a working group to develop new the regulatory framework, encompassing the FHN role

Preparation for FHN Implementation:

- Establish pilot sites with WHO/World Bank support
- Establish Family Health Ambulatories to provide community services
- Change legal framework to promote nursing
- Mentorship training scheme established at national nursing centre
- Information resources centre for nursing established
- Nursing administration infrastructure developed in hospitals

Annex 8. Suggested questionnaire distribution



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Annex 9. The Family Health Nurse Education Programme

The education programme was designed to educate nurses in the pilot countries for the role of Family Health Nurse as defined in HEALTH21 (WHO 1998). A WHO Europe multi-national curriculum was developed by a small planning group from different member states to provide a framework for countries (WHO 2000b). Based on the European Health21 targets, this curriculum aimed to prepare nurses using a competency and evidenced based approach. Seventeen core competencies were developed to prepare the Family Health Nurse in the key areas of:

- care provider
- decision-maker
- communicator
- community leader
- manager

Variables such as the maturity of the nurse education systems, financial resources and the experience of those teaching the programmes all contributed to the ability of countries to develop their programmes in line with the WHO Europe multi-national curriculum.

A guiding principle for the education curriculum was the conceptual framework. The multi-national planning group used systems theory, interaction theory and developmental theory as the conceptual model to provide direction and focus for the curriculum. Systems theory provides a useful way of representing and analysing the complexities of a situation. Interaction theory

encourages consideration of the nurse/patient relationship, the nurse family relationship and the concepts of partnership and teamwork which are central to the philosophy of primary health care. Developmental theory is important in aiding understanding not only of individual human beings but also of the development of the family, in the context of the major life course events that are faced by all people and which vary in intensity and impact, depending on many complex factors.

Mapping the Curricula

Four countries submitted their curricula for evaluation. Comparison was challenging due to the differing nature of the material submitted. Likewise the non-submission of curricula from other pilot countries means that only a limited comparison is possible.

First level analysis was used to look at similarities and differences between the pilot country and multi-national curriculum in the key areas of programme length, content (teaching modules) and teaching methods. This is summarised in the table below.

(NB where information was missing this is denoted with an asterisk.)

Table 3.5 Comparison of WHO Europe Multi-National Curriculum and In-Country Curricula

Curriculum	**WHO Europe Curriculum**	**Portugal**	**Slovenia**	**Finland**	**Scotland**
Programme length	*40 weeks full-time*	148 hours	*	*	40 weeks
Level	*Post-registration*	Post-graduate	Post-graduate	*	Post-registration
Fieldwork	*yes*	yes	*	yes	yes
Teaching methods	*Lecture, seminar, case-study, community profiling, reflective learning, health assessment*	*	*	Lecture, tutorial, group work, seminars, Learning portfolio, case studies, computer learning	Lecture, tutorial, group work, seminars, Learning portfolio, case studies, computer learning, self-directed study
Content (modules)	*Concepts, practice & theory* *Working with families Decision-making* *Information management* *Working with Families*	Theoretical basis for family health nursing Family health nursing : from evaluation to intervention Fieldwork within	Social-political issues Informatics & research Professional profile development Nursing care	Orientation to family health nursing Health promotion of families Networks of family health nursing Community-based family health nursing	Research, decision-making & evaluation Working with families in the community Communication Principles & practice of family health nursing

	Managing resources *Leadership & multi-disciplinary working*	the context of practice Family health nursing: a reflective analysis	Diploma studies	Developing competencies of a nurse & public health nurse	

*** denotes information was not available**

Discussion

Central to all programmes was the concept of *family*. All submissions listed competencies similar to those specified in the multi-national curriculum. When the indicative content (syllabus) of the modules was considered there was evidence of a strong influence from the WHO Europe curriculum. This was particularly evident in the areas of communication; decision-making; primary, secondary and tertiary care; family theory and practice; underlying theoretical concepts; research; and the interface between individuals, families and communities. Intergenerational care and the life cycle approach were clearly articulated in three out of the four curricula.

The recommendation from WHO Europe was that candidates should have a minimum of 2 years post qualifying experience – including community work – prior to undertaking the FHN education programme. Portugal and Slovenia run the course at post-graduate level and Scotland at post-registration level, in line with WHO Europe thinking. The entry requirements and academic level of the FHN programmes is likely to be strongly influenced by the in-country nurse education regulatory system.

Adult teaching methods were used in the delivery of the two curricula that provided details. This approach recognises the knowledge and skills which students bring to the learning environment, so that it becomes a shared experience for the participants. However the use of this approach is also dependent on the skills and expertise of the nurse teacher.

Whilst the use of different teaching methods is seen as creating a positive active learning environment for the student, it is also acknowledged that resources need to be in place to facilitate such approaches. This would include having nurse teachers with knowledge of the curriculum content as well as expertise of different teaching methodologies such as those identified in the table. In addition nurse teachers require learning materials, a suitable teaching area, and access to information systems to enable them to use different teaching methods.

Fieldwork with an associated clinical assessment component was reported in three programmes (Portugal, Finland and Scotland). This theory/practice mix is seen as important in the preparation of Family Health Nurses. However this assumes the presence of adequately skilled practitioners in the fieldwork area who can support and assess the student Family Health Nurse. As the Family Health Nurse is a new role, the reported the use of experienced community nurses who had undertaken additional education to undertake this supervision role is promising. These nurses were supported in their supervisory role by nurse teachers.

In conclusion the WHO Europe curriculum appeared to provide a useful framework for in-country programme development. However limitations exist in terms of the number of countries who submitted details of their programmes and the type and amount of information supplied by the four pilot countries. Due to these limitations it is not possible to accurately determine the extent to which the WHO Europe curriculum was used in all pilot countries. However evaluation is also about learning from the experience. The learning from the educational element of the multi-national pilot suggests the following:

- Member states remain at different states of readiness in their ability to organise, run and monitor competency based programmes of education.
- There are certain prerequisites which are required to be in place prior to running such programmes. These include government support, adequately prepared nurse teachers and practitioners, learning materials and a suitable teaching environment.

For future multi-national studies it would be valuable to create a template for completion by pilot countries to ensure standardisation of data. If time allowed it would also be useful to follow up those countries who did not submit their curriculum. Such information would provide useful learning for similar projects in the future.

Annex 10. Thematic Analysis on the WHO Euro Family Health Nursing Multi-national Evaluation: Standard Questionnaire Q 10 & 11: Organisational Issues

Introduction and Background

This analysis is concerned with Part 3 (Questions 10 and 11) of the Standard Questionnaire and examines the organisational issues surrounding the implementation of the Family Health Nurse (FHN). It covers of the questionnaire. The questions are qualitative and so a thematic analysis has been carried out both intra- and inter-country.

The questions in this section of the questionnaire focus on the change processes required and/or undertaken to support and develop the FHN role and function and are listed below:

Question 10

1. **What changes do you believe have taken place in the Community Health Services following the introduction of the FHN?**
2. **What barriers do you believe that you have in your country, which need to be addressed to ensure the successful performance of the FHN?**
3. **What could still be done to facilitate the performance of the FHN?**
4. **What measures have been introduced to support the FHN in their new roles?**

Question 11 is an open question inviting additional information and response to the evaluation study and to the FHN programme.

Question 11

Please add any further comments that you would like to make, regarding the whole study, comments on the questionnaire, or the FHN programme in general.

Responses to this section of the Standard Evaluation Questionnaire were received from 6 countries, Tajikistan, Slovenia, Moldova, Finland, Portugal and Scotland. The number returned for each country ranged from 1 (Tajikistan) to 74 (Portugal). This means that the level of analysis for each country will be different, as it is dependent on the quantity and detail of information provided, which has varied between countries.

While it may be possible to carry out some simple inter-country comparison of response, this is not possible for every country, due to limited or absent information.

Where it is possible to identify some common themes across countries this has been done.

There are several common issues in relation to the FHN seen across countries; however, what is very obvious is the difference in the interpretation and realisation of the FHN role, depending on the stage countries are at with the development of their welfare policies, infrastructures and practices in relation to community health services. In addition to this, the results need to be interpreted within the cultural context of each country.

The questionnaire responses are in English and it is very clear that some countries and respondents had these translated and/or used translators to complete the questionnaires. Others possibly spoke and wrote English sufficiently well to complete the questionnaires without the help of translators. It is not known who the translators were or their background and it is obvious that there is some considerable variation in the quality of the translations provided. Having the responses in English has been extremely helpful and the effort made by the respondents to have their responses translated, was greatly appreciated. Time has been taken over the analysis in order to understand not only the words as they are written but also the intention and message behind the statements and to provide an honest interpretation of information so generously provided.

Process of Analysis

A thematic analysis has been completed for each question by country and is reported below. Common key themes occurring across countries have also been identified, so allowing a degree of inter-country comparison. However any such comparison must be made with some caution, and interpreted with regard to the different contexts of each nation's health service and welfare infrastructure.

1. Scotland

Scotland returned 23 questionnaires for this section of the Standard Questionnaire. Responses were included for Questions 10 and 11, however not every questionnaire was fully completed.

10.1 What changes do you believe have taken place in the Community Health Services following the introduction of the FHN?

This question stimulated a considerable and varied response from participants of this evaluation study. The main themes to emerge in relation to this question are:

1. The question is difficult to answer at this point in time: It is too early to make comment on any changes as the first cohort of FHNs has only recently completed the training course (4 responses). A number of respondents (3 responses) said that they had only recently started practicing as FHNs and could not comment except to note that people were unsure of the FHN role and some colleagues had shown some resistance to the new FHNs in practice. One respondent said that she did have contact with the Health Visitor and also visited families with her. It is not clear from the response whether this resulted in an overlap of roles or they complimented each other.
2. Communication and liaison with the wider multi-disciplinary team (MDT) has improved and this can be seen through better collaboration between the GPs and the FHNs.
3. The focus of care has changed, with emphasis now on the family and the wider community. This has meant that health promotion, health education and public health have become more important and a proactive, holistic and long-term approach to health is being adopted when dealing with family and community problems. As one respondent notes, "*The whole family is of legitimate interest to the FHN".* Where the FHN role is operational, families are receiving a more comprehensive service, including those who live in remote areas and do not access the GP.
4. The changes in service delivery have been beneficial. These changes have been mainly observed in staff delivering direct care to service users. The implementation of the FHN, however, is not uniform across the country. The introduction of the FHN appears to be most effective in rural areas. There is no data provided on the advantages of this role in urban areas. There is a perception, however, that embracing change is much slower at strategic levels, where individuals do not seem to have altered their practice or views. There is a sense that the FHNs have yet to be able to reach their full potential. FHNs could be used as a catalyst for change in primary care teams, providing an opportunity for working in new and different ways.
5. The introduction of the FHN has raised awareness of the different models of health care provision which can be successfully used to assess and treat people, and has provided a wider range of strategies for dealing with health needs including access to better assessment tools.

6. There is an increased awareness of the potential of nurses and their extended role, which the FHN can undertake. *"Consideration is being give to the idea of a new generic primary care role within the current established team roles,"* thereby providing an opportunity to review, for instance, the roles and responsibilities of the GP, Health Visitor and District Nurse roles. There are possibilities for developing a more "hands on" public health role and a family advocacy role. This also offers the potential for an individual nurse to undertake both a specialist and generalist aspect to the FHN role. One suggestion is that roles could be combined, for example the District Nurse and the Practice Nurse, allowing the nurse to treat patients in the home and the surgery. There is now an opportunity to try new techniques and methods of working.
7. The FHN is most useful in a rural role.
8. There is an improvement in communication and collaboration between the health, social and voluntary care sectors.
9. The FHNs are "*picking up cases that were previously not seen by other professionals",* suggesting that one advantage is the identification of previously unmet needs. There is also a sense from the responses given that this is resulting in better use of resources and much more creativity in the way nurses are practicing.

10.2 What barriers do you believe that you have in your country, which need to be addressed to ensure the successful performance of the FHN?

Some subjects mentioned as positive initiatives to the introduction of the FHN in Scotland, also appeared as barriers to the successful performance of the FHN. The themes identified are:

1. Caseload sizes. These are perceived as too big and prevent nurses carrying out there role effectively. In addition to this, high levels of paperwork with inadequate time to complete it properly also mean that time is taken away for practice. Allocation of time for nurses to undertaken their specific FHN role and function is seen as vital to its success.
2. Misunderstanding and mistrust of the FHN role. Some nursing colleagues in the multi-disciplinary team (MDT) feel threatened by the FHN role. GPs do not understand the role and patients and families are confused about who the FHN is and how they relate to them. This confusion has resulted in some opposition to the FHN, through other professionals "guarding" what they see as their professional remit, and refusing to share information or to cooperate with their FHN colleagues. In the case of patients and families, there is confusion over the many similar sounding titles used by different professionals working in primary care. In addition there is a concern expressed by some of the respondents that

somehow public expectations about the FHN may be unrealistic and there is a request that more must be done to inform the public about the FHN role.

3. FHNs need to be better paid and their skills properly recognised and utilised.
4. Lack of funding and other resources to support the implementation and development of the FHN is seen a problem. The possibility of future funding not being available to continue training FHNs is also a concern.
5. The process of change is perceived as problematic. Where there is resistance to change, this is being manifested through poor cooperation between professional colleagues.
6. The lack of a clear definition and job specification for FHNs is an issue of concern. FHNs feel that they are not being allowed to develop their health promotion/public health role and on occasions are use to “fill the gaps” in care and be give tasks that no-one else wants to do. Where nurses have dual/multi-roles such as that of District Nurse, Health Visitor, Midwife, their FHN role becomes “lost” as they have no dedicated time to develop the role. It is proving difficult to integrate a generalist model of nursing into an environment used to specialist nursing.
7. More support is needed to shift the culture and practice of health care towards public health and health promotion. This function should not just reside with FHNs. There is a fear that if FHNs are perceived by others as somehow “elite”, working differently to the rest of the team, then they will continue to meet resistance and even be ostracised. The danger is that without continued support, staff may revert back to traditional practices to avoid being “different” from their colleagues and in order to be accepted by the team.

10.3 What could still be done to facilitate the performance of the FHN?

The following suggestions were felt to be the key areas to address in order to facilitate the work of the FHNs:

1. The need for FHNs to be recognised as a distinct professional group, which meet regularly with other FHNs around the country. There should also be a support network for FHNs and a recognised professional body to which FHNs can belong and which will provide a framework for them to practice within.
2. To publicly promote the FHN.
3. FHNs should have access to continuing professional education and development. This may be through attendance at courses or through the use of ICT to work with other FHNs around the country. This should include access to research information.
4. FHNs should be paid more for the job they do.

5. There needs to be more education and work around change management for all professionals.
6. Support for the development of the role needs to be at all levels, from Government downwards, including financial support and improved human resources. There is a need for more FHNs.
7. Time needs to be given to nurses to develop their new FHN role, including allowing the FHNs to develop an understanding of the local context in which they will be working. This should be supported through improved Clinical Supervision.
8. The outcome of the FHN evaluation project is seen as important in order to stimulate further debate on the future direction of the FHN role in Scotland.

10.4 What measures have been introduced to support the FHN in their new roles?

Apart from one respondent feeling very negative about the support they receive and feeling let down by their management and the University, the responses were generally positive. They offered practical examples of how the FHN role is being supported. The responses include:

1. Good managerial support and access to a Practice Mentor (Orkney)
2. Regular meetings with the FHN implementation group and access to peer support at these meetings.
3. The introduction of a FHN leaflet to promote the FHN role (Orkney)
4. Regular Clinical Supervision
5. Production of Professional Development Plans
6. Networking with other FHNs through, for example, local and national meetings, the FHN website, and use of video links. The University and the Health Board have been helpful too in the support they have provided.

Question 11

Please add any further comments that you would like to make, regarding the whole study, comments on the questionnaire, or the FHN programme in general.

Although some respondents found the questionnaire difficult to answer the general view is that this evaluation project is very important to the future development and direction of the FHN. There is great interest in receiving feedback from the project. Respondents

are keen to find out how the FHN role is developing in other European countries and to make contact with their peers in other countries.

2. Slovenia

Slovenia returned 50 questionnaires for this section of the Standard Evaluation Questionnaire. Responses were included for questions 10 and 11 and each questionnaire was completed. However the responses were all the same and therefore the analysis is limited as there is no variation in response.

10.1 What changes do you believe have taken place in the Community Health Services following the introduction of the FHN?

In answer to this question, the respondents stated that they have had the FHN in Slovenia since 1957 and this nursing role is enshrined in national policy. The FHN is an independent and autonomous practitioner (50 responses). Other information provided stated that FHNs work within the local community (45 responses), they have one '*Polivalent'* nurse for the whole family (45 responses) and this has resulted in shorter hospitalization of patients and a focus on health promotion in the community (1 respondent). The response to this question suggests that these changes have been sufficient to protect the role, function and development of the FHN in Slovenia.

10.2 What barriers do you believe that you have in your country, which need to be addressed to ensure the successful performance of the FHN?

The barrier identified here is the shortage of FHNs due to policy not yet being fully implemented (50 respondents). No details are provided on what is operationally required to overcome this barrier.

10.3 What could still be done to facilitate the performance of the FHN?

The presence of FHNs in insurance companies is identified as the main requirement to facilitate the performance of the FHN (50 responses). No further details or elaboration is provided however.

10.4 What measures have been introduced to support the FHN in their new roles?

The single measure identified as supporting the FHN in their role is the introduction in 1957 of new legislation to create this role (50 responses).

Question 11

Please add any further comments that you would like to make, regarding the whole study, comments on the questionnaire, or the FHN programme in general.

"We are proud that the FHN is active in our country (Slovenia) for the last 48 years" (50 responses)

3. Finland

Finland returned 23 questionnaires for this section of the Standard Evaluation Questionnaire. Responses were included for Questions 10 and 11 however not every questionnaire was fully completed.

10.1 What changes do you believe have taken place in the Community Health Services following the introduction of the FHN?

Respondents provided considerable comment on this question with the main themes being:

1. A greater cooperation and collaboration with other professionals, in particular doctors, with a transfer of tasks taking place between doctors and nurses. One respondent notes that on occasions doctors and nurses meet patients together in order to work out the best health solutions in partnership. Joint working and collaboration has helped improve overall contact with primary health care personnel. A further advantage is that patients now have named doctors and nurses, which improves the continuity of care provided.
2. More active and effective collection of data is now taking place and that which is collected is more relevant.

3. FHNs are experiencing increased responsibility and independence in their working practices, which is viewed as very welcome. However there is an feeling that this should result in an increase in salary to reflect this expanded role.
4. Many respondents felt that the FHN education and training had been most beneficial and the "*final examination has been an excellent tool to collate and analyse relevant data".* However the positive responses to the FHN education and training have come with a caveat that the education programmes were not well planned; the opportunity to apply the FHN principles in practice is problematic and in some areas of the country the FHN education has not been translated into practice through the lack of employment of FHNs. Three respondents felt that the FHN programme largely remains at the theoretical stage.
5. There is the beginning of a shift in work patterns and culture taking place with a focus on family-centred care and supporting families to improve their health. This way of working has led to a shortening of queues for acute care and a perception that the FHN project has helped to standardise community care and clarify the division of work amongst the primary health care teams.
6. One respondent felt that the concept of the FHN has remained unclear and the title causes confusion as it seems to combine former and other titles.

10.2 What barriers do you believe that you have in your country, which need to be addressed to ensure the successful performance of the FHN?

As with the above question, the respondents provided some rich data for analysis. Many of the same issues seen as positive changes in question one, also appear as barriers to the performance of the FHN and suggest that the process of change is both complex and not uniform across the country. The themes to emerge here are:

1. There is a poor understanding, recognition and appreciation of the FHN role in some areas (Espoo). Both professionals and public do not recognise the FHN or the FHN education and training, making it very frustrating for those FHNs employed in the health services to practice their new professional skills. Added to this it would appear that some employers are not making it easy for nurses to qualify as FHNs as they are not providing cover to allow nurses to attend the FHN education and training programmes.
2. The small numbers of FHNs employed by some area health services (Espoo), with the associated heavy workload, is also perceived as a barrier to the future progression of the profession. The need for increased financial, political and economic support, combined with additional resources is seen as crucial to the success of the FHN. This appears to not be forthcoming in all areas of the

country. Also FHNs feel that they should have a better salary for the job they do and the additional responsibilities they undertake. Poor pay and increased responsibility can be a disincentive to becoming a FHN.

3. In some areas (Helsinki) respondents said that the barriers are practical ones such as lack of team working, issues around responsibility and autonomy as well as not being able to use data or professional skills effectively.
4. Accessing education can be a problem for some and is linked to the poor understanding of the FHN role and function. It is also associated with a need to change attitudes towards FHNs in particular, and to shift towards a health promotion/health education/public health focus in general. One suggestion to support this change is that the FHN concept needs to be introduced at the student nurse level of education and training in order to inform nurses about the FHN and to start changing attitudes to health care provision. However it appears that this shift in attitude needs to start with some FHNs themselves. One respondent noted that in "*my opinion we don't need FHN in Finland because we have a good health care system now with different kinds of nurses and health visitors…"* This suggests that another type of nurse is not required. Four respondents, however felt that there should be no barriers to successfully implementing the FHN and if there were barriers *" they are in our minds and it is an attitude issue"*

10.3 What could still be done to facilitate the performance of the FHN?

In response to this question, a small number of people answered that they did not know. However most respondents offered constructive suggestions such as :

1. The need for more education and training, both of FHNs themselves and other professionals.
2. The need for better understanding of the FHN role and function. Doctors in particular were singled out for some criticism. They could facilitate FHN performance through demonstrating a better understanding of the FHN role and its significance to community health care; including the FHN as a member of the team; respecting the FHN contribution and communicating / collaborating with them better.
3. The need for more support from managers and leaders to reform practice is seen as vital to the success of the FHN, suggesting that promotion of the FHN must come from all levels within the organisation and be promoted through national and local actions.
4. There is a need to clarify and standardise the duties of the FHN.
5. FHNs need to have an increase in salary

10.4 What measures have been introduced to support the FHN in their new roles?

Interestingly this question provoked a strong and somewhat negative response, suggesting that there is still much to do to support the FHN role now and in the future. The main responses were:

1. *"None yet", "Nothing!! - only a few (under 100 FHN) educated in Finland".* (19 responses). One response implied that any personal development of skills and knowledge has to be undertaken without support or objective assessment of personal competencies gained. However another respondent did note that the role of the nurse has expanded and that this had had an impact on the doctors' role. Whether this is perceived as occurring by design, and whether seen as advantageous is not clear.
2. The need for management support for studying to become a FHN is suggested but it is not clear from the respondent what level of commitment is required to make this happen.

Question 11

Please add any further comments that you would like to make, regarding the whole study, comments on the questionnaire, or the FHN programme in general.

Those respondents who completed this section of the questionnaire felt that the questionnaire design was too complicated and was difficult complete because it was "*quite abstract"* . The other main response was that the questions were not suitable or applicable to nursing in Finland: this is perceived as very different from nursing in England or other European countries (10 responses). Three respondents went on to say that they feel the FHN programme is not suitable for the Finnish health system and that there is no future for the FHN in Finland. Two respondents did state that the education and training had been good.

4. Tajikistan

Tajikistan returned one questionnaire for this section of the Standard Evaluation Questionnaire. However the questionnaire was blank and therefore no data are available for analysis.

5. Portugal

Portugal returned 74 questionnaires for this section of the Standard Evaluation Questionnaire. Responses were included for questions 10 and 11 however not every questionnaire was fully completed.

10.1 What changes do you believe have taken place in the Community Health Services following the introduction of the FHN?

This question produced a wide variety of response. The main themes to emerge are:

1. The emergence of and access to better knowledge about the demography and characteristics of the population being served. The result of this is that FHNs and their associated health teams are able to provide a more responsive and appropriate service to their families. (15 responses).
2. As a result of improving public health knowledge, trust and empathy between health teams and patients/families has increased. "*Through this model in primary care, there is a greater openness towards the team…creating empathy and greater trust"* (11 responses). This model has personalised care and has improved the quality of the care provided. It has also allowed for the adoption of a holistic and "humanistic" approach to care and a movement away from task orientated nursing (4 responses). In addition it has improved the consistency of the care provided (3 responses) and provided better accessibility to users (2 responses). This is perceived as advantageous to professionals and public alike.
3. There is greater and more effective communication between doctors, nurses, families and the wider community since the introduction of the FHN. Six respondents noted that they had always worked this way, suggesting that the degree of change undertaken by individuals is hugely variable, being much easier for those who have been trained and educated within the FHN framework from the beginning. However on respondent did note that, *"moving from the old nursing system to that of FHN has been enriching".*
4. The introduction of the FHN and the shift in focus and provision has led to the reorganization of services into geographical areas.

5. There is evidence of greater professional recognition and job satisfaction amongst FHNs such as: more professional accountability and autonomy (11 responses); better access to IT facilities and improved documentation (3 responses); improved working conditions and access to facilities; improved application of the nursing process resulting in improved provision and follow up of care (3 responses); greater job satisfaction; nurses are undertaking an active role in resolution of family problems – they are no longer passive participants (2 respondents). They also have the ability to take on a health promotion/health education role.
6. Better accessibility to community health care has led to an increase in user satisfaction. For example users (as well as professionals) see the FHN as the point of reference for advice and help. Users seek their FHN as they know that their FHN understands their family situation and together users and FHNs take responsibility for health outcomes. For the FHN having the wider contextual understanding of the individual's circumstances means that they are better able to detect and respond to problems at an earlier stage.

10.2 What barriers do you believe that you have in your country, which need to be addressed to ensure the successful performance of the FHN?

As with the previous question, the respondents provided some rich data for analysis. Many of the same issues seen as positive changes in question one, also appear as barriers to the performance of the FHN and suggest that the process of change is both complex and not uniform across the country. The themes to emerge here are:

1. The lack of recognition of the FHN role and function by other professionals, (22 responses), especially doctors who are perceived as blocking user access to FHNs (7 responses). FHNs also expressed a need for better team working and communication and collaboration and a reduction in "professional protectionism" over the sharing of knowledge and information.
2. The lack of FHNs employed (15 responses).
3. Competing political, economic, structural and financial demands at both government and local level making health promotion/public health goals difficult to achieve. There is a concentration on meeting and measuring "*short-term priorities rather than medium to long term priorities such as health promotion/disease prevention"* (14 responses). The dominance of the medical model of care is also seen as an obstacle to the development of public health strategies.
4. The lack of provision of national and local funding and resources for the proper development and implementation of the FHN is also seen as significant problem

(10 responses). This is compounded by the perception that there is a lack of consistency in legislation and nursing acts when it comes to the FHN role and function. Exactly what these might be is not stated.

5. There is a need to shift the cultural barriers surrounding the role of the FHN. This remains a problem while the focus of health service provision continues to be on acute hospital care. The more global public health role of the FHN will only be properly realized if there is a shift in the planning and management and structure of services. This need for a cultural shift is not only for health professionals and managers to make. It is noted by one respondent that, *"the educational background of our families (Portugal) is a barrier, since a great percentage of our inhabitants only seek the health services when they are sick, not valuing our knowledge regarding health promotion and the prevention of disease".*
6. There are logistical barriers also to be considered such some users not belonging to the same geographical area and nurses not being allowed by other professionals to go out into the community to see clients.
7. From the FHNs point of view other important barriers which need resolving are: the time taken up with administrative tasks thereby reducing their time in practice; the need for improved working conditions; the need for a career structure and better pay; a reduction in the patient/nurse ratio; the need for access to more equipment and the need for assistance with travel and associated costs.

10.3 What could still be done to facilitate the performance of the FHN?

The main themes to emerge here are:

1. The need for a lower number of families per FHN to allow for more health promotion and public health work (19 responses).
2. The need for more resources: staff, funding and equipment.
3. There is a need to get rid of the situation where families do not have a doctor. This could be overcome by assigning them to a FHN.
4. The need for better working conditions such as, flexible working; access to a car and mobile phone; secretarial/administrative support; better working facilities, including improved organisation and management of these facilities; better subsidies for using own resources such as a car; better organisation of working sectors to increase efficiency and the restructuring of local municipalities into smaller work areas.
5. Better teamwork with more joint visits with doctors, social agencies to improve effectiveness of health interventions.

6. A need for a cultural change that recognises and utilises the role and function of the FHN, valuing the skills that the FHN can bring to community care.
7. Users need to be alerted to their rights and duties so that they can make best possible use of the FHN.
8. There is a need for clear legislation on the FHN role and function and also a need to recognise that FHNs should be more active in policy decision-making, particularly in relation to health promotion and disease prevention.
9. Further research is needed on the FHN role and its impact on care. This should be a national study.
10. Other areas identified for improvement are: the need for better partnerships with other institutions; improved structures and infrastructures to make the FHN role work in practice; improved accessibility to FHNs by other professionals and the public; the opportunity to do more public health work; the opportunity for FHNs undertake research and study and share their skills with others/peers and the provision of a clear definition of the FHN role and function which includes clear objectives for practice.

10.4 What measures have been introduced to support the FHN in their new roles?

This question produced a mixed picture in relation to the perception of the advancement of the FHN role, suggesting that progress is not even across the country, with some areas doing better than others. The themes here are concerned with:

1. The need for regular and compulsory training at work and access to education and research. Fifteen respondents said that they have this in place; however 11 respondents said that no measures are in place to support the introduction of the FHN. They suggest that there are few incentives for nurses to become FHNs. No details are provided on the areas were education and training are available or not.
2. Introduction of IT facilities has improved documentation and access to patient information.
3. The introduction measures to improve working practices, for example, workload planning; more staff; better facilities; the implementation of new technologies; improved procedures based on research evidence; the allocation of FHNs to already formed user lists, have all helped to support the introduction of the FHN role.

Question 11

Please add any further comments that you would like to make, regarding the whole study, comments on the questionnaire, or the FHN programme in general.

Some respondents found this questionnaire difficult to complete because it was seen as too complex or asked questions that were not really applicable to the FHN role in their country.

Others (9 responses) however felt the exercise had been very worthwhile. They viewed the questionnaire as pertinent and timely, as the outcome of the evaluation will contribute to an improvement in nursing practices and provide a wider vision of the practice and possibilities of the FHN; extending beyond national borders.

6. Moldova

Moldova returned 37 questionnaires for this section of the Standard Evaluation Questionnaire. Responses were included for question 10. No data was provided for question 11 with the assumption that respondents had included all they wished to in question 10.

10.1 What changes do you believe have taken place in the Community Health Services following the introduction of the FHN?

The main themes to emerge from respondents in relation to this question were concerned with:

1. The implementation of reforms to the medical service, which has resulted in more family focussed care, concentrating on health promotion and healthier lifestyles (25 responses).
2. The implementation of obligatory medical insurance (19 responses).
3. The opportunity for patients to have their health needs and medical conditions supervised through out their lives, from birth to death (16 responses). All categories of the population are now being served and receive health care. This has resulted in a shift in focus of care towards a population/ public health approach.
4. The improvement in data collection and information systems means more is now known about health issues and family problems (4 responses). One respondent

did suggest that information systems can be problematic. What can be concluded is that with the introduction of the FHN, information systems have changed and this is generally seen as positive.

5. The socio-economic conditions of the FHN as perceived to have improved (1 response).

10.2 What barriers do you believe that you have in your country, which need to be addressed to ensure the successful performance of the FHN?

This question created a large number of responses and interestingly some of the themes emerging in question one were repeated here, suggesting that for some respondents the positive changes identified above were barriers for others. The sense that the uniformity of service provision and development is not consistent across the country emerged in this question. The main themes to arise from this question were:

1. The amount of time spent on documentation and paper work was prohibitive, causing frustration because staff felt that this reduced the time they could be practising their FHN skills of promoting health and healthier lifestyles. It takes them away from direct patient care (34 responses) *"We cannot realise and apply in practice all received knowledge, as much time (90%) is spent on completion of medical papers, forms, documentation".* While it is not possible to know the proportion of time spent practising nursing skills in relation to the time spent on paperwork and administrative duties, the perception is that this proportion is out of balance and is having an adverse effect on the FHN role.
2. Problems with information systems. A number of respondents (7) feel that lack of access to information and specialist literature is a major barrier. This suggests that the problem lies with lack of access to web based information and library resources. Curiously while respondents are generally positive about the improvements in data collection and information systems in question one, 18 respondents feel that there are no proper centralized information systems and this acts as a barrier to effective working. It would appear, therefore that the real access and use of information systems is not universal across the country.
3. FHNs feel they are not involved in decision-making. It is not clear if this is at national and/or local level. It does seem to be linked with the perception of FHNs self-worth and the feeling that FHNs are not always appreciated, respected, or valued by other professional groups.
4. The working conditions of FHNs are seen as an area of frustration and a barrier to encouraging more nurses to become FHNs. These are identified as poor economic status of FHNs; the need for improvements in the work and leisure conditions of FHNs; the need for FHNs to have a better salary; the need for a reduction in the volume of work assigned to FHNs (16 responses) and the fact

that some respondents noted that "*we do not know, or have access to knowledge about our rights"* (4 responses).

5. The lack of access to medical equipment and devices is also seen as a major barrier to effective working (23 responses).
6. One respondent made the comment that if the costs of medical services became too high it might have an adverse effect on the performance of the FHN, but did not give details on how or why.

10.3 What could still be done to facilitate the performance of the FHN?

The themes here are primarily concerned with professional and operational issues such as:

1. The urgent need to improve the work and leisure conditions of the FHN (25 responses), with a reduction of workload (2 responses); access to medical equipment and supplies (12 responses), and an increase in salary (19 responses).
2. The need to be able to obtain specialized literature and general professional information (36 responses); to access up-to-date knowledge and research, which should be linked to continuous and obligatory education and training (18 responses). In addition there is a desire for the opportunity to exchange professional experiences, locally, nationally and internationally (15 responses).
3. The importance of better collaboration between FHNs and other agencies is also critical to facilitating the performance of the FHN. This should be with all levels of society, and include, for example, the Government, the Mayoralty, kindergartens, schools, the Police, the Church, the Media and also social assistance agencies. In addition to this, better collaboration between FHNs and other parts of the health care system would provide patients with greater choice over where they want to be treated and to recover and who can best provide this care.

10.4 What measures have been introduced to support the FHN in their new roles?

The main themes here are:

1. The creation of courses based on the FHN concept has been a major factor in supporting FHNs with their roles (26 responses).
2. External support in the form of funding from the World Bank (18 responses).
3. Internal support in the form of increased administration (18 responses).

4. Access to education and training e.g. seminars (10 responses)
5. Allocation of essential equipment to carry out role.

Two respondents however felt that nothing has been done to support the FHN role. They were in the minority.

Question 11

Please add any further comments that you would like to make, regarding the whole study, comments on the questionnaire, or the FHN programme in general.

No further information was provided in relation to this question.

Summary

The analysis has been undertaken country by country. Apart from a small number of issues identified as very specific to the respondent country, such as the need for more FHNs employed in insurance companies (Slovenia), what emerges from this evaluation exercise is that each country has identified a list of very similar issues which preoccupy them. However whether a country's respondents comment on these issues in relation to changes, barriers, support measures etc, appears to be largely dependent on where in the change and development cycle they perceive they are. For instance, one country may identify issues under Question 10.1 (action has already taken place), where as another may identify the same issue under Question 10.3 (action is needed to put this in place). Indeed there is considerable repetition of material submitted for all four questions, showing that these changes and developments are dynamic, ongoing and continuously evolutionary in nature.

Where the same themes are raised under different questions, particularly questions 10.1 and 10.2., this shows that respondents see the same issues as both beneficial to the implementation of the FHN and as barriers to the development and future of the FHN. This suggests that aspects of an identified issue have been identified and acted upon by the key "shapers" of the FHN, but action has not been taken on this issue as a "whole". The longer term consequences and outcomes of the initial action have not been addressed. Where decisions have been made, it is primarily about initial investment of time and money to instigate change. Decisions have not necessarily been made as to the investment required to maintain and sustain the initial achievements. Respondents are concerned that the change required here is acted on

and completed, and that the implementation of the FHN is not mistaken as the completion of the change process. Long-term commitment is required to achieve changes in individual, organisational and societal values. Only when this is addressed will the FHN role really achieve its full potential.

Inter-country key theme comparisons

This information is presented in tables 10.1-10.4. Bearing in mind the summary comments made above, there may well be more common inter-country themes. However it is only possible to examine them here by question.

Question 10.1

Theme	Scotland	Slovenia	Finland	Portugal	Moldova
Improved communications/collaboration- teams, across agencies, patients, public, local/national	*		*	*	
Shift in practice from individualist care to holistic/population focussed care. Cultural shift	*		*	*	*
Identifying and meeting previously unmet needs	*			*	
Improved data collection/knowledge of population needs			*	*	*
Increased responsibility, accountability, autonomy			*	*	

Question 10.2

Themes	Scotland	Slovenia	Finland	Portugal	Moldova
Case load size, workload, lack of time to practice FHN role	*			*	*
Mistrust/misunderstanding of FHN role – professional protectionism, professional resistance	*		*		
Need for better pay	*		*		
Lack of funding/resources to support the development and implementation of the FHN/competing demands	*		*	*	*
Resistance to change/need for cultural change at all levels	*		*	*	
Lack of clarity/definition of the FHN role/function and associated poor recognition of FHN in practice	*		*	*	*
Shortages of staff		*	*	*	

Question 10.3

Theme	Scotland	Slovenia	Finland	Portugal	Moldova
FHNs require a distinct professional identity/role specification and associated support at all levels national/local	*		*	*	
Better publicity/knowledge of the FHN –all stakeholders and at all levels	*		*		*
Access to continuing professional education and development	*		*		*
Better pay/working conditions	*		*	*	*
Support for the development of the FHN role (all levels)	*		*		
Time to develop the role/do more public health work	*		*	*	
Need for the outcome of the evaluation project/further research into the FHN role	*		*	*	

Question 10.4

Themes	Scotland	Slovenia	Finland	Portugal	Moldova
Good management support	*				*
Networking- including local, national and international support	*				*
Improved education and training and access to research				*	*
Access to IT facilities and other equipment				*	*