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Research Papers

Analysis of Pathological Situations and Confrontation of Wounds Caused from the Entrance of Missiles in the Thoracic Cavity .... p. 53

Cervical and Breast Cancer Screening Tests Utilization in a Greek Island Population .... p. 58

Nurses and Emotional Intelligence: a Descriptive Study .... p. 63

Reviews

Counseling and Health Education Program Planning in the Field of Education: The Role of the School Nurse .... p. 69

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:

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- 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
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editorial

The Hellenic Journal of Nursing Science, the official scientific journal of the Hellenic Regulatory Body of Nurses, has received the status of "National Recognition"!
All Journal's contributors wish to express their pride for its progress and their gratitude for the continuous support and assistance they have received from the Hellenic nursing community.

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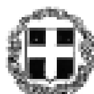

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Ο ΥΠΟΥΡΓΟΣ ΥΓΕΙΑΣ ΚΑΙ ΚΟΙΝ/ΚΗΣ ΑΛΛΗΛΕΓΓΥΗΣ

Έχοντας υπόψη:

1. Το Π.Δ. 95/2000 «Οργανισμός του Υπουργείου Υγείας και Κοιν. Αλληλεγγύης» (ΦΕΚ 76/10-3-2000 τ.Α΄) όπως τροποποιήθηκε μεταγενέστερα.
2. Τις διατάξεις της παρ. 2 του άρθρου 1 του Ν. 2256/94 «Συμβούλια κρίσης και επιλογής Ιατρικού και Οδοντιατρικού προσωπικού και άλλες διατάξεις» (ΦΕΚ 196/Α/94) με τις οποίες επανήλθαν σε ισχύ οι διατάξεις των παραγράφων 4 (εκτός της περίπτωσης δ΄) και 5 του άρθρου 27 του Ν. 1397/83 «Εθνικό Σύστημα Υγείας» (ΦΕΚ 143/Α/83).
3. Τη γνώμη του Κεντρικού Συμβουλίου Υγείας (ΚΕ.Σ.Υ.) όπως διατυπώνεται με την αριθ. 3994/24-6-09.
4. Το γεγονός ότι, από τις διατάξεις αυτής της Απόφασης δεν προκαλείται δαπάνη σε βάρος του κρατικού προϋπολογισμού.

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Στα περιοδικά με Εθνική αναγνώριση στα οποία οι δημοσιευμένες εργασίες των γιατρών, αποτελούν κριτήριο συγκριτικής αξιολόγησης για την κατάληψη θέσης του κλάδου γιατρών Ε.Σ.Υ. προστίθεται και το περιοδικό «ΕΛΛΗΝΙΚΟ ΠΕΡΙΟΔΙΚΟ ΤΗΣ ΝΟΣΗΛΕΥΤΙΚΗΣ ΕΠΙΣΤΗΜΗΣ» που εκδίδεται από την ΕΝΩΣΗ ΝΟΣΗΛΕΥΤΩΝ ΕΛΛΑΔΟΣ.

Η απόφαση αυτή να δημοσιευτεί στην Εφημερίδα της Κυβερνήσεως.

Ο ΥΠΟΥΡΓΟΣ

ΔΗΜ. ΑΒΡΑΜΟΠΟΥΛΟΣ

Analysis of Pathological Situations and Confrontation of Wounds Caused from the Entrance of Missiles in the Thoracic Cavity

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ABSTRACT

The aim of the present inquiring work is the study of the missile's effect of different caliber diameter and velocity, which enters in the thoracic cavity of the human body. The direct diagnosis and confrontation of wounds in the thorax are considered very important, while the wounds of the thoracic cavity can probably lead to instantaneous death or serious pathological situations, like blockage of windpipes, pneumothorax, bloodthorax, collection of pus in the pleura's cavity, lesion and dysfunctions at the area of heart, which are potentially dangerous in the future. The results of the study showed that the importance of wounds of thoracic cavity depends on the missile's characteristics, which enters in the thoracic cavity, and on the characteristics of thorax's tissues that are affected.

Keywords: blockage of windpipes, characteristics of missile's entrance, collection of blood in the cavity of pericardium, lesion, pneumothorax, thoracic cavity.

Introduction

In the modern field of battle, the wounds usually result from explosive mechanisms (artillery, mortars and mines) and in a smaller percentage they result from missiles of high and/or of low speed of proportional caliber diameter. The importance of these wounds depends on the systems of the human body, which are offended, as well as on the characteristics of missiles that offend them (Ordog G.J. et. al., 1988). Consequently, 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 (Alexandropoulou C.E. et. al., 2009). The present work examines the types of wounds and analyzes the pathological situations, which can probably be caused in the thoracic cavity by the entrance of missiles (Picture I). The wounds of the thoracic cavity are of major importance and they have occasionally occupied enough scientists, while in the antiquity they were considered lethal. Of course, in our season this perception is not true, while with the progress of medical technology in combination with the direct and correct confrontation of thorax's wounds, the life of wounded person can be saved and the prognosis of wound can be excellent.

Picture I: Wounds at the thorax of the human body caused from missiles with high speed and small caliber diameter

Historical retrospection

The fractures of ribs are known from the season of Hippocrates (5th B.C. century), who considered the haemoptysis as complication. He therapeutic proposed the bandaging of thorax with linens fabrics, a practice that constituted the base of wound's confrontation for centuries (Ntolatzas Th., 1992). Later, Ambroise Pare, the most famous surgeon of 16th century, faced the subcutaneous emphysema with multiple incisions of skin and subcutaneous tissue. In 1740, Daniel Hoffman described the clinical picture of wounded person with paradoxical mobility of thoracic wall and in 1807 Andrew Halliday presented his knowledge about pneumothorax (Tountas K, 1977).

The first successful correction of traumatic cardiac rupture is attributed to the German Von Rehn. The same year, Paget declared that the surgery had reached its limits and the correction of heart's wounds was impossible. Dupuytren and Larrey had already attempted similar interventions without success and the year 1709 Boerhaave declared that the heart's wounds are always lethal (Ntolatzas Th., 1992). Giovanni Battista Morgagni is the first scientist who described the pulmonary rupture and in 1833 J. Jobert distinguished three degrees of importance of pulmonary rupture. Up to the end of 19th century, there were enough cases of closed wounds of thorax. G.J. Guthrie, English military surgeon of wars, described the complications of closed wounds of thorax (pleurisy, pneumonia, abscess e.t.c.) and Paget, at his first English book about surgical situations of thorax, refers that the lung's wounds can be attributed to the energy of lesion and not only to the fractures of ribs (Nteros Mr et. al., 1999).

The studies of E. Graham and R. Bell, the period of 1st world war, helped at the complete comprehension of physiology of pneumothorax and of value of closed channelling of pus with pipe. Up to the 2nd world war, this simple method was used very little. Moreover, the peeling of lung was established therapeutic, for the cases in which the simple channelling with pipe failed and led to the stay of residual collection. The frequency of collection pus in the lungs at the thoracic wounds during the 2nd world war and during the war of Korea was 25-30%. With the above practice, the frequency of collection pus in the lungs was limited to 6% during the war of Viet-Nam (Ann H. Ross, 1995).

The last years, the American College of Surgeons developed a system of confrontation of wounds, which is known as Advanced Trauma Life Support (ATLS). The purpose of this system is the recognition and effective confrontation of wounds, which threaten the life of wounded person, aiming at the precocious stabilisation. This confrontation is known as Initial Estimate and it includes the total of essential energies, from the point of wound up to the centre, which will offer the final treatment. The First degree and Secondary Estimate are essential steps. With the First degree Estimate, the dangerous for the life lesions are recognized and faced, the situation of the wounded person is stabilised and the possibility of benefit of final treatment is determined. The secondary Estimate is, in fact, the detailed clinical examination that intends to reveal the total of lesions. The failing of benefit of final treatment is followed by secure evacuation of stabilised wounded person at the nearest and more suitable centre, which has the possibility to offer services of high level (Murphy G., 1980).

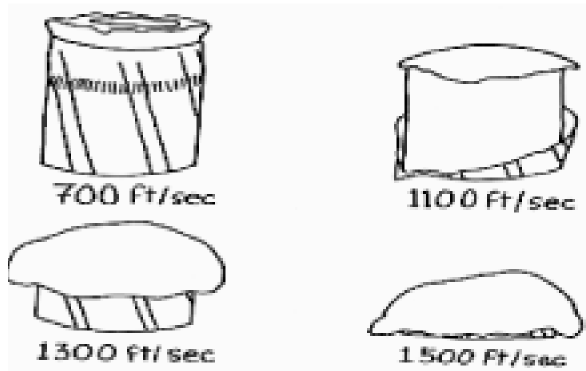
Effect of missile

In the previous sections, it was reported that the importance of wounds depends not only on the systems of the human organism that are affected, but also on the characteristics of missile that offend them. The missile's spinning momentum has big relation with the way that the damage is caused, when the missile strikes the thoracic cavity. A missile of small caliber diameter, which is moved with high speed, begins to palpitate fast while it enters in the tissues, forcing more tissues to be moved. With this way, the bigger part of missile's kinetic energy is transmitted in the thorax. A heavier missile of bigger caliber diameter transports more kinetic energy in the thorax, even from bigger distance (Picture 2). But, the missile can probability puncture so much the thorax and as a result to penetrate the thoracic cavity with the rest of the kinetic energy. In addition, a missile with low kinetic energy can cause important damage at the thorax, if it is drawn to transport all its energy on the target. Essential condition, however, is the near distance of the shot (Coe J.I., 1982).

Moreover, the missile's planning determines significantly the wound's importance. The convention of Hagen and consecutively Geneva prohibit the use of explosive missiles in war time. This is the reason, why the military missiles are metal casing. In our days, the missiles have casing of copper, because the missiles begin to be made red-hot by the heat, which is produced in speeds bigger than 2000 ft/s (approximately 60 m/s). A missile, which is sharp and small in diameter, (Picture 3) can penetrate the thoracic cavity and cause damage equal with a knife or a lance. The missile's tip, drawn in order to destroy human tissues, should have a "brake", so as to transport all the kinetic energy at the target (Peter's C.E., 1997).

In addition, the missile's speed plays an important role. The speed that ought to have a missile in order to penetrate the skin is 163 ft/s (almost 50 m/s) and in order to penetrate a bone is 213 ft/s (at about 65 m/s). Both values are low enough (Definis Gojan vic M., 1995) to cause damage at the thorax, but in combination with other

factors, which were analyzed in the previous units, can possible cause instantaneous death or various serious pathological situations, which are potentially dangerous in the future and require direct and correct confrontation. The most significant of these are analyzed extensively in the following sections.



Picture 2: Indicative speed values for various missile bodies. As long as bigger is missile's speed, so much bigger is its kinetic energy.

Picture 3: Various types of missiles with differently geometric characteristics and proportional caliber diameter.

Blockage of windpipes

It is evinced with voice's alteration, dyspnoea, which can possibly be accompanied with cyanosis, weakness of function of thoracic wall, intense anxiety of wounded person, use of complementary respiratory muscles, as well as with the presence of hematomas or wounds at the neck (Gardika K.D., 2005). The effort of maintenance of practicable of windpipe with simple ways, like the breathing of air into the windpipes and the placement of mouthpharygnal windpipe are short-lived solutions and do not protect the windpipe. The nurse ought to place artificial windpipe for the facilitation of breathing of wounded person. If the blockage last for big time interval, it is possible to befall heart failure due to deficiency of oxygen. If the blockage is raised and the wounded person has not pulse, the support of respiratory and circulatory system should begin immediately (Makos K. et. al., 2003).

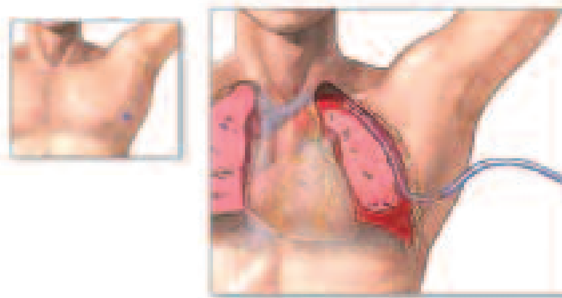
Pneumothorax

It is evinced with the collection of air in the cavity of pleura. The pneumothorax is named open, when via the aperture the air enters in the cavity of pleura and comes out with the respiratory movements. On the contrary, the pneumothorax is named closed when the air ceases to enter and come out. The air is gradually absorbed and the cavity is disappeared. The most dangerous is the pneumothorax under strain, at which the mechanism of valve is presented. Therefore, the air enters in the cavity of pleura, but it is unable to come out. As a result, a big quantity of air is collected, which causes movement of middle-thorax, bending of big veins with intense respiratory and circulatory deficiency (Athanasopoulou P. et. al., 2004).

The pneumothorax is evinced with strong pain of thorax, dyspnoea, cyanosis, anxiety and distress. At pneumothorax of severe level, particularly under strain, the pressure into the thorax amounts fast and the return of blood via the veins is impeded. As a result, the heart-blood is reduced. If the air is not removed, it is possible to befall death due to respiratory and circulatory deficiency. At pneumothorax of small level, it is recommended rest and fighting of pain. In every case of severe level pneumothorax, it is necessary the entrance of catheter in the cavity of pleura, while the other tip of pipe is placed in the bottom of container that contains water (apparatus billow). The lung begins to function within 12-14 hours. After the complete function the catheter remains for 2-3 days. The insistence of pneumothorax indicates bronchopleuritic fistula and the patient should be subjected to thorax's incision and sewing of fistula. The patients, who present relapsing pneumothorax, should be subjected to rib's incision, at which the pleura's wall is removed (Sachini - Kardasi A. et. al., 1993).

Bloodthorax

The bloodthorax is the collection of blood in the pleura's cavity. It is not recognized by a special point, but by the general points of bleeding. Apart from the general points of bleeding, the bloodthorax is recognized by the lowering of respiratory whispering during the auscultation and from the obtuseness during the percussion. The treatment consists the blood's channelling via the apparatus billow (Picture 4), which aims at the correct function of lung and at the restoration of circulating volume of blood. At severe level bloodthorax, namely continuing bleeding 200 ml/hour for the next 3-4 hours, the thorax's incision is necessary (Rachmanidou M. et. al., 2000).



Picture 4: Blood's channelling via the apparatus Billow

Collection of pus in the pleura's cavity

It is evinced with high fever with ague, pain at the thorax, perspiration and cough. The puncture gives purulent liquid and there are points of pleuritic liquid. When the pus is extended, there are intense weakness and swelling at the fingers. In infrequent cases there is inflammatory swelling of soft molecules, while the pus comes out to the skin with fistula from the pleura and the intercostals intervals. The treatment consists permanent channelling of pus with flexible pipe with the condition that the pus remains for long time interval. If the pus is rendered chronic, the peeling of lung should be held, in which the sac of pus is removed (Malgarinou M.A et. al., 2005).

Crushing or closed lesions of thorax

The simple fracture of one or two ribs is a painful damage, which limits the cough and the respiratory movements. If the fractures of ribs are multiple, the paradoxical breathing is created. Therefore, the steady osseous prop of thorax is suppressed. The part of thorax that lost its osseous prop, during the inhalation, pressed from the atmospheric pressure, recedes and the parenchyma's air, which is found under this part, is moved to the remainder parenchyma of the same lung and to the other lung. On the contrary, during the exhalation, the air from the other lung and the remainder parenchyma of the same lung is moved to the parenchyma, which is found under the offended part (Hefts D., 1991). The confrontation includes stabilization of thorax with the hands, application of pressing bandage, turning to the suffering semi-thorax, tracheotomy or placement of endotracheal intubation, connection with mechanic respirator for the correct function of lungs and administration of sufficient quantity of oxygen (Tountas K., 1988).

Collection of blood in the cavity of pericardium

The collection of blood in the cavity of pericardium impedes the fulfilment of heart's cavities and its function. The blood stems from the heart's wound, the coronary vessels or the aorta. It is evinced with dyspnoea, palpitation and shock's points. The known triad of Beck, which consists in distention of neck's veins, increase of cardiac tones and fall of arterial pressure, can set the diagnosis of blood's collection in the cavity of pericardium. The parallel increase of central venous pressure in combination with closed wound of thorax is also clues of blood's collection in the cavity of pericardium (Rachmanidou M. et. al, 2000). The nurse in collaboration with the doctor ought to realise pericardium's puncture and channelling of pericardium's cavity, which constitute saving interventions (Gourgouli E. et. al., 2005).

Rupture of trachea and big bronchuses

This lesion has as a result the massive escape of air that is added up in the pleura's cavity. The haemoptysis, the continuing escape of air from channelling semi-thorax and the incomplete pulmonary function are clues that require further examination. The bronchoscopy is a method, which is preferred, and reveals rupture, if there is, at distance 2.5 cm from the mainly bone of sternum and particularly right (Gardika K.D., 2005). The therapy requires surgical treatment, under the condition that the initial stabilisation of wounded person, with channelling of semi-thorax, which is recommended unconditionally, has been preceded (Susan C. deWit, 2009).

Heart's fracture

The closed lesion of heart can lead to myocardium's fracture, valve's dysfunction or rupture of heart's cavities. In the last case, the blood is collected in the pericardium's cavity, which was analyzed in the previous sections. In the other cases, there are not special points. The arrhythmias, the hypotension, the pain at the thorax and the dyspnoea are clues of heart's fracture. The measurement of level of cardiac enzymes is useful, as also useful is the observation of wounded person with electro-cardiogram at least the first 24 hour/day after the wound (Nteros K. et. al., 1999).

Aortic lesion

The rupture of thoracic aorta is lethal. Only the wounded people with incomplete ruptures of thoracic aorta's wall, which are located near its arterial ligament, survive. The diagnosis is placed with the aorta's check-up. Alternative, the helical calculating tomography with infusion of suitable substances can be used, which if it does not show the presence of blood, the presence of aortic lesion is excluded. The revelation of aortic lesion and its suspicion are essential elements for the salvation of wounded person. The therapy requires surgical treatment (Tountas K., 1977).

Conclusions

According to the analysis, which was held in the previous sections, it is obvious that the importance of wounds of thoracic cavity depends on the missile's characteristics that enters in the thoracic cavity and on the characteristics of thorax's tissues that are affected. Each scientist in the sector of health ought to know the way in which the missile enters the thoracic cavity and the type of wound that it is possible to be caused on the basis of the characteristics of missile body, so as to be able to face the wound immediately and effectively.

The thorax's wounds are particularly threatening for the life of wounded person and need direct diagnosis and confrontation with simple means, like administration of oxygen, insurance of windpipe, channelling with apparatus Billow, support of breathing, retention of bleeding, replacement of blood and others, depending on every case. It is remarkable that if the wounds of thoracic cavity are not faced immediately and effectively, it is possible to lead to instantaneous death due to the continuing bleeding and damage of tissues or they can cause serious pathological situations, which are potentially dangerous in the future, like the blockage of windpipes, pneumothorax and others.

In the present work, we examined the most serious pathological situations that are caused by the missile's entrance in the thoracic cavity. However, there are and others pathological situations, less dangerous and threatening for the life of the wounded person, like the fractures of scapula, sternum and collar-bone. In every case, the medical and nursing intervention is essential, which aims at the promotion of health and prevention of complications that are possible to be caused at the person due to the wounds of the thoracic cavity that are caused by missiles motions.

Conclusions

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Cervical and Breast Cancer Screening Tests Utilization in a Greek Island Population

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ABSTRACT

Background: Cervical and breast cancer still remain two of the most common types of cancer worldwide, with a great mortality rate. The purpose of the present study was to investigate the participation of women in a Greek island in cervical and breast cancer screening tests. Mammography, Clinical Breast Examination (CBE) and Pap test were studied.

Material and method: Two hundred women from the broader area of the island of Chios filled in equal number of closed type questionnaires regarding the demographic information of the subjects, the usage of gynecological health care services and gynaecological cancer screening tests.

Results: The mean age of the women of the sample was 43± 11.02 years old. Rates of mammography. CBE and Pap test in the whole sample were 41.5%, 69.5% and 87%. Employed, engaged and women of high income had higher rates of Pap test. Women gratuates of high school or lower had higher percentages of mammography. Women over 40 yrs old had higher rates of all the three screening tests, at least once in a lifetime.

Conclusions: Pap test is the most frequent examination. Socioeconomic status is related to screening test utilization. Women of lower income underutilize screening services. Special attention should be paid to younger ages.

Introduction

Cervical and breast cancer still remain two of the most common types of cancer worldwide, with a great mortality rate (Ferlay et al 2004, Knutson & Steiner 2007). The screening tests can lead to a decrease of the incidents these two cancers. Indeed, this has partly happened both in Greece and in other developed countries, during the last 10 years (Kiriakogianni et al 1998, Dimitrakaki et al 2009). The screening guidelines for the diagnosis of breast cancer are continually changing. Because of increased awareness of the signs and symptoms of breast cancer and the use of screening mammograms, breast cancer is increasingly being diagnosed at earlier stages. Annual mammograms and clinical breast examinations are recommended for women

older than 40 years. Women older than 20 years should be encouraged to do monthly breast self-examinations, and women between 20 and 39 years of age should have a clinical breast examination every three years. (Knutson& Steiner 2007). Regarding Pap test, the test should be taken within 3 years of onset of sexual activity (http://www.cdc.gov/std/hpv/ScreeningTable.pdf)

Nevertheless, women participation are far than optimal and considerable disparities among various population groups exist. Higher rates are reported for Pap test in comparison to mammography, while breast clinical is often neglected. Indeed, after robust, rapid increases in reported use of mammography by women in the U.S. since 1987, estimates from the 2005 NHIS showed a decline compared with 2000 (from 70% to 66%)(Breen et al 2007). Rates for Pap test are usually beyond 70 %, while clinical breast examination rates are usually below this point (Peterson et al 2008).

Data from Greece are sparse, especially those regarding clinical breast examination. The purpose of the present study was to investigate the participation of Greek women in cervical and breast cancer screening tests. Mammography, Clinical Breast Examination (CBE) and Pap test were studied.

Material and Method

Researchers visited workplaces, homes, hair salons and beauty parlors in order to include unemployed women in the sample. A closed type questionnaire was used. This questionnaire has been used in similar surveys in Greece in the past(Davou 2005). Questionnaires were also distributed to Public Services and Legal Persons of Public Law. The workplaces where the data were collected were a public hospital, the central offices of some banks and some private companies. The participants were informed regarding the purpose of the study and then the questionnaires were handed out to the women who were interested in the study. It was made clear that the data were collected confidentially and that no person could be identified from the results of the study.

The questionnaires were completed in the presence of the researchers, to whom the participants could ask explanatory questions. The questionnaire was created by the research team and contained questions regarding the demographic data of the subjects and the use of gynecological Health Care Services. Two hundred women participated in this research.

Statistics

Initially, a descriptive statistical analysis was conducted and contingency tables were formed on the questioned variables. The x^2 test was used on the qualitative variables along with Yates correction for 2x2 tables. Variables regarding screening test frequencies were dichotomized to "never" and 'at least once". The statistic package SPSS, 13.0 for Windows was.

Results

The average age of the women of the sample was 43± 11.02 years old, with 18 years being the minimum and 71 the maximum age. Eighty seven percent (174)of the women were married. A 79.5% (159) of the women were working, while of the women reported up 52.6 % to as their monthly income. Regarding their educational level, 5% were Elementary graduates, 12.5% were Junior High School graduates, 45% were High School Graduates or Technical School of secondary education graduates, 39% University or Higher Technical Educational Institute graduates (Table 1). Rates of mammography. CBE and Pap test in the whole sample were 41.5%, 69.5% and 87% (Table 2). Mammography rates in women over forty years old were 56.7 % (Table 2). Women of lower educational level(high school or lower) had higher percentages of mammography (at least one in their lifetime)(Table 3). Employed, engaged or married women,of higher education and income and had statistically significant higher rates of Pap test. CBE was more frequent among women of higher income(>1000 euros) (Tables 4, 5, 6). Women over 40 yrs old had higher rates of all the three screening tests (Table 7).

Table 1. Demographic characteristics of the sample

Variables	N	%	Mean(± SD),
Age (years)	200	100,0	43 ± 11,02
			71-18
Age of married people	174	87,0	42± 10,52
Age of unmarried people	26	13,0	34± 12,01
Total	200	100,0	
Employment			
Yes	159	79,5	
No	41	20,5	
Total	200	100,0	
Monthly income			
< 500 euros	32	16,5	
500-1000	70	36,1	
1000-1500	67	34,5	
1500-2000	16	8,3	
> 2000	9	4,6	
Total	194	100,0	
Educational level			
Elementary graduates	10	5,0	
Junior high school graduates	25	12,5	
High school and technical schools	90	45,0	
Universities/TEI	72	36,0	
Post-graduate studies	3	1,5	
Total	200	100,0	

Table 2 . Percentages of screening tests in the sample

Mammography		
Yes	83	(41.5%)
No	117	(58.5%)
Total	200	(100%)
Μαστογραφία σε γυναίκες άνω των 40 ετών		
Yes	68	(56.7%)
No	52	(43.3%)
Total	120	(100.0%)
KEM		
Yes	139	(69.5%)
No	61	(30.5%)
Total	200	(100%)
Παπ τεστ		
Yes	174	(87 %)
No	26	(13%)
Total	200	(100%)

Table 3. Educational level and screening tests

		High school or lower	AEI/TEI	Total
Mammography ever				
	Yes	57	26	83 (41.5%)
	No	62	55	117 (58.5%)
Total p=0,026		119	81	200
Clinical Breast Examination ever				
	Yes	79	60	139
	No	40	21	61
Total p=0,246		119	81	200
Test Pap ever				
	Yes	103	71	174
	No	16	10	26
Total p=0,820		119	81	200

Table 4. Employment and screening tests

		Employment		Total
		Yes	No	
Mammography ever				
	Yes	64	19	83
	No	95	22	117
Total p=0,48		159	41	200
Clinical breast examination ever				
	Yes	112	27	139
	No	47	14	61
Total p= 0,57		159	41	200
Test Pap ever				
	Yes	144	30	174
	No	15	11	26
Total p=0,003		159	41	200

Table 5. Monthly income and screening tests

		Monthly income		Total
		≤1000€	>1000€	
Mammography ever				
	Yes	37	43	80
	No	65	49	114
Total p=0,139		102	92	194
Clinical breast examination ever				
	Yes	64	71	135
	No	38	21	59
Total p=0,029		102	92	194
Test Pap ever				
	Yes	80	88	168
	No	22	4	26
Total p=0,000		102	92	194

Table 6. Marital status and screening tests

		Engaged or married	Unmarried	Σύνολο
Mammography ever				
	Yes	76	7	83
	No	99	18	117
Total		175	25	200
p=0,143				
Clinical Breast Examination ever				
	Yes	124	15	139
	No	51	10	61
Total		175	25	200
p= 0,270				
Test Pap ever				
	Yes	160	14	174
	No	15	11	26
Total		175	25	200
p= 0,000				

Table 7. Age and screening tests

		Ηλικία ≤40	Ηλικία >40	Σύνολο
Mammography ever				
	Yes	15	68	83
	No	65	52	117
Total		80	120	200
p= 0,000				
Clinical Breast Examination ever				
	Yes	48	91	139
	No	32	29	61
Total		80	120	200
p= 0,017				
Test Pap ever				
	Yes	64	110	174
	No	16	10	26
Total		80	120	200
p= 0,000				

Discussion

According to the findings of the present study the Pap test, was the most frequently conducted screening test. High rates of Pap test are reported in developed countries, even though the extent of the mass population checks varies depending on the country. For example, in England, 83% of the women of age 25-64 years old are checked in recommended interims in comparison to 53-74% of the women in Italy age 25-64 years old. (Antilla et al 2004). Mammmography and CBE rates are lower in general and questions about future cancer cases are emerged. The percentages of Korean American women who ever had a CBE and mammography was estimated at 67 % and 58 %, respectively (Han et al 2000).The rates in developing countries are disappointing. In a research which was conducted in Nigeria, it was found that 2/3 of the students (60% of whom were sexually active) didn't know the purpose of the Pap test, whereas none of the 220 people in the study had done the examination (Akujobi et al 2008). Data from previous studies in Greece reported breast and cervical cancer screening rates between 50 -70 %, depending on age and social groups) (Paraskevopoulou et al 2005,Dimitrakaki et al 2009). Specifically, the percentage of women aged 21-69 years having received the Pap smear test within the past 3 years was 59.4%, and the percentage of women aged 50-69 years having received mammography within the past 3 years was 53.8 and 8.3%, respectively. It was also found that 25% of the women (average age of the sample was 42 years old) had never done a Pap test in their life. There were significant effects of age, education and marital status on carrying out the Pap smear test or mammography) (Dimitrakaki et al 2009)

SocioEconomicStatus has an effect on breast and cervical cancer screening. In general, women of low household income, less educated are at particular risk of preventive care underutilization (Katz & Hoffer 1994, Peek & Han 2004). According to a study in the USA, women with lower SES are more likely to be uninsured and lack a usual source of care. Compared to their middle-class and wealthy counterparts, low-income women have the lowest rates of breast cancer screening, even when adjusted for race, ethnicity, and insurance status (Katz & Hoffer 1994). Regarding Pap test, a study conducted in the largest cities of the USA, showed that low family income (< $15,000), and also the relatively low level of education (Junior High School graduates) came together with lower percentages of women conducting the Pap test (approximately 75%)(Coughlin et al 2006).

Studies conducted in various countries, such as the USA, Canada, Taiwan, as well as Latin America pinpoint the role of the social inequalities in the matter of prevention (McDonald & Kennedy 2007, Reyes-Ortiz et al 2007). A research in Taiwan revealed that even when there is free access to breast and cervical screening, the participation of people with low socioeconomic level was limited (Lin et al 2008). However, regarding mammography, lesser-educated African American women showed higher rates versus comparable white women with higher educated less often conducted the examination(Wilson et al 2009). Screening for cervical cancer shows a higher educational gradient than for breast cancer screening and although there is an increase in the mammography practice related to the educational level in older groups, this fact is not observed in women younger than 40 years (Borras et al

1999). Women of high education in Greece has been found to conduct mammography slightly less often in comparison to those of middle and basic education (Dimitrakaki et al2009). Perhaps one could make an assumption that the higher the education, the greater the fear either of a positive examination or mammography consequencies. As for marital status, screening percentages are lower in single women, both in Greece and worldwide (Dimitrakaki et al 2009, Cabeza et al 2007). Younger ages (<40 yrs) had lower rates of screening. This is a point demanding further attention of health professionals and Public Health services, especially in the case of cervical cancer, where the early onset of preventive tests are extremely important.

Limitations of the study

The sample of the study was rather small and not stratified. The number of elderly women was small and no conclusion could be drawn regarding screening test frequencies in older age.

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Nurses and Emotional Intelligence: a Descriptive Study

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ABSTRACT

Background: Emotional intelligence (EQ) in health institutions is a field presenting a particular interest, because this particular environment of workplace presents some traits that are not met elsewhere. Soul-destroying working conditions make it imperative to use and develop emotional skills for two main reasons: firstly in order to have a good work output and incidentally to protect the working staff from soul-destroying environment.

Objectives: The aim of this study was to measure the emotional intelligence of nurses working in Public Hospitals.

Methods: A specialised questionnaire was developed and subsequently given to 251 nurses working in Public Greek Hospitals. The questionnaire included 69 questions describing the following 7 dimensions of emotional intelligence: self-consciousness, self-adjustment, motivations of behaviour, social skills, awareness of another person's emotional state, humour, and critical thought. The answers were given based on the 4 point Likert scale (not at all - a little – quite enough – a lot). To process our data statistically, we used the SPSS 14.0 (Statistical Package for Social Sciences).

Results: Statistical analysis revealed that 50.5% of our nurses sample working in Public Hospitals allocate a satisfactory level of Emotional Intelligence (EQ), 29.2% presented high EQ and 20.4% allocate below the mediocre EQ.

Conclusions: Stressing environment of Health institutions imposes the development of emotional skills in order to achieve exceptional clinical performance and to protect nurses from this particular environment.

Keywords: Care, Emotional Intelligence, emotions, nursing

Introduction

Emotional intelligence (EQ) in health institutions is a field presenting a particular interest, because this particular environment of workplace presents some traits that are not met elsewhere (Cadman & Brewer, 2001, Cherniss, 2002, Evans & Allen, 2002, Freshman & Rubino, 2002). The official definition of emotional intelligence quotes as: "a form of social intelligence that includes the ability to recognize our own emotions and emotions of others, to perceive between emotions and the use of information (that arises from emotions) so as to guide our thoughts and actions" (Goleman, 1995, Mayer & Salovey, 1997, Davies et al., 1998, Bar –On, 2000, Law, 2004, Murphy, 2006). In other words an individual allocates the ability to comprehend with precision his and others' emotions, thus being able to direct thoughts and actions (Goleman, 2000, Safran, 2006). Daily interactions concern colleagues with different specialities, often with overlapping duties, that face persons found by definition (as ill) in physical and psychological stress when working as a team or individually. Through literature, we conclude that relations between the two largest working teams in the hospital, that is to say doctors and nurses, pass through a phase of redefinition, a fact that increases intensity in work (Mohammadreza et al., 2002, Mohammadreza et al., 2003). Soul-destroying working conditions make it imperative to use and develop emotional skills for two main reasons: firstly in order to have a good work output and incidentally to protect the working staff from soul-destroying environment (Graham, 1999, Strickland, 2000).

In his book "The Emotional Intelligence at Work" Goleman reports the work of Williams and Sternberg who first developed the idea of a common intelligence indicator. In their classic study "Group Intelligence", the basic condition for exceptional performance is the good relation between members of the team. Those who are not socially skilful and cannot be coordinated with the feelings of others constitute a brake to the total effort, particularly if they miss abilities of resolving differences and of effective communication (Druskat & Wilff, 2001, Code of Professional Conduct, 2002, Cherniss, 2007).

Emotional abilities that make groups distinguishable are:

- Awareness of another person's emotional state or interpersonal understanding
- Collaboration and single effort
- Open communication, attitude of explicit specifications and expectations and open confrontation of members of the group with low performance
- Tendency for improvement
- Self awareness, as evaluation of the strong and weak points of the group
- Initiative and convenient preparation to resolve the problems
- Self-confidence as a team
- Flexibility concerning the implementation of collective duties
- Conscience of the organization's situation in terms of perceiving the needs of other basic groups in the company and creative exploitation of resources that the organization has to offer.
- Affiliations with other groups (Druskat & Wilff, 2001, Code of Professional Conduct, 2002, Semple & Cable, 2003, Cherniss, 2007).

Emotional intelligence is found to develop throughout our life and climaxes between 40-50 years of age. In this age the persons are able to correspond better to the requirements and pressures of environment because:

- they are more independent in their thoughts and actions
- they have better perception of other's emotions
- they are socially more responsible
- they are more easily adapted
- they are taking into consideration all situations and resolve problems in a better way
- they face stress more effectively than the younger (Six Seconds' EQ Institute for Healthcare Leadership, 2007, Vitello-Cicciu, 2003).

Method

Study design

The purpose of this study was to measure the emotional intelligence of female and male nurses working in Public Hospitals. Two hundred and fifty one questionnaires were distributed in nurses working in three Public Hospitals from May 2007 until May 2008.

Sample

The sample emanates from the reference population of Nurses who work in Public Athens Hospitals and Region of Adults and concretely from Nursing departments, laboratories, offices of education and administrative services of Hospitals. The determination of the size sample in this particular study was determined by the following factors:

- Desirable precision level of results
- Available financial expense
- Available time margin
- Fluctuation of the population under this study
- The number and the type of variables that concern in the inquiring process (Williams, 1978).

An application and protocol were deponed in the corresponding scientific committees of Hospitals for approval. The sampling was deliberate and randomly chosen. The entry criteria in the group were the following:

- Workers in the Nursing Institution for more than a year

• Workers in any department of Hospital
• Workers holding at least a degree of a one-year study educational institution.

The exclusion criteria involve workers that have not completed their studies. The choice of this particular way of sampling was selected in order to avoid problems when recovering the sample. Nurses participated in this study under informed consent.

Data collection

Content development of the measurement tool was supported by an extensive literature and inquiring retrospection, by searching corresponding questionnaires (EQi of BarOn, ECI of Daniel Goleman and Jefferson Scale of Patient' s Perceptions of Physician Empathy) and by submitting the questionnaire to experts who were asked to annotate and modify parts of it.

The questionnaire included two parts: one to collect demographic elements and one for to collect elements regarding skills that the nursing personnel allocate. The answers were given based on the 4 points (by no means - little - enough - very) Likert scale.

Moreover, the questionnaire:

• is structured in such a away, so that it constitutes a suitable, complete and precise tool of justifying the aim and objectives of the research. It elicits answers concerning the research and not their general opinions.
• is simultaneously composed from simple but at the same time full in content, phrases and questions – and no elaborate verbal forms or complex conceptual manufactures.
• is unbiased, it does not prompt the questioned person towards one or other direction, but gives a possibility of choice of answers through a scale of four points (by no means – little – enough – a lot).

Data Management - Statistical analysis

Statistical data processing took place by using the SPSS 14 (Statistical Package for Social Sciences) statistical parcel for Windows. The methods used in the analysis are:
• Test research (pilot study) in a small sample
• Reliability evaluations of internal cohesion (internal consistency reliability) based on alfa factor (Cronbach ' s alpha coefficient).
• Descriptive statistics on demographic data
• Descriptive statistics of emotional intelligence categories

Results

Demographic characteristics

84.9% were female and 15.1% were male, 66.5% were married, 28.3% bachelors, while 5.2% were divorced and widowers. Table 1 describes the basic characteristics of the nurses.

Statistical analysis

The reliability of the measurement tool to determine Nurses EQ is satisfactory and oscillates around 0.88 (Norusis, 1990).

Descriptive analysis of questions regarding the ` self awareness' axis showed that 2.6% do not recognize their emotions, 20.7% recognize them partially, 54.2% recognize them satisfactory while, 22.5% absolutely recognize their emotions, the repercussions and their results. 0.8% are not aware of their internal reserves, 8.8% are partially aware, 53.9% are satisfactorily aware, 34.3% are absolutely aware of their internal reserves, abilities and limits. 3% do not have self-confidence, 8.8% have low self-confidence, 53.9% have self-confidence in a satisfactory level while and 34.3% allocates high self-confidence.

With regard to axis ` self-adjustment', 27% cannot handle their disrupting emotions and impulses, 42% can partly handle them, 24.7% handle them quite well, while 6.3% handle them effectively. 15.8% do not take the responsibility for their personal progress, 9.7% partly take it, 35.2% takes the responsibility quite enough, 39.3% take it completely, maintaining at the same time their integrity of honesty. 28.4% of the asked present a satisfactory flexibility in handling changes and are open in pioneering ideas, approaches and new information contrary to 19.2% who present weakness in the way that they face the facts and search of new ideas. The remainder 52.4% handle multiple requirements, change of priorities and generally fast changes well.

With regard to axis ` motives of behaviour', 24.7% try to improve themselves ultimately or to correspond in certain perfection data, 47.2% try a lot while, 28.1% do not learn how to improves their record. 37.1% fully carry out the objectives of the Association, 59% carry them out to a large extent while, 4% do not energetically seek occasions in order to achieve the mission of the group. 33.1% present absolute readiness to act as soon as an occasion comes up, 50.2% satisfactory seek objectives beyond those that others impose to them or expect from them while, 16.7% do not neglect bureaucracy and rules so that work could be done quicker. 20.5% insist on achieving objectives despite obstacles and misadventures, 36.5% insist partly while, 43% function more on fear of failure and least on the base of hope for success.

With regard to axis ` Awareness of another person's emotional state', 80.5% satisfactory comprehend emotions and opinions of the patients and show active interest to their concerns contrary to 19.5% that do not conceive the emotional signals of patients and do not allocate the dexterity of listening. 92.6% forecast and recognize the needs of patients that they satisfy while, 7.4% do not seek ways to satisfy the patients and thus gain their devotion. 92% support that they sense the patients' needs in order to be developed and strengthen their possibilities while 8% do not recognize other's

achievements. 18.3% fully recognizes emotional tendencies of the health group and it contribute in strengthening relations, 50.2% recognize them partly while, 31.5% are unable to understand forces that shape patients' opinions and movements.

With regard to axis`social skills', 65.7% allocates the required skills in order to gain other's trust while, 34.3% it do not use effective methods of persuasion. 59% communicate well, 26.7% allocate the ability of good listening, seeking mutual understanding willingly accept to share information with others while, 14,3% do not encourage open communication. 75.7% support that they allocate inspiration and can guide groups and persons while, 24.3% cannot take initiatives and do not act as leaders irrelevantly from their rank. 21.5% are advocates of change and recruit others to their objective, 54.6% provokes partly the system to admit the need of change while, 23.9% do not recognize the need of change. 8.4% are strongly capable to handle with diplomacy stringent individuals and situations of intensity, 73.7% can partially negotiate and solve disagreements while, 17.9% cannot detect the probability of conflicts and do not care for disagreement de-escalation. 53.8% create bonds and it have good and continuous communication with others, 43.4% knits up partially with friends and maintain personal friendships with colleagues and collaborators while, 2.8% grow minimal functional relations. 48.2% allocate group skills and cultivate a sense of identity within the group, 49.4% partially contribute in creating cohesion within the group in order to achieve objectives while, 2.4% are keen to collectiveness. With regard to axis ` humour', 32.1% support that have a sense of it and use it daily in order to be flexible, 49.2% have a sense of humour that do not always use while, 18.7% have a little or no humour.

With regard to axis` thought', 25.3% of the asked support that they use their capabilities so that they can copes with the work challenges, 55.7% use the critical thought but not on a daily basis while, 19% allocate a little up to no critical thought.

Table 1 Demographic characteristics

Age	%
20-30	20.7
31-40	47.8
41-50	27.5
>51	4.0
Educational status	
Higher Education Institutions	3.6
Polytechnic colleges	53,8
Postgraduate title	3.2
PhD	2.0
Speciality	23.0
One year lasting	1.6
Biennial lasting	12.4
Place ob birth	
Crete	39.4
Sterea Hellas	15.5
Peloponnese	9.6
Thessaly	9.2
Epirus	8.0
Macedonia	8.8
Thrace	1.2
Islands	6.4
Cyprus	1.6
Russia	0.4
Department of work	
Clinic	39.8
ICU	24.3
Surgery	12.8
Laboratory	8.8
Office	5.6
Emergency	8.8
Foreigner languages	
One (I)	62.2
>2	18.3
None	19.5

Discussion

The present study revealed that half of those participating recognize and sublimely manage their internal situation, preferences, personal reserves and have the emotional tendencies that lead to achievement of objectives. Half of the participants report that they have good self awareness and enough motives of behaviour, moreover they allocate humour used selectively and they use the critical thought but not on a daily base.

Recognition of emotions and thus satisfaction of patients' needs is achieved only through the ability of health professionals to initially recognize their own emotions and needs. In the present study, roughly ? of the participants reported that they recognize their emotions. Researches have shown that Head Nurses, who allocate emotional intelligence in a satisfactory degree, precisely conceive their emotions as well as others' and thus, they are differentiated by those expressing false emotions. For example, they can distinguish anger of Nurses related to decision-making and manage it in such a way as to restore Nurses in the initial objective, that is to say, the care of patient. Besides, they are able to comprehend complex emotions of relatives and of health personnel that accompany cases of dying patients (Vitello – Cicciu, 2002, Caruso et al., 2002).

The soul-destroying environment of Health institutions imposes the growth of emotional skills on one side for exceptional clinical performance and on the other side for protection of the worker from this particular

environment. In this study a large percentage of participants cannot handle rightly their impulses and their disrupting emotions and this results in a malfunctioning group with regard to the care of patient. At the same time it was found that, while Nurses align themselves absolutely with the objectives of Nursing Institution, however they are distinguished by a disposal for personal evolution. We mark that groups in workplaces fall into three levels of performance. In the worst case, frictions within the group him lead to failure, resulting in a performance lower from the mean of individuals. When groups function well enough, the grades are higher than the mean of its members. However, when a true collaboration exists within the group, its grades exceed by far even the grades of the best individual. When groups function at their outmost, the results could be more than cumulative, they can be multiplicative as the most important talents of an individual push forward the most important talents of a next individual, producing more results than a sole individual. When the members of a group give their best the results are not anymore cumulative but multiplicative, because talents and abilities of all members are used (Goleman, 2000).

Awareness of another person's emotional state is an essential component of medical and nursing care. The present study showed that Nurses comprehend satisfactory the emotions and opinions of patients. Similar results resulted when in a research the subject of awareness of another person's emotional state was approached, evaluating the answers from medical and nursing personnel and from Nursing and Obstetrics students. The same study showed that men and women equally comprehend the needs and problems of patients. 28 However patients participating in other study and suffering from chronic respiratory deficiency had a contradictious opinion. Therefore, when they were asked to determine the sectors of care that medical and nursing personnel should improve, the majority of their answers were focused in biggest emotional understanding (Papageorgiou, 2006).

A far as social skills are concerned (or social influence), in this study we found that Nurses influence the environment with persuasiveness and inspiration, partly recognize the need for change and promote the collectiveness and collaboration.. An older study showed that the human brain is related with the growth of social skills, as it can create new nervous webs and nervous connections throughout adult life that ` fight' against rooted patterns already existing in the brain (Goleman & Boyatzis, 2008).

Humour is the ability of an individual to see the funny side of every situation instead of remaining serious all the time. In this study the necessity of using humour was stressed. A large percentage uses it selectively among members of personnel or with the patients. Research that has become has shown that the use of humour contributes in intellectual prosperity of individuals, minimising the effect of negative situations and protecting the individual from everyday difficulties (Ojanen, 1996). In another study, it appeared that everyday use of good humour helped Nurses to satisfy the needs of patients even more (Astedt – Kurki & Isola, 2001).

Deductively, analysis of results showed that 50.5% of the Nurses sample working in Public Hospitals allocate a satisfactory indicator of Emotional Intelligence (EQ), 29.2% have high EQ and the following 20.4% allocates below mediocre EQ.

Limitations

In this study certain limitations exist which should be taken into consideration for a better process and generalisation of results. The size of nurses sample could be considered small as far as reliability of measurement is concerned, as it constituted an indicative sample from the total nurses population that work in public hospitals at the time the research took place. A second restriction is that the results of this study reflect the opinions of nurses from only three hospitals of the country without essentially reflecting opinions of the total number of nurses that work in public hospitals all over Greece. Given the variety of health professionals who function under the umbrella of administering care in Hospitals, the fact that personnel participating in the present study constituted only by nurses, is perhaps a third restriction in generalisation of results. The comparison of opinions about emotional intelligence of nurses who work in public civil and military hospitals of Greece would be particularly interesting.

Conclusions

Emotional intelligence is a basic factor of success. It results and develops when a person undertakes the complete responsibility of his/her behaviour, his/her reaction on different events, of his/her thoughts and emotions.

Taking into consideration the restrictions above, a similar study with a bigger sample of nurses, and particularly from a more representative breadth of national hospitals, could also lead to larger generalisation and validity of results.

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Counseling and Health Education Program Planning in the Field of Education: The Role of the School Nurse

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ABSTRACT

Mental health issues were considered, even to this day, an exclusive responsibility of the health professionals. However, recent studies, based on the development of needs, led to the realization that an effective school is not only responsible for the mental development of its students, but it is also required to incorporate counseling support programs which would aid the students on their emotional and psychological issues.

Therefore, the role of the school nurse seems to be determinant for the promotion of the students' mental health and today, the school is considered to be responsible for the children's safety and well-being. Besides, all children are equally entitled to learn the methods that will help them ensure and shield both their physical and mental health and safety.

Key-words: counseling support, health education, school nurse, prevention, intervention.

Introduction

According to the constitution of the World Health Organization «health is the condition of the full physical, emotional and social well-being and not just the absence of an illness or a disability». A different definition views health as the result of a person's physical condition, which is also influenced by the environment.

The definition of health, according to the World Health Organization, includes at least three dimensions. The first focuses on the biological side of health and is mainly about the physical disability or the social roles which are adopted by each person and the last is about the psychological factors. According to the last view, personal experiences and cognitive factors can predict a person's good health or the occurrence of a disease and therefore, people are responsible or in charge of their own health and health is a psychosocial phenomenon.

In 1972, the World Health Organization issued the following definition for Health Education: «Health education is a process which bridges the gap between health information and health practice». That definition was modified later on: «Health education is an educational process with many parameters (mental, psychological and social) which includes activities, which help identify a person's health problems and reinforce that person's responsibility and ability to make the right decisions regarding his personal well-being, and also the well-being of his family and the society he is a part of».

The definition of Health Education that was approved by the EU in 1986 reports that «Health Education is a process which is based on scientific principles and uses planned learning opportunities which give people a chance, either as individuals or a group, to decide and act consciously (informed) on matters that affect their own health».

Purpose and goals of counseling in the matter of Health Education

Health Education is an cross-thematic activity, an innovative action which has a particularly significant and necessary contribution in school life today. The role of Counseling in Health Education is to advocate, improve and promote the students' emotional and physical well-being, on one hand by increasing their social skills and critical thinking, and on the other hand, by upgrading their social and physical environment.

Alongside the above main purpose, there are various general goals which provide both general and specific directions to the counseling support programs.

The main goals are the following:

- Inform young people thoroughly about the risks that threaten their mental and physical health. Alyson Moon (1998) reports that all children are entitled to learn the methods that will help them ensure both their physical and mental health and safety.
- Develop the children's skills and critical thinking, improve their self-confidence and self-esteem, and also improve their ability to negotiate and make the right choices.

The role of the nurse in the school environment

Nurses get the chance to be around children, come close to them in the school environment and recognize the students' difficulties (Malikiosi – Loizou, 1999).

A Health Education program in the school environment may focus on improving the student's ability to «take care completely of himself», but it is the school nurse who is called to resign of her traditional role, and become a «student» and a partner of the students inside the program.

He is required to not have any prejudice, to care about everyone without any discrimination and respect the students' temperament; to coordinate the ideas and the experiences that are learned and not just solely emit knowledge.

School nurses must first investigate and evaluate their own feelings, values and views, in order to cultivate feelings of self-esteem, self-evaluation and self-control to their students through their behavior. It is necessary to show respect to their students, their choices and the way they express them and show them clearly that they accept them. Acceptance is a decisive factor that promotes interpersonal relationships.

However, in order for the school nurses to possess these skills, a training and support network must be created by the school nurses and the various mental health professionals. The training of the school nurses is the means for them to learn the required know how, in order to operate as councils within the school community to help deal with the preteen and teen issues in health promotion.

The modern school nurse takes on the duty to contribute to the creation of capable and mentally healthy people. He is called, therefore, to act as a council whose relationship with the students may sometimes include some or all of the following factors (absolutely necessary in the counseling relationship):

1. Recognize the problem her student/s might have
2. Coincide with the students and be authentic towards them
3. Always acknowledge the students unconditionally, in a positive way
4. Understand and empathize with them

The acknowledgement of the students and their feelings, even the ones that scare them, is considered important for their emotional development and helps them find positive solutions.

The role of the parents

Everyone accepts society today demands from adults, both parents and educators, in order for them to help their children grow, that they also «grow» along with them. In an ever changing world, solid reference points cannot be found «outside», but inside the person.

The role of the parent is «learned» and almost every parent goes back to the experience he had from his parents and his early infancy. However, in modern times, there are no solid values, set roles and other solid reference points. The changes are frequent and rapid, and these changes, that affect the role of the parents, include a lot of anxiety and uncertainty, but also include opportunities for a better personal journey for the parents and their children, as well as more efficient inner growth (Kalogridis, 2006). The current Health Education programs deal with the parental role not only as an emanation of an external learning process, but also as an honest internal procedure (Kleftaras, 2002).

Methodology for developing Health Education programs

A certain methodology with specific teaching tools is used in order to develop Counseling support and Health Education programs. The current Health Education methodology is no longer based on just information and knowledge communication regarding specialized health issues. Instead, various means, aiming towards the more energetic and experiential learning of the program's material, are used in order to complete its goals.

This methodology recommends:

- To approach the school class as a group
- To focus on the pedagogic relationship
- To use energetic listening as a form of communication
- To use an cross-thematic approach through a more unified form of teaching
- To use researching methods in order to gradually build knowledge

The Psychosocial model is recommended as the most fitting approach. The model introduces the concept of social skills and develops:

- ways of communication
- ways of resolving a problem
- ways of decision making
- ways of making conscious choices, etc.

In regard to health promotion and education, therefore, it is apparent that the implementation of teaching and learning methods, which encourage participation and cooperation, is required. Just teaching people what is useful, helpful and right does not suffice in producing the necessary results. All people, and of course all students, must be actively involved and feel that what they are learning is relevant to their own experiences.

In the traditional teaching method the communication of information is a one-way street, from the educator to the student. In the participial approach or the active learning the School Nurse implements a dual process: she discovers the students' needs, their views and how they feel and she finds ways to satisfy these needs; according to the theory of Rogers, «I know that I cannot teach anything to anyone, I can only create the environment in which a person might learn something» (Malikiosi – Loizou, 1999).

Using the method of the group- centered teaching and the participial approach, the school nurse encourages the students to take on the responsibility of learning and growing, in order to feel capable to take control of their lives and be responsible of their own decisions. Specifically, when we refer to mental health promotion, people must be assisted in order to recognize their views and feelings, to accept them and thus support their sense of self-value.

The children's interaction within the group contributes to the reduction of the mistakes and helps them manage the various suggestions and alternative solutions (Georgas, 1986). Children understand better that in order to resolve their problems, they need to interact with the «significant others» that surround them (Cross, 1981).

Malcolm Knowles suggests that a necessary condition of the learning process is a learning contract which would be used by the trainees to identify their needs, define their goals, identify their learning strategies and evaluate their progress (Cross, 1981).

By observing the Health Education programs that were conducted in our country, we discovered that they were designed based on the aforementioned methods, by considering methodology as one of the most important factors contributing to the program's success.

It is important to point out that in order for the Health Education programs to have the desired outcome, certain skills are required; certain conditions in order for the counseling relationship to function right and constructively in the program (correct perception, focus, search for/accentuate the child's talents, careful observation and active listening, use of questions, encouragement, reflection of emotions, rephrase, paraphrase, interpretation, information and guidance).

Planning and implementation of prevention programs and intervening counseling and health education programs

Counseling and Health Education are mainly cross-thematic and cross-scientific activities. Therefore, in order for their respective programs to be efficient, they must deal with holistic matters and they must integrate with other courses of the analytical program through the cross-thematic approach. Both the student's composition and the nature of our courses allow us to implement and direct us towards the implementation of the most effective learning process, the cross-thematic approach.

Through the cross-thematic approach the subject isn't just being studied during a specific hour inside or outside of the schedule with the participation of those who feel willing, but it is brought up again inside the schedule, connected with other classes. Moreover, with that method, all the students are activated to participate. The cross-thematic approach enables the student to enrich and formulate his knowledge around a subject, through various aspects of the schedule and transform school knowledge in daily practices and actions that have a direct positive effect on his lifestyle. The school nurse's ability to integrate what her students need to understand regarding a health promotion matter in various cognitive subjects is what is going to lead her to the success or failure of the identified goal.

Counseling isn't dealt as a single cognitive subject, but it is a component of every aspect of the school life and

supplies students with abilities, such as:
- To identify, sort out and utilize information.
- To design a research and evaluate the data of that research.
- To communicate.
- To interpret the relationships between people and the natural world.
- To identify the risks that threaten them.
- To cooperate with others.
- To socialize.

The role of the school nurse in developing prevention and health promotion programs in Primary education

Objectives:
- To understand the role of family as a «place» that provides safety and protection and to point out the various roles of each member (parent, child, grandfather, grandmother, etc.).
- To realize how friends are made and stress the importance of friendship in their lives.
- To discuss issues regarding the way children utilize their environment, in order to satisfy some of their needs.
- To understand basic parameters and ways in which the social and cultural habits affect and shape views and models of behavior and identification.

Some indicative activities:

Through the following activities we can achieve the goals below:
- Group dynamic development,
- role playing games,
- research questionnaire,
- artistic creation,
- work in small groups on health education issues,
- mimetic games on health issues.

The role of the school nurse in developing prevention and health promotion programs in Secondary education

Objectives:

a) To identify the factors that contribute to shaping each student's personal identity.

b) Self-awareness and to understand the way each student relates to his classmates and especially to the «significant others» in his life.

c) To realize the importance of their feelings and the effect that these feelings have on the relationship with other people and on the way they feel about themselves.

d) The interaction between teenagers and its importance on shaping views, behaviors, emotions, needs and desires; connection with more specific issues, such as how I am affected by other on matters of eating, sexual behavior, use of substances, how I deal with cases of pressure from others on matters regarding my personal safety, use of substances, my relationships with the other sex.

Some indicative activities:

Group dynamic development, role playing games, research questionnaire, artistic creation, work in small groups, all of the above must deal primarily with health education issues.

Furthermore, the role that a school nurse might have on developing prevention programs against the use of addictive substances is extremely important.

Primary prevention programs aim to inhibit or delay the onset of substance abuse, as well as the transition from experimenting to using systematically. Contrarily, secondary and tertiary prevention aim to help systematic users so as not to relapse or to avoid further complications that have to do with drug use. Research on some of the causes that lead people to using drugs justifies the emphasis that is given by the primary prevention programs on supporting individual and social skills.

Afterword

The conclusions that are drawn from implementing Prevention and Intervention programs on health issues in schools worldwide are not so favorable in regard to their performance on children functioning. Particularly, it has been concluded that (Hatzichristou, 2004):
- A large percentage of children and teenagers face many developmental problems
- These issues are complex, interconnected and are related to various socioeconomic parameters.
- Only a few of the professionals involved care about the children's mental health.
- Lack of counseling support and therapeutic intervention.

Therefore, according to these conclusions, there is a strong and urgent need for:
- Cooperation between all of the professionals in the field of health, education, social welfare and justice.
- Full scale development of service provision models.
- Cooperation, coordination, connection of services, professionals, systems and cross-scientific cooperation of experts.
- Service development depending on the individual characteristics of each area (ethnic/cultural differences).

- Activation of groups, PTAs (parent-teacher associations).
- Frequent evaluation of prevention and intervention programs.
- Frequent expert training and education (Hatzichristou, 2004). The school nurse can become a connective link between all of the related parties in order to help them achieve their goals; provide constant and substantial aid to students in primary or secondary education.

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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.

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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.

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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. 1. Ekblad & Co, Vastervik, pp. 117-126.

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

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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.

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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
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- For professional matters
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- For legal issues
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- Proclamations via the Hellenic public organization for hiring personnel "ΑΣΕΠ"
- For positions in the health sector