

<b>HEALTH PROMOTION AND DISEASE PREVENTION</b> <b>A Handbook for Teachers, Researchers, Health Professionals and Decision Makers</b>	
<b>Title</b>	<b>Patronage Nurses: The Outreach Nursing System - a Milestone of Health Promotion</b>
<b>Module: 3.2</b>	<b>ECTS: 0.5</b>
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<b>Key words</b>	Nursing, health promotion, community/patronage health nursing
<b>Learning objectives</b>	<p>After completing this module students and public health professionals should:</p> <ul style="list-style-type: none"> <li>• be aware of concept of community outreach nurse/patronage services;</li> <li>• recognise role of patronage outreach nurses in addressing the needs of the family within the context of the community.</li> <li>• increase knowledge of community team work on health education and health promotion;</li> <li>• understand the principles of outreach patronage service;</li> <li>• identified the specificities of nurse undertaking community health needs assessment.</li> </ul>
<b>Abstract</b>	<p>In the health systems of countries of South-East Europe, the public health services have maybe suffered the most during the last fifteen years, with depreciated infrastructure and in some cases outmoded public health interventions. Recent positive trend has been visible in rehabilitation and reinforcement of population based public health interventions. Health staff profile likely best to accomplish function of the community based health education and health promotion are nurses. The patronage outreach nurses have received comprehensive training on methodology and techniques of adult-learning. They have knowledge of epidemiology, community assessment, programme planning and evaluation, biostatistics, research, nursing theory, public health administration and history and politics. They are the milestone in achieving the main principles of community health with its' participatory process to improve population health and the health promotion empowerment process to reduce social inequalities in health. Additionally, their scope of work helps in readdressing the injustice in health, identifies a complex and mutually interrelated problems that involves individuals, family and community and link them with the local culture, wider policy decisions, economic and socio-cultural forces.</p>

<b>Teaching methods</b>	Interactive lectures, exercises, individual and group work.
<b>Specific recommendations for teachers</b>	3 hours lecture, 5 hours supervised work on groups presentation and discussion. Working groups of students will have no more than 6 students. Copies of the WHO. Community Health Needs Assessment - An Introductory Guide for the Family Health Nurse in Europe. World Health Organization Regional Office for Europe, Copenhagen; 2001. should be made available to students before the module.
<b>Assessment of students</b>	<i>Individual assignment</i> Students take home essay (up to 2000 words) on country organization, functions and education of patronage/community health nurse. Selection of country based on student choice.

## **PATRONAGE NURSES - THE OUTREACH NURSING SYSTEM A MILESTONE OF HEALTH PROMOTION**

**Marija Kisman, Doncho Donev**

### **Introduction**

The last decade of the 20<sup>th</sup> century has been marked with major health care reforms commencing across Europe, particularly in countries of South-East Europe. Most of the societies in those countries are experiencing a prolonged complex transition from planned toward market economy, while recognizing and facing the poverty, unemployment, marginalization of vulnerable population groups, consequences of inter-ethnic wars and conflicts.

In this setting, the health systems of the countries of South-East Europe strives to cope with amplified pressures on public expenditures (usually owing to conditions imposed on structural adjustment loans), increasing cost of newly developed medical devices and medicines (as a result of rigorous international property rights rules), bulky health care settings (remains of the previous systems) that suffers from long period of underinvestment, increased awareness and population demand for high quality health care services, donor focused vertical health programmes, decreased investments in health research and trained medical professionals brain-drain.

The public health services in those countries maybe have suffered the most during the last 15 years. With depreciated infrastructure and in some cases outmoded public health interventions. The essence of those public health interventions in the former communistic systems were deeply rooted in the philosophy of that political system and its' social policy which refuses to recognize the poverty and income related marginalization and consecutively eliminating one of the key determinant of ill health. Owing to the essence of public health – to promote health and prevent disease and disability focusing on the health of entire populations - the principles of those interventions has lately gone through profound change and new understanding of population based public health interventions.

From another side, the length of the patient's stay in hospital is shortening; early discharge leads to more acutely ill people requiring care in their own homes, and primary health care services are becoming more and more in focus of the governments' reform interventions. As a result, there is notable, but still gradual shift of health care financial resources towards community care with less emphasis on acute care in hospitals.

There is one prominent concept of outreached health care services in the countries of South-East Europe, especially well developed in the countries of Former Yugoslavia, which encompasses the health education and health promotion, home health care delivery and community based interventions. Those services has been known under different names such as patronage nurses services, home visiting nurse services, community outreach nurse/ patronage services, etc., which we will try latter in the text to terminologically and conceptually describe. Those services have been widespread with well trained personnel and clear hierarchical links of reporting. After a period of stagnation in those services, the countries of South-East Europe are raising their efforts this 'heritage' of the previous health system to rehabilitate and empower with modern approaches to public health counting on those services rational use of recourses and achieved input.

As the largest group of health care providers, nursing professionals play an integral role in the management and delivery of health services.

WHO has repeatedly stressed the key contribution of nurses to public health and primary health care, mainly in the community either in patients' homes or in primary health care centres. However, in most WHO European Region Member States, nurses – the important human resource of nursing – have been educated and trained to work almost exclusively in hospitals. There is therefore an urgent need to prepare those skilled nurses to work in a totally different environment, i.e. the community and patients' own homes, and to work in a more independent and autonomous capacity than is required in hospitals (1).

The Second WHO European Ministerial Conference on Nursing and Midwifery, held in Munich, 15–17 June 2000, has addressed the unique roles and contributions of Europe's six million nurses and midwives in health development and health service delivery. At this Conference the Ministers has adopted a so called "*Munich Declaration: Nurses and midwives: A Force for Health, 2000*". Special focus in the Declaration has been given to establishment of family-focused community nursing and midwifery programmes and services as well as to enhancing the roles of nurses and midwives in public health, health promotion and community development. Those are the two key issues that patronage/outreach nursing service needs to accomplish (2).

The public health nursing has been developing along with the public health movement in Europe for the last 100 years under the auspices of national, regional and/or local government public health departments. Although the range and scope of this development varies greatly between Member States, the main reasons worldwide for the development of public health nursing have been crushing poverty, inequity, lack of basic health services, environmental pollution and infectious diseases (3).

The involvement of nurses in community work dates more than 100 years. As an illustration Ms. Florence Nightingale, one of the establishers of modern nursing in Europe, in one of her letters to *The Times* (4), states:

A district nurse must first nurse. She must be of a yet higher class and yet of a fuller training than that of a hospital nurse because she has no hospital appliances at hand at all and because she has to take notes of the case for the doctor who has no one but her to report to him. She is his staff of clinical clerks, dressers and nurses.

### **Terminology**

There has been a wide variety of terms in literature and practice defining activities of nurses performed in the community and which have health promotion and health education aspects.

Countries in Europe with a public health nursing workforce that use either the title "public health nurse" or "health visitor" include Croatia, Denmark, Finland, France, Ireland, Israel, Norway, Sweden and the United Kingdom. The role of the feldshers in the Russian Federation, reviewed by WHO in 1990 and 1998, is described as having a role similar to that of an advanced nurse practitioner. The authors of both reviews are of the view that feldshers play an important part in delivering aspects of public health programmes in those countries where they practice (3).

With aim to define the term of patronage nursing system, as a form of specialized nursing care that includes series of public health functions, terms as patronage nurses services, home visiting nurse services or community outreach/patronage nursing services has been used.

The patronage health nurse has been defined in the countries of Former Yugoslavia as a unique primary health care service dealing with preventive activities in broader scope,

preparing the individuals, the families and the community for rational use of health care services and more efficient acceptance and implementation of preventive measures (5).

Furthermore, following description of patronage nursing system has been found. Patronage health service is defined as an integral part of the health system which uses specific methods of work focusing on health education. Its' main purpose is outreach health care, active tracing of individuals in need of health and social protection, empowering and supporting individuals, families and other groups and their training independently to apply measures of their health protection. Depending on the number of health problems that patronage nurse covers the patronage service could be monovalent, bivalent and polyvalent (5, 6).

At the last decade, the WHO has been introducing a new concept of so called family health nurse.

The *family health nurse* as having a role along the whole continuum of care, including health promotion, disease prevention, rehabilitation and providing care for those who are ill or in the final stages of life. While the title "Family Health Nurse" suggests that the focus of the nurse is only on people who live within families, as this concept is generally understood, the role embraces much more than that and includes 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, and it also includes the community itself. The family health nurse will also have important roles to play, in empowering communities and working in partnership with them to foster their own resources and potential, and to find their own solutions to issues of concern (7).

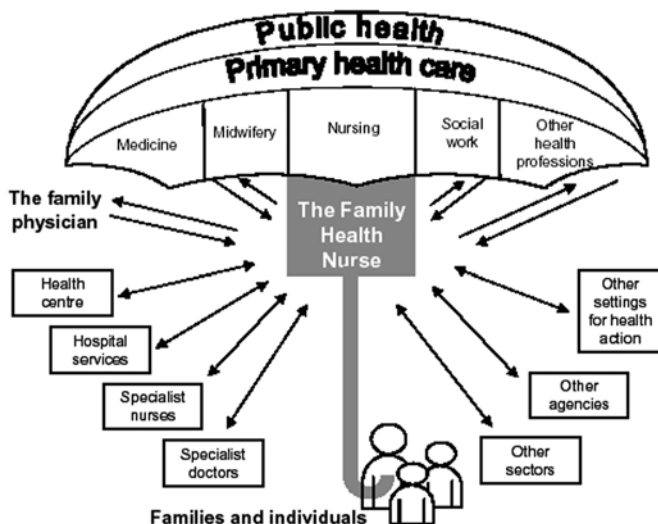
The multidimensional functions and interlinks with other health and non-health sectors of the family health nurse has been illustratively presented on the figure 1, prepared by WHO (7).

A WHO survey conducted in Europe about the extent and type of their community nursing services, 60% of countries (responses received from 31 countries) has identified two models of community nursing practice: the generalist model and the specialist community nursing model. The specialist community nurse was found to be described under 23 different titles, including public health nurse, district nurse, family nurse, health visitor, patronage nurse and mental health nurse (1).

Nevertheless, whatever terms have been used to name those types of outreach patronage nurses four main functions can be defined:

- Public health nurses: primarily involved in health promotion/illness prevention activities within the community. Many public health nurses dealt with issues of child protection, included health visitors and school nurses;
- District nurses: provide nursing care and treatment interventions in a non-hospital setting;
- Community midwives: provide support to women and their families during pregnancy, delivery and puerperium;
- Community psychiatric nurses: provide care and treatment to those with mental health problems and learning disabilities in their home environment, including crisis intervention measures (8).

**Figure 1.** Multidimensional functions and interlinks of the family health nurse within and outside the health sector (7)



### **Qualifications and curriculum of outreach patronage nurses**

In general, training of outreach patronage nurses should aim both to increase theoretical knowledge, as well as to develop practical skills. This usually demands ample time for dialogue and personal feedback during trainings. Self-training/group exercises and techniques for problem solving are to be the most efficient in enhancing the learning effect.

The entry requirements for a patronage/community nurse training, for example in UK, USA and EU countries, most often are nurses who have successfully completed a recognized training programme and have had a minimum of two years of nursing experience. Training usually minimum lasts a year. However, this requirement has not been usually a rule in countries of South-East Europe. Majority of those nurses are either an experienced nurse with four years general nursing education (an example could be the countries of Former Yugoslavia where the secondary school and the nursing vocation school have been merged) or nurses with advanced training of additional two to maximum three years education where rarely a specialization as such has been offered. Anyhow, situation started with changing from the beginning of 1990's and in particular for countries with aspirations for EU accession who equilibrate their education programmes with EU Directives, including the education for outreach community nurses.

Competencies of the patronage nurse/community nurse should cover the following broad range of tasks and activities (1):

- work as a member of the primary health care team and/or independently, in caring for patients in their own homes;
- promote health in the family and the community;
- participate in disease prevention;
- assess, plan, implement and evaluate nursing and health care for people within their own homes or communities according to their physical, mental and spiritual needs, and throughout the age span;

- make decisions about care in health and illness, based wherever possible on available evidence and founded on cultural values and ethical principles;
- provide rehabilitative nursing care;
- act as the patient's, client's or family's advocate for health;
- set health priorities together with the patient or community;
- utilize epidemiological and statistical data to prioritize needs for health care;
- mobilize appropriate community resources to optimize care of the patient/family in the community;
- using objective health-related data, participate in and seek to influence in a politically aware manner, the social and health issues within the community;
- be active in health-supporting projects;
- maintain professional relationships with other members of the community nursing team;
- seek to empower the community, the family and the individual patient; and
- accept authority and responsibility for her actions and decisions.

Special emphasis in the WHO Regional Office for Europe proposed curriculum for the community health nurse has been given to health promotion. The didactic themes for the community nurse and health promotion encompasses the following (1):

- Defining health – primary, secondary, tertiary prevention
- Epidemiology
- Social medicine (public health/environmental health)
- Health screening – disease prevention
- Community profiling – working with local communities, using a health needs assessment approach
- Immunization/vaccination
- Family planning and women's health
- Child/maternal health
- Health in the kindergarten/school
- Occupational health
- Nutrition
- Substance abuse (alcohol, drugs, nicotine)

An emphasis should be given to psychology of individuals, groups and community as being important aspect of training and expected mastered skills for patronage nurse to apply in their every day work. Particularly, regarding knowledge of developmental psychology, the influence of family relationship's on the child's development, family dynamics, child abuse and neglect (to recognize the signs of it, to assess the risk, to know how to follow up, when to refer to others, and to whom), as well as presence of abuse and violence towards other family members. Effects of drug and alcohol abuse, unemployment and other social stressors on the health status of individuals and families, should be well elaborate in the training programmes. The problem-solving strategies and developing, supporting coping skills are also relevant topics of the training. Communication, is a very important issue, including both communication skills and ethical issues such as confidentiality, should be among the core topics addressed in the training. All those broad aspects of psychology are with aim to give both understanding and a tool to patronage nurses to help people and to enhance their quality of care giving relationships.

The determinants of health and how to streamline the knowledge of coping with them into patronage nurse health promotion practice, is of particular importance. The broad issues of environmental determinants are prominent. In addition, it is illustrative to point out that the appearance of the first outreach nursing activities coincided with so called '*the age of environment (1875-1930)*' in development of public health.

It is estimated that over 30% of the global burden of disease in children can be attributed to environmental factors. Children have different susceptibilities during different life stages, due to their dynamic growth and developmental processes. Some examples of health effects resulting from developmental exposures prenatally and at birth include miscarriage, still birth, low birth weight and birth defects; in young children, infant mortality, asthma, neurobehavioral and immune impairment; and in adolescents, precocious or delayed puberty. Emerging evidence suggests that an increased risk of certain diseases in adults such as cancer and heart disease can result in part from exposures to certain environmental chemicals during childhood (9).

The outreach/patronage nurse should have knowledge and awareness of causal links between environment risk factors causing or enhancing diseases and understanding of the interactions between exposure, biological susceptibility, and socioeconomic and nutritional factors at the lifespan. This will help them in accurate assessment of health education and health promotions needs of the population that cover, better plan and instigate population based or individual interventions. For example, a number of factors should be regularly monitored and assessed by the outreach/patronage nurse, namely:

- *Pollution.* Pollution of air and water causes disease and death and this is evident throughout the world, whether it is lead in petrol or a chemical spill from a factory, or drinking-water contaminated by sewage;
- *Sanitation.* Good sanitation eliminates some diseases such as cholera and dysentery completely, and where this break down gastrointestinal illnesses are quickly evident. In communities lacking basic sanitation, threats to health will arise from the contamination of water supplies by human excrement;
- *Housing.* The lack of a home affects all aspects of health – shelter from the weather, an environment to sustain a family, a place to feel safe. The availability and type of housing will reflect local history, culture, the economy and political climate, with a wide range of housing existing across Europe such as tents in the Negev desert, tower blocks in cities, new housing estates, private housing, refugee camps and hostels. The type, quality and suitability of housing will have an important affect on health. It is essential to look for factors such as overcrowding, dampness and poor heating, as these are significant factors affecting health. Also should be considered how far homes are from work, pharmacies, schools and shops;
- *Transport.* Transport systems are important to monitor, as they can influence people's access to services, social support networks and employment. Transport may also have an impact on health through accidents, noise and air pollution (10).

The role and importance of the outreach nursing system/patronage nurse in emergencies situations are well documented, commencing from Crimean war (Florence Nightingale activities) to recent Balkan wars, earthquakes and floods.

Natural and man-made disasters frequently cause major problems which affect a population's health and hinder a nation's socioeconomic development by draining its scarce



financial resources in an effort to repair damages. Often, those damages are so great that neither the efforts of the stricken country nor international cooperation suffice for complete reconstruction and rehabilitation. The effects disasters have on the health field cover a broad range of implications stemming not only from the demand for the immediate care of victims, but also from the medium- and long-term effects of the intermittent suspension of basic sanitation services, food shortages, and the interruption of disease surveillance and control programs; these aspects require coordinated efforts and the efficient use of knowledge and resources (11).

The outreach nursing system/the patronage nurse is best placed with its' knowledge of health, demographic and socioeconomic status of the population as well as the catchments area housing patterns, which significantly contribute to preparation of the disaster management and response health plans, and disaster mitigation activities. Its' position provides excellent opportunity to timely and accurately prepare, advise and educate the population under authority.

Drills including simulation exercises of the disaster management and response health plan should regularly be carried out aiming to assess the efficacy of the plan, management and modes of patient evacuation, triage, referral system and means of communication.

Specific function of the outreach nursing system should be seen when disaster hits communities in rural areas, seriously injuring the residents that usually have only small health posts with limited equipment, basic staff, and serious communication problems. It is possible that the area will remain isolated for several days. This hampers transfer and external support systems and leads to a breakdown in the service supply/demand ratio, adding one more problem to the disaster. The impact and its consequences are generally more than can normally be handled, and a careful study of all the alternatives for making maximum use of the scarce resources available should be undertaken. The patronage nurse role perhaps should most importantly be to teach and train the community itself in cooperation with the health staff and other relevant parts of the public system, to organize first aid, rescue of casualties, transportation of the injured, mutual aid, census-taking and the search for the missing, camps for the victims, the organization of brigades, and post-disaster rehabilitation activities (11).

The work of patronage/community nurse in taking care of patients with chronic illnesses, both communicable and noncommunicable, such as TB, AIDS, hypertension, diabetes, Parkinson's disease, cancer, depression, asthma etc., with health education, health promotion, as well as curative approaches, palliative care and social support to patients and their families, has been of significant effect. Community patronage nurses are likely to ask more questions and offer more information and choices. They also tend to spend slightly longer with their patients than the doctors. Studies indicate patients appreciate the nurse practitioners' communication skills and the extra time spent; in one study, 99% of patients in the nurse practitioner group said they would see a nurse practitioner again for a similar problem (12).

Experiences on the field has shown very positive results with the responsibility of patronage/outreach nursing system enrolled in the TB dispensaries that enable them to visit TB patients and their families. During and after hospitalization the TB patient they continue with their DOT treatment from home setting. The patronage nurses visit these patients at home to ensure that they are taking the drugs regularly, to reinforce the importance of completing treatment and to encourage family members to get tested for TB. This monitoring and reinforcing patient treatment is decreasing the number of defaulters, thus stemming the

development and spread of multi-drug resistant TB. Moreover, initiating contact tracing increases the early detection of TB. A significant issue in this regard is the goal of providing health education to TB patients; to educate them about the disease, their treatment, and give them an understanding of their responsibility as patients. In addition, key health education messages focused on increasing TB knowledge among both patients and the general population, regarding early recognition of TB symptoms, treatment regimens, the availability of free drugs, preventive measures, and stigma are tasks assigned to patronage monovalent nurse, they as a nurses directly involved in caring for TB patients served as key implementers of the education component.

## **Conclusions**

The patronage outreach nurses that have receive specific training on methodology and techniques of adult-learning, have knowledge of epidemiology, community assessment, programme planning and evaluation, biostatistics, research, nursing theory, public health administration and history and politics are to the milestone in archiving the main principles of community health with its' participatory process to improve population health and the health promotion empowerment process to reduce social inequalities in health. Additionally, their scope of work helps in readdressing the unfairness in health, identifies a complex and mutually interrelated problems that involves individuals, family and community and link them with the local culture, wider policy decisions, economic and socio-cultural forces.

Immense value of this profile of nurses as part of interdisciplinary community outreach team represents an interface between other nursing, health and social care services.

Nevertheless, much investment in education and in-service training is needed patronage nurses to fully apply their incomparable advantages in community care and health promotion.

## **Exercise 1.**

Exercise to be assigned at the end of the first lecture.

Students should be divided in three groups.

Each group should perform a *health promotion needs assessment* for following virtual or real (according to their preference) model settlements:

- Urban;
- Rural;
- Settlement with vulnerable population group (i.e. Roma population).

Each settlement with maximum 5000 population.

Each group should prepare a bullets point one page text covering the following:

- Demographic trends;
- Religion, language and literacy;
- Mortality/morbidity indicators;
- Water and sanitation status;
- Living conditions specificities;
- Cultural and socioeconomic characteristics;
- Health care provision and its' accessibility;
- Key health promotion and health education needs.

Presentation of the findings should be made by each group at the beginning of the second lecture. 5 minutes per group for presentation followed with 5 minutes discussion.

## **Exercise 2.**

Exercise to be assigned at the end of the second lecture.

The three groups remain the same as for the Exercise 1. Using the *health promotion needs assessment* prepared from the previous exercise, students should develop a health promotion and education plan by using the scopes and range of authorities of patronage / family nurse functions.

Plans should not exceed one bullet point page having the following structure:

- Short, medium and long term interventions;
- Main points of entry;
- Referral system (both to health and social services).

## **References**

1. WHO. Community Nursing for Countries in Transition. World Health Organization Regional Office for Europe, Copenhagen. 2000 (document EUR/00/5019305).
2. WHO. Munich Declaration: Nurses and midwives: A Force for Health, 2000. Health Organization Regional Office for Europe, Copenhagen. 2000
3. WHO. Public Health Nursing: Past and Future, A Review of the Literature. World Health Organization Regional Office for Europe. Copenhagen, 2001.
4. Nightingale F. London: The Times; 1876.
5. Donev D. at al. Polyvalent Home Visiting Nurse and Health Education. In: Lets' Talk About Health. Skopje: Republic Institute for Health Protection and Republic Committee for Labour, Health and Social Policy; 1989:133-7.
6. RIHP – Skopje. Information on Patronage Health Services in the Republic of Macedonia for the year 2004. Skopje: Republic Institute for Health Protection; 2005.
7. WHO. The Family Health Nurse Context, Conceptual Framework and Curriculum. Copenhagen, Denmark: World Health Organization Regional Office for Europe; 2000 (document EUR/00/5019309/13).
8. WHO. Family Health Nurse Multinational Study: Intercountry Evaluation Report on a WHO workshop. Copenhagen: World Health Organization Regional Office for Europe; 2005, (document EUR/05/5049078).
9. WHO. Principles for Evaluating Health Risks in Children Associated with Exposure to Chemicals. World Health Organization, Geneva; 2007.
10. WHO. Community Health Needs Assessment - An Introductory Guide for the Family Health Nurse in Europe. World Health Organization Regional Office for Europe, Copenhagen; 2001.
11. PAHO. Health Services Organization in the Event of Disaster. Pan American Health Organization, Washington, D.C.;1989.
12. Knowledge Transfer and Exchange staff at the Canadian Health Services Research Foundation. Myth: Seeing a nurse practitioner instead of a doctor is second class care. *Eurohealth* 2005;11(3):29-30.

## **Recommended readings**

1. Salvage J. Nursing in Europe: A Resource for Better Health. European Series No. 74 World Health Organization Regional Office for Europe, Copenhagen;1997.
2. Wallace M. The European Union Standards for Nursing and Midwifery: Information for Accession Countries. World Health Organization Regional Office for Europe, Copenhagen; 2001 (document EUR/00/5019308).
3. Fooks C, Maslove L. Health Human Resources Policy Initiatives for Physicians, Nurses and Pharmacists. Canadian Policy Research Networks Inc., Ottawa; 2004.
4. Health Policy Research Bulletin, Issue 13. Ministry of Public Works and Government Services Canada, Québec; 2007