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THE SCIENTIFIC JOURNAL OF THE HELLENIC REGULATORY BODY OF NURSES

The Hellenic Journal of Nursing Science is the official journal of the Hellenic Regulatory Body of Nurses. It is a peer-reviewed, multidisciplinary journal that aims at promoting Nursing Science in Greece.
Through this specific scientific publication, the Hellenic Regulatory Body of Nurses both contributes to the promotion of the scientific nursing knowledge and signals a new era for the contemporary Greek Nursing history.
Under this framework, this scientific journal intends to:

- promote Nursing Science
- contribute effectively to the quality of concern for people as individuals, groups and the society as a whole in every healthy and sick condition
- scientifically highlight and broaden Scientific Nursing issues
- produce Nursing Policy and Policies and
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editorial

Dr. Kyriakos Kouveliotis
Editor - in - Chief

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Autism	1362-3613
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Home Health Care Management & Practice	1084-8223
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Journal of Family Nursing	1074-8407
Journal of Health Psychology	1359-1053
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All the contributors of the Scientific Journal welcome you to this new source of knowledge for the Hellenic Nursing Community.

Traumatic Ballistic : Analysis of Parameters and Confrontation of Wounds Caused from Missiles in Human Body

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ABSTRACT

The aim of the present inquiring work is the study of the damages which are caused in the human body in case it offends by missiles, the confrontation of wounds that are attributed to these missiles, the nursing and medical diagnosis which is held through the examination of wounded people. Regarding the diagnosis of the damage, which is caused in the human organism, is essential the knowledge of parameters that recommend the wound of missile, like penetration medium, permanent cavity, temporary cavity and fragmentation. The results of the present study shows that the central nervous system and the circulatory system need direct confrontation, when they are offended, while it is possible to lead to instantaneous death.

Key words: cavity, fragmentation, hydrostatic shock, mechanism of missile's wound, penetration medium, traumatic ballistic.

Introduction

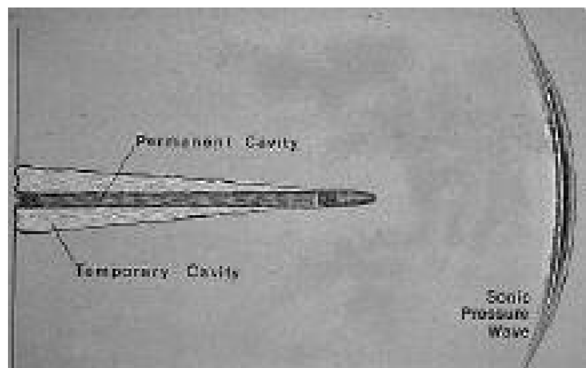
In the past, when people hadn't created the first cultures, they wasted the bigger part of their life trying to ensure food, roof and water. Many times, they were called to face other people and other kinds that were trying to ensure the same things. Centuries later, people faced the problem of immigration, since they abandoned the place, in which they lived, so as to look for new grounds with better conditions to live in. In these days, people are involved in conflicts in order to gain their freedom, money or raw materials.

In any season of human type we are referred, we can observe with regard to the conflicts that the person studied and searched the methods, which were the most damaging for his opponents. For instance, what kind of material should he use in order to manufacture the peak of javelin, what parts of the opponent's human body are more frail, in which parts of the human body will a damage cause faster death e.t.c. In these days, the arms, which are used, exploit explosive materials (like the gunpowder) in order to transmit big quantity of kinetic energy in missiles against mobile and constant objectives of offence. In this principle is supported the function of machine-guns, the shotguns and some kinds of grenades (Winter J.M., 1989).

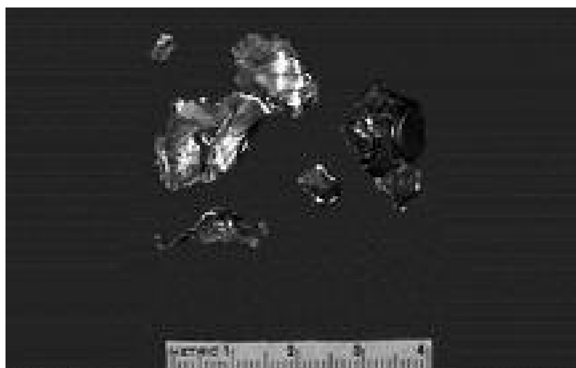
The Traumatic Ballistic is an important field of science of ballistic, which studies the damages in the human body that result from missiles and modern arms of battle that enter into this (Ann H. Ross, 1995). Particularly, this field examines the types of wound which are caused by various bullets of different calibre, the parts of the human body, which if they offend, will cause faster death, as well as the damages which are caused from bullets in the human body that are not obvious (Ann H. Ross, 1995).

Ballistic Wound Mechanism

The present study is focused on the investigation of the level of knowledge, attitudes and beliefs of the healthcare students of the University of Athens. This study is keen to analyse the parameters that have an impact on the disease and the role of the health authorities in preventing the spread of the disease. The study used as a representative sample healthcare students, a fact that is of particular interest, because this group of individuals due to their knowledge and experience based on their clinical practice are expected to be more sensitized regarding the disease.



Picture 1: Illustration of permanent and temporary cavity creations, which are attributed to the kinetic energy that is transported in the tissues of the human body from the entrance of missile. It is also depicted the form of pressing sound wave that is created by the bullet due to its high speed.



Picture 2: When a bullet strikes a target, it is possible to cause remarkable deformity and fragmentation. In this case, the bullet's head is deformed completely and broken away from its wrapping of (right of the head).

Damages in the Human Organism

The wounds resulted from missiles in the human organism, is possible to cause collapse or death. This can happen either by destroying some points of the central nervous system, either by causing serious loss of blood offending big arteries of circulatory system or by interrupting the supplement of oxygen in the brain (Peter's C.E., 1997). If the parameters of a missile's wound cause or increase the damages of the above three mechanisms in important degree, then possibly they will increase the possibility of collapse or death.

1. Shots in the central nervous system: The shots in the central nervous system are almost always lethal (Picture 3). When a bullet penetrates the brain, it is possible to injure or even to cut the nervous tissues that result in vital systems, like the myocardium, the liver and the lungs. As a result, these systems cease their function. In addition, it is possible the centre of senses of brain to be destroyed. Consequently, the individual goes into a coma from which it is difficult to come back. The shots in the cerebellum cause instantaneous death, while the shots in the spinal marrow, which is the inferior point of the central nervous system, can possibly cause from palsy to death (Sellier K.G et. al., 1994).

2. Shots in the circulatory system (Picture 3): According to clinical surveys that have been conducted, it has been proved that the organism of a medium person can put up with up to 20% loss of blood. Practically, this means that a person's organism can function only with the 80% of his blood, despite the appearance of small intensity of anaemia's symptoms. Bigger loss of blood leads to progressive necrosis of the parts of brain. How much is therefore the most minimum time that is required, so as someone, who has been struck from bullet, can lose the 20% of his blood? The answer is the following: The cardiac attribution of an individual of 70 kilos amounts in 5,5 litres per minute (this means that his heart bloods his body with 5,5 litres of blood per minute). The volume of his blood is 60 ml per kilo, which means that totally is 4,2 litres. Supposing that the individual is being in stress, his cardiac attribution increases to 11 litres per minute. If a missile, while it penetrates the individual's body, manage to cut the thoracic aorta, it will need only 4,6 seconds so as the individual lose the 20% of his blood from only one point. Surely, the brain will continue functioning for some more seconds due to the oxygenated blood that circulates in the brain (Sachini – Kardasi A. et. al., 1993).

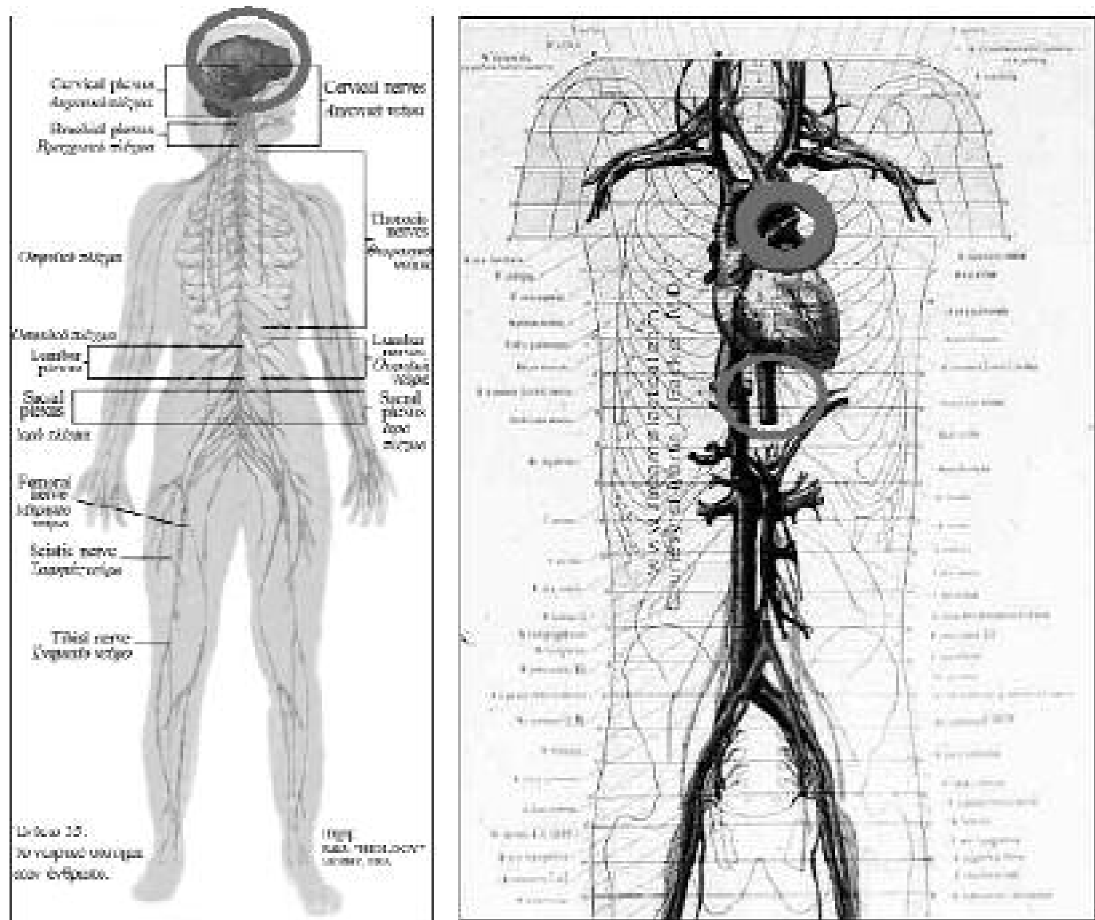
It should be marked that the majority of missile's wound do not bleed with such rythm, but in enough smaller, because: a) the bullets do not usually cut perfectly the arteries, b) while the blood pressure falls, the bleeding is decreased, c) the around tissues function as dam that limits the loss of blood, d) the bullets maybe can't hit a big artery (Peter's C.E., 1990).

3. Hydrostatic shock: It is the phenomenon, at which a missile that penetrates the body, causes damages in tissues, which are far away from the permanent cavity, due to hydraulic phenomena that are presented in parts of body, full with liquid, such as the vessels, the brain and the liver (Patel HC et. al., 2002). According to the theory of hydrostatic shock, the pressing wave that a bullet creates by virtue of high velocity speed, in case it enters in the body, displaces a big part of flesh up to ten times its size. By this way is created the temporary cavity.

A pressing wave can be created when a fluid (like the air and the water) abandons with big speed the place in which it calmed down, absorbing energy from an explosion or a missile of big speed. The tissues of the human body have a behaviour, which is similar with the water's behaviour, when enters a bullet, creating pressing waves of force above 100 atmospheres. The tissues recede violently under the effect of this pressure, creating the temporary cavity, while they drift in their movement liquids of the human body, like the blood (Sellier K.G et. al., 1994).

Moving with speed in the blood vessels, the blood is possible to destroy the smaller vessels creating bleedings far away from the orbit of entering missile. From a shot at the breast, through the vessels, the pressing wave can reach the brain creating disorders at the function of hypothalamus and of some nerves, while it is possible to be marked some small bleedings by virtue of the increased blood pressure. This

phenomenon was confirmed by the inquiring team of Goransson, who held experiments with pigs (Goransson A.M et. al., 1988). According to this research, the pigs were connected with electronic brain device and afterwards the team held shots with revolver in the breast of animals from near distance. The electronic brain device presented clues of decreased cerebral function almost immediately. Afterwards, the studies in the brain of pigs showed that a part of the nervous tissues became dead enough, before the animal dies. Similar results showed the experiments, which were held at dogs. Moreover, the inquiring team of the doctor Roberts proved with experiments of shots in bulletproof waistcoats Kevlar that even if the bullet does not penetrate the waistcoat from a shot in the breastbone with missile of mass of 8 grams and speed 400 metres per second, the heart will accept pressure 2 MPa (280 psi), while the lungs will accept pressure 1,5 MPa (210 psi).



Picture 3: Depiction of systems of vital importance of nervous (left) and circulatory (right) system, which if they are offended by missiles, they can lead to instantaneous death

"Ballistic" Examination of Wounded Person

Necessary condition for the correct confrontation of wounded person is the ascertainment of damage that he has existed. This ascertainment can be based on information, which is taken either from the wounded person or from the people who were present at the accident (medical and nursing historical), as well as on the examination, which will be held (Roupa – Daribaki Z. et. al., 2005).

The questions will be held:

a) At the people who were present at the accident and they are supposed to mention the conditions of the accident,

b) At the wounded person for the symptoms he feels (pain, difficulty while he breathes etc.).

The examination of the wounded person aims to point out the following:

1. Bleeding.
2. Fracture in the cervical fate of vertebral column. If the patient has difficulty in moving his head, right or left, it is very likely to be suffering from fracture in the nape. The fractures of cervical fate are possible to lead to wound of spinal marrow. As a result, the patient is possible to be handicapped or it is possible the roots of brachial mesh to be injured (Malgarinou M.A et. al., 2005).
3. Fracture in the thoracic and lumbar fate of vertebral

column. If the patient aches while we press lightly with our hand his back, it is likely to be suffering from fracture in the thoracic or lumbar fate of vertebral column. We meet more often, such kind of fractures, at the eleventh and twelfth thoracic vertebra, and at the first and second lumbar vertebra. In the case of fracture of spinal marrow, the patient is handicapped for the rest of his life (Sachini – Kardasi A et. al., 1993).

4. Fracture in the thorax. If the patient, while he breathes, he aches, it is very likely to be suffering from fracture in the thorax. A fracture in the thorax can cause to the wounded person big difficulty while he breathes, especially if it is accompanied by various diseases of the respiratory system. In this case, the artificial breathing does not benefit, while the patient's situation does not improve, but remains the same (Steyerberg EW et. al., 2008).
5. Fracture in hands and legs (Picture 4). If the patient presents acute pain in his hands or legs and can't move them or if one of them presents swelling or has taken unnatural place, it is possible the wounded person to be suffering from fracture in his hand or leg that suffers (Nteros K et. al., 1999).
6. Internal wounds in the abdominal area. These are usually accompanied from fracture of the basin's bones. The frailest abdominal parts of the human body are the urinary bladder, the urethra, the small and large intestine (Malgarinou M.A et. al., 2005).

Picture 4: Wounds at the legs from: A) handgun, B) shotgun, C) military rifle

Confontation of Wounds From Missiles

The usual handling of all wounds from missiles is based on the direct support of respiratory and circulatory system. The medical and nursing personnel ought to be educated on the placement of endotracheal intubation and on the support of breathing. It is necessary the venous catheter to be placed directly so as the intravenous administration of antibiotics to begin within the first 48 hours for the prevention of contaminations. The contaminations are caused while the bullet enters the human body. This happens because the bacteria are widely widespread in the human body and in the clothes. As a result they are transported at the wound's area (Peter's C.E et. al., 1996). In case of contamination is recommended the intravenous administration of penicillin. If there is doubt for damage in the thorax, it is placed an incision of thorax.

The use of temporary arterial access is recommended when it becomes extended surgical investigation. The arterial access, as first step of surgical intervention, allows at the medical and nursing personnel, who are involved in the surgical treatment, to work without important bleeding in tissues that are more far away from the point of artery's rupture, without the danger of thrombosis, and allowing by this way the better evaluation of viability of the involved systems (Sachini – Kardasi A. et. al., 1993).

In traumatic amputations, the mutilation should not be closed immediately, as well as the nerve's wounds should not be treated surgically immediately (Nteros K. et. al., 1999). The tablets that are administrated for the blood's coagulation, it is likely to cause dangerous side effects. It can exist rupture of intestine far away from the point of entrance of wound and sometimes is required the realisation of big extent of intestine's amputation (Roupa – Daribaki Z. et. al., 2005). Big extent of liver's amputation usually is essential due to the destruction of hepatic parenchyma. The effect of waves of percussion is observed in the liver and the spleen, which is the result from the wounds of thorax (Goransson A.M et. al., 1988).

The creation of cavity in the brain probably causes irreversible damages of cerebral substance and direct wound at the brain, which usually is incompatible with the life (Perel P. et. al., 2008).

The direct wound of abdominal area is proved mortally fatal, except if it is treated surgically directly. In some cases, it is likely to be needed a second surgical investigation. The wounds of thighs and buttocks should be dealt with attention and with big suspicion for wounds in the body's basin and in the abdomen, which are not located easily. If there are wounds at the nape, it is required surgical investigation, while further thorax's incision should be our next movement (Patel HC et. al., 2002).

The trap of "neurosis of battle" should always be in our mind with its known symptoms: the fear, the stress, the without aim movement and the precessions of conscience. These symptoms can easily deceive us, pretending cerebral wounds, shock situation, deficiency of oxygen at the brain and various other pathological situations (Steyerberg EW et. al., 2008).

Conclusions

According to the analysis, which was held in the previous units, the factors that determine the importance of wound depend on the missile's characteristics and on the characteristics of tissues of the human body that are affected. As long as bigger are the speed and the missile's mass, the form and the deceleration into the body, so much bigger is the opening up of the permanent cavity and bigger the wound. The kind of tissue, which is affected, is a decisive factor for the survival of the wounded person. The wound of brain, of big vessels or of liver are usually incompatible with the life.

In the field of battle, all wounds should be considered as though result from missile, even if they result from abrupt fall or sudden deceleration and acceleration, particularly the wounds that result from explosion. The medical and nursing intervention, in the field of battle, is very important for the patient's life. Anyone who knows how to support the basic vital functions of the human organism, like the support of breathing, the reduction of bleeding, the immobilisation of fractures, can contribute to the patient's treatment. Particular attention should be given in the medical and nursing handlings for the maintenance of open airways, so as a wound in the vertebral column, in case it exists, not to be in a worse situation than it was. In addition, the wounded person should be led in a secure place (for instance, far away from a fire) and transported at the hospital, in order to be treated.

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PEST and SWOT Analyses of the "Home Care" Program in Greece

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ABSTRACT

Background. The "Home Care" program is an intervention aiming at the creation of a social support and solidarity network and the avoidance of exclusion and institutionalization for low income elderly who face health problems related to disability or intense loneliness and seclusion.

Introduction - Objective. The present study aims to assess the implementation of the program in Greece, in order to identify and address strategic issues which could define its future course.

Methodology. The assessment is carried out by PEST and SWOT analyses, which provide a systematic and comprehensive reflection of the internal and external operational environment of the program, aiming at developing its strategic planning and improving its functioning.

Results. The "Home Care" program in Greece is a successful social support program, valued very positively by the local communities. However, there are substantial problems, the most important of which concerns the uncertainty about the program's future funding, and therefore its viability. Other problems relate to the program's technological infrastructure, which is in many cases nonexistent, and to the inadequate training and further education for the program's personnel.

Conclusions. The "Home Care" program may constitute an important pillar of primary health care in Greece, provided that the necessary steps for improving its functioning would be taken. For this purpose, it is necessary to ensure the program's unhindered funding, along with upgrading its technological infrastructure and provide opportunities for continuous education and training of its personnel.

Key words: Home Care, PEST analysis, SWOT analysis

I. Introduction – the "Home Care" Program

Population ageing is a phenomenon occurring with particular intensity in recent years[1] in almost all European countries in recent years . In Greece the issue has become particularly alarming, whereas "as of today there has been no estimation of the economic and social costs associated with population ageing" (Yfantopoulos, 2005). Greece, since 2004, has the third highest dependency ratio (elderly to working age population) in the European Union, namely 26.4 compared with an EU average of 24.5. In 2050 will also be in the third place, albeit with a much higher ratio, namely 58.8 compared with an EU average of 52.8. In the same year, Greece will have the sixth higher dependency ratio among the OECD countries (OECD, Health Data 2007). As a result, the health care needs of the elderly will be continuously increasing[2].

Care of the elderly traditionally belonged to the family. Today however, an increasing number of families, for various reasons, are unable to fulfill this role and provide care to their seniors. Thus, there is an imperative requirement to implement programs of social support and care for the old aged people, as well as for people in need of assistance, such as the disabled.

In this context there have been developed in recent years a number of programs, mainly at the local level, which aim at creating a social support network to prevent social exclusion situations for these individuals. The "Home Care" Program is one of these efforts, while others are the "Open Care Centers for the Elderly" (KAPI), the "Day Care Centers for the Elderly", the "Centers for Creative Occupation for Disabled Children", the "Offices for

psychological and social support", etc.

The "Home Care" Program sets as its primary goal "to meet the basic needs for social care and decent living for the elderly and people with temporary or permanent health problems or disability"[3]. The program was implemented locally usually under the supervision of a municipal corporation of the respective local authority and is funded by the European Social Fund through the Regional Operational Programs of the 3rd Community Support Framework.

The programs operate with fairly very good results in most cases. In studies of this or other similar programs (KAPI) the degree of satisfaction shown extremely high levels and ranges in excess of 80% (Alexias and Flamou, 2007; Pergamali, 2006; Chalkoutsaki, 2006; Daniilidou et al., 2003).These satisfaction percentages are a bit exaggerated, mainly because the elderly are often prone to errors of response (Bauld et al., 2000; Geron, 2000). Nonetheless, the satisfaction rates are indeed high, which fully justifies the adoption of such programs and stresses the need for their further widening and expansion. Moreover, their operation has employed a significant number of people, thus contributing to solving the problem of unemployment at local level. It is estimated that some 3.600 unemployed are engaged and found a job in the program throughout the country (ANKA, 2006).

1. According to Eurostat predictions, in the period 2005-2050 total population of Europe will fall by 2.1%, but the elderly (65-79 years) will increase by 44.1% and the very old (+80 years) by 180.5%. [European Commission, Green Paper "Confronting demographic change: a new solidarity between the generations", COM(2005) 94 final, 16.3.2005, Brussels]

2. "The rising demands of an ageing population – the Greek experience", Speech by the Governor of the Bank of Greece N. Garganas, in the Economist Conference "Social Security Reform in Greece", Athens, 14.02.2008, http://www.bankofgreece.gr/announcements/files/14%202%2008_Economist.doc

3. Article 13, Law 3106/2003: Reorganization of the National System of Social Care, Greek Government Gazette 30/10.2.2003, Vol. A.

2. PEST analysis

The PEST (Political – Economic – Socio-cultural – Technological) analysis is an important tool of strategic management through which the political, the economic, the socio-cultural and the technological operating environment of an organization is comprehensively described.

Political environment

The "Home Care" program was initiated as a pilot project in the Municipality of Peristeri in 1997 and subsequently extended to 102 municipalities throughout the country. With the implementation of the 3rd Community Support Framework, the program expanded to the all municipalities in the country, receiving adequate funding for an initial period of two years. However, the continuation of the program proved problematic, since there has never been a definite settlement and consolidation of its operation and its functioning was based on last minute renewals. This is illustrated by the successive laws and legal enactments: the Joint Ministerial Decrees Π4β/5814/1997 and Γ4β/Φ383/οικ.4504/1998 regulated the initial operational details for the program. The Law 3106/2003 (Article 13) set a more concrete framework for the operation of the program, while Law 3146/2003 (Article 13) gave an extension of the program for two more years (until 2005). Then, with Law 3329/2005 (Article 26) a further two year renewal has been given and with Law 3613/2007 (Article 27) the renewal was "renewed" until 31/8/2008. Finally, just four days before the program's ending (27/8/2008), the Joint Ministerial Decree 60292/2158/27.08.2008 extended the program's operation until 31/12/2008. Meanwhile, with the same JMD, the program for the 4th Programming Period (2007 – 2013) was renamed to "Measures to strengthen social cohesion and improve quality of life for the elderly and people in need of home care". Under this titled the program is about to be proclaimed, and calls for proposals are about to be announced, in the framework of the new Regional Operational Programs. It should be noted however that in these calls for proposals the eligible applicants include not only the local municipal corporations which run the program thus far, but other bodies as well, such as the Church, various organizations and NGOs, even private bodies. That means that the existing structures are in jeopardy once again. The inability of the state to provide a definite solution has created a state of insecurity and anxiety among workers, which certainly has adverse effects on the overall operation of the program.

Economic environment

The program's local structures throughout the country are not financially independent and self-ruled. Coordination, support, supervision and control are exerted by the Project Management Group set up in the Ministry of Health specifically for that purpose (Joint Ministerial Decree 4035/27.07.2001). Auditing and control is conducted in three levels: primary level, which is carried out by the respective Regional Operational Program's Managing Authority, secondary level, which is carried out by the Paying Authority of the Community Support Framework and tertiary level external fiscal auditing, carried out by the Fiscal Auditing Committee. However, direct operational supervision, as well as financial control and support of the program's local structures, belong to the municipal corporation of the respective municipality, which is the implementing body at the local level. According to recent data (ANKA, 2006), each local structure has an average cost for consumables 149,13? per month, average cost for the car use 135? per month and average cost for fixed assets 2.345?. Evidently, the local structures operate at a very low cost per capita, much lower than having to provide closed hospital care to these people. Depending on the level

of care and the time period of care, home care could cost no more than 40% - 75% of hospital care (Hollander and Chappell, 2002; Uchida et al., 2001).

Socio – cultural environment

Factors such as kinetic disability, emotional and cognitive disorders, fallings, widowhood and a poor subjective perception for one's own health status are related to larger demand for private or public home care services, worldwide (Stoddart et al., 2002). Population ageing and the general social trends that have reduced the share of informal care provided by the family are also factors that contribute to the development and expansion of the services provided by the "Home Care" program. Each local structure of the program served an average of 94 individuals (ANKA, 2006). Most of these are pensioners of the Farmer's Pension Fund.There are no detailed income data, however, according to recent estimates about 90% of them belong to the lowest income scale of 0-500 € per month.

Technological environment

The use of supportive technologies for providing better care for the elderly in their own place is an issue that has been promoted for several years (Elliott, 1991). Nowadays, the vast proliferation of information and communication technologies, and the widespread diffusion of the Internet, the integration of new technologies in the health sector is at the forefront of health policies. The adoption of e-Health initiatives offers new approaches in many areas of care. The advanced technological environment could be exploited in order to provide up to date and sophisticated health care services in the context of the "Home Care" program. However, in most structures of the program there is not the immediate possibility even of a simple computer. It is therefore an urgent necessity to bridge this gap between the technological reality that is now readily available on the one side, and the nonexistent technological capabilities of the program's structures on the other side.

3. SWOT analysis

The SWOT (Strengths – Weaknesses – Opportunities – Threats) analysis is a important tool of strategic management developed in the early 1970's (Andrews, 1971). It is implemented in order to identify and thoroughly describe the strengths and weaknesses present within an organization and the opportunities and threats that exist in the external environment of the organization. Usually all these elements of the analysis are presented in the comprehensive and concise form of a four-section diagram, so as to constitute a valuable analytical tool in the hands of the administration of the organization, which could be used to improve the overall operation and performance of the organization, through capitalization of its strengths, elimination of its weaknesses, exploitation of opportunities and confrontation of threats.

Strengths

High-quality services provided. The services provided to the elderly facilitate the assurance of a dignified and healthy living in their own home. At the same time, the beneficiaries' families are alleviated and disengaged by an important load of care.

Decreased institutionalization rates. Many cases would end up in the patient's institutionalization, were not for the program's provision of care for chronic illnesses.

Decreased utilization of hospital services. Many cases would end up in the hospital, whereas now, with the program, the stressful contact with the hospital is avoided or minimized. This has also important economic implications, as hospital care is very costly. On the other hand, there is a significant relief of the work load for the hospital personnel which in many cases is already working under severe pressure.

Satisfied beneficiaries. In their vast majority the beneficiaries are satisfied with the services provided by the program (ANKA, 2006).

Wide social acceptance. The program enjoys a wide social acceptance throughout the country, and it has been announced the most best service provided by the municipalities (ANKA, 2006).

Thorough knowledge of the local conditions. Each local structure has an extensive awareness and understanding of its surrounding environment and specific local conditions. The initial collection and recording of data for the region's elderly population as well as everyday practice of the structures' operations help in achieving this acquaintance.

Experienced personnel. The personnel is usually employed in each structure since its establishment and therefore is fully aware of the structure's operating details and has accumulated a very important experience related to effectively deal with each particular case which arises.

Sense of social responsibility on behalf of the personnel. The program's personnel has is fully aware of the important social role and contribution to the wellbeing of the local societies.

Good relationships among personnel members. The establishment of good relationships among workers helps in improving the everyday operations of the structure.

Good relationships with the managing authority. The establishment of good relationships with the municipal corporation which is the managing authority helps in achieving a smooth overall functioning.

Networking with other social structures. Establishing networks with other social structures in the area (hospitals, health centers, pharmacies, social welfare) helps in providing high quality services.

Innovative actions. Each structure can undertake innovative actions in their local area which promote the structure image and social acceptance. For example, it can

operate a medicine collection program, and collect medicines that have not been used by people. These medicines, after being checked for their appropriateness, can be forwarded to the program beneficiaries, thus saving an important amount of money for them.

Weaknesses

Personnel shortages. In many structures there is an urgent need for a physiotherapist and a psychologist, because most of the structure beneficiaries face kinetic problems as well as psychological and emotional distractions.

No training for personnel. The program's workers have not been trained at all. There has been no initial training neither when the structures were established, nor some continued education and training ever since. This fact deprives workers from updating their knowledge and be aware of recent trends and advancements in their field of action, namely in nursing, in consultation, in psychological support, etc.

Job stress and staff burnout. Many structures operate with the absolutely necessary personnel which in many cases is not enough to cover the increased needs. This, combined with pending decisions by the state about the program's consecutiveness and viability, creates stressful working conditions for the program's workers.

Shortages of equipment. Many structures operate with severe equipment shortages, not having even a simple computer for the maintenance of their records.

Limited mobility. Each structure possesses one car for visiting the beneficiaries in their houses. This restricts staff mobility and limits the number of visits. Should the structure have a second car the visits' scheduling would be greatly different, most probably resulting in better provision of services.

Weak management. Usually no staff member in the structure has even elementary knowledge and experience of management and this has as a result poor programming of the structure's actions, and poor overall performance.

Nonexistent business plan. In most cases the structures do not prepare a business plan on an annual or any other basis.

Lacking of evaluation. Audits usually are administrative in nature and there are no impact evaluations performed in order to assess the program's effects and outcomes for the local community. It should be noted that in most European countries impact evaluation is a widespread process which is almost compulsory in many cases. Evaluation is one of the main components of the implementation of the system of social programs (Rossi et al., 2004). Specifically with regard to programs for the elderly, they are nowadays evaluated in their entirety (van Campen, 2008).

No disclosure of the actions. In most cases there is no adequate disclosure and broadcasting of the actions and results, which could further expand the acceptance by the general public.

Opportunities

Clarification of legal status. Moves to safeguard the future of the structure, such as permanency of staff, may occur because of the increased needs and demands that society raises for the provision of the structure's services

Modernization of operations. The acquisition of a computer and an external evaluation are basic steps that can significantly improve the internal workings of the structures.

Staff training. There are opportunities that should be exploited to provide training and continuous education for the structures' personnel on many issues, such as management and administration of health services and social services, various health care issues, psychology etc.

Expansion of activities. Each structure may extend its activities with some simple steps such as obtain a second car, or employment of a physiotherapist or a psychologist.

Strengthening and better exploiting relations with other social structures. Relationships with other structures can be expanded and strengthened to allow broader cooperation, exchange of good practices, joint actions and initiatives, etc.

Collaboration with voluntary organizations. Each structure can establish relationships with voluntary organizations in joint activities and initiatives, both by promoting volunteerism and assisted by the same expansion of volunteering.

Threats

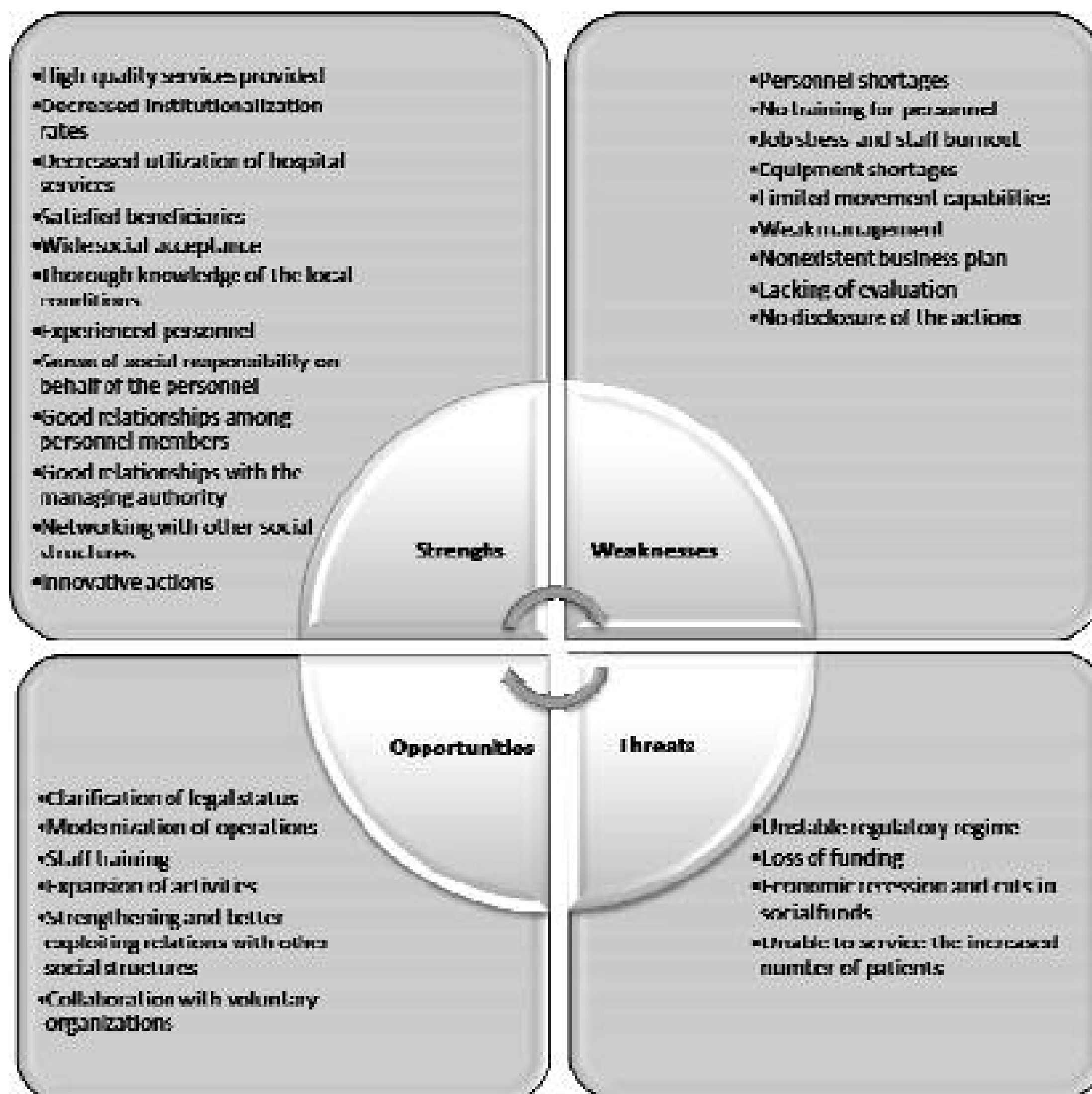
Unstable regulatory regime. The legislative regime is unclear and there may be changes that threaten the viability of local structures and create disruption in several regions.

Loss of funding. The funding is guaranteed only until 2011. Then, the structures should work with local authorities' own resources or seek funding.

Economic recession and cuts in social funds. The recent financial crisis could have serious effects on overall social costs and threaten the sustainability of social structures.

Unable to service the increased number of patients. The number of people needing assistance is increasing, partly because of an aging population and because of the increasing difficulty of the elderly's families to meet the increased care needs.

3.I. SWOT Table



5. Concluding remarks

It is obvious that the "Home Care" program is a positive contribution to tackling social problems at local level and is an important component of primary health care in Greece. But we must raise awareness of the central authority to allocate the necessary resources in order both to ensure the survival of structures and to create conditions for growth and expansion of their role, which would relieve a large number of elderly people who have an immediate need for such services. A modern welfare state is characterized, among others, by the smooth and effective functioning of structures of social care and this is something that remains a challenge for Greece.

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Evaluation of the Effectiveness of Nutrition on the Burn Patient. – Randomly Controlled Trial

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SUMMARY

Background The nutrition of the burnt patients is of major importance due to their increased metabolism. Early start nourishment plays a very important role in the result of the illness.
Objectives This study aims to estimate the role of nutrition of a burnt patient by relating the total calories received with the prices of total album in the blood serum.
Designs In order to determine the effectiveness of nutrition, two formulas were used to calculate the calories of the nourishment received by the burnt, as proposed by international bibliography. Then the two applied formulas were compared. Participants The sample constituted of 16 patients that where hospitalized in the Increased Care for Burns Unit in Greece and had 20-30% of their total body surface burned (partial or total thickness). All the patients were adults between 25 to 68 years old and the sample was randomly selected.
Methods- Results The study showed a positive cross-correlation between the calories received by the patient and the prices of total album. Using t test there was no apparent significant statistical difference, in the two administered methods of nourishment, regarding the sum of calories (t=0,226, p>0,05)
Conclusions Consequently it is not significantly important which of the two formulas are used to calculate the calories administered since they both have the same effectiveness. It is important, however, to apply a health program that will lead to the cure of the illness.

KEY WORDS : Nutrition, burn patient, Total albumins

Introduction

The metabolic reaction, to an organism's heavy illness, is generalised and independent from the type of damage that is caused- sepsis, lesion, burn or operation. Usually, it is characterized by an acceleration of the metabolism. Patients with heavy burns react with a hyper-metabolism and therefore have a direct need for calorie support. Nutritious reserves are activated in order to offer essential amino-acids, glucose and greasy acids that will cover the increased needs of the organism, resulting in proteolysis, glycolysis and lipolysis. An accelerated metabolism resumes proportional to the extent of damage and is supported by a combination of chemicals, neurogenesis and environmental stimuli (Bessey P.Q., Downey R.S., 1997). However, intense and extended stimulation of the metabolism can cause exhaustion of the metabolic reserves, disturbances in the immune system and disturbances in the function of vital organs. Therefore, if this situation remains uncontrolled it will be followed by increased morbidity and mortality. It is necessary to recognize and confront it on time (Deitch F.A. 1999, Mizock B.A.2000, Sayeed M.M. 2000).

The right therapeutic treatment and a suitable diet of burnt patients will accelerate the cicatrization of the burnt surface and enhance survival. The initiation of nourishment must come immediately after the burn, because the gastro-intestinal system constitutes the target organ that is most affected from this shock. Considerable reduction of the

blood flow to the gastro-intestinal tube results in the derogation of this function (Peck M., Ward Q., 1997). It is known that lack of irritation of the intestinal mucous for a time interval above six hours causes atrophy and allows the passage of bacteria and toxins through the intestinal barrier. Therefore, there is an obvious need to protect the mucous and apply the nutrition. (Tayek J. 1999).

The best way to achieve this is the early beginning of enteral nutrition. Results of a study indicate that enteral nutrition was a more effective route to preserve gastric secretion and the mobility of the gastrointestinal tract. (Zhongyong C., 2007) An important issue is infusion of glutamine to burn patients, which is an great energy source to the immune cells (Xi Peng, 2006). However, recent study found that delayed nutritional support, after 24hours, did not influence the result of a burn injury in comparison to early nutritional support (Wasiak J. et al, 2006).

Indirect calorimetry is often used for the calculation of the calorie needs of patients that are in catabolism. Bibliography report's various formulas that calculate these needs, as they appear in table I. (Curreri R.W., Richmond D., Marvin J. 1974., Wolfe 1981. , Dickerson R.N., 2002). Even though it has been years since the Boston group and Curreri announced their formulas, these remain very popular until today. The Boston formula proposes that even the most serious burns do not need more calories than the double the energy that is consumed when the body is in complete calm as it is shown in the Haris - Benedict equation (Table I), (Wolfe 1981).

Materials-Methods

The present study deals with the application of these two formulas on 16 burn patients, who were hospitalized in burns units, with partial or total thickness burns on 20 - 30% of their total body surface (TBS - Total Body Surfau). They were separated in two groups, A and B. 9 individuals constituted group A where the Curreri formula was applied and 7 individuals constituted group B where the Boston formula was applied. Then, with the use of Pearson's cross-correlation factor the mean prices of total albumin in the blood serum was calculated for each patient. Then, based on the above formulas, this number was related to the number of days the nutritious diet was applied. The prices of total albumin are indicators with which nutrition can be evaluated in clinical practice.

Then by using t for control on pairs the two formulas were compared regarding their effectiveness in relation to the level of total albumin in the blood serum of patients. The data of this study are presented on Table 2. Data analysis was based on SPSS Vs 16.0 program.

Results

By using Pearson's cross-correlation factor for each sample separately we got r =0,55 for group A and r =0,668 for group B. Consequently it appears that a moderate to powerful relation exists between the prices of total albumin and the amount of calories administered to burnt patients. More precisely, positive cross-correlation appears, which means that an increase of the amount of calories leads to an increase of the total albumin in the blood

Moreover we were interested to compare the mean prices of total albumin for the two populations by using the mean numbers of samples A and B. Applying the control t for pairs it was found that means of the two populations were the same (t = 0,226 p >0,05). This means that both formulas of indirect calorimetry have the same result with regard to the sufficiency of nutrition of burnt patients. .

Furthermore from table 2 we can observe that in women the number of calories is similar for the two groups. Contrary, this dose not apply to men. According to the formula men in B group appear to need higher number of calories than the men in A For example, a burnt man from A group with 20% of his TBS (Total Body Surface) burnt needs according to the Curreri formula about 2500 calories, while a burnt man with 20% of TBS burnt needs roughly 4300 kcal based on the Boston group formula. This difference is very important if we take into account that the prices of total albumin are almost the same.

Conversation

It is generally accepted that the metabolic rate proportionally increases in a linear relation to the length of the burn. Consequently administering the right therapeutic treatment and a suitable diet is necessary. This is also proven by Pearson's cross-correlation index. However, special attention should be given in interpreting Pearson's cross-correlation index, because maintaining the total albumin level of the blood serum in normal prices may be an effect of either a calorie –nutrition program or a total health care program.

In addition, the results showed that the medium prices of total albumin of the two samples of the two populations were the same. We therefore conclude that even though there are certain differences in the number of calories of the two groups, the alimentary needs of burnt patients are covered by the Curreri formula that gives men a

considerably smaller amount of calories. This is because; the formula of the Boston team is determined by age while the formula of the Curreri team is influenced by the extent of the burn, as it is presented in table I.
Therefore, the qualitative composition of the diet is more important than the precise amount of calories granted. In addition, according to research carbohydrates should amount 45 - 55% of the total sum of calories calculated (Burk, 1980). A higher percentage of carbohydrate provision is accompanied by various side effects on the respiratory function.
The proteins required by the burnt patient for the cicatrisation of an extensive lesion, given the increased loss of nitrogen from urine, are obviously many. Specifically the needs of proteins according to Curreri and the Boston team are presented in table 3.
In addition, it has been proven that in patients with an increased protein catabolism it is beneficial to issue protein rich in amino-acids that have divaricated chains (BCAA), (Echeniqui, 1984).
Finally the total quantity of fat issued should constitute the 30 - 40% of total calories without overlooking that the diet should be enriched with electrolytes, vitamins and elements. Therefore we can conclude that the qualitative composition of the diet is more important than the precise amount of calories that will be granted.

Table 1 • Methods of estimating the calories that burnt patients need.

Method	Estimation of the administered calories (kcal/d)
Curreri et al	Adults (25 x ΣB/kgr) + (40 x % TBS)
Boston Group	2 x REE (is estimated based on the Harris – Benedict formula) Women: REE =655 + (4,3 x weight (kg)) + (4,3 x height (cm)) Men: REE = 65 + (6,2 x weight (kg)) + (12,7 x height (cm)) – (6,8 x age)
Xie et al	Energy consumption = (1000 kcal x BSA (m2) + 25 x % TBS)
	where BSA: body surface TBS: burn surface

Table 2- Data

Group A- Curreri Formula						
Gender	Age	Weight(KG)	TBS %	Kcal	Total Albumin	
Θ	25	75	23	2800	5,4	
Θ	38	82	25	3000	5,7	
A	35	78	24	2900	6	
Θ	37	65	20	2400	5,1	
Θ	42	87	22	3000	4,8	
Θ	45	86	27	3200	5,5	
Θ	28	58	25	2400	4,8	
A	29	67	20	2500	5,3	
A	58	86	24	3100	6,5	
Group B- Formula of the Boston group						
Gender	Age	Weight(KG)	TBS %	Kcal	Total Albumin	Height (cm)
Θ	35	76	25	2900	5,2	155
Θ	27	65	26	3000	5,8	162
Θ	50	79	24	2800	4,8	160
Θ	51	92	24	2900	5,1	158
A	68	60	20	4000	5,5	171
A	62	68	25	4000	5,6	170
A	65	72	20	4300	5,8	165
correlation Group A	0,555					
correlation Group B	0,668					

Table 3 • Estimation of the need of proteins in burn patients

Curreri	Proteins in gr/d = 3 gr x ΣB (kgr)
Boston group	Proteins in gr/d = 1,5 – 2 gr x ΣB (kgr)

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Lifelong Learning in Nursing Science and Practice: A Bibliographic Review

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SUMMARY
Learning is not a simple absorption of information, facts and theories, but the development of critical thinking to cope with the overabundance of information that we are overwhelmed with. Nurses work in an environment of rapid change, which requires them to update their knowledge and skills to prepare them for a different domain of knowledge. To acquire the required knowledge they are integrated in educational programs which consist of 'adult' students. The objective of this bibliographic review is to explore the prospects of continued vocational training of nurses in the field of health.
This bibliographic review, which was carried out for this aim, was based on the Greek and International bibliography in respect to lifelong learning of nurses and the implementation of this in Greece.
Retrospective studies were sought in published Greek and International scientific journals. The Internet was used as a primary bibliographic withdrawal tool. Keywords set for the search were: Lifelong learning, In-service training. Professional development, Quality health services, Continued vocational training.
The modern nurse must learn continuously. While their original, basic education is the obvious prerequisite for professional competence, participation in continued educational programs and thirst for learning are the hallmarks of their increased professional conscience. The benefits of lifelong learning for professional nurses are, other than having access to new knowledge, the possibility of expanding their qualifications, abilities and skills to enable them to cope with the multitude of changes, new technologies and the successive development of the field of health.

Keywords: Lifelong learning, In-service training, Professional development, Quality health services, Continued vocational training.

I. Introduction

The development of human resources, especially the modernization of skills and the expansion of lifelong learning is crucial in knowledge based economy. Training is a set of actions designed for the acquisition of the necessary established professional knowledge and skills. Particularly, continued vocational training, consisting of a continuous process, which aims to ensure that the knowledge and skills of individuals are adapted continuously and meet the evolving requirements of employment and labour market needs. Therefore, continued education is aimed at maintaining, renewing, upgrading and modernizing professional knowledge and skills (National Technical University of Athens).

Reference to the Past

Continued education as an independent term first appeared in the Anglo-Saxon countries in the 1960s and prevailed in being indicated as this in offer of vocational training for university graduates. It was clear that for 'scientific professions' this knowledge should be enriched with new scientific discoveries which were directly related to the proper performance of professional functions and the effort of enrichment taken on their own initiatives the national in scope scientific societies (EPEAEK II).

By the late 1980s, Continued Vocational Training (CVT) was a rather minor object of collective negotiations in most European countries. CVT employees started acquiring more importance, which was particularly evident by the mid-1990s. This development was due primarily to changes, which were realized in the approach of administration functions (Soumeli, E.).

Quality of Health Services

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Lifelong Learning

A reason why 'lifelong learning' has become so important is the rapid development of science and technology. 'Lifelong learning' is subjective and is associated with whether someone can be open to new ideas, decisions, skills or attitudes.

Worldwide there is a wealth of skills and qualifications, which essentially, reflect the socio economic level of each country. For each country, structured detection is considered necessary for skilled and qualified nursing staff and proven programs already adopted in other countries in the implementation and evaluation of the adequacy and decision making of professional nurses as skilled or specialized.

With the aim of improving the quality of care and patient safety in European context, it is imperative that all nurses participate actively in knowledge and nursing practice. The nurses have individual responsibility and assume leadership to improve the quality of care. The requirements for quality improvement, responsibility and efficiency of nursing practice underline the necessity of continued interest on the part of the nurses to continuously update new knowledge, techniques and developments concerning the profession.

Continuous Professional Development

Continuous professional development is part of 'lifelong learning' and is defined as the continuous process of personal development to improve the capacity and recognition of maximum capacity of health professionals in the workplace. All this can be achieved through the acquisition and development of a broad range of knowledge, skills and experience, which are usually not acquired during training or everyday practice, which together develop and maintain competence in the implementation of their job.

In-Service Education

In-service education is defined as: 'The education which is delivered in a structured work environment and which strengthens the individual to become more efficient professionally'. Thus, the person (in this case the health professional) has the potential to develop further in competency in relation to knowledge on technical subjects, in order to maintain and broaden the educational and technical content and the processes in a changing environment with a view of developing their personal abilities.

Continuous in-service education helps health care providers (nurses) to acquire, maintain and improve their abilities and skills in specialized areas of nursing.

Continuous in-service nursing education is undoubtedly necessary in the clinical area. The use of appropriate capabilities may help greatly in the effort to broaden knowledge and improve skills of the nursing staff (Meeting Minutes of the Pan-Cyprian Association of Nurses and Midwives, 2007).

F. Nightingale in 1860 noted the need for continued education of nurses, but this is still being carried out occasionally and without gravity (Yfanti, E., 2006).

It is imperative, therefore, that nurses today broaden their knowledge with continued education (Albani, E., 2006). In the field of health, where many developments occur daily, each health professional requires to be equipped with modern knowledge and skills (Papageorgiou General Hospital). The monitoring programs of continuous education will contribute to the validation of the nurse as a responsible health professional (Albani, E., 2006).

Job Satisfaction – Continued Education

The phenomenon of job satisfaction in nursing has been studied extensively in recent years. Job satisfaction relates to the degree that the person is pleased in their job.

From a survey carried out in six public and two private hospitals in Attica, an important factor, which seemed to be linked to feelings of resentment of participants from the workplace were the limited possibilities of continued education.

The participants in the survey seemed to acknowledge the need for continued education, as they linked this not only to the strengthening and professionalism of the nursing role, the improvement of quality and safety of nursing care, but also to the strengthening of feelings of satisfaction, confidence and competence (Karanikola, M., and associates, 2008).

The Hospital environment is characterized as an area of 'intense labour' and human resources are the means by which the complex mechanism moves. The Nursing Staff

because of the nature of working in intense situations stress and cancellations. Nurses are the most vulnerable emotionally and psychologically of all health professionals. Therefore, creating incentives for their dynamic activation is imperative.

An incentive consequently, is the investment in the systematic professional development of the employees, a way of activation towards positive attitudes. Continuous training, seminars, advanced educational programs and participation in conferences gives rise to change and development.

According to a survey of Ms Kontogianni, A., (2007), in two public Pediatric Hospitals in the pediatric departments of two General Hospitals in Greece, concerning the conflicts between nursing and medical staff, a management proposed settlement of these conflicts, is continued education and scientific research, because individuals and groups will come closer and with closer cooperation one will respect the work of the other.

From research carried out by Ms Michaelidou, L., (2005) in 79 Hospitals of Greece, concerning the participation of health service users in Greek public hospitals, respondents felt that continued education and staff training deserves documented improvement, suitable training of employees was particularly emphasized, since respondents have an important dividend in the success participation of health service users and in education.

Enthusiasm, desire, patience (job satisfaction) and leadership in conjunction with the relevant know-how, it is possible to lead to small or big changes.

Culture and Nursing Education

Today's society is composed of many different groups, including people with different racial, national and socio-economic background. This results in the existence of social groups from different cultures and different civilizations and different cultures. Culture is integral to both health and disease. Therefore, nurses should be informed about the different cultural needs of different individuals in order to effectively understand and contribute to their satisfaction.

However, according to research, the lack of cultural education of health professionals causes a loss millions every year and sometimes, has a result of misdiagnosis of a patient's problem. Therefore, it is worth stressing the necessity of the provision of Continued Nursing Education to nurses, with an aim covering the educational needs concerning Intercultural Nursing (Gerogianni, G., Plexida, A., 2008).

An effective health system depends mainly on the competency and quality of the health staff. Constant reference must be made to the special education which must be provided to all the staff of health services. For this education funds will be needed, however, the economy of this money is considered to be made directly from the efficiency of the services (Polyzos, N., Yfantopoulos, I., 2000).

According to the Press Conference of Ms Linou, A., there are inequalities-differences in education/training, lifelong learning and continued education of health services in EU countries.

Despite the differences, according to research carried out by Ms Turimou Prodromou H. and associates, (2007), Nurses acknowledge the importance of continued professional education. They state that continued professional education must be compulsory for all and optional only in specific and specialized cases.

Modern Tools of Education in Nursing Practice

The health area is especially important, not only for the community and health professionals, but also for the image of a country. Staff and health organizations must not fear the introductions and use of computers and new technology, but they must support it (Madgana, B., 2008).

In the last decades, not only a worldwide rapid increase in the production of scientific knowledge has been observed, but also pioneering methods of transmitting this knowledge to health professionals. Electronic Learning as a pioneering tool of learning might constitute a means to lifelong learning of nurses contributing to their professional and personal development and to the upgrading of the services offered in the health system (Halaris, I., 2006). The aim of the program for learning through the internet is the provision of knowledge, information on new practices and innovations, support and cooperation amongst those interested (Mallidou, A., 2005).

The new possibility of the Internet, for instance Distant Learning, as a main vehicle of continued education, has acquired new meaning in the context of the Internet. There is a possibility of same intensity and pace of studies independent of the physical presence of an instructor and trainee at the same place and time. Easy access to all global sources and the possibility of using them gives each person interested the ease to search for advice, influences and mentors in the field which they are interested in (Taraktsis, A., 2002).

Epilogue

Modern nurses must learn constantly. Although their initial and basic education is an obvious prerequisite for their professional competency, their participation in continued educational programs and their thirst for learning consist hallmarks of their increased professional conscience (Theofanidis, D., Fountouki, A.).

Continued Education is needed for professional development, strengthening and autonomy in decision making. For an organization to be made competitive and attractive to maintain a highly trained nursing staff, it must adopt continued education, which is a means of ensuring quality (Findings, 14th Pan-Cyprian Convention of Nursing and Midwifery, 2007).

What is needed is, awareness-raising for Nurses so they can be constantly updated, the operation of the continued education service in every Nursing Institute, correct staffing with trained staff, moral staff, so professional development of staff is made possible with incentives for learning (Meeting Minutes of the Pan-Cyprian Association of Nurses and Midwives, 2007).

The Offices of Hospital Education can organize advanced programs on focused interest in the context of an overall strategic in –service training. A prerequisite for the successful participation in activities of continuous training apart from the mood of the nurse for training, is the practical convenience and moral encouragement from all the levels of the nursing hierarchy (Theofanidis, D., Fountouki, A.).

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Education on Sexual and Reproductive Health Within the Context of European Policy: A Literature Review

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ABSTRACT

Introduction: The initiation of sexual activity in early age, the increasing percentages of teenage pregnancies, the abortions, the HIV/AIDS infection and he Sexual Transmitted Diseases (STD's) are some of the factors that have a negative effect on young people's sexual health in contemporary years (UNAIDS, 2004). Sexual and reproductive health is affected and formed through specific cultural frameworks, such as religion and family.

Aim: The aim of this article is the review of the data in Greece and in Cyprus, in relation to sexual and reproductive health and education, in the bases of the European Union policies on this matter.

Methodology: The methodology included the review of research studies and documents referring to the Greek and Cypriot data, related to the sexual and reproductive health and education through the European Union policy. Methods were based on literature review in the data bases of MEDLINE and CINAHL (1990-2009).

Conclusion: The recent methodology of health education does not aim to the plain acquire of knowledge, but it aims to the development of skills intending to the adoption of positive behavior, which advocates and promotes health through the active and synergic learning and experiences. Educators and health professionals through teaching and daily practice have the opportunity to transfer knowledge and reform attitudes and behaviors relatively to the sexual and reproductive health. Both in Greece and in Cyprus, students in secondary education are taught different aspects of sexuality education in the context of their school programs. The European Parliament and the European Council have passed several directives highlighting the necessity of sexuality education, underlying a wide field of knowledge and learning.

Key words: Sexual and reproductive health, education, European policy

Introduction

Worldwide, sexuality education has been and still is a topic very often discussed. It which consists of many dimensions, such as the content, the time frame, the teaching methods, the efficiency of the teachers, the appropriate age to begin and other.

According to the European Directive 1567/ 2003 article 3, teenagers have the right for "…a sufficient access to information, training and… services in relation to sexual and reproductive life…". A multidimensional approach seems to be essential due to the different factors that contribute to the social and personal development for dealing with issues such as HIV/ AIDS and unwanted pregnancies. This approach should not deviate from the existing socio-cultural infrastructure of each country; neither can ignore the rights and responsibilities of young people regarding sexual and reproductive health matters.

In Europe, 25% of teenagers they are sexually active at age 15 old, while this in the United States comes to 50% (Knerr, 2006; Warren et al, 1998). In Cyprus, the average age for the initiation of sexual activity is 16 years (Youth Organization and Institute of Reproductive Medicine, 2006) and in Greece is about 15-16 years of age (Youth Health Unit, 2009). Today, the initiation of sexual activity at early age, the increasing percentages of teenage pregnancies, the abortions, the HIV/ AIDS and the STD's are some of the factors that negatively influence youth's sexual health (UNAIDS, 2004).

Sexual Health and Education

According to the World Health Organization (WHO, 2002), sexuality is a dominant meaning of human existence throughout life and includes gender roles, sexual orientation, satisfaction, sexual relations and reproduction. Sexual and reproductive health requires a positive approach, characterized by respect for the meaning of sexuality and sexual relationships, as well as the potential for pleasant and safe experiences without coercion, discrimination and violence (WHO, 2002).

Sexuality education, behaviour and sexuality itself (e.g. initiation of sexual intercourse, are formed within a cultural framework of each society and is influence by social values and religious beliefs (Bonell et al, 2006). Further, family and peers play an essential role in the development and expression of attitudes and beliefs related to sexuality, while research has shown that sexuality education may reduce risky sexual behaviour (Aspy et al, 2006; Wight et al, 2002). In some Scandinavian countries, parents seem to be more mature in openly discussing sexuality issues with their children, rather than in other countries, such as England or Greece. It appears that young people in those countries are more informed and prepared to make mature choices in their sexual life; the initiation of sexual activity is prolonged and they have safer sexual intercourse (McCafferty, 2007).

Sexuality education is not limited in providing knowledge about STD's or contraception; it is a life long learning that includes sexuality the relations and feelings related to the sexual experience. It approaches sexuality as a normal, natural, inseparable and positive part of life and that exist in all stages of development and existence (Kavga- Paltoglou, 2008). Sexuality education should promote the gender equality, self-esteem and respect for sexual and reproductive health rights.

In refer to sexuality education programs Kirby et al (2007) stated that their effectiveness depends on the investigation of educational needs and on their appropriate planning. An effective sexuality education 'course', one can take in account the knowledge, the attitude and the behavior that young people adopt towards different sexual matters, such as sexual relations and contraception (WHO, 2003). In Greece and Cyprus, students in secondary education, are taught some sexuality matters within the context of their school program. In these 'courses' the students are informed and discuss topics like: sexual development, reproduction, contraception interpersonal relations. This "new" knowledge seems to be essential and be a base for young people in order to adopt responsible lifestyle behaviors, ways of thinking and skills in relation to sexual health (Davou and Sourtzi, 2009).

Sexual Education and European Policy Here

The European dimension on education has to be approached in the context of the wider Community educational policy, as a factor that contributes to the development of the Community and the establishment of a uniform European conscience. In practice, the term is directly related to the educational dimension. It is establishment the theoretical framework of the Community's educational policy in the everyday practice at school and health settings. Consequently, the essence of the European dimension has to be correlated to the teaching principles and the pedagogic methods; it has to be combined and integrated within educational curricula; it has to be promoted through books and literature and finally it has to become part of continuous education for teachers and health professionals (Danassis-Afentakis, 2003).

The European Union Directive 1567/ 2003 among other things mentions:

- The freedom of all persons to have access to information, education and services for teenagers.
- The support of heath policy and programmes on sexual and reproductive health.
- The continuous provision and availability in low prices of acceptable methods of contraception and protection from STD's, HIV/ AIDS
- The right for safe termination of pregnancy and the opportunity to have counseling before and after.
- The training on family planning.
- The education on gender equality in relation to the sexual relations behavior such as responsibilities.

The European Parliament and the European Council clearly highlighted the necessity of sexuality education and determine a wide leaning framework.

Moore and Rienzo (2000) suggested a more specific context for sexuality education:

1. Human development (e.g. anatomy, physiology, adolescence, body image, sexual identity).
2. Relations (e.g. family, love, marriage, dating).
3. Personal skills, Values (e.g. negotiation, decision-making).
4. Sexual behavior (e.g. masturbation, celibacy, phantasy).
5. Sexual health (e.g. contraception, abortion, violence).
6. Culture and Society (e.g. legislation, religion, mass media).

These suggestions seem to promote a more holistic approach of sexuality education. They combine different parameters, viewing adolescents as a bio- psycho- socio-cultural entity.

European politics gives certain directives, however, it is the discretion of each country in what way and/or degree will be included and applied in the context of their society and culture.

Sexual Education in other countries

Almost in every European country, sexuality education has been introduced in the school programs as an obligatory or an optional 'course'. In the countries that are more progressive, such as Holland and Sweden, sexuality education begins at the nursery school and continues at primary school, while is taught multi-thematically.

It is important to mention that in the educational procedure includes peer education and parent education (Moore, 2000). In England, despite that the sexuality education is applied multi-thematically, it seems there is no holistic and/or systematic teaching approach. Probably, that explains the existence of high percentages of abortions.

Further, the same problems may be seen in other countries, where sexuality education is limited or fragmentary or consciously focused on specific areas/topics. In Romania for example, there is enough theoretical knowledge mainly related to risky behavior. In Russia, education is focused on topics primarily concern the women (e.g. pregnancy, menstruation) and not sexual relations between genders. In some countries the social and religion beliefs create resistance that obstructs and complicates objective education on sexuality (e.g. Poland, Ireland) (Okun, 2000).

Legislation related to the sexual and reproductive health in Greece and in Cyprus

Abortion [EU 2001/2128 (INI)]

In Greece the termination of pregnancy is under the law 1609/86 "Medical termination of pregnancy for the protection of woman's health". Abortion is legal until the 12th week of pregnancy with the consent of the woman. Between the 12th and the 20th week of pregnancy, abortions are allowed only if special medical reasons exist in national health system hospitals. In Cyprus, abortion is permitted under certain circumstances (e.g. medical reasons; Abortion law 1986, article 169A). In the public hospitals is more difficult to be performed, mainly due to socio-cultural reasons and stigmatization. In cases of rapes, the police is obliged to have a medical (forensic) report a long with a medical testimonial.Abortion is forbidden by the Greek-Orthodox Church.

Public Health [EU 2001/2128 (INI)]

In Cyprus there is no official public health service of immediate help and support for young people, regarding their sexual and reproductive health. Family Planning Association is very active; however is a non-governmental organization. In Greece, Family Planning is recognized as a civil right in the national health system by the law 1397/83, in which it is defined that is the exclusive responsible institution for providing such services (Sourtzi, 2006).

Sexuality Education [EU 89/C 3/01; 2001/2128 (INI)]

In Cyprus, there is no legal or obligatory form of sexuality education, however it does exist in health education programs since 1992. In Greece, health education was legally established at primary and secondary education: "In primary and secondary educational institutions, health education programs are implemented, that consist of the curriculum and include specific teaching material and activities, are applied…" (article 7, law 2817/ FEK 78/14-3-2000). The health education curricula have been approved by the corresponding departments of the Pedagogic Institute and are implemented in the schools with a Minister decision 2/6006/7-11-2001 and F11.2/818/78436/G1/25-7-2002 Circulars and the G2/43520/FEK/543/T. B'/ 1-5-2002.

Conclusion

Adolescents' education and training on sexual health, target at shaping a safer and healthier behavior, using appropriate teaching methods, providing knowledge and awareness regarding sexual behavior and practice. The recent methodology of health education is not consisted of simply providing informing and knowledge, but it refers to the development of skills for adopting positive lifestyle and behaviour that advocate and promotes health. Health education is practiced by scientists regardless their specialization, on the bases that they have comprehend its fundamental meanings and principles (Kalokairinou and Sourtzi, 2005).

Sexuality education in its wider meaning raises the issue of access to the special youth services (information and service) and especially deprived communities/groups regarding sexual and reproductive health rights.

Abortion has not yet been legalized in many countries. Even where is permitted, the administrative formalities create an obstacle for many women. In some cases in many countries, very strict time limit exists for the termination of pregnancies and consequently this particular right is of no value in practice. It seems extremely important to ensure the right and possibility of proving information and referral to young people to the appropriate support services, when is necessary. Consequently, those involved with sexuality education become a pressure group for the creation of such structures.

Educators and health professional through teaching role and everyday practice, have the opportunity to shape attitudes and behaviors. It is necessary to adopt a comprehensive strategy within the educational and health care system, through continuous education programs.

Sexuality education programs consist of scheduled activities based on the needs assessment, the experiences and the potential risks for the young people that are referring to. They intend to the reinforcement of positive forms of behavior and the prevention from influences or changes that

imply an unhealthy life style. The programmes are based on different theories (educational, sociological, health) aiming at the formation and the alteration of behavior. Relatively to the sexuality education, the teaching of mechanisms avoiding psychological pressure by social or other factors is of prime importance (Danassis-Afentakis, 2000).

The modernization of books, the awareness and the acquirement of skills of the teachers and health professionals are essential. Sexuality education presupposes continuous, evolutionary and responsible information, beginning at the first years of one's life and demands an interdisciplinary collaboration in the educational system and in the wider community (Vidaliaki et al., 1990).

The ultimate target of sexuality education is the promotion of sexual and reproductive health, especially of youth, and the prevention of unwanted pregnancies with all the psycho-social and physiological effects they may result in. taking advantage the possibility of prevention, this consist the safest method. Young people with knowledge, self confidence and positive sexual choices, promote their sexual and reproductive health today and in the future (Danassis-Afentakis, 2003).

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Guidelines for authors are available at **www.nursingjournal.gr** or can be sent on request

GUIDELINES FOR AUTHORS

The *Hellenic Journal of Nursing Science* is the official journal of the Hellenic Regulatory Body of Nurses. It is a peer-reviewed, multidisciplinary journal that is intended to promote Nursing Science in Greece.

The *Hellenic Journal of Nursing Science* provides a forum for publication of scholarly papers that report research findings, research-based reviews, discussion papers and commentaries which are of interest to an international readership of practitioners, educators, administrators and researchers in all areas of nursing, midwifery and the caring sciences. Papers should highlight their contribution to the theoretical or knowledge base of the discipline.

Papers should have an international dimension and those which focus on a single country should identify how the material presented might be relevant to a wider audience.

Selection of papers for publication is based on their contribution to knowledge (including methodological development) and their importance to contemporary nursing, and relevance to midwifery and related professions. Papers should be submitted in English.

TYPES OF PAPERS CONSIDERED FOR PUBLICATION

The HJNS publishes papers under three main categories:

Editorials and Perspectives

Generally editorials are commissioned but authors, who have ideas for editorials which address issues of substantive concern to the discipline which can be linked to material published in the journal, should contact the Editor in Chief. Editorials are typically short (200 words maximum) although there are no fixed limits.

Original Articles – Research Papers

- Full papers reporting original research can be a maximum of 5000 words in length, although shorter papers are preferred.

- Protocols of controlled intervention studies and systematic reviews of up to 2,500 words. Authors should make a case for publication of the protocol in which they should state the trial registration number (if any) and when the findings are due to be reported.

Reviews and Short Reports (up to 2000 words)

- **Reviews, including:**
  - systematic reviews, which address focussed practice questions;
  - literature reviews, which provide a thorough analysis of the literature on a broad topic;
  - policy reviews, i.e. reviews of published literature and policy documents which inform nursing practice, the organisation of nursing services, or the education and preparation of nurses and/or midwives.

- **Short Reports** and 5 references, reporting the development research instruments and measuring scales and including a copy of the relevant instrument so it can be published in full. If authors wish to retain copyright - they can do this by simply marking it as copyright to them / their institution and saying it is reproduced with permission.

- **Book Review Articles**, i.e. papers which provide a critical discussion of an aspect of nursing with reference to two or more recent publications on a similar topic. The Editor-in-Chief welcomes proposals for book review articles (of up to 1000 words), and may also commission them.

SUBMISSION PROCEDURE

Authors should submit manuscripts to the journal electronically via the journal's email: hjns@otenet.gr. All correspondence, including notification of the Editor's decision and requests for revisions, will be by e-mail. Any author who is unable to submit electronic copies for good reason should contact the editorial office in the first instance for advice (contact details at www.nursingjournal.gr).

Submission of a paper implies that it has not been published previously, that it is not under consideration for publication elsewhere, and that if accepted it will not be published elsewhere, in English or in any other language, without the written consent of the publisher.

Review Process

All papers accepted for publication undergo a double blind peer review by at least two reviewers. Initially all papers are assessed by an editorial committee. Papers which are unlikely to be published, for example because their novel contribution is insufficient or the relevance to the discipline is unclear, may be rejected at this point in order to avoid delays to authors who may wish to seek publication elsewhere. Occasionally a paper will be returned to the author with requests for revisions at this point in order to assist the editors in deciding whether or not send it out for review. Authors can expect a decision on this stage of the review process within 2-3 weeks of submission. Manuscripts going forward to the review process are double-blind peer reviewed by members of an international expert panel. We aim to complete this process within 8 weeks of the decision to review although occasionally delays do happen and authors should allow at least 12 weeks before contacting the journal. The decision with regard to publication is based on the reviews and editorial assessment of priority for publication. The Editor-in-Chief reserves the right to the final decision regarding acceptance.

PREPARATION OF THE MANUSCRIPT

General instructions: Submitted papers should be relevant to an international audience and authors should not assume knowledge of national practices, policies, and legislation. They must be typewritten, double-spaced with wide margins on one side of white paper. Authors should not identify themselves or their institutions in the manuscript other than on the title page, which is removed before review. For hard copy good quality printouts with a font size of 12 pt are required. Authors should consult a recent issue of the journal for style if possible. Since the journal is distributed all over the world, and as English is a second language for many readers, authors are requested to write in plain English and use terminology which is internationally acceptable. The Editor-in-Chief reserves the right to adjust the style to ensure certain standards of uniformity.

Paper length: All papers are subject to review and authors are urged to be brief; long papers with many tables and figures may require shortening if they are to be accepted for publication. There is no specific word limit, however, (except in the categories listed above) papers may be up to 5000 words in length, plus tables, figures, and references. Ordinarily there should be no appendices although in the case of papers reporting tool development or the use of novel questionnaires it is usual to include a copy of the tool as an appendix. Authors of any papers, which do not comply with these restrictions, should make preliminary enquiry to the Editor-in-Chief before submitting the manuscript.

ORGANISATION OF THE MANUSCRIPT

Organise the manuscript in the following order: title of paper, title page, acknowledgments, abstract and key words, text, references, tables, figure legends, figures, appendix (font: Times New Roman size 12, 1,5 line space). Please number the pages of your manuscript.

Title: The title of a paper should indicate its subject and where relevant the population, clinical problem and its method of enquiry.

If the paper is a review, this should be indicated in the title; e.g. 'Nurse led units: a systematic review', 'Patient empowerment: a literature review', 'Phenomenology for nursing research: a methodological review', 'UK guidelines for treatment of depression: a policy review'.

For research papers the research design adopted should be indicated; e.g. 'The effectiveness of nurse led units: a randomised controlled trial', 'Coping with chronic pain: an ethnography', 'Communication barriers perceived by older patients and by nurses: a questionnaire survey', 'The psychometric properties of the Pain and Stress Scale: scale development'.

Title page: Include full name, job title, highest academic and professional qualification and institution for each

author. Indicate an e-mail address for the corresponding author.

Acknowledgment: Limit acknowledgment to key contributors.

Abstract: Prepare a structured abstract. Abstracts should be less than 250 words, and should not include references or abbreviations.

Abstracts of research papers should adopt the following headings, where possible: Background; Objectives; Design; Settings (do not specify actual centres, but give the number and types of centre and geographical location if important); Participants (details of how selected, inclusion and exclusion criteria, numbers entering and leaving the study, relevant clinical and demographic characteristics); Methods; Results, report main outcome(s) / findings including (where relevant) levels of statistical significance and confidence intervals; and Conclusions, which should relate to study aims and hypotheses.

Abstracts for reviews should provide a summary under the following headings, where possible: Objectives, Design, Data sources, Review methods, Results, Conclusions.

Abstracts for book review articles should provide a concise summary of the line of argument pursued and conclusions. A structured format is not essential.

Key Words: Provide between two and six key words in alphabetical order, which accurately identify the paper's subject, purpose, method and focus. Use the Medical Subject Headings (MeSH®) thesaurus or Cumulative Index to Nursing and Allied Health (CINAHL) headings where possible.

Text: in the text's introduction it is required for all papers to have a reference to what is already known about the topic and to what the paper adds to nursing science.

Tables/Figures: Tables and figures are printed only when they express more than can be done by words in the same amount of space. Indicate suggested placement of tables or figures in the text. Tables should be numbered consecutively and given a suitable caption and each table typed on a separate sheet.

Abbreviations: Avoid abbreviations wherever possible. Any abbreviations which the authors intend to use should be written out in full and followed by the letters in brackets the first time they appear, thereafter only the letters without brackets should be used.

Statistics: Standard methods of presenting statistical material should be used. Where methods used are not widely recognised explanation and full reference to widely accessible sources must be given.

Informed consent: Where applicable authors should confirm that informed consent was obtained from human subjects and that ethical clearance was obtained from the appropriate authority.

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Questionnaires: Questionnaires and assessment schedules used in research studies that are not established and well known should be included as an appendix.

References: All publications cited in the text should be presented in a list of references following the text of the manuscript. In the text refer to the author's name (without initials) and year of publication (e.g. "Since Peterson (1993) has shown that?" or "This finding is supported by results obtained later (Kramer, 1994)"). For three or more authors use the first author followed by "et al.", in the text. The list of references should be arranged alphabetically by authors' names. The manuscript should be carefully checked to ensure that the spelling of authors' names and dates are exactly the same in the text as in the reference list. References should be given in the following form:

Arthur, D., Sohng, K.Y., Noh, C.H., Kim, S., 1998. The professional self concept of Korean hospital nurses. International Journal of Nursing Studies 35 (3), 155-162.

Barnes, B., Bloor, D., 1982. Relativism, rationalism and the sociology of knowledge. In: Hollis, M., Lukes, S. (Eds.), Rationality and Relativism. Basil Blackwell, Oxford, pp. 21-47.

Dijkstra, A., Buist, G., Dassen, Th.W.N., 1996. Nursing-care dependency: development and psychometric testing of the NCD-scale for demented and mentally handicapped in-patients. In: Proceedings of the 8th Biennial Conference of the WENR, Research on Nursing throughout the Lifespan, vol. I. Ekblad & Co, Vastervik, pp. 117-126.

Gower, B., 1997. Scientific method: an historical and philosophical introduction. Routledge, London.

REVISED ARTICLES

If you are re-submitting a paper that has been revised please include a covering email or letter which provides a detailed account of how you have responded to editorial and peer review comments and other guidance you may have received. Where suggestions have not been followed you must explain and justify your decision. This should include specific reference by section / page / paragraph number to alterations in the text.

AUTHOR SERVICES

Proofs

Proofs will be sent to the author (first named author if no corresponding author is identified of multi-authored papers) and should be returned within 48 hours of receipt. Corrections should be restricted to typesetting errors; any others may be charged to the author. Any queries should be answered in full. Please note that authors are urged to check their proofs carefully before return, since the inclusion of late corrections cannot be guaranteed. Proofs are to be returned to the Hellenic Regulatory Body of Nurses, Vas. Sofias 47 str., 10676 Athens, Greece.

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Queries For queries relating to the general submission of manuscripts (including electronic text and artwork) and the status of accepted manuscripts, please contact the Editor in Chief (hjns@otenet.gr)

THE EPITOME OF USEFUL INFORMATION

INCORPORATION OF THE HELLENIC REGULATORY BODY OF NURSES

The Hellenic Regulatory Body of Nurses was constituted by the law 3252/2004 as a form of a Public Body and functions as the official professional body representing the nurses. The enrolment of all nurses is compulsory as is done in corresponding chambers overseeing other professions and functions as a regulatory body and the official counselor of the state (Pan-Hellenic Medical Association, Legal Association of Athens, Technical Chamber of Greece etc.)

MAIN GOALS OF HRBN

In an effort to make the reasons that all nurses should be subscribed to HRBN clear, shown below are the basic goals as presented by the law 3252/2004 and these should be implemented by HRBN:

- The promotion and development of nursing as an independent and autonomous science and art.
- The research, analysis and study of nursing matters and the formulation and submission of scientifically documented studies of the various nursing problems in the country.
- The construction of proposals on nursing matters.
- The continuous training and educating of nursing staff and the materialization and utilization of training programmes.
- The participation in materializing programmes which are funded by the European Union or other international organizations.
- The editing of certificates which are necessary for obtaining a license to practice the nursing profession.
- The evaluation of the nursing care provided.
- The representation of our country at international organizations regarding the nursing department.
- The publication of a journal, an informative bulletin, text books and leaflets so as to inform its members and the public.
- The study of Medicaid matters and the organization of scientific congresses that are independent or in cooperation with other bodies.
- The creation of an ethics committee for the nursing profession.
- The definition and cost assessment of nursing activities.
- The protection and enhancement of the level of health of the Greek population.

MEMBERS OF HRBN

It is compulsory for members of HRBN to be nurses, in other words they should be graduates of the following:

a) University level nursing schools
b) Technical level nursing schools
c) Former higher school for nursing, visiting nurses belonging to the ministry of health, welfare and social security
d) Former nursing school "KATEE"
e) Foreign nursing schools with degrees that are accepted as equivalent to the corresponding Greek schools
f) Military supreme nursing schools

STRUCTURE OF HRBN

HRBN is composed of a central administration, which is located in Athens, and seven peripheral sections, one in each health district of the country.

CENTRAL ADMINISTRATION

The central administration is made up of a 15 member executive council and has its central office in Athens. The address is 47 Vasilisis Sofias Avenue p.c. 10676, tel: 210 3648044-048 and fax: 2103617859 and 210 3648049. HRBN's website is www.enne.gr and email: info@enne.gr .

PERIPHERAL SECTIONS

The peripheral sections correspond to the number of health districts in the country and include:

1. 1st P.S. Attica: 47 Vasilisis Sofias Avenue, p.c. 10676, tel: 210 3648044-048 and fax: 2103617859 and 2103648049
2. 2nd P.S. Piraeus and Aegean: 47 Vasilisis Sofias Avenue, p.c. 10676, tel:210 3648044-048 and fax: 2103617859 and 2103648049
3. 3rd P.S. Macedonia: 11 Mavili St., Thessalonika p.c. 54630, tel: 2310 522229 and fax: 2310 522219
4. 4th P.S. Macedonia and Thrace: 11 Mavili St., Thessalonika p.c. 54630, tel: 2310 522229 and fax: 2310 522219
5. 5th P.S. Thessaly and Mainland Greece: 2 Navarinou St., Larissa p.c. 41223 tel: 2410 284866 and fax: 2410 284871
6. 6th P.S. Peloponnese, Ionian Islands, Epirus, and Western Greece: 1 Ipatis and N.E.O Patra-Athens, Patra p.c. 26441 tel. and fax: 2610 423830
7. 7th P.S. Crete: 116 Menelaou Parlama St., Irakleio p.c. 73105 tel: 2810 310366, 2810 311684 and fax: 2810 310014

MEMBER REGISTRATION AND SUBSCRIPTION

All nurses are obliged to apply for registration at the nearest peripheral section. The application form requires a certified copy of the nurse's degree and official identification, two coloured photographs, the receipt from the bank statement for the amount of 65 ?, a simple copy of the license to practice the nursing profession and other titles that the applicant might have are optional (postgraduate degrees, certificates for foreign languages, social activities etc.).

All nurses are obliged to renew their subscription annually, in person or by post (not by fax) till the end of February, by handing in the appropriate statement to the nearest peripheral section. The statement should be handed in simultaneously with the annual subscription fee, which has been assigned to the amount of 45 ? by the law 3252/2004.

All nurses who register or renew their subscription to HRBN are given a Nursing Identity Card.

LICENSE TO PRACTICE THE NURSING PROFESSION

The license to practice the nursing profession can be administered at the local prefecture by presenting the necessary documents and certification of registration at their HRBN peripheral section. When receiving the license to practice it is compulsory to present a copy to the peripheral section to which they belong.

According to the law 3252/2004, whoever practices the nursing profession without a license to practice will be prosecuted according to the article 458 of the Greek penal code.

Any individual of the peripheral council or the board of directors can file a complaint for illegal practice of the nursing profession and thereafter must notify the judiciary authorities.

In the case of a temporary disciplinary sentence or final disqualification from HRBN the license to practice is automatically suspended.

ADMINISTRATIVE BODIES

HRBN is administered by the assembly of representatives and the executive council. The peripheral sections are administered by the general assembly and the peripheral council.

HRBN'S INTERNATIONAL REPRESENTATION

HRBN is a member of FEPI and has one of the seven positions on the board of directors. England, Italy, Spain, Ireland, Poland, Croatia, Romania and Portugal participate in this European federation. France, Cyprus and Belgium are under consideration for participation. For more information the website is www.fepi.org.

SELECTION AND SERVICE OF ADMINISTRATIVE BODIES

HRBN's board of directors is elected by the assembly of representatives. The representatives are elected separately for each peripheral section by the members of the department's General Assembly. The peripheral councils are elected in a similar way by the members of the peripheral department's General Assembly.

These elections take place every 3 years and Nurses that take part are members in good standing (subscription payed).

DISCIPLINARY CHECK

The members of HRBN are initially submitted to a disciplinary check by the peripheral section, which also functions as a disciplinary council. The secondary disciplinary check, as well as the disciplinary check of the members of the board and the peripheral councils is executed by the supreme disciplinary council, whose president is the supreme court judge.

SCIENTIFIC JOURNAL

HRBN created the "Hellenic Journal of Nursing Science" in 2008 which is its official journal. It is a multidimensional journal with an editorial committee which aims at the promotion of the nursing science in Greece.

The "Hellenic Journal of the Nursing Science" is a reliable, modern, quarterly scientific journal which is published in Greek and English and is available in electronic and print-

ed form. A nominal fee is offered to all interested researchers, university teaching staff, students and the entire nursing community in general as well as the tertiary university and technical level schools (Greek or foreign).
Simultaneously it offers young scientists easy access to knowledge and the chance for nursing to progress, as well as a scientific step for the nurses who work in the academic area and the clinical area to publish their work and undergo some constructive criticism. The journal publishes research studies, reviews, original dissertations and book reviews.
The papers that are published, are credited in a manner that is regulated and certified by the Greek legislation according to international standards.

INFORMATIVE JOURNAL

HRBN created a monthly informative journal in 2008 "Rhythm of Health – Ρυθμός της Υγείας", aiming at promoting and demonstrating each nurse as a unified psychosomatic and professional personality.
The nurses in Greece have the need to solve primary issues that concern their profession as well as the need to express themselves, to communicate, to enjoy themselves and to demonstrate the diverse aspects of their social purpose.
"Rhythm of Health - Ρυθμός της Υγείας" aims at uniting the voice of all nurses in the country and becoming an immediate and dependable form of communication, giving a chance to all voices of the professional community to be heard.

GOALS FOR THE FUTURE

With the collaboration of all its members HRBN aims at materializing and completing some important projects that are requested by the nursing community, some of which have already started being carried out:

- The definition and cost assessment of nursing activities.
- The creation of an open line of communication so as to record and solve the nursing problems.
- The enhancement of international relations between Greek nurses and organizations, for and international institutes.
- The creation of an electronic digital library which can be used free of charge by members of HRBN and to which the whole country will have access.
- Will offer specific training and postgraduate courses.
- The organizing of scientific congresses and day meetings with formal accreditation.
- The formation of specific project committees such as a training committee, a documentation committee, a foreign affairs committee and an informative committee.
- The creation of a network of experts on nursing issues and the provision of legal advice.
- The creation and function of specialization programmes.
- The certification of nursing specialties and nursing adequacy.

CONTACTS

Nurses can contact us :
Tel: 2103648044, 210 3648048 (8:00-15:00)
Fax: 2103648049, 210 3617859
Email: info@enne.gr

- For professional matters
- For training matters
- For legal issues
- For their registration or renewal of subscription
- For general information (congresses, activities, etc)
- Proclamations via the Hellenic public organization for hiring personnel "ΑΣΕΠ"
- For positions in the health sector