Informing and guiding the development of a Framework to Strengthen the Capacity of “Tipat Halav” nurses in Israel

Final Report

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Executive Summary

The overall objective of this qualitative study was to generate in-depth data that unveil effective processes and strategies which need to be in place in order to achieve a practice-change among nurses. Qualitative data, which were gathered through semi-structured interviews with 7 training providers and 2 practitioners, from different countries across the world, will inform and guide the development of a framework to Strengthen the Capacity of "Tipat Halav" nurses to advance the developmental outcomes and well-being of young children and families in Israel.

Training providers' perspectives

Qualitative data highlighted that Maternal and Child health nurses have a multi-layer, complex role and that under this role they need to address challenges and problems not only at the child and family levels but also at the community level in order to ensure that the different systems in which families and children operate, ensure a continuum of nurturing care. However, in order to respond to this multi-faceted role, practitioners need to have a number of necessary knowledges, skills and attributes which can facilitate the collaborative working with families, policy makers and communities and at the same time can further promote their social role.

As there is a great variability among training programs and practitioners' background, the need for in-service training programs was highlighted. Training providers highlighted that those programs should target all different roles that Maternal and Child health nurses need to play and as such they should aim to address needs at three levels: 1) the needs of the professionals; 2) the needs of the profession; and 3) the needs of children and their families. Participants also highlighted that effective programs not only address those needs but are also characterized by a number of factors, which include: training obligatory and part of CPD; combination of theory and practice; continuity in communication and support; inter-sectoral training; provision of monitoring tools; experiential learning and reflective practice: Training based on the principles of adult learning; variety of assessment methods; trainees with the right attributes; practice portfolio, video feedback, coaching and supervision; and peer support.

However, although there is a consensus about the success factors that characterize effective training programs, still the profession, the professionals and the training programs phase a wide variety of challenges. These challenges include:

1. Wide field and unpredictability of the situations that practitioners will phase
2. Direct entry to the profession - Inadequate and not content-related (specific) preparation as well as lack of recognized legal status
3. Duration of the training, which is either too long or too short and does not achieve its objectives
4. Instability in initial training, as each training provider has a different curriculum
5. Variability in terms of previous experience and academic background
6. Lack of support and supervision
7. Lack of bottom up approaches: Maternal and Child health nurses' training needs are not taken into account
8. Lack of field experience and quality assurance issues
9. Shortage of practitioners
10. Cost related challenges, such as lack of universal funding and lack of funds to train all practitioners or master trainers

11. Challenges that stem from the practitioners, such as resistance to change and to some modalities, extensive paperwork and administrative related work, vicarious trauma and burnout, etc.

The interviews revealed a number of suggestions about the ways that can be used in order to tackle the existing challenges. These include:

1. Longer training in order to ensure the expected results are achieved
2. Having practitioners who are adequately prepared and their preparation and training is in line with the context of their practice
3. Central to adequate preparation is not only the provision of training, but also the provision of education and training that is more targeted to the scope of practice and covers more issues inherent to the home visiting practice. Three of the interviewees mentioned that there are gaps in preparation in terms of the content of the training – which is more focus on illness rather than on public health and more general and that the specialization of different cadres is key
4. Continuous learning and ongoing professional support
5. National standards: every practitioner should be trained to the same level at issues that are central to their practice
6. Having recognized legal status of the practitioner role
7. Need for a filtering system being in place so as to support the recruitment and training of people with the light attributes or who lack training
8. Taking into consideration the fact that the training is not long enough and it cannot cover all that the Maternal and Child health nurses need to know and practice, a good preceptorship program can help manage those challenges
9. Providing Maternal and Child health nurses with supervision and having a practice teacher going at home with them in order to observe their practice is an effective way of addressing existing challenges
10. Practitioners should be autonomous in their practice, so as to have the flexibility to tailor their approach depending on the needs of the family, to be able to determine the caseload and how to manage it. Autonomy can also support practitioners to work based on the principle of progressive universalism
11. Models of effective modalities: Experiential learning is one of the most effective ways of training. Coaching and working in one-to-one basis or in small groups is also very important. We should also be able to see videos of what Maternal and Child health nurses do in their practice. In addition, we need models of coaching
12. Communities of practice and peer to peer support are considered as helpful in addressing existing challenges
13. In their majority interviewees highlighted that in order to address existing challenges there is a need to train not only practitioners, but also the trainers of trainees
14. Need to work in partnership with the trainees and with other institutions/official bodies. That collaboration builds on bottom-up approaches and ensures that trainees' needs are taken into account when the training is developed and delivered

Practitioners' perspectives

Interviews with the practitioners also revealed a number of challenges at the service, training, workforce and family levels. At the *service level,* challenges include: quality of services is dependent on the person and on the attributes and experience of the practitioner; lack of universal standards

and rules for the practice; lack of supervision and monitoring system and the fact that emphasis on the number of visits but not on the quality of visits; variations across regions; lack of a progressive universalism approach. At the *training level*, challenges include: practitioners, during the trainings, do not seek help or state that they do not know how to do something; during trainings some practitioners (mainly older ones) dominate; the training does not affect all practitioners; ineffective types and modalities of training. At the *workforce level* challenges include: lack of educated staff and/or staff committed to life-long learning and practitioners' age, meaning that if they are very young, they might face parents' reservations. Finally, at the *family level* challenges include: service delivery and take-up decline after some time, variability among families, difficulty in communicating to parents the "correct" approach, parents are not aware of the services provided or they have a negative image of the services, difficulty in identifying pregnant women and a type of service that points the finger instead of support the parents.

Thus, interviews highlighted that success is dependent on the *characteristics of the practitioners* and the *characteristics of the services and the training*. In terms of practitioners, a number of characteristics and competencies should be in place. These are: 1) practitioners should be college graduates / educated and specialized practitioners; 2) practitioners should have good communication skills: Practitioners who know what to ask and how and work in cooperation with the families so as to solve the problem; 3) practitioners should have an aptitude for life-long learning; 4) practitioners should be reflective. On the other hand, successful trainings and services have the following characteristics: 1) they provide mentorship; 2) they support documentation practices and training on documentation; 3) provide effective supervision and an effective and supportive supervisor; 4) provide opportunities for peer learning; 5) use modalities such as video-feedback; 6) offer alternative types of services such as e-services and phone services; and 7) have good reputation.

Interviewees stressed that there are a number of factors that need to be in place so as to ensure that the services and the training are effective. In order for *services to be effective*, interviewees highlighted:

1) Need for common standards/rules who should apply for all Maternal and Child health nurses, so as to deliver the same services, irrespectively of their quality as professionals
2) Without a monitoring system, which will enable them to show to other how to do things right, having only individuals doing things rights, does not help sustain change
3) Enhance practitioners' autonomy
4) Ensure bottom up approaches by monitoring parents' experiences from the services
5) Provision of services that build on the progressive universalism approach
6) Cooperation with other professional groups so as to identify families

At the *training level*, the following suggestions were formulated:

1) Provide opportunities for practice in a safe environment
2) Having smaller groups during training, with more younger nurses and only one older nurse
3) Shorter training

Conclusions

In order to achieve practice-change it is important to acknowledge that challenges are stemming from all levels and that we need to start by re-considering the status of the field itself. Establishing universal national standards of practice, having recognized legal status of the practitioners' roles, allowing practitioners to be autonomous are the starting point for practice change. Central to enhancing and improving the system level is to provide adequate and content-specific preparation before the entry in the profession, by establishing a higher education system that specifically addresses the needs of

the home visiting profession. Three of the interviewees mentioned that there are gaps in preparation in terms of the content of the training – which is more focus on illness rather than on public health and more general and that the specialization of different cadres is key. Finally, at the service level it is important for practitioners to have access to continuous professional development opportunities and supportive supervision.

Turning to the in-service training programs, in order to practice change to be achieved they should provide a combination of theory and practice. Thus, effective modalities, rather than lecturing and power point presentations, should be employed, such as videos, role play, experiential learning, coaching and working in one-to-one basis or in small groups, online components, labs, portfolio, etc. In addition, both training providers and practitioners highlighted the importance of peer-support and communities of practice. In addition, programs should consult with the trainees in order to ensure that they meet their needs. Finally, special attention should be given to the competencies of the training providers and master trainers, as the overall quality of the program is inseparable linked to their quality.

Introduction

Background and Context

The purpose of this review is to inform and guide the development of a framework to Strengthen the Capacity of "Tipat Halav" nurses to advance the developmental outcomes and well-being of young children and families in Israel.
In Israel, Tipat Halav service (Family/Maternal-Child Health), run by the Ministry of Health, Israel's four HMOs and local municipalities, are the first healthcare station for parents and babies. It is a free, universal service, reaching ~95% of the population in Israel across all sectors. Babies have a standard schedule of visits with the Tipat Halav nurse across the first few years of life. The Ministry of Health, in rolling out its new strategy for The First 1000 Days, has found that parent support during the early years is a key issue that the public has expressed a need for that is not being sufficiently met. The Ministry is committed to bringing about change in this area, including in Tipat Halav services. A new vision has been developed for the Tipat Halav service and its critical role in supporting families and promoting optimal child development.
However, Tipat Halav nurses face many challenges in their work, including limitations on scope of service, opportunities for professional development and in-service support to translate learning to action. Nor do they have up-to-date tools to specifically support parents and promote positive parenting behaviors. This is especially true for nurses working in under resourced communities with families experiencing socio-economic disadvantage and vulnerability.

The partnership between the Bernard Van Leer Foundation, Yad HaNadiv Foundation and Israel's Ministry of Health has identified an opportunity to work together on the aspect of nurses' professional development in promoting parent and child outcome. The objective of this initiative is to develop a National Program to Strengthen the Capacity of Tipat Halav Nurses to Support Parents. This initiative can be framed as an **organisational practice-change** process; and it involves building a **leadership** group, developing knowledge based **professional development** tools (e.g. training module, protocol, screening tool) and **implementing** them across the service.

The first phase of the initiative will be a one-year program for a group of leading nurses. Goshen has developed a conceptual framework for this phase, based on the following guiding principles:

1. ***Co-design***: the tools and the plans for implementation will be developed by nurses for nurses, with support from experts and consultants.
2. ***Evidence-informed practice***: Selecting an effective intervention strategy is not simply a matter of choosing an intervention from a list of 'proven' strategies but rather a shared decision-making process with parents incorporating three elements: evidence-based programs/strategies (content- what is delivered), evidence-based processes (how is it delivered) and client and professional values and beliefs.
3. ***Implementation science principles:*** training/intervention contents will be developed with an implementation plan that included the resources and organisational wrap-around processes to ensure successful and sustainable integration in the service.
4. ***Improvement science principles***: learning, planning and implementing are intertwined, using short cycles of planning, testing, and modifying.

This group of leading nurses will undergo training in core skills of leadership and promoting change; working in partnership with parents and selected topics related to parenting and child development. Together with content experts and consultants, during this year the nurses will develop training

modules and programs around specific content areas, and will then lead their implemented at scale within the service.

Aim of the review

Clearly, undertaking a course or a training module is just the beginning of a process of practice-change. The purpose of the review is to inform the implementation of the initiative and uncover the strategies and processes needed to be in place in order to successfully achieve a practice-change among nurses, which will then lead to change in parents and children. In this review we want to build on the systematic evidence and practice wisdom gained from similar models. These include professional development/training programs for nurses, and interventions that included training of nurses, conducted in a universal setting, aimed to improve parents and children's outcomes.

Methods

The review will utilize a brief systematic review and case studies, to develop a rigorous and rich base of knowledge that will inform the development and implementation of the program. We aim to identify similar models which have been implemented globally, extract and synthesize the evidence related to:

- Contents – which subjects and/or interventions were included and which key behaviours were targeted.
- Strategies - Modalities of training and learning (e-learning, peer-learning, role-playing, etc) and the structure of the training program (length, frequency, etc)
- Process- Elements of ongoing implementation and sustaining the change (e.g., supervision, coaching, video feedback).
- Evaluation - how was "success" defined and measured?
- Evidence of effectiveness – to what extent did the program achieve its goals?
- Learning from success- Common elements of successful programs
- Learning from difficulties - barriers and challenges in implementation

Purpose of the Study

Assuming that practice-wisdom cannot be fully captured in the formal scientific literature and reports, we used case studies and we conducted semi-structured, in-depth interviews in order to gain rich information, especially related to the implementation processes and challenges and how they can be tackled.

Specifically, this part of the study aimed at mapping:

1. the strategies and processes that need to be in place in order to successfully achieve a practice-change among nurses;
2. the common elements among successful programs;
3. the barriers and challenges in program implementation.

The overall objective of the qualitative study was to generate in-depth data that unveil effective processes and strategies which need to be in place in order to achieve a practice-change among nurses. Qualitative data will inform and guide the development of a framework to Strengthen the Capacity of "Tipat Halav" nurses to advance the developmental outcomes and well-being of young children and families in Israel.

Note on terminology

Across the globe different terms are used to describe Maternal and Child health nurses (e.g. Nurses, Home visitors, community health workers, etc.). In this report we use the term Maternal and Child health nurses, in order to relevant to the Israeli reader. However, during the interviews the term "home visitor" was used for convenience reasons, instead of the longer term "Maternal and Child Health nurses".

Methodology

a. Selection of case studies and interviewees

A comprehensive list of 30 training providers and training programs across the globe was developed based on the following criteria, defined by Goshen Institute:

1. Middle-high income countries
2. Programs delivered to and by nurses in a primary, universal, community health-care setting
3. Programs relevant to parenting and child development
4. Programs with a specific focus on Maternal Child Health rather than on health (hospital-oriented)
5. In-service training programs

In addition, the list included 4 senior practitioners from 4 different countries.

This list with the potential interviewees was sent to the Principal Investigator of the study, with whom ISSA worked closely in order to select the interviewees that matched those criteria and their expertise was more closely related to the aims of the study. The team shortlisted 16 potential interviewees.

b. Sample and Recruitment Procedures

An email was sent to all 16 potential interviews that were shortlisted. The email was intended to invite potential participants to an online, semi-structured interview. Along the invitation, the consent form (Appendix 1), which was developed by ISSA in collaboration with the Principal Investigator of the study, was sent to potential interviewees. Of the 16 individuals that were conducted, 13 expressed their interest to participate in the study. Of them, 4 did not respond to the second email that was sent to them in order to schedule the day and time for the interview. Out of the 9 participants, 7 are training providers and 2 are senior practitioners.

A brief overview of training providers' demographic information is provided below:

Participants pseudonym	Country	Role(s)
Al	Albania	1) Lecturer at University 2) Clinical pediatrician and neonatologist at the University Hospital 3) Trainer at the home-visiting program
Ch	UK	Executive director
Jo	USA	1) Associate professor 2) Researcher and program evaluator 3) Part of a national group called the Home Visiting Applied Research Collaborative

		4) Member of the technical advisory group for the Eastern European and Central Asian region of UNICEF
Ka	UK	1) Reader in Child and Family Health 2) Health visitor
Sv	Serbia	1) Specialist in social medicine at the Institute of Public Health 2) National and international expert in early child development, mainly on home visiting
Mi	UK	1) Registered public nurse 2) Program manager of the specialist public health nursing program at the University 3) PhD student
El	Kenya	1) Coordinator for maternal and child health services at the county level 2) Part time teaching at the university

As far as practitioners are concerned, one is from Serbia and is a chief of Maternal and Child health nurses service as well as a national trainer of UNICEF. The second practitioner, is based in the Netherlands and works as a nurse at the Consultation Bureau, the Dutch service providing preventive care for children for zero until four years.

c. Data collection

After reviewing existing literature, we developed two interview protocols: one for training providers (Appendix 2) and one for practitioners (Appendix 3). Both protocols were structured using the same broad categories, but questions were specific to the context of practice and the experience and background of each of the two groups.

The categories included in the interview protocol for training providers were:

- Demographic information (3 questions)
- The in-service training program (5 broad questions with various sub-questions)
- Perceptions about effective practice and practice-change processes (9 broad questions with various sub-questions)
- Promising approaches (1 question)

The interview protocol for practitioners included the following categories:

- Demographic information (2 questions)
- The context of practice (7 broad questions with various sub-questions)
- Perceptions about effective practice and practice-change processes (6 broad questions with various sub-questions)
- In-service training programs (5 broad questions with various sub-questions)
- Promising approaches (1 question)

Both protocols were reviewed by the Principal Investigator of the study and were subject to pilot testing initially at the level of the research team. Minor modifications were made following the first interviews.
Interviews were conducted online, using the GoToMeeting, online meeting and web conferencing tool. Each interview lasted from 45 minutes to 1:20 minutes. Interviews were recorded and they were transcribed by researchers at the Goshen institute.

d. Data analysis

Qualitative data underwent a thematic and content analysis using a qualitative analysis software (Altas.ti). Specifically, analysis followed the well-known stages of data reduction, exploration and synthesis. Each transcript was read closely and was coded using open coding. Subsequently, when all interviews were coded, codes were classified into different themes according to their similarities. When necessary, the name or the sorting of the categories was refined (axial coding).

Training providers’ perspectives

The various roles of the Maternal and Child health nurses

Qualitative data highlighted that Maternal and Child health nurses have a very complex role, with different levels. Across questions during the interviews, it was highlighted that Maternal and Child health nurses have a **holistic role** to play.
According to Ch:
“*The health visitor needs to keep an eye on child development, to advise on nutrition, breastfeeding, to weigh and measure babies, that's one level. If it's a role as ours is, which is holistic, where the health visitor works at the level of the family, recognizing that the outcomes for the children will be a measure of family's wider health. So the health visitor will be addressing and managing things like domestic violence, perinatal mental health, mental illness, tackling things like smoking and substance abuse and so on, which reflect on the child. So that's the approach we take. We look at the whole family, and the child as being in the center of the whole family. But when we see a child, for instance, for a developmental assessment, we would also be talking to the mother about how she is, how the family are, and picking up on things like, I don't know, bereavements that could impact on the family's well-being. Loss of jobs, finance, housing, so wider. Wider determinants of health and inequality*” (Ch).

El, also, mentioned that the practitioner needs to address the child holistically, not only for example if the child is sick to check only this and this is the aim of the training, to equip the practitioner to treat the child holistically:

“*Now, that is maternal health. Now, under child health, we have various trainings for our practitioners. The first training that we want to, we are trying to ensure that is done to all is called Integrated Management of Childhood Illness. I-M-C-N-I. Integrated Management of Childhood and Newborn Illness. Now, why do we call it integrated? We are saying it's integrated in the sense that you don't treat only one thing when a mother comes with the child. You also do the normal screening. You screen for malnutrition, you screen for any other illness that she is not presenting to the clinic, so that you address the whole, the child, the problem of the child holistically, so that's another training that the government is really advocating for, and we are trying to train our healthcare providers on… The reason is to enhance continuum of care, and ensure that at least there are no missed opportunities both at the facility and at the community. Previously, a healthcare provider would address the presenting problem. A mother comes with a child with fever, and the mother is only asked, "How many days?" And then tests are done, and then they manage if it is malaria, but we are saying alongside that the child could be having developmental issues, the child could be having malnutrition, the child could be having some other underlying problems, and that is the essence of having the Integrated Management of Childhood and Newborn Illness*.” (El)

In addition, it was stressed that Maternal and Child health nurses’ role **focuses not only at the child but also at the family level**:
“*The roles are different. The focus is different. I think ours is perhaps wider. I mean, a lot of countries just focus on the baby. We feel it's really important to focus on the parents as well, and we have training, for instance, in paternal mental health*” (Ch).

This was also stressed by Ka who referred to that level of practitioners’ role as ecology. Ka went beyond by stressing that Maternal and Child health nurses’ have a role **as policy influencers**:

“*The health visitor has to influence policy and shape the overall environment in order to positively influence the family and child development: “Or indeed, it might be that one of the problems around diet is the availability of the shops or the resources locally to be able to buy a healthy diet. Or it could*

be about the financial benefits system, if families are workless, or the housing benefits, if they don't have a home, you know. So all that would fit under influencing policy. That's where the health visitor is operating... it's almost outside of the family, but to shape the environment for the sake of the family, to improve child health" (Ka). Mi also refered to practitioners' role in influencing policy that affects health.

Also Ka mentioned that there are **three core areas of practice that health visiting is orientated around:**

1. That concerns **human ecology**, it concerns the principle of health creation so we refer to salutogenesis for that. It's not about treating ill health, it's about creating good health.
2. Then the third principle is about **human valuing**, so the fact that it's a service that should be offered to anybody, regardless of their ethnicity, regardless of their gender. If they're a child and if they're in this country then they should be eligible for the service. So it's not about income or where they live. It should be that, if they fit in that age group, then they should be eligible for the service, so whether as a mother or as a father or as an infant.
3. Then the fourth topic was that health visiting is operationalized through home visiting. The fourth important element is that, at its core is home visiting and **relationship development.**

In relation to the third principle mentioned by Ka, Mi mentioned that health visitors have two central roles to play: 1) **a social role – managing well people in the community**:

"*There's quite a mind-shift change that they have to undergo, to go from healing people and mending and fixing problems, to supporting people, guiding, and facilitating, and allowing... helping family. So I think the most we do about that is helping them make that social shift in how they understand their practice role*" (Mi);

and 2) **building thepeutic relationships with families**:
"*there's a whole module around health visiting practice, building therapeutic relationships, working in partnership with families, being an advocate for the family and the child, very much look at children's rights in that health visiting contemporary approaches, to health visiting module. We cover the theory behind that and they work day to day with children and families and to develop effective therapeutic relationships with them to get the best possible outcomes for children and their families. From a theory perspective that's very much addressed and then addressed in their portfolio also*" (Mi).

Thus, related to human valuing, El refered to the **humanistic approach** that should be inherent to practice. According to El:

"*That is the most important thing, because, again, not all women who come to the facility come because of the pain that is bringing them. Probably, it's just some issues that are psychological. Just need hearing and you make a difference, so if training institutions can ensure they really change the perspective of the provider, that this person is sick and I want to treat, and look at the provider holistically, in the sense that this a ... The humanistic approach. They come to you, and the first thing is to appreciate that they have come, and the next thing is to start communicating in a way that you appreciate their presence. I don't know how you'd call that course, but that is something that even Kenya we are struggling with*" (El).

Finally, Ka referred to **prescribing**, which was described as a response to families' needs:

"*Oh, prescribing, that's the other thing that they do in this country. Nurses can prescribe medication from a limited list. Most of the areas in England like to have their health visitors qualified in being able to write a prescription. I think it's seen as a way of enabling the nurse to be more responsive to the*

family's needs without creating an extra demand on the medical general practitioner for minor things, not for serious things. So it's a very limited list that they can prescribe from, but it would be things like paracetamol, head lice lotion, or creams and emollients if there was a eczema or rashes. Common products to use for minor problems with baby care, really" (Ka).

The various roles of Maternal and Child health nurses: Synopsis

- Maternal and Child health nurses have a very complex role, with different levels.
- Maternal and Child health nurses have a **holistic role** to play and they need to address the child and the family holistically.
- Their role **focuses both at the child and at the family level.**
- Maternal and Child health nurses have a role to play as **policy influencers**.
- They have a strong **social role** since they need to manage well people in the community.
- A central tenet of practitioners' role is to **build therapeutic relationships with families** and to adopt a **humanistic approach**, which builds on human valuing.

Necessary knowledge, skills and attributes

All interviewees highlighted a number of necessary knowledges, skills and attributes that effective Maternal and Child health nurses should have.
According to Ch:
"*So they themselves are professional, they* ***will focus on the person, they're self-aware, they know when they're crossed the line. They're open, they listen, they're positive. They're curious. They are accepting of people's differences, and they're tolerant of differences***".

Communication skills and relationship building:
One of the most frequently mentioned skill is that of communication, which was mentioned by all interviewees and which according to Ch "is everything… are critical". According to Ch:
"*health visitors go into every home, and it's just so important that they have the personal abilities to be able to form relationships and to work with families*". Ch also mentioned: "*So research in England on the health visiting role has demonstrated that the most important skills are* ***communication****, the ability* ***to very quickly form a relationship with a family****, so you knock on the door, you're invited in. Very quickly, you must have this skill, and it's a* ***higher level skill*** *to be able to form a relationship, which gives the mother, it's usually the mother, the confidence to be able to talk about any issues that she has. So the* ***skills of communication, relationship building"*** (Ch).

Ka, also highlighted the importance of communication skills and she stressed that practitioners should be able to adopt them based on the group with whom they intend to use them:

"*I think communication skills are very critical, and understanding how to adapt those depending on whether they're communicating with the family or whether they're communicating with a colleague or whether they're within their team or whether they're communicating with a colleague from outside their team. I think there's a different style of communication that goes on in each of those situations. So that's very critical*" (Ka).

Ka also stressed the importance of valuing the relationship that practitioners build with the family and how important this is for the reputation of the service:

"*The other thing that's really important from the strength of our service we would say, is allowing the service to be designed in such a way that the practitioner understands that what they're doing is they're developing a relationship with the family and using skills that allow relationship qualities to come to the fore because the services rests on the ability of the family to be able to trust the practitioner. If the relationship skills aren't used then the trust won't develop and that reflects badly on the whole service and the likelihood of the family accepting any intervention, whether it be something as simple as immunization or whether it be something more complex as a parenting training or something, or safety measures. So valuing the relationship*" (Ka).

Jo from his side, referred to the importance of an emotional connection with the family:

"*at the foundation of what a home visitor does, is that they have a good****, strong working alliance with the family****. So they need to know how to form an* ***effective, responsive partnership with families*** *where they are, so that the families can trust the home visitor enough to be able to reveal things about themselves, to be able to like ask the right kinds of questions, to seek out information. And* ***the home visitor has to feel comfortable enough with the family, that they know how to ask the right questions, and they know how to present the information.*** *I tend to think of it in terms of psychotherapeutic concepts, the idea of the working alliance, and there needs to be an* ***emotional connection****, but there also has to be kind of* ***an agreement on what are the tasks and goals for the***

home visit. *So if the home visitor and the parent cannot get on the same page about, this is why I'm coming to your house, then it's most likely not going to be an effective partnership*" (Jo).

Finally, El, also, mentioned that it is important to go beyond technical courses to courses that enhance communication skills and that enable the practitioner to provide a welcoming and responsive environment:

"*We are actually really trying that. For example, with the introduction of scaling up of nurturing care for early childhood development, we are trying to really encourage practitioners to listen. To use their eyes, their ears, all the senses, when they have a particular taste. For example, when the woman is talking, we encourage them to give time, so that she can say even other things that may be probably are not things that she'd say if you don't give her adequate time, and we train them in counselling how to counsel the caregiver*" (El).

<u>Personal attributes:</u>
Ch described an interesting experience she had, which indicates that personal attributes are very important for building a good relationship with the family:

"*It can look very simple, but I had an interesting experience. I went to Denmark and I spent a day health visiting, and the health visitor I was with was operating with Danish families that were speaking Danish. But I could see that she was doing exactly what I would do in England. It was exactly the same. I could see how she **was smiling**, how she **was looking relaxed**, where she **was sitting**, how she had **eye contact with the mother**, how she was **listening**, the **empathy** she was showing. And actually, I didn't need the language, and I could see where things were not good, and she was picking up on that. It was quite fascinating really. So language is only one component of it*" (Ch).

Empathy was stressed by Jo and Ka, too, as an essential personal attribute. According to Ka:
"*Sometimes some of the areas of practice can be very sensitive, then as part of that communication, then empathy is really important, but at the same time, being able to offer advice and guidance in quite a direct way sometimes as well*" (Ka).
Mi mentioned that practitioners should also be passionate about their role and the importance of their role.

El stated that competent practitioners are brighter and more friendly:

"*Now, you said also with the attitude of a competent practitioner, it will be very different from the attitude of a practitioner who is not sure about a particular management of a particular case. You will even see from the way they receive their client. They are brighter, they are friendly to the client, as opposed to that one who is not competent, who may even want to disappear or to delay, because they don't have that competence, so there are many things that we look at, and sometimes like in a delivery room, we even look at the way they monitor the labor, the mother in labor*"(El).

<u>Confidence:</u>
The second most frequently mentioned attribute is self-confidence. Ch mentioned that when they leave the training practitioners do not have a supervisor, someone who can observe their practice, and so they need to have the personal confidence to be able to deal with whatever they find behind that door. And so, according to Mi, the training contributes into building practitioners' confidence. In addition, Ka mentioned that the program should equip practitioners with the confidence to speak up, so as to influence policy, and the confidence to use their knowledge and apply it. Specifically, she highlighted that:

"*Then I think we could do more in the area that boosts their confidence so that they can develop arguments that are succinct and to the point, then that'll make them stronger in influencing senior people with decisions. It's about the need to influence the commissioners that I think is really important*" (Ka).

Jo also stressed the importance of boosting practitioners' confidence so as to be able to influence people and policy:
"*Then I think we could do more in the area that boosts their confidence so that they can develop arguments that are succinct and to the point, then that'll make them stronger in influencing senior people with decisions. It's about the need to influence the commissioners that I think is really important*" (Jo).

Finally, El stressed:

"*You know, one thing about competency, competency will be seen in the way you deliver, and the first thing you will see is a confident practitioner. A competent practitioner will be confident about what they are doing, and that's why I was saying there'll be no panicking, because the moment a client comes with a condition that you do not know how to manage, the first thing is panicking. And when you are panicking and this is a health sector, and this is a sick person, then you mess. Now, confidence is one thing that we will see in a competent practitioner*" (El).

<u>Collaborative working and facilitating outcomes:</u>
Ch highlighted the need for practitioners to be able to work collaboratively with other professionals, so as to facilitate outcomes:

"***Facilitating outcomes**, so the public health nurse, health visitor needs to **be able to work with doctors, with many other community structures**, and needs to be able to **form relationships** to be able to support families to access different sorts of interventions. **Collaborative working** is bringing evidence into practice. Negotiation skills. And conflict resolution. And solution-focused approaches*" (Ch).

<u>Assessment skills:</u>
According to Ch assessment skills are critical. She mentioned:
"*So again, it's a **high level skill to be able to assess need**, so you assess need at different levels. You talk to the mother, you talk to the mother in a way, you ask questions, it can seem quite simple, as if you're just perhaps having a conversation and a cup of tea, when actually the questions that you're asking are all taking you to an endpoint, which is either, "This family is doing well, everything's great," or they have needs in this area*" (Ch).

Related to the assessment skills, is also practitioners' ability to tailor their approach and not offer a one-size fits all approach. Ka mentioned:
"*Another key feature of practice is to be able to tailor your approach so that they're not using the same approach with every single family. They can most definitely tailor how they behave, what they offer, depending on the circumstances of each family in each situation. Because again, if they offer this one size, same-founded approach to absolutely everybody, then very quickly the families will feel that the service isn't relevant to them and they won't trust it" (Ka). Ka also mentioned that "It's that principle of giving everybody a standard level but being able to tailor it up or down, depending on need. That's the crux of it really, I think. Through that you're using your relationship, you're going out into the homes, you're decision-making, you're making judgments but on the basement of the information that you have, and you do it in co-operation with the family*" (Ka).
Sv also highlighted the need for practitioners to be able to apply standardized assessment tools.

Negotiation skills:

Ch mentioned that another high-level skill, essential for practitioners, is negotiation:
"*And then to be able to **discuss those needs with the family and negotiate alongside them**, what type of help you might be able to offer. But it takes a higher level set of skills. So when she's talking to that mother, she would be **pulling on the knowledge and the evidence base** for effective breastfeeding. She would be pulling on her skills in **communication and negotiation***" (Ch).

Marketing skills:

Ka stressed that home visiting is unsolicited, and therefore practitioners should have marketing skills in order to offer the service in an appealing way:

"*A lot of health visiting or public health is what we call unsolicited. It's provided to families without the families inviting it to happen. We contact them and say, we want to make an appointment to come and talk to you about your child's development, rather than other health services where it's the patient who contacts the doctor and says, I would like an appointment about my leg or whatever. So because it's not coming from the parents and we say we want to offer it to you, we have to offer it in such a way that it's appealing and that they would want to take it. Also, offer it in such a way that it doesn't look like we're criticizing them by making the offer. I think there's also an important role in marketing and communication around how the offer of the service is marketed. So that the impression that the nurse makes to the families is always a positive one because any level of criticism soon influences that public impression of what the service is and the risk of stigmatization. So I think that's probably fairly critical*" (Ka).

El also stressed the importance of marketing skills and of providing attractive services so as for the parents to come back again. She mentioned:

"*It has been a challenge, because the country, in the whole country, the uptake is only about 50%, so we have, we are training healthcare workers, though have not managed all, to ensure that the first visit, the first time you meet a mother, you treat the mother like you will not meet this mother again, so that she's attracted to the services, and she's able to come for the subsequent service*" (El).

Time-management skills:

Due to high workloads, practitioners should have very good time-management skills. Ka mentioned:
"*but at the same time, being able to offer advice and guidance in quite a direct way sometimes as well. Because coupled with all of that, if they've got lots of families to see, then they still have to time-manage their communication. They can't just decide to give everybody an extra half-hour conversation because then there won't be enough hours in the day to meet everybody's needs. So the professional nature of it is also about judging the timing of each consultation. That, I think, is a very skilled process, how to close down the conversation but do it in a respectful way so that the person doesn't feel ignored, and to manage the consultation so that the families still are very clear what happens next or what advice has been given*" (Ka).

El also mentioned that practitioners due to challenges (e.g. few practitioners due to cost-related issues) may not give adequate time to families and that they need to have good time-management skills:

"*That is we'll show competency, and how as managers we will see that competency is the timing that the facilitator takes, that the practitioner takes to manage such, because again time is of value in the management of patients, so you'll realize that even the time she took to try and time she took refer, it's a short time that cannot cause death*" (El).

Resilience:

Mi referred to the difficult situations that Maternal and Child health nurses frequently phase and stressed how important is for them to be resilient:

"*So I think they will come across complex situations. They might come across a child death, they might come across significant child abuse which are really complex. They might come across that victim of domestic abuse who doesn't want to leave her partner. So they will have to deal with this on a day to day basis who's building up there. I want to use the word resilience, it's very well used now, isn't it*?" (Mi).

Knowledge:

Interviewees highlighted that it is important for practitioners to have content-related knowledge of issues that are inherent to their everyday practice. Ch mentioned that although depending on the family cases practitioners should have additional suitable skills and knowledge, all of them:
"*should be trained, for instance, to the same level around breastfeeding, around mental health, around nutrition, skin diseases, and so on*" (Ch).

In addition, Jo highlight that practitioners have to master many differe things, a lot of content, and therefore it is essential to be "really quick learners" (Jo).

All mentioned that practitioners need to have more theoretical knowledge on the following three topics:

1) **More theoretical knowledge related to normal, and not normal**. Just to know this, some people not know, first of all. And when they say this is not normal, we ask them, we discuss with the supervisor, and so on.
2) **Knowledge to help mother**. How to help with children.
3) **Knowledge about how to involve all the family around**, the other person, the family to help themselves is big. Education related to the homes, the home to play, the father to help the mother and so on.

Ka, also referred to the need for practitioners to know how to work with the whole family:

"*It's very much not just about being an individual who just works with an individual mother or father, it's about **being an individual who works with the mother and father, always appreciating the wider situation that the family live in**. I think that's the key thing we have to work on getting them to understand by the end of their program*" (Ka).

Jo highlighted that Maternal and Child health nurses are expected to be a source of knowledge for families and therefore they need to have knowledge about many different things:

"***So they need to have a basic understanding** of infant and early childhood development. They need to have a kind of a good understanding of what are the important milestones. So if there are concerns about delays, the home visitor has kind of an intuitive sense, and they know what to do in terms of how to do a screening… And they need to **have kind of a toolkit of what are the kinds of activities that they can promote**, that parents and children can do together that promote the child's development …They need to have **a basic understanding of issues around child, health and safety**. They have to have a basic understanding about **what parent wellbeing involves**. So in terms of, like for example, maternal mental health or more broadly, I think just parent mental health*" (Jo).
In terms of knowledge, Sv that practitioners should have knowledge about the importance of the early years, the cultural context, home safety, health, professional practice, etc. As she mentioned:

"*I mean there are different topics when we talk about the content, the content is quite broad, so different things really*" (Sv).

Ch, Sv and Jo mentioned that it is very important for practitioners to be knowledgeable of the community, of the services and resources in the community, so as to be able to link the family to those services. According to Jo:

"*And I think the other skill they need, **because home visitors can't do this all by themselves, is they need to have an understanding of what are the available resources in the community, and they need skills about how do I make referrals** that can stick or that can land so that you can make a referral to a parent, for example, to a mental health clinic. But if the parent never goes to that clinic, then it's not a helpful referral… And so they need to have **a knowledge of the community resources**. They need to know how to make the referral, but they also need to do what people sometimes call them warm handoff, where they can find ways to kind of connect the family to the services and facilitate that process. So, I think that covers it. I'm trying to think if there's other major content areas. I think the part of their knowledge of infant and early childhood development, they have to have a fundamental understanding of issue like attachment and early bonding*" (Jo).

Finally, Jo stressed the importance of research skills, that is practitioners being able to read and interpret research.

Necessary knowledge, skills and attributes: Synopsis

Effective Maternal and Child health nurses possess the following knowledge, skills and attributes:

- Communication skills and relationship building
- Personal attributes (e.g. empathy, passion, friendliness)
- Confidence in self and in their role so as to speak up, influence policy, use their knowledge and apply it
- Collaborative working and facilitating outcomes
- Assessment skills and ability to tailor their approach
- Negotiation skills
- Marketing skills
- Time-management skills
- Resilience
- Content-related knowledge of issues that are inherent to their everyday practice

The need for in-service training programs

Data from the interviews with the training providers highlighted that the training programs aim to address needs at three levels: 1) the needs of the professionals; 2) the needs of the profession; and 3) the needs of children and their families.

The needs of the professionals

All interviewees highlighted that the training aims at meeting professionals' needs at different levels:

<u>Practitioners' confidence:</u>
One of the most frequently referred need is practitioners' confidence. 3 of the interviewees mentioned that the training aims at increasing practitioners' confidence. Ka mentioned that the program is "*about giving them the confidence to speak up and the confidence to use their knowledge and apply it*" (Ka), whereas Mi said that through the practice teacher the program builds practitioners' confidence. She said that even though they are qualified practitioners they are going back to become novice health visitors and that although they might have extensive experience in intensive care unit the community health system is different. El also mentioned that the program strengthens participants' confidence in their work and in their role, through giving them the knowledge they need and also through the exercise – practice:

"*Now for one reason, you may find a healthcare worker who, despite having gone through the pre service, maybe is not really competent in an area, and needs further retraining and further probably support. Mentorship, for them to enhance that skill, so when they don't have a skill, they do not know how to carry out a procedure, that will interfere with the confidence. Two; a healthcare worker who tries out a procedure and succeeds, the self esteem is increased and the confidence is built, because you've tried and it has worked, and the mother is alive, or the child is alive. You saved a life. That will build your self esteem and will build your confidence, such that next time a child or a mother who comes with the same condition, you will want to do it even better, so that boosts your morale and builds your confidence. Now, sometimes confidence is built because of experience"* (El).

<u>Enhancing skills and capacities:</u>
In addition, interviewees mentioned that the training aims at enhancing trainees' capacities so as to deliver high quality services. Specifically, El highlighted that the training supports trainees to become more competent and to feel less panic in emergencies. She also mentioned that this is achieved through enhancing particular skill that they were taught during pre-service training (El).

<u>Peer learning and sharing:</u>
In addition, the training supports practitioners to share their experience and feelings from their everyday practice (Al).

<u>Grow trainees in adult learners:</u>
Mi, mentioned that the aim of the program is to grow the trainees into adult learners:
"*We very much work very closely as a team with our students. Not to nurture them, but also to grow them into adult learners because they have to take responsibility for their learning as well and we set that out from the outset of the program*" (Mi)

The needs of the profession

In addition, interviewees highlighted that there are some competencies and qualities which are central to home visiting practice and the training was developed in order to respond to these specific needs of the profession.

Having the right people, with the right attributes:
According to Ch:
"*After a review conducted by all involved stakeholders (the government, the registration body, the professional bodies, and educationists) and which aimed ta exploring the key elements of the specialist community, public health nurse, or health visitor, it was revealed that **it is not enough just to train anybody, you've got to have people who have the right attributes and the right approach**. So the following two aspects are key: the personal attributes of the professional and the academic background – do they have the ability to undertake the academic training?".*
Drawing on these conclusion, Ch mentioned that the training was developed with the aim to provide the **skills and knowledge of the role of the job**, to do the job, to learn the role.

Practice change:
According to Sv, the aims of the training program were not only to increase and improve the skills and knowledge of the practitioners but also to support practice change. In order to achieve this aim, a monitoring system has been developed in order to monitor practitioners' everyday practice.

Influencing policy:
Ka mentioned that an important role of the Maternal and Child health nurses is to influence policy, so as to contribute into shaping the environment in order to influence positively the family.

Need for intersectorial collaboration:
El mentioned that the training is **intersectorial** in order to address challenges in the country context.

Re-socializing the practitioners and re-conceptualizing the social aspects of health:
According to Ka the training aims at helping practitioners make that social shift in how they understand their practice role:
"*I think it is the combination of having practice and theory running alongside each other. I think the one thing that we definitely do do is... What health visiting is in the course is you're really re-socializing the nurses because traditional nurse education mainly prepares nurses to manage sick people in hospitals. The course that we then put them through is to manage well people in the community. It's almost like the complete opposite of what they originally were trained to do… There's quite a mind-shift change that they have to undergo, to go from healing people and mending and fixing problems, to supporting people, guiding, and facilitating, and allowing... helping family… So I think the most we do about that is helping them make that social shift in how they understand their practice role and they become*" (Ka).

In the same line, Ka mentioned that the aim of the program is to showcase the social determinants of health:

"*I think it's a mixture of providing them with theory and learning around the social determinants of health. We introduce them to the fact that health is much bigger than the health service, than the National Health Service, and that health is also influenced by housing, by transport, by the pollution, by food available, et cetera, et cetera. That's one thing where you start to see people change in their realization that if we want to improve the health of a population, we have to look at the bigger situation, the bigger picture. So there's that bit*" (Ka).

El also stressed the importance of a humanistic approach that goes beyond treating sick children:

"*That is the most important thing, because, again, not all women who come to the facility come because of the pain that is bringing them. Probably, it's just some issues that are psychological. Just need hearing and you make a difference, so if training institutions can ensure they really change the perspective of the provider, that this person is sick and I want to treat, and look at the provider holistically, in the sense that this a ... The humanistic approach. They come to you, and the first thing is to appreciate that they have come, and the next thing is to start communicating in a way that you appreciate their presence. I don't know how you'd call that course, but that is something that even Kenya we are struggling with*"(El).

Giving voice to the field:
Ch mentioned that the program/institute was developed with the aim to give voice to the profession. "*What was behind it was that we didn't believe that health visiting had a strong enough voice, and we felt that the profession needed to be determining its own destiny, not having it decided for us*" (Ch).

Developing unified standards/unified practice:
Two interviewees mentioned that the training aims at unifying the standards for the profession as well as the practice. Ch mentioned that due to lack of unified standards, although all practitioners may be trained the curriculum may be implemented differently across providers. Specifically, Ch said:

"*In England, all the doctors have medical royal colleges, and they set their own standards, their curriculum. They set the exams, they mark the exams. There's a national standard if you're a surgeon, everybody takes the same exam. In nursing, it's much more regional and there's much more variation, and we wanted to ... and again, in health visiting. So when I did my doctorate, I discovered that depending on where you trained, although we have national standards for the training, they would be interpreted into a slightly different curriculum. So for instance, parenting would be in the training, but one provider might do half a day on parenting, another might do a whole module on parenting. And to me, this isn't acceptable… So what we hoped was that the institute could start to set national standards, and that's what we're doing. And we've done that a lot through training. Through developing national training programs which are then cascaded so every health visitor has access to the same evidence base and the same knowledge and the same training. And that way you upskill them, so it doesn't matter whether they're in Yorkshire or in Essex, they will be delivering, we hope, services against the same evidence base*" (Ch).
Sv on the other hand, mentioned that the training supported them in developing "*something like checklist for them in order to unify their practice. To show that each nurse will provide full scope of activities for each family, and additionally to provide some activities according to the needs of each family*" (Sv).

The needs of children and their families

According to Al, the content of the training was adopted in a way that meets families' needs and also that the training supports practitioners to protect families, according to their need. El also mentioned that the aim of the program is to support the professionals to support the family to address problems at the household level, even before the problems reach to the service. In addition, the aim is to ensure that families/caregivers are responsive to children's needs and that they are providing nurturing care to their children.

In addition, El mentioned that the program ensures that families have access to a continuum of care and that there are no missed opportunities at the facility and community levels for families to get that continuum of care:

"*Alongside of that, as it is done by practitioners in the facility, we are also training the community health volunteers on the same, what is now called community case management of childhood illnesses, so that at least the children who need referral are identified at the community, and referred for this integrated management at the facility. The reason is to enhance continuum of care, and ensure that at least there are no missed opportunities both at the facility and at the community. Previously, a healthcare provider would address the presenting problem. A mother comes with a child with fever, and the mother is only asked, "How many days?" And then tests are done, and then they manage if it is malaria, but we are saying alongside that the child could be having developmental issues, the child could be having malnutrition, the child could be having some other underlying problems, and that is the essence of having the Integrated Management of Childhood and Newborn Illness*"(El).

Thus, the training supports practitioners to address the child holistically:

"*The first clinician that you get in contact with will first manage you at that level, because in most of our health facilities, we don't have specialists, so this integrated management has really helped for one clinician to be able to address the child holistically, unless there is a complication, so they refer to another level*" (El).

Mi summarized all the above, by stating that the program aims at producing proficient health visitors that will improve the health and well-being of the future generations:

"*We need our students to have an all encompassing, example of what health visiting is and a whole range of experience to develop them into competent and then proficient practitioners who can work with families, make a difference, which sounds idealistic but that's what we want them to do, improve the health and well-being of our future generations. We've got a well-being and future generations act here in Wales. We're very much focused on the public health agenda, we have an obesity crisis within Wales and across the world. Health visitors, because they're working with families from birth, they could have a great influence on the public health agenda. That's our goal really, to be passionate about how important the role of health visitors is into developing a healthier nation. But also students who are able to recognize complex issues such as abuse and neglect and supporting the mother or father who's in a domestic abuse situation. That's why it's quite an intensive program and our students are well supported within that but we want them to be able to, when qualified, go out and make a difference in the health and well-being of children and their families* (Mi).

In the same line, El mentioned that the aim of the training is to reduce infant mortality and improve children's health:

"*The main goals of the training, one; as a county, as a county where I work in, our vision is to ensure that we reach every woman and child with quality healthcare services, as a way of reducing infants under five maternal mortality. The county is having a high burden of disease, which ends up bringing in the issue of high infant mortality, high under five mortality and high maternal mortality, so we are working towards reducing the mortality levels and the morbidity levels*" (El).

The need for in-service training programs: Synopsis

Data from the interviews with the training providers highlighted that the training programs aim to address needs at three levels:
1) *the needs of the professionals*;
2) *the needs of the profession*; and
3) *the needs of children and their families*.

Professionals' needs include but are not limited to: increased confidence, capacities so as to deliver high quality services and be more competent, peer learning and sharing of experiences and emotions and need to grow into adult learners.

The needs of the profession include on the other hand: having the right people with the right attributes, practice change, influencing policy, intersectoral work, re-socializing the practitioners and re-conceptualizing the social aspects of health, giving voice to the field, and developing unified standards/unified practice.

Finally, the training aims at addressing **families' and children's needs** for protection, for having access to a continuum of care and for being addressed holistically.

The training programs

Provider

In the following Table the provider of the training program is presented:

Participant	Provider
Al	Ministry of Health, UNICEF
Ch	A UK-wide professional body: The institute is a UK-wide professional body, academic professional body and charity
Ka	University
Mi	University
Sv	Institute of Public Health of Belgrade
El	The Saya County

Duration

The following Table presents the duration of the training program

Participant	Duration
Al	7 days
Ch	45 weeks
Ka	52-week long program for a full year: It's more like 42 weeks course and 10 weeks holiday periods at different times
Mi	Full-time program: 1 year Part-time program: 2 years Extended part-time program: 3 years
Sv	17 days, 1 day for each of the 17 modules (once or twice monthly)
El	Emergency obstetric care training: 1 week Care for child development module/training: 5 days

Participants' demographics

The following Table presents the demographics of the training participants

Participant	Academic background
Al	Nurses
Ch	Health visitors
Ka	Registered nurses
Mi	Qualified nurses and midwives
Sv	Home visiting nurses
El	Community health volunteers, medical healthcare workers, medical officers

Components

The following Table presents the main knowledge and skills components for each of the training programs

Participant	Components
Al	- Children's (0-6 years of age) movement - Fathers' role and involvement - Feeding and nutrition - Safety at home - Discrimination training - Parents with economic problems - How parents can play, interact, to talk with children - Communication: "Each module plays a part of this communication part

Ch	<u>- Knowledge components</u>: "So **leadership** is a big component. **Assessment** is a massive component, effective assessment. But assessment is <u>at the public health level</u>, understanding public health statistics, as well as <u>at the individual level</u> with a family and what the family tells the health visitor. And obviously, **public health and public health practice, social justice decision-making, working with technologies, research** is a big important component. **Safeguarding** will always be a component. **Human development**". <u>- Skills components: "</u>So these are the skills that will be taught in university and in practice. So again, you **see leadership assessment**. **Facilitating outcomes**, so the public health nurse, health visitor needs to be **able to work with doctors, with many other community structures**, and needs to be able to **form relationships to be able to support families to access different sorts of interventions**. **Collaborative working** is bringing evidence into practice. **Negotiation skills. And conflict resolution. And solution-focused approaches**. So different courses will teach slightly different skills, so they may teach a **motivational interviewing**. It's very popular. **Solution-focused therapy. CPT, cognitive behavioural therapy.** communication skills are everything. Communication and assessment skills are critical.
Ka	1. **Searching for health needs:** The assessing health needs, obviously it's fairly self-explanatory. That's all about how to do assessment, both of community-level need or family-level need or individual need, so different processes for that. That would include the communication skills required, familiarity with tools. They use things like the Ages and Stages questionnaire tool to assess development and other measures for assessing child developmental or maternal mental health. 2. **Stimulating awareness of health needs** 3. **Facilitating health activities**... health promotion fits into that: Then facilitating health and healthy activities would then be about... Once you've established need, it would be about working with the families to assist the family in making the necessary behavioural adjustments they might need to make to perhaps make healthy choices. It might be about improving the amount of exercise they have or changing the family diet. It might be the parenting responses and communication with the child. So, it's all the guidance that would go into facilitating those new behaviours, or healthier behaviours. 4. **Influencing policy:** Influencing policy is as much about influencing what the commissioners believe they need to commission... So, it could be policy at the regional level, but it could be policy at the local organizational level as well. Also, about thinking about the wider determinants of health and public health. So, appreciating that it might that the families don't come to the baby clinic to have the necessary immunizations or weighing the babies because perhaps there isn't a transport system that enables them to get to the clinic. So, you'd be looking at the whole community and looking at those sorts of challenges. Or indeed, it might be that one of the problems around diet is the availability of the shops or the resources locally to be able to buy a healthy diet. Or it could be about the financial benefits system, if families are workless, or the housing benefits, if they don't have a home, you know. So, all that would fit under influencing policy. That's where the health visitor is operating... it's almost outside of the family, but to shape the environment for the sake of the family, to improve child health. 5. **Social determinants of health**: I think it's a mixture of providing them with theory and learning around the social determinants of health. We introduce them to the fact that health is much bigger than the health service, than the National Health Service, and that health is also influenced by housing, by transport, by the pollution,

	by food available, et cetera, et cetera. That's one thing where you start to see people change in their realization that if we want to improve the health of a population, we have to look at the bigger situation, the bigger picture. So there's that bit 6. **Local policy development and influence:** Alongside it we do exercises with them as part of their assessments and project work. When they're out in practice we encourage them to go and make appointments with key people and have conversations about those bigger things. We give them opportunities to sit on project groups or boards, attend meetings, where they get to witness where local policy is developed and made. That's about giving them the confidence to speak up and the confidence to use their knowledge and apply it. That's quite hard, but I think that's why the education program needs to be at least a year long. Ideally, we would like it to be 18-months long because there's quite a psychological shift and confidence growing that has to happen in the person for them to move. Some of them are already very politically aware so they're already happy to do that. 7. They have modules specifically on **public health and social policy**, they have modules on **research methods** so that they're able to learn about research evidence and... not so much to do research, more so to have the skills to learn how to read and understand about the research evidence. They have **a module which is specifically about the core area of practice**. That is about the whole role of being a health practitioner as a health visitor and working with families. So that... cover activities that are very specific to the role. They do... I'm trying to think now. There are two modules... Maybe nearly half of the course is specific to the area of practice, and then, as I say, they have these generic topics, which is public health, social policy... Oh**, prescribing**, that's the other thing that they do in this country
Mi	**1. research in health and social care,** **2. contemporary approaches to health visiting practice,** **3. health promotion,** **4. public health with community nurse prescribing** **5. safeguard in children and young people in health visiting practice**" - Our health promotion module is a little bit bigger because it has a nurse prescribing element in it, so that's a little bit bigger. The learning outcomes, map to our theory, evidence-based, looking at the difference between audit and research and development, I'm just thinking of the research module off the top of my head here. Within health promotion, they have to look at the theory, they do, quite a lot of reading on their own to look for a theory to back up their practice, I guess. - **Leadership:** "We do a session on authoritative practice and authoritative leadership. Because a lot of the research states that to be challenging you need to have an air of authority about you, as a nurse if you're challenging any safeguarding issues…. We look at transactional, transformational, authoritarian, all of those sorts of leadership and have a discussion around what could fit best or do they need to adapt their leadership style based on the situation that they're in. We cover leadership within that safeguarding module, although because it's a specialist community public health nursing program, we very much adopt a leadership throughout the program, I would say but it's aligned from a modular perspective and a learning outcome perspective to the safeguarding module" - In their first week they have an introductory session into **the principles of health visiting.** There are four key principles. It very much draws on searching for health needs, getting the families to recognize that there's a health need, and then getting the families to engage with them as practitioners to improve their health - And then there's another health visiting principal that looks at **influencing policy affecting health**.

	- There's a whole module around health visiting practice, **building therapeutic relationships**, working in partnership with families, being an advocate for the family and the child, very much look at children's rights in that health visiting contemporary approaches, to health visiting module. - We cover the theory behind that and they work day to day with children and families and to develop effective therapeutic relationships with them to get the best possible outcomes for children and their families. From a theory perspective that's very much addressed and then addressed in their portfolio also.
Sv	- Example topics that are addressed during these trainings: milestones, stimulation of child development, father involvement, postpartum depression, responsive parenting. - Also, one part is about **communication skills, attachment and bonding**. Also, **work without prejudice**. Also, prevention of **child abuse and neglect, home safety**. Something about **developmental delays and co-operation with other sectors**. - We have topics also on **immunization, breast feeding, complimentary feeding**, and so on. Also, one part is about **supervision of home visiting.** - We have one part about **communication skills** so we're trying to learn them about **approach in working with familie**s. You have **relationship-based partnership** with parents to build parental competencies, not to blame them or to label them. To set goals for parents, which parents also see as important to build mutual trust and respect also. They have to provide all these activities what we learn them during the trainings. All this assessment of comprehensive family needs, counseling, modeling, referral, to all these topics which I mentioned earlier. - The following modules are only online: "about ECD and some general principles. Another is about attachment. The third is about communication skills…"
El	- "For those practitioners that we have, the ones I'm saying that work in the health facilities both at rural and urban centers, what we normally do is to train them to start with **maternal health**. We train them on emergency obstetric care, and that training takes a week" - "Now, the second training that we do, we do what is called **respectful maternity care**" - "Another training that we have on maternal health is a training on **focused antenatal care**, so we said we want all women to receive at least four antenatal care visits" - "**Under child health**, we have various trainings for our practitioners. The first training that we want to, we are trying to ensure that is done to all is called **Integrated Management of Childhood Illness**. I-M-C-N-I. Integrated Management of Childhood and Newborn Illness. Now, why do we call it integrated? We are saying it's integrated in the sense that you don't treat only one thing when a mother comes with the child. You also do the normal screening. You screen for malnutrition, you screen for any other illness that she is not presenting to the clinic, so that you address the whole, the child, the problem of the child holistically, so that's another training that the government is really advocating for, and we are trying to train our healthcare providers on. - Alongside of that, as it is done by practitioners in the facility, we are also training the community health volunteers on the same, what is now called **community case management of childhood illnesses**, so that at least the children who need referral are identified at the community, and referred for this integrated management at the facility. The reason is to enhance continuum of care, and ensure that at least there are no missed opportunities both at the facility and at the community.

	- Basically, those are the main areas that we focus, and now, what the County started introducing is other than **treating the sick child, what about taking care**? That is not sharing care, that Siaya County is now scaling up. Let us not wait downstream, and we start addressing issues upstream, so that's what we are saying. If a caregiver is able to offer responsive caregiving, then they will identify issues when they are not too late, so now Siaya County is scaling up what we call nurturing care for ...". -Promote the nurturing care framework. As such the training focus on the care for child development module: "What I was saying is now we are scaling up nurturing care as an intervention to address problems at the household level before they get to us, for them to come to the facility, so what we are saying is that we are advocating for responsive caregiving, and what we are doing is to empower the caregiver, especially the primary caregivers, to be able to respond to the queues of the children in good time. We want to ensure that at the time of conception the mother, woman who is pregnant, is in touch with the child in the womb, so that she's able to know when the child is not kicking, when there is fever, how is it going to affect the child? And therefore address issues as they move on, until the time they give birth, and immediately after birth start stimulating the newborn to enhance brain development. That we are doing as a county, and we are doing it using various platforms that we have, so as a way of strengthening that, now, our healthcare practitioners in the facilities have been trained on what is called care for child development. Now, this cost for care for child developments, again, takes five days. Both theory and practice, so what we have done is at the time you are being trained as a practitioner, when you are trained you are given a task to go and do in your facility where you are working. And one major task is to start up a play corner for the children, so that when the children come to the hospital they have an opportunity to get the toys to play, and that way the health practitioner is able to assess the level of illness that the child is presenting with. Yes, are you still there?" - **Leadership skills** are targeted at a higher level, for managers etc: "That happens at various levels. Like I told you, when it comes to issues of health system strengthening, that is the mandate of the national government, so you will find over and over again the management or the leaders are called for these trainings on enhancing their competency. I think last, two weeks ago, immediately when we came back, there was even a similar training going on through support from AMREF. They were training the managers on the leadership, leadership and governance, so that happens, but usually it is organized at a higher level

Modalities

Interviewees mentioned a wide range of modalities that are used during the training. The Figure below presents the modalities that were mentioned:

Theoretical part: reading theory and lectures	Workshop-based teaching	Practice	Engagement in the public domain	Observations
Practice portfolio	Real-life examples: Students bring anonimized cases that they discuss	Presentations delivered by the students	Link-visits: Each student is allocated a named lecturer who will also visit them during their practice	Action learning set
Skills lab, where they use mannequins in order to demonstrate what they learned in theory	Small-seminar groups (e.g. reading groups, discussions about case studies, etc.)	Small scale independent work	Online components	Role play / interactive modalities
	Video / film week to initiate debates	Peer support from previous students	Assessments	

Theoretical part:
All interviewees highlighted that a theoretical part is inherent to the training, so as to support them back up their practice with the necessary theory. That theoretical part may include individual reading of theory (Mi), discussions from their previous experience (Al), large lectures (Ch, Ka, El). Al mentioned that the no practice or supervision is provided and the training is theoretical, combined with role play and discussions. Ch mentioned that the academic part is "quite theoretical" and although it equips trainees with the necessary theory, at the end of the training they feel that they had little experience of actually doing these things. Ka finally, highlighted that for some modules students from different programs participate in the lectures.

Workshop-based teaching:
Mi mentioned:
"*We're very aware that students don't like sitting for long periods of time and we call it death by PowerPoint, when lectures are just stand and reel off, the PowerPoint slides". In order to address this challenge, they use workshop-based teaching, which involves engaging trainees and generating discussions with them. In addition, they have introduced interprofessional education sessions. According to Mi "In my safeguarding module, I've introduced a neglect workshop. We go over to the school of social sciences building and work that day with students social workers. They thrive in that sort of environment and my colleagues do the same in the contemporary approaches module when they're looking at therapeutic relationship building. And we do interprofessional education with psychology students. So we've incorporated and we'll do more of that perhaps in our future programs. We also do a perinatal mental health session with our mental health nursing students. They thrive in that environment and it keeps the discussion alive. It keeps them motivated and we're introducing contemporary research and approaches just to make their practice as updated as possible*" (Mi).

Practicum:
4 of the participants highlighted that the training is a combination of theory and practice. Practice complements theory and allows trainees to observe and learn:
"*They have to do 50% in practice and 50% in the university of their time… That's mostly done through the modules that they do that are more directed on the field of practice. They go to practice every week and they're in university every week as well. So there will always be an opportunity, when they're back in the classroom, to talk about what has happened this week and for them to have a discussion about that*" (Ka).

"So these 45 weeks, each week will be half in practice, and they have a practice teacher who will provide supervision, teaching in practice, opportunities for observation and learning, and as the year goes on, the student is given opportunities to do visits by themselves, and then come back and discuss the visit and so on. And in the early part of the year, they observe" (Ch).

"So they're the four taught modules, but the program is 50% theory and 50% practice. And our students are aligned a practice teacher during their time with us. And they work on a one to one basis at the moment with the practice teacher to undertake a practice portfolio. And all of the learning outcomes in the practice portfolio align to each of our modules" (Mi).
"*The nurse do her work during the course visit and the person who is mentor have a task to observe the visit, to assist to the nurse if she needs assistance during the visit. After that, when they go to the family health care center, they have a talk about the content and the quality of the visit"* (Sv).

El mentioned that during their practice trainees have to perform different tasks. One of them is to establish a play corner in their facility:
"Both theory and practice, so what we have done is at the time you are being trained as a practitioner, when you are trained you are given a task to go and do in your facility where you are working. And one major task is to start up a play corner for the children, so that when the children come to the hospital they have an opportunity to get the toys to play, and that way the health practitioner is able to assess the level of illness that the child is presenting with" (El).

Engagement with the public domain:
Ka mentioned that they try to engage their trainees with the public domain using different modalities. She mentioned that they encourage them to **go and make appointments with key people and have conversations** about those bigger things, they give them opportunities to **sit on project groups or boards, attend meetings**, where they get to witness where local policy is developed and made, they **encouragee them to listen to different news channels, use social media in a different way to influence as well, to join in in public conversations about different issues.**

Observations:
Two types of observations were mentioned. Ch and Mi mentioned that trainees observe the practice teacher in order to see how he/she handles and approaches different situations. Ka on the other hand, mentioned that trainees are supported to observe the environment around the family, the neighborhood and understand how this might affect families' choices.

Practice portfolio:
Two interviewees mentioned that during their practice, trainees use a practice portfolio. According to Mi:
"*And they work on a one to one basis at the moment with the practice teacher to undertake a practice portfolio. And all of the learning outcomes in the practice portfolio align to each of our modules. So that's what we're trying to get them to do within the practice portfolio. And then they're questioned by their practice teacher based on some of the written work that they've done and also based on some of the practical elements that the practice teachers have observed in the practice area, their learning outcome is very much linked to our theory component*" (Mi).
Ka also stressed the importance of the portfolio:
"*One of the big, important documents, actually, that they do as part of their practice assessment is they have to develop a portfolio. They have to produce a piece of evidence that can be mapped against all the professional standards that the national body sets. So these four areas that I was mentioning before are broken down into about...there's about 20 bullet points underneath each area. The student*

has to produce written evidence of a practice experience that they've had, to illustrate that they have engaged in some learning around that area of assessment" (Ka).

<u>Action learning set:</u>
According to Ka:
"*Sometimes they have what we call an action learning set. That will be where they are put into very small groups of about four people with a facilitator. It is a process where they have to note down maybe a challenge that they have experienced that week. Then they each were given 10 minutes to talk about that challenge. The rest of the group is to ask them about it, but they are not allowed to give them solutions. They are not allowed to give them answers. It has to enable the person who has experienced the challenge to answer the questions and work out for themselves what the next steps that they need to take should be. It is used as a highly reflective... but a way of really getting the practitioner student to think deep and critically about the issue without being given an answer, if you see what I mean. They have to work out the answer for themselves. It is always facilitated, so if the group wasn't following the rules then the facilitator would have to bring it back again. Obviously, if anything came up that was concerning or not deemed to be safe practice, then the facilitator would need to step in and say, well, actually... If direct advice was needed then they would need to step in. So that's one method that we use for really bringing the two together*" (Ka).

<u>Role-play and interactive modalities:</u>
Four interviewees mentioned that interactive modalities and role play are used during the training.

"*We provide a lot of mental health training, and we use role play a lot. We don't call it that, because I hate role play. We say, "We are going to do an exercise. One of you be this, and one of you be that." And then afterwards they say, "That was role play." Yes, we do. It's really important*." (Ch)
"*They definitely do role-play. They do other interactive things. For example, there's a child protection game that was developed a few years ago and sometimes that's used as well. It's a board game. It's got cards and things and it's got key theories on the cards. It encourages a different conversation and sharing of knowledge about what does that mean or how would it apply. The board game is about risks for babies. It's a snakes and ladders game. I think you pick up cards and it creates a scenario. Some of those scenarios it increases the risk, and some of the scenarios increase the protective factors. If there's risks the babies go down the snakes, and if there are protective factors they go up the ladders. It's just another way of engaging with the topic of protecting children. That's just one simple tool*" (Ka)
"*The method we use is a very interactive approach through different exercises based on the main principles of adult learning. We have different group work, role-playing, also [inaudible 00:07:21] of models implemented through e-learning as well*" (Sv)

"*And we do something called* ***forum theatre,*** *as an example, in our safeguarding module. It's not a new concept but it's <u>just a bit more of enhanced role play</u>. We incorporate role play into our module, especially in the safeguarding. When they have to deal with complex situations, sometimes it's good to act those out for them to see and just to participate and perhaps practice in a safe environment what they might be exposed to in practice, so mainly lecture-seminar run*." (Mi)

<u>Other types of modalities/support:</u>
Different interviewees mentioned also other types of support available to trainees, during the training. Sv mentioned that support is provided through **different trainings, meetings with them, this mentorship kind of monitoring, supervision**, and through **different professional gatherings, through conferences** in order to promote good practice, examples of good practice. Mi mentioned the following modalities: a **mix of lectures, seminars, online learning, e-learning packages, workshops,** one-to-one meetings with students, **looking at evidence-based practice** (e.g. what is the evidence behind a certain issue? How does that influence practice?), writing a 500-word piece, etc.

Monitoring system

In terms of monitoring systems, different methods were mentioned.
Sv mentioned that they have developed a monitoring system in order to monitor their daily practice. That monitoring systems works in the following way:
"*Among other things, we have kind of mentorship for them and go together with nurses to families, to do things together, to observe their practice, and to have some kind of restorative supervision*" (Svetlana).

Ka mentioned that they have developed a checklist in order to support practitioners unify their practice. Sv also mentioned that trainees use questionnaires to monitor change in families' attitutes and practices.

El mentioned that when practitioners go to the facility they do assessments using a method that is called assess, classify, and treat.
"*Now, when you take them to the health facility, at the child health clinic we pick on a child, so you give to the healthcare worker to do the assessment. Then to classify which condition is that, and then to treat, so after that you are ... During that time, you are doing observation and awarding them marks, and then correcting as they do that, until you are satisfied that the healthcare worker has mastered that particular skill*" (El).

Program evaluation

3 interviewees commented on if and how the program is evaluated. Mi mentioned that the program is evaluated based on pass rates and students' evaluations. Sv mentioned that at the end of the training trainees fill in questionnaire, which aim at assessing their satisfaction with the training. El mentioned that the training is evaluated by the outcomes at the community level (e.g. percentage of infant mortality), by the outcomes at the trainees' level, by using pre- and post-tests, which aim at recording improvement in their knowledge and skills and by the trainees' satisfaction with the training.

Effects of the program

Four of the interviewees referred to the effects of their training programs. Those effects are:

1. **Increased awareness of the network among practitioners and use of that network in their everyday practice:**

"*Because, the home-visitors, before the training just go to the home and say, tomorrow you will get vaccination time. And so, nothing else... and now they have not only know it, the ability, and know the network, because, one day, except for this six days training, is all the persons in the district. For example, [inaudible 00:17:55] political, or some...who have something to do, for example, I need a chair for the child, is network. They didn't know before this exist, this network, and didn't think to use it. Now, they have this network and they get telephone number contact and they call them*" (Al).

2. **Trainees know how to use new opportunities and respond to families' needs:**

"*And so, is something very easy, because is not just to go...you must have patience, ask you to help to have a solution for this family. And so, after the training, and not only after the training because we have some nurses training for this district finished. We are very happy. For example, now that we have at least some groups for children in the town. So the wives, the possibility at the home-visitors, now are changed. They are using new opportunities to help more to address the family with problems. This change their position*." (Al)

3. **Increased professionalization:**

"*The outcome is that they have the ability to deliver the professional role, and that they meet the academic criteria*" (Ch).
They have more knowledge on different contents: "*We made assessment of changes of knowledge immediately after the training. We found that knowledge was increased, and also we monitor changes in the practice of nurses. They gained knowledge in their practice and their reports, the main part of their activities was about assessments of different risks and advising families and modeling on different topics about attachment, responsive parenting, stimulation of child development, father involvement*" (Sv)
And also, better skills: "*During these joint visits we observe changes in the skills of nurses. They were more competent to observe different risks, to advise families in a more friendly way and to work with families really together like partners*" (Sv)

4. Improved parenting practices:

"*We found changes in parental practice, in area of nutrition of a child, stimulation of child development and used age-appropriate play, about discipline methods, and home safety as well*" (Sv)

5. Holistic approach to children's needs and good health of children:

"*Now, for us, that is not the case. The first clinician that you get in contact with will first manage you at that level, because in most of our health facilities, we don't have specialists, so this integrated management has really helped for one clinician to be able to address the child holistically, unless there is a complication, so they refer to another level…. With regards to the issue of obstetric care, the emergency obstetric care, again, I would say that the effectiveness is seen in the sense that the rural facilities are the first contact points for the communities in Kenya, so there they get free services. So the first place the mother would run to when they're in labor or unwell are those facilities, so having a skilled provider who can handle an emergency at that level has helped us reduce a lot of deaths as a result of delay number two. That is delay in transportation from one level, one place to another, so I think it has really worked. I think the training is helping to address the delays*" (El).

The training program: Synopsis

- The training programs **vary considerably in terms of provider, duration and participants' background experience**.
- In terms of components all programs address both **knowledge and skills**.
- In their majority programs provide a **combination of theoretical and practical training, but programs provided by university institutions seem to focus primarily on the theoretical aspects**, a fact that has been described as a challenge.
- Different modalities are used across programs, including but not limited to:
  - Workshop based teaching
  - Opportunities for engagement in the public domain
  - Observations
  - Practice portfolio
  - Real-life examples
  - Presentations by students
  - Link visits
  - Action learning set
  - Skills lab
  - Independent work
  - Interactive modalities, including role play
  - Peer support, etc.
- In terms of **program evaluation**, only three of the interviewees mentioned it. Two of them mentioned that the program is evaluated directly by its users, whereas in two cases the program is indirectly evaluated by the pass rates or the outcomes in the community.
- Four of the interviewees referred to the **effects of their training programs**. Those effects are:
  - Increased awareness of the network among practitioners and use of that network in their everyday practice
  - Trainees know how to use new opportunities and respond to families' needs
  - Increased professionalization (more knowledge and improved skills)
  - Improved parenting practices
  - Holistic approach to children's needs and good health of children

Continuous professional development – Support provided after the training

When CPD is available to trainees' the following types of support were mentioned by the interviews:

Supervision:

Ch mentioned that practitioners are supervised from time to time, along other types of support:
"*So they would be monitored in the same way as any employee. So they have a job to deliver, and they would have, yeah, supervision from time to time, professional development reviews to check on their progress, and so on*" (Ch)

Annual training:

Ch also mentioned that an annual training is available to practitioners:
"They will have annual training in certain areas. Unfortunately, a lot of them are things like fire training, which are considered institutionally necessary. But yes, they will have regular updates in certain areas so they keep their skills up to date. Things like ... I mean, the world changes all the time, so the latest approaches to, I don't know, managing speech and language, hearing, vision, nutritional updates are really important, it changes all the time" (Ch)

Monitoring system:

According to Sv, after the training, in order to sustain change, there is a monitoring system that works in the following way:

"*Among other things, we have kind of mentorship for them and go together with nurses to families, to do things together, to observe their practice, and to have some kind of restorative supervision". This is done on a monthly basis*" (Sv).

"*Yes, they also have ... A part of this activity is checklist instruments. We implemented that in, how you call it, in [inaudible 00:25:08]. It was decree on medical documentation in reporting so we made it a change, not only in the practice, but in order to assure to have it [inaudible 00:25:23] in the future, we put it in the legal basis*" (Sv).

Ka mentioned that the monitoring system is not directly linked to the university and that it also gives data about the quantity (how many visits took place) and not the quality of the visit:

"*That data has to be submitted so that is available publicly. It is the data that is matched to the employer of the health visitor, so I suppose the product of the course. So, it doesn't directly link back to the university in terms of... I guess it is only one level of performance because it's just telling you whether something has happened. It does not tell you anything about the quality of the visit or whether the patient was satisfied with the immunization experience or whatever. They are fairly crude, really, I would say. It's something that we still probably need to develop*" (Ka).

Preceptorship program:

"*Yes, they have a year-long preceptorship program within the health boards. Once they finish our program, they leave us and then they're left to work within that health board. And there are different versions of that preceptorship program across all the health boards, but they are supported successfully within those health boards. And then that year passes, they... For example, I'm just thinking of safeguarding supervision, they would have monthly supervision, perhaps on some complex cases within that preceptorship period, whereas then it goes to group supervision after that year has passed. And they have a training program, sort of introduction to certain processes within the health board and they have a mentor for that year... or preceptor I should say sorry, for that year post qualification. So they are supported*" (Mi).

Mentorship:

El mentioned that they have different kinds of support after the training, depending on the training. For one of them this support involves mentorship for some period:

"*Okay. That's a good question. I want to say it's both, I have an answer and partly I don't have an answer. What happens in our county, after the training, depending on the training. For example, the one for management of childhood illnesses, once you are trained, after the training you are not certified. You are given the number of cases to manage, as you have a tool that you sign, you manage and you enter the assessment that you've done, the classification, and the diagnosis that you've made, and then the treatment, so that you are put under mentorship for a period of time, and then you are satisfied. Now, that is for childhood illnesses, management of childhood illnesses*" (El)

Follow-ups:

Another type of support provided for another training, is according to Eli follow-ups:

"*Now, for emergency obstetric care training, what normally happens after the training, we do follow-ups, but I would say that it's not very regular, because again, that also needs resources. According to the program, you are supposed to do follow-ups, at least interact with one, a trainee, once every quarter, and there's a form they fill to show some of the programs, some of the cases that they have managed, and also, there's a form that they fill to share the challenges that they have gone through, so this we don't do it regularly I would say, because of resources. Sometimes, we are short of transport to follow up a particular trainer, trainee, but that is the requirement. That you do mentorship, until that you are certain that this knowledge is already sustained*" (El).

Different types of support:

Finally, Sv mentioned that there are different types of support available to the practitioners after the training:

"*Through different t**rainings**, **meetings** with them, this **mentorship kind of monitoring**, **supervision,** and also through different **professional gatherings**, through conferences in order to promote good practice, examples of good practice*" (Sv).

No communication and support:

Al and Ka mentioned that there is no communication after the training and Ka stressed that if any communication takes place, this is very informal.

Continuous professional development: Synopsis

- **When CPD is available** to trainees' the following types of support were mentioned by the interviews:
    - Supervision
    - annual trainings
    - monitoring systems
    - preceptorship program
    - mentorship, follow-ups,
    - and other types of support such as meetings with the trainees and professional gatherings.
- However, **CPD is not available in all programs**
- Two interviewees mentioned that **there is no communication after the training** and that if any communication takes place, **this is very informal**.

Success factors

The interviews revealed a number of success factors that characterize effective training. These are presented below:

Training obligatory and part of CPD

Two of the interviewees mentioned that is important for the training to be obligatory and part of the CPD. According to Sv:

"What is important that all these educations and trainings are part of continuous medical education for nurses. … This … should provide all these licenses for the nurses and they are obliged to collect exact number of credits during the years to get new license. All these things in the survey are obligatory, only the content of the training is not obligatory for them" (Sv).

El also mentioned that if training is linked to licensing then practitioners are more willing to participate even if they have to pay for the training:

"*Okay. Let me give an example of the nursing profession and the clinical medicine profession. The biggest motivation usually is that when, sometimes it is conditional, in the sense that, for me or for the nurse in that facility to renew her practice license annually, you must have undergone some professional development trainings, so you have hours. Like, for example, you will find a particular person is tasked to have 40 hours of professional development for your license to be renewed, so that will prompt you to go for this training, even if you have to pay for them. Both the clinical medicine, what we call continuous professional development. They give you some points, so when you attend a training it awards you some points for your licensing in the coming year"* (El).

Combination of theory and practice

Having practice and theory running alongside each other was mentioned as the success factor of the program from two interviewees. In addition, one of the interviewees mentioned that this is in line with what trainees want and mentioned that they want during evaluation of the programs: According to El:

"*Most of the time, you know, if there is change, for example, if you see that you came at 30, you are now at 100, you are excited and you say the training was very useful. It has really helped you to gain knowledge and now you are going to practice, but that may not be what's the case at the practice time now, so what positive thing is, one; they've always appreciated the mix. Most trainees appreciate the mix of theory and practice, theory and practice, immediately. You do the knowledge, and then you go to the skill…. Yes? The integration of the two. Not that you just do knowledge, and then they go back to practice. I think that's one thing that I've always appreciated*" (El).

Continuity

Two of the interviewees highlighted the need of continuity in the process. They mentioned that in order for the training to be effective there must be in place a continuous communication with the participants, which does not finish with the training:

"*I was saying, if there is a way that courses, some short courses can be developed, that can be used to engage practitioners every other time regularly, so that you just remind them of a particular, they can be in form of drills. You remind them of a particular case, and you show them how to manage them. Then you give them an exercise, and they do. I think that interaction is necessary on a regular basis, just to keep people updated of the management of various key cases that come. And also pegging that to their CPDs, so that they always want to be part of it. You peg that to their professional development points*" (El).

Inter-sectoral training

Two practitioners referred to inter-sectoral, workshop-based training as success factor. According to Mi:

"*From a teaching perspective, we're already changing some of our teaching. Students, as I said to you earlier, don't like to be sat in front of PowerPoint presentations. So, we're just trying to be a little bit more innovative. We've introduced some interprofessional education sessions. In my safeguarding module, I've introduced a neglect workshop. We go over to the school of social sciences building and work that day with students social workers. They thrive in that sort of environment and my colleagues do the same in the contemporary approaches module when they're looking at therapeutic relationship building. And we do interprofessional education with psychology students. So, we've incorporated and we'll do more of that perhaps in our future programs. We also do a perinatal mental health session with our mental health nursing students. They thrive in that environment and it keeps the discussion alive. It keeps them motivated and we're introducing contemporary research and approaches just to make their practice as updated as possible*" (Mi).

El also mentioned that the effectiveness of the training is linked to its integrated approach:
"Say they're actually very effective ... My country, bringing an integrated module for management of childhood illness has really helped us. As I told you, one; we have shortage of staffing, so if you split a training like I think in the developed countries, you'll find this child is being managed by a specialist in this area. This one, for example, probably if it is an ear problem you take to an ear specialist. If it's an eye problem, you take to an eye specialist. Now, for us, that is not the case. The first clinician that you get in contact with will first manage you at that level, because in most of our health facilities, we don't have specialists, so this integrated management has really helped for one clinician to be able to address the child holistically, unless there is a complication, so they refer to another level" (El).

Provision of monitoring tools
One of the interviewees mentioned that one of the success factors of the program is that it equips trainees with monitoring tools that can help them in their everyday practice. Sv mentioned:

"*We found that this monitoring system was crucial, together with the good quality of the training, with a lot of interaction… this online modules were an innovation for them. This checklist we provided was quite useful because it is quite useful for them to monitor progress in the family, to have kind of reminder what aspects of family health they have assessed, and also it's good to promote their role to other colleagues when they come to the topic of what is the content of their work… Also, what was important that we developed something like checklist for them in order to unify their practice…To show that each nurse will provide full scope of activities for each family, and additionally to provide some activities according to the needs of each family*" (Sv).

Experiential learning and reflective practice: Training based on the principles of adult learning
Three of the interviewees mentioned that the training should be based on the principles of adult learning, including experiential learning and reflective practice and different modalities should be used. Sv highlighted:

"*We found that this monitoring system was crucial, together with the good quality of the training, with a lot of interaction. I already said that it was based really on the main principles of adult learning with a lot of self assessment, peer review, group work, and so on"* (Sv).
Jo also stressed the importance of experiential learning and reflective practice in order to support practitioners develop their own skills and practice:

"*But I think it would probably be more focused on experiential learning and coaching, more than theoretical learning, and my guess is that, it should also involve a lot of kind of structured, reflective*

opportunities for reflective practice where they are watching themselves, provide services to families and in a ... This is why I say coaching model, and then to have, basically through a supervisor, be provided guidance about and they get a chance and opportunity to watch what they're doing, and to think about what are the strategies that are successful and what are the strategies that are not successful" (Jon).

Mi also stressed the importance of using real-life examples, which support experiential learning:
*"And then the support that we give them throughout the program we often use live examples, anonymous examples I suppose. We would bring into university… In the safeguard module, I do a session, I do a massive group supervision session where I use a framework. And I'll ask them if they want to bring a case to discuss, let's discuss it, anonymize it, so there are no names involved. However, with that remit, if there is something I'm concerned about, I will take that back to practice to raise that issue. So I think they will come across complex situations. They might come across a child death, they might come across significant child abuse which are really complex. They might come across that victim of domestic abuse who does not want to leave her partner. Therefore, they will have to deal with this on a day to day basis who's building up there. I want to use the word resilience; it's very well used now, isn't it? Working with them here at university but in practice, it is that practice elements that is important. And that's how they deal with these situations because they are been exposed to them on a day to day basis. They come into university two days a week, the rest of the time they are with their practice teacher, I'm using the full-time program as an example… I just think that they are supported. I think that practice element is essential. I think without being exposed to it in practice, if we would just do in theory and just do in a theory-based program, they would have difficulty adapting that then into practice but by jointly matching theory and practice, it gives them that exposure and they bring it back and see in the evidence-based of certain situations. So I think that really helps" (*Mi).

Variety of assessment methods

Mi mentioned that one of the effective elements of the program is the use of different assessment methods, which are aligned to trainees' needs and aims at "pulling on their strengths because some students might not write particularly well but they might be very good at designing a poster. So, we're just trying to mix up our assessments too" (Mi).

Trainees with the right attributes

Two of the interviewees highlighted that it is important to select trainees with the right attributes. According to Ch:
"*What the reality we find in practice is, if you take people with the wrong attributes, very quickly they create chaos, it doesn't work, they don't get on, they don't work as a team, they don't form the right relationships with families, there are complaints about them, and so on. So it's been well recognized for a very long time that it's really important to only recruit nurses with the right attributes, and recognize that actually, every health visitor, every nurse won't make a good health visitor"* (Ch).

Ch explained why it is important to not just train everybody, but those we have the right attributes:
"I guess it's all about trying to avoid that situation by bringing the right people in, you have the right attributes, giving them the skills, and the confidence to use those skills, and the supervision. Because you don't really want to ... it's quite difficult. Once you've created this workforce, they operate by themselves, so there isn't somebody sitting on their shoulder watching how they're behaving with families. So it's really, really important that they leave the training competent. They may not have the experience, but they need to have the competence to be doing the basics well. And from there, they build confidence, and obviously experience in different settings" (Ch).
Jo also mentioned that is important to "capture" if the practitioners have the right attributes, before you hire them:

"And I feel that these are skills that can be taught on visitors. Now, there are fundamental kind of, like people skills are more intuitive skills, that are much harder to teach. They can be supported through supervision, but being able to have empathy for other people's experiences, those kinds of like soft skills are to some extent, that comes out in terms of the recruitment and hiring of home visitors. So just knowing that they have these, I don't want to say intuitive skills, that they know how to work with families, that they have this ability to be able to form these emotional connections. Some of that is more inherent, and that is something you just have to try to capture when you're hiring them" (Jo).

Practice portfolio, video feedback, coaching and supervision

Four interviewees highlighted that coaching and supervision as well as the use of modalities such as practice portfolio and video feedback are elements of a successful training program.
In terms of practice portfolio, Mi mentioned:

"*So the question is how a structured training program can support teachers and can help them face that unpredictability and that complexity if they are in everyday practice, how we translate theory into practice I would say?.... I think the practice portfolio really helps with that. And being and being aligned to a practice teacher for the whole of the program, I think that really supports them in the complexities that they face. And they have that opportunity, they're based in health visiting teams. They are based out there in practice, who support them when these complexities arise. So our health visitors have supervision and so they very much made aware of that supervision process in the safeguard in modules, but also they would be exposed to that supervision process in practice as well as students"* (Mi).
In terms of coaching, it was stressed that it important for practitioners to be able to observe themselves and their colleagues during practice. Ka mentioned:

*"It might be that **videoing interactions when practicing and peer observation**, I think, in the real world. But then that is skilled as well so you need to have very skilled peer-reviewers to feedback to the practitioner, because at the same time we don't to undermine the confidence of the practitioner because sometimes the work is very hard anyhow, and if we then have peer-reviewers that criticize then that wouldn't be helpful. So that as well has to be carefully managed"* (Ka).
Jo also stressed the importance of a more structured coaching with an opportunity to observe themselves and reflect upon what they're doing:

"*it should also involve a lot of kind of structured, reflective opportunities for reflective practice where they are watching themselves, provide services to families and in a .. This is why I say coaching model. And then to have, basically through a supervisor, be provided guidance about and they get a chance and opportunity to watch what they're doing, and to think about what are the strategies that are successful and what are the strategies that are not successful… There's a fair amount of research about using video feedback with parents and infants where home visitors video record parents and infants… Even though there are other professional fields that do use this for whatever reason, home visitors have been more wary about video recording themselves or creating ways for them to be able to watch themselves in action. And for me, I think this is probably, even though there isn't a lot of evidence for it, but just based on my experience, doing this kind of work and seeing it kind of emerged, I think this is the training that will be most effective for them… I think again, talking about asking home visitors still to watch their practice and reflect on their practice, is important because I think there are these fundamental kind of communication skills or strategies that home visitors can do in working with families that facilitate the development of these responsive partnerships. Basically, like being able to ask open-ended questions, being able to incorporate what the parent says into their response back…*
And so, again I've said this like a half dozen times in this interview, but opportunities for home visitors to watch themselves in practice, I think it's important and for them to have kind of a structured opportunity to identify what areas of skill that they want to work on, and then to create a feedback

loop so that they can work on those skills and get immediate feedback about how they're doing is really important. So there are, like I said, different models about how to do that" (Jo).

Ch discussed about the importance of clinical supervision that helps you learn on the job:
"Well, the best way of doing that is through clinical supervision. Clinical supervision. In England, we have safeguarding supervision. We have clinical supervision, but the clinical supervision isn't always prioritized, but it's very helpful. So you can bring difficult situations and talk those through with somebody who's more expert and learn. So you learn on the job. You have to learn on the job, because you can't possibly be prepared for everything you're going to need to know and come up against." (Ch)

Peer support
Bringing people together, to learn from each other and support each in a way that fosters the creation of a community of learners, was stressed as an important aspect of the training from two interviewees. According to Ch:

"*I mean, to be honest, bringing people together to learn together is a really important element*." (Ch)
Al also stressed the importance of bringing people together to create a community of learners:
"*All the home-visitors that have a problem of something else they are core of this community and to discuss everything so the people, and discuss every day. These people check nurses just to help them to do it. They do the exams, all the visits at the end of the day, they discuss with the doctor. Every doctor is helpful for some community. All home-visitors related to the number of the children. So, all of this help. First, the home-visitors to come, to see, to discuss, to gain experience. Then after this they more equipped for this position*" (Al).

Success factors: Synopsis

Interviews revealed the following success factors that characterize effective training:

- Training obligatory and part of CPD
- Combination of theory and practice
- Continuity in communication and support
- Inter-sectoral training
- Provision of monitoring tools
- Experiential learning and reflective practice: Training based on the principles of adult learning
- Variety of assessment methods
- Trainees with the right attributes
- Practice portfolio, video feedback, coaching and supervision
- Peer support

Key challenges for the profession, the professionals and the training programs

The interviews revealed a variety of challenges that the profession, the professionals and the training programs phase. These challenges are presented below:

Wide field and unpredictability of the situations that practitioners will phase

Ch stressed that the profession is surrounded by unpredictable situations:

"*The home visitor does not know what he/she will find behind the door. She might be going to discuss about breastfeeding, but when the door opens she might find an incidence of domestic violence and she has to adopt properly*" (Ch).
Other interviewees also stressed that the field is so wide that practitioners need to know many different things:

Ch mentioned:
"*The health visitors need to know so many different things to work with so many different problems and issues, and you can't learn all of that ... you can't learn to work with families with substance abuse before you've learnt to actually get through the front door and form a relationship. So at the end of the training, they still have a massive amount of learning to do. I think in a way, health is just learned all the time, because suddenly you're faced with a family who are managing, I don't know, perhaps a baby with a condition that you haven't seen before, so you need to learn about that condition to be able to help them. So the learning is continuous once they're trained, but I think 45 weeks is a very limited preparation, certainly for what we expect*" (Ch).

In the same line, **although we do not expect them to have skills before they enter the profession, we expect them to have many skills later on**:
"*but I'm with a group of people, we did a national survey of home visiting programs in the US, and we asked the program directors, what kind of skills do you expect home visitors to have coming into their job? And then what kind of skills do you expect them to have at the end of their first year? And they don't expect them to have a lot of skills coming into the job, but they expect after one year that they're high functioning, competent home visitors*" (Jo).
El mentioned that they still struggle to find ways to "teach" skills that cannot be taught, such as communication, etc:

"*I want to be very honest, that we are struggling, to have that alone, and like you say, it is not got in a classroom. There are innovations that we have to come up with, because the moment the people appreciate the others, then things just change. Yeah, what is it that we can inculcate in our trainees, that will bring that out? I don't know*" (El).

Direct entry to the profession - Inadequate and not content-related (specific) preparation

Almost all interviewees mentioned that in many cases, we have direct entry to the profession and the initial training of the practitioners is not content-related (e.g. they might be coming from the health sector) or it is inadequate and that nurses are not adequately equipped for their role (Al).
According to Ch, education, curricula and preparation are one of the main challenges. Practitioners need long training and specific courses, additional skills and knowledge, more related to public health. Also, the lack of standards, as in other professions is a challenge (Ch). In addition**, in many cases, there is lack of specific training on health visiting** and you have to be trained as e.g. a nurse and then to take a short course in home visiting:

"*If you wanted to become a health visitor, you would have to train for three years as a nurse, and then one year, 45 weeks, as a health visitor to become a health visitor, which one can argue, isn't that madness? If you really want to be a health visitor, you don't want to be a nurse, you want to be a health visitor, but you have to train as a nurse or midwife to become a health visitor*" (Ch).
Jo, also mentioned that there are gaps in preparation and that there is not a specialized training. This, **the lack of specialized initial training**, is also the case in the USA.

"*In the United States, you don't get a degree in home visiting, like in higher education, there aren't really training programs for home visitors. So, and I don't know nursing programs quite as well, but I do know that the nursing programs that emphasize public health nursing don't really emphasize home visiting. And so people learn how to be a home visitor on the job basically. And so they fall into the job for many different reasons*" (Jo).
Jo also mentioned:
"*Yes, I can tell you in my country we don't really have that. And I think there are some groups that are working about, trying to develop some curriculum at the university level for home visiting, and there have been some pilots of these, but it's pretty slow to get incorporated*" (Jon)
"*The fact that we do not have a good pipeline, so **we don't have like a higher education system** that use home visiting as a profession, I think is also a real challenge to getting good home visitors*" (Jo).

Lack of direct entry in the profession was also mentioned by Ka:
"*One of the things that some people are arguing for in the UK, that we don't have, is what we call direct entry into health visiting. At the moment, you have to be a qualified, registered nurse before you can then go on this other training program to become a public-health nurse. To be a midwife, however, you can go onto a course which takes you from zero to qualified midwife. Or you can go onto a course that makes you a nurse and then a qualified midwife, but you can't go from zero to becoming a health visitor. You've got to do the nursing program*" (Ka).

In the same line, there is **a lack of recognized legal status**: In many cases home visiting is not legally in statute. As mentioned above the lack of direct entry causes many problems:
"*That has made a big difference to the visibility of the role within policy because the legal stake is actually there. We then have to constantly remind people how different the role is from a general nurse. If you take the approach of a general nurse and apply it in health visiting it wouldn't work because general nursing is an illness model, whereas we take a health-creating model. Having recognized legal status of the practitioner role, I think, is important*" (Ka).

El also referred to the fact that there is not one specific workforce with specialized training and how this interferes with knowledge and skills retention: "*Yes. For example, Kenya, I told you, Kenya, you are a nurse, you are a midwife, you are a community health practitioner, and you are one person, so you do bits and bits here and there, so I'm just thinking of, and it's something that we are advancing in advocating for. A midwife should be a midwife, and a midwife alone. A nurse should be a nurse, and a nurse alone, you know? So that it is not that today she's in the medical ward, tomorrow she's in the labor ward. That interferes with knowledge retention and skill retention, because the year that you are in medical ward you have forgotten everything immediately. You can only now do medicine, but now we feel, my feeling is if then as the midwife is a midwife and is always in maternity, that will help in building the competency of that person, so that's what I'm talking about. If a pediatric nurse, nurse should be pediatric nurse and work in pediatric department, because that will also help the providers choose on what they like most, and specialize on it. Yes*" (El).

Duration of the training

Two of the interviewees mentioned that taking into consideration what we expect from the trainees, the training is short and does not go in-depth but rather it gives trainees only the starting points of the key topics and also does not allow to go far from the theoretical part. Ch mentioned:

"*I think the problem is that it's not long enough. It's a degree in 45 weeks, so it doesn't really have time to move very far from the theoretical. They have assignments, so in that year, you maybe do four big assignments. So if you focus on, I don't know, say domestic violence, you'll come out quite well-informed on that. Or breastfeeding or something, but you'll have a lot of gaps as well. But I think that's the challenges, yeah it's the length of time*" (Ch).
According to Ka: "*That's about giving them the confidence to speak up and the confidence to use their knowledge and apply it. That is quite hard, but I think that's why the education program needs to be at least a year long. Ideally, we would like it to be 18-months long because there is quite a psychological shift and confidence growing that has to happen in the person for them to move. Some of them are already very politically aware so they're already happy to do that*" (Ka).

Thus, Ka mentioned: "*Where we're limited at the university is that we have to work in this modular structure which means that we, as lecturers, are only given so many hours to teach a whole module, which means that if you take all the topics, then something like postnatal depression will get three hours, infant feeding will get three hours. If you think that, actually, they could do a whole course on parental mental health, or they could do a whole course on infant nutrition, but actually we have to condense it down into three hours. What we teach them is really just the starting points. There's a very much reliance on the students going and doing the wider reading I think*" (Ka).
On the other hand, Sv mentioned that when the training is too long is also challenging: According to Sv:
"*Sometimes for them, most challenging is the duration of the training because we have this face to face, whole day things, and it is hard for them to be in training for six or seven hours. It was the most frequent complaint*" (Sv).

Instability in initial training

Two if the interviewees also stressed that although standards might be available, each training provider might deliver a different curriculum, that leads to instability of knowledge and skills.
"*So when I did my doctorate, I discovered that depending on where you trained, although we have national standards for the training, they would be interpreted into a slightly different curriculum. So for instance, parenting would be in the training, but one provider might do half a day on parenting, another might do a whole module on parenting. And to me, this isn't acceptable. We have an evidence base, babies are born okay into different circumstances, but every baby needs staff or health visitors supporting them, helping them who have a core set of skills, which should be the best possible skills according to the evidence and need. And then obviously if you're a baby who's born into, I don't know, a Romani community or a homeless community or a whatever community, the staff working in those environments need additional suitable skills. But every health visitor should be trained, for instance, to the same level around breastfeeding, around mental health, around nutrition, skin diseases, and so on*" (Ch).

Ka also mentioned that the quality of the Maternal and Child health nurses, is dependent on the quality of their initial professional preparation and the aspects that the program emphasizes:
"*So if the organization is supporting certain ways of working or even limiting certain ways of working, that has a direct impact on what the student ends up being equipped to do. That can include how many child health assessments they complete. If they have a policy that it's a nursery nurse who does the assessments, then the students will struggle to get that experience. Or if they're working in an area where there's very little breastfeeding in the families and very little additional support or project work*

to support breastfeeding, then they won't get much experience in that area of mother-infant feeding. I think the big challenge is it depends very much on what is going on in real in-service provision, to some extent" (Ka).
In the same line, it was mentioned that since there are no universal standards for in-service training, each program may provide different opportunities to its personnel.

Variability in terms of previous experience

Two of the interviewees highlighted that there is variability in terms of practitioners' previous experience:
"*The health visitors in England are autonomous practitioners. They are expected to go out and work with a number of families and manage whatever those families need. So obviously, when you're first trained, you have very little experience of a lot of the things you're working with. I mean, each trainee brings different things. Some of them will maybe have years of nursing behind them, they'll be mothers, they have brought up children and actually understand an awful lot, or they come from a midwifery background, so they obviously understand the needs of the mother after birth and the baby. So each one does bring unique factors. Some come from a mental health training, so they find that element much easier, but may struggle more with the sort of physical health issues that they get confronted with sometimes*" (Ch).

This variability in terms of previous experience, affects also, according to El, the time trainees need in order to master the skills the training targets. Specifically, El mentioned that in their feedback trainees frequently mention that the same time for mastering a skills is given to all participants and there is not an individualized approach which takes into account the needs of each practitioner:
"*In most cases, like I would say that for the training that, I'm just going to talk about one training, because it's not cutting across all the trainings. In one training, let me talk about the one for emergency obstetric care, for example. The participants thought, felt, that, one; time was not adequate, because they were saying that we are giving equal time to all participants, and yet mastery of skill is not something that you do, you can cut across. The way I would master a skill is not the same way the next person will master a skill, and it's because those who are exposed to these cases have a better chance of faster mastery, but those who have not been exposed to these cases need more time. So what they were telling us is we need to have a way of dividing the classes, such that we know that these ones will need more time, these ones will take a shorter time, so that we don't assume that once it is done in 15 minutes everybody is at the same level. That has come on every time in most training, by the way. The issue of time, versus the participants, versus their various levels, and let me tell you why I'm saying that. For emergency obstetric care training, we train medical officers. That is doctors, clinical officers, and nurses in one classroom, so there are those who will grasp very fast, but there are those who will need at least more time, with a lots of explanation and mentorship. Yeah"* (El).

Lack of support and supervision

Three of the interviewees mentioned that practitioners do not have the support they need around them:
According to Ch *"there isn't enough support around them, and it's sort of sink or swim. And they have to really get themselves going without perhaps sufficient support, the sort of support that we would feel that they need as a health visitor"* (Ch).

Jo also stressed:
"*And although we do not expect them to have certain skills when they enter the profession, later on we expect them to gain lots of skills on their own and without proper supervision and support: "And they don't expect them to have a lot of skills coming into the job, but they expect after one year that*

they're high functioning, competent home visitors. And so it's a really steep learning curve, and there's lots of stuff they have to absorb and be able to do in the first year, and it's unclear what kind of support they're getting to do that. And so, I think those are all factors that make it more challenging for home visitors to do their job well" (Jo).

El also mentioned that due to cost-related challenges, practitioners do not have the constant support/supervision that they need and, in many cases, this leads into some time after the training, the practitioner forgets and cannot handle not even simple cases:
"Sometimes, we are short of transport to follow up a particular trainer, trainee, but that is the requirement. That you do mentorship, until that you are certain that this knowledge is already sustained. Still, within our lower level management level, we have trainer of trainers, so they're also expected to do the same at their level, but again, still, I would say, because of limited resources, sometimes they do not do that, so sometimes you find you have trained somebody, but the person after a while is not even able to manage a very simple case. And this is because of knowledge retention and lack of support supervision" (El).

Lack of supervision is also mentioned as a type of support. Maternal and Child health nurses in many cases, are getting on the job training, since they do not have a pre-service training background and they do not have the support they need in order to learn effectively on the job:
"*I think related to that is, I think home visitors often do not 8 get very good supervision. They might not get very frequency supervision. The supervision might really be focused on basic administrative issues and paperwork. Home visitors do not get a lot of training before they get on the job. So, like I said, a lot of it is just kind of on the job training*" (Jo).
Thus, it is mentioned that although supervision should be on one-to-one basis it is usually on a group basis. Thus, it mainly concerns families with children who have problem rather than overall clinical supervision (Ka)
E
l mentioned that due to financial constraints there is a lack of effective and adequate mentorship in their county.
For the big apprenticeship training that is developed in the UK, **it is mentioned that although practitioners will be learning in practice, they will not be having a practice teacher to support them and the quality of their learning will depend on the quality of their colleagues with whom they learn along:**

"*The problem is that there won't be enough money to train enough health visitors, so it's not going to work. It's also, the person will be learning in practice, but they won't have a practice teacher, so they won't have somebody who is closely linked to the university and has a higher level of training in mentorship supervision, stays really up to date with the evidence and so on, because they are a practice teacher. So instead, they would be learning alongside colleagues. So, if you're in an office with colleagues who aren't very good, you're not going to learn very well. If you're with excellent colleagues, you're going to get a better training. So, there won't be very much quality assurance, I don't think, around that. So, there's lots of worries"* (Ch).

Maternal and Child health nurses' training needs are not taken into account

Jo stressed that in many cases the needs of the practitioners are not taken into account:

"I think what happens is, at the field level, if the agency where home visiting is administrated, if it's a very well run program, they will have a kind of a system set up for professional development where, for example, if they undergo a yearly review, part of that review will be asking the home visitor to identify the areas where they feel like they need to focus their content knowledge and the skill

development, and then help them identify opportunities to do that. What I know about different training institutes that have been set up by some of the larger program models in the US, I feel like that does not happen as much. It doesn't happen that often, and it is something that they could probably, I think listening to at home visitors say, they need help with ... Is something that would probably be beneficial to the field" (Jo).

Lack of field experience and quality assurance issues

Another major challenge is that although practitioners might have learnt a lot and they might have had an intense training, they do not know how to implement this new knowledge into practice.
"*And one of the problems we found with our training is the students qualify and they say, "Well, we've had a very interesting, intense training. We know an awful lot about leadership and assessment and how to negotiate and so on, but we've actually had very little experience of actually doing these things. So, when they go out into practice, they feel all their learning really starts when they're given a caseload of families to look after. They feel very ill-prepared, actually, which is a reason why we can lose health visitors in the beginning*" (Ch). So, there is a need for a preceptorship phase, when they can take over a caseload of families.

Related to cost-related challenges El mentioned that sometimes you may do a training on a specific topic but if you do not have the resources/equipment to practice the skills you learned then the knowledge is lost since without practice you cannot enhance your skills:
"*For example, you train, we have trained our healthcare providers on what is called assisted vaginal delivery, but now when it comes to you doing assisted vaginal delivery, you need the kits for doing the assisted vaginal delivery, but you'll find that most facilities don't have them, so that kind of knowledge is lost, because without practice you cannot enhance your skills*" (El).

In addition, even if field experience is available, three of the interviewees highlighted the lack of quality assurance of the field experience. According to Ch:
"*It's also, the person will be learning in practice, but they won't have a practice teacher, so they won't have somebody who is closely linked to the university and has a higher level of training in mentorship supervision, stays really up to date with the evidence and so on, because they are a practice teacher. So instead, they would be learning alongside colleagues. So, if you're in an office with colleagues who aren't very good, you're not going to learn very well. If you're with excellent colleagues, you're going to get a better training. So, there won't be very much quality assurance, I don't think, around that. So, there's lots of worries*" (Ch).

Ka also mentioned that quality of training is very much dependent on the quality of the practice teacher:
"*There is a problem in that I think a lot of that we are dependent on the quality of the practice teacher. They can have a good teacher but if the practitioner who is the teacher isn't given license to practice in the ideal way then the student won't necessarily witness the best way of working. To some extent, the things that the student ends up believing, the right things to do, can be very much influenced by the period of time in which they study*" (Ka).
Jo also mentioned that in many cases supervisors are not well-trained and they also need CPD.

Shortage of practitioners

Two of the interviewees (Ch, Sv) mentioned that there is shortage of staff and this inhibits their participation in trainings, as there is not a lot staff to perform the duties and deliver the services.

Cost related challenges

A number of cost-related challenges were referred by different interviewees. One of them was that there is **not enough money to train all the practitioners,** which was mentioned by Ch and El:
"So, first of all, they targeted nurses, and they created apprenticeship training in nursing, and it's not going particularly well. But it hasn't stopped them. They're now creating post-registration apprenticeship training in health visiting, school nursing, district nursing. So, the concept with that is that there's still the university element, but it's a two-year training. You are part of the establishment rather than being extra to it as a student, and you learn more as you go along. And it's being funded by taking what they call business rates, they're taking a percentage of money off the budgets for all employers. And that money is expected to be spent then on training staff. The problem is that there won't be enough money to train enough health visitors, so it's not going to work." (Ch).
In addition**, due to lack of funds we do not select some influential types of training** such as experiential learning and we prefer less expensive types such as for example conferences (Jo).

El also mentioned that one of the key challenges is that the training is expensive, since **it is expensive to train the facilitators**:
"*Now, there is a challenge, because usually we rely a lot on donors to support this training, because it is an expensive training, and you have to hire more facilitators to undertake the trainings, and these are facilitators that are trained by an organization. It's known as Liverpool School of Tropical Medicine, and therefore they're the ones who have been certified to offer this course. I am one of the course directors for this course in the country, and you, as a course director, you bring on board eight more ... Facilitators for one training*" (El).

Also, the lack of **universal funding** inhibits the opportunities practitioners have for in-service training and creates wide variability across cities and programs (Jo):
"*The services that are available very much depend upon where you live in the country, what city you live in, and what resources the different agencies that provide the home visiting have been able to take advantage of. I'll just tell you in my state, in the state of Illinois, approach there, the state does provide some funding for home visiting and they do build into the grants, money for professional development. They leave it up to the agencies to decide what that professional development will look like. And they also leave it up to the agencies for how much money to write into the proposal for how much professional development to give. And so the agency has to decide if they have, for example, if they're going to apply for $100,000 in funding, how much of that is going to be devoted to salaries, how much to administration, how much to training and professional development, how much to materials, and they have to make their own internal decisions. And so, you can have some programs that will put a lot of money into professional development and other programs that feel like they can't, because they need to focus on just providing services to families*" (Jo).

Resistance to change and to some modalities- professional culture

Two of the interviewees mentioned that some practitioners show resistance to change and to some modalities: According to Jo:
"Especially in the past, home visitors were reluctant into video-recording their practice, because they show it as invasion of family privacy and they believed that this will change the nature of the relationship and the quality of the interaction and that families will become more self-conscious, and more embarrassed, and less willing to talk and reveal things about themselves. Yet, this attitude starts to change the last years" (Jo).

El also mentioned that sometimes people are resistant to change, but when they see results then they run for change:

"Okay. How well? Is a difficult question, but I know everyone wants to change. Change may be a bit, people may be resistant to change, but when the change is yielding results, then they will adopt it. It's not something that may be very easy to introduce, but when they see results then everybody runs for it. Yes" (El).

It is challenging for the practitioners to go back to the role of the student

Three of the practitioners mentioned that sometimes, it is also challenging for the practitioners to go back to the role of the student:
According to Mi: *"At the beginning, some of the students have been qualified nurses for a long time. So, they go back to that novice, that lack of knowledge I suppose, around a new role. So, I that's a challenge for them. And some of them adapt very well, and some of them take a little while to adapt to being students… It's intensive. It's a bit of a shock to them coming in and coming to be students again, especially those who haven't studied for a long time, so they feel a little unsettled but we support them as personal tutors. And the groups support each other, they build very cohesive relationships throughout the program because it is such an in-depth program over that one or two or three years*" (Mi).

Ka also mentioned that some trainees are so much practice-oriented that it is difficult for them to bother with reading and research:
"Many of them are so focused... They're in a practice mode. They're concentrating so much on just being a practitioner, they don't want to really bother with research and reading…. They only want to do the reading which means that they can apply directly. So, if I give them a research paper and say, right, read that and let me know whether you think it's a good piece of research or not, that's boring to them. But I think those sorts of skills are really important" (Ka)
El also stressed that practitioners focus a lot on the work rather than on reading and doing research:
"*Let me start by saying that, that is an area of weakness, because research informs practice and informs policy, but I'm telling you that once a healthcare provider is employed in our county here, they are glued to their work and not thinking about research. Why? The shortage that is in our health facilities, I think they're already overwhelmed even with the service provision, so in most cases you'll find research is done by the management mostly, and even the management still is not that effective, so most of it we rely on research from partners like CDC, these other donors that are coming in to support the county. They're the ones who usually rely on their researches*" (El).

Extensive paperwork and administrative related work that may not allow time for the actual visits

According to Jo:
"*the biggest challenges are kind of administrative and paperwork demands that home visitors are expected to do more and more these days. There is a lot of reporting of what they need to do. There's a lot of forms that needed to be filled out. There's a lot of information they need to collect from families. So, I remember talking to a home visitor a couple of years ago who said that the first four visits that she has with a family is nothing but gathering information from them. And she found that often families didn't want her to come back for a fifth visit because they were kind of tired. It didn't feel helpful to them. All they felt like was, they just felt like they were in this lengthy interview process, but there was so much information that the funder and the state service system wanted them to collect about the family, that she didn't have time to actually do anything else. And so, I think that's a big issue*" (Jo).

Vicarious trauma and burnout

Jo stressed that there is vicarious trauma and burnout, especially among those Maternal and Child health nurses who work in disadvantaged communities and who see that they cannot do a lot to change things and also, they do not have the support needed in those cases.

"*I think another issue is vicarious trauma and burnout that I think home visitors, especially in the US often are seeing the populations of families that are a considerable risk and vulnerability, and they hear difficult stories. And if they live in low resource communities, they often feel like there's not much they can do, but just kind of bear witness and that's emotionally draining and exhausting"* (Jo).'

Evaluation centers on quality not on quality of the visits

According to Ka: *"This isn't so much an assessment of the training program but, in terms of the performance of the workforce, to some extent... Our national body within the government, so the public health, it's called Public Health England. They require all the health organizations to submit their data on, for example, the number of children who have been breastfed and for how long; the number of children who have had their health reviews, so the developmental health assessments; the number of children that have immunizations. Also, whether the five contacts have been completed. That data has to be submitted so that is available publicly. It's data that is matched to the employer of the health visitor, so I suppose the product of the course. So, it doesn't directly link back to the university in terms of... I guess it's only one level of performance because it's just telling you whether something has happened. It doesn't tell you anything about the quality of the visit or whether the patient was satisfied with the immunization experience or whatever. They're fairly crude, really, I would say. It's something that we still probably need to develop"* (Ka).

Uptake is low and home visiting is unsolicited so it should be motivating to families

Two of the interviewees mentioned that home visiting is unsolicited and sometimes is low:
"*A lot of health visiting or public health is what we call unsolicited. It's provided to families without the families inviting it to happen. We contact them and say, we want to make an appointment to come and talk to you about your child's development, rather than other health services where it's the patient who contacts the doctor and says, I would like an appointment about my leg or whatever. So, because it's not coming from the parents and we say we want to offer it to you, we have to offer it in such a way that it's appealing and that they would want to take it. Also, offer it in such a way that it doesn't look like we're criticizing them by making the offer. I think there's also an important role in marketing and communication around how the offer of the service is marketed. So that the impression that the nurse makes to the families is always a positive one because any level of criticism soon influences that public impression of what the service is and the risk of stigmatization. So, I think that's probably fairly critical*" (Ka).

El also mentioned that uptake in the country is low and so the first time the Maternal and Child health nurses visits the family, it should be attractive to the mother/family, so as to come back again in the service:
"It has been a challenge, because the country, in the whole country, the uptake is only about 50%, so we have, we are training healthcare workers, though have not managed all, to ensure that the first visit, the first time you meet a mother, you treat the mother like you will not meet this mother again, so that she's attracted to the services, and she's able to come for the subsequent services" (El).

Key challenges for the profession, the professionals and the training programs: Synopsis

The interviews revealed a variety of challenges that the profession, the professionals and the training programs phase. These challenges are:

- **Wide field and unpredictability** of the situations that practitioners will phase
- Direct entry to the profession - **Inadequate and not content-related (specific) preparation** as well as lack of recognized legal status
- **Duration of the training**, which is either too long or too short and does not achieve its objectives
- **Instability in initial training**, as each training provider has a different curriculum
- **Variability in terms of previous experience** and academic background
- **Lack of support and supervision**
- **Lack of bottom up approaches**: Maternal and Child health nurses' training needs are not taken into account
- **Lack of field experience** and quality assurance issues
- **Shortage of practitioners**
- **Cost related challenges**, such as lack of universal funding and lack of funds to train all practitioners or master trainers
- **Resistance** to change and to some modalities (e.g. video feedback)- professional culture
- It is **challenging for the practitioners to go back to the role of the student**
- **Extensive paperwork and administrative related work** that may not allow time for the actual visits
- **Vicarious trauma and burnout**
- **Evaluation centers on quantity** not on quality of the visits
- **Uptake is low and home visiting is unsolicited** so it should be motivating to families

How challenges can be tackled

Interviews revealed a number of suggestions about the ways that can be used in order to tackle existing challenges. These are presented below:

Longer training

Three interviewees (Al, Ka, Ch) suggested that the training should be longer in order to ensure the expected results are achieved. Ka mentioned:
"I think we could do better at evaluating that journey that the student makes as they go along. In many ways, if we could have more time with them, I think that would be good because I think there will always be a range of experiences that they haven't had. I don't think that we necessarily do as well as we could with them to get them to appreciate evidence, research studies, and understand that evidence" (Ka).

Adequate preparation

In their majority interviewees stressed that challenges can be tackled by having practitioners who are adequately prepared and their preparation and training is in line with the context of their practice. Al stressed that adequate preparation is the key that can help resolve all other challenges that surround the field, whereas Sv stressed that there is a need to provide more training to practitioners.
Specifically, Ka stressed the need for proper preparation, due to the roles inherent to that profession:
"It's that principle of giving everybody a standard level but being able to tailor it up or down, depending on need. That's the crux of it really, I think. Through that you're using your relationship, you're going out into the homes, you're decision-making, you're making judgments but on the basement of the information that you have, and you do it in co-operation with the family. Preparing somebody to move into that role takes a lot of time. It often takes a different mind-shift as well, which is why you need to the time and you need both theory and practice to support that happening" (Ka).
According to Ch preparation challenges can be addressed via **longer training**, via providing **training more focused** on public health and via developing **standards for the profession** and for health visiting practice.

Thus, Jo stressed the importance of developing a framework that informs existing university courses and reflects the whole range of roles that practitioners have to play:
"Okay. Well, I would say it's a framework that needs to consider all of the different levels of training. So I think it would be a framing that should have a component that reaches out to higher education institutes to maybe be able to do like a good scan, or to think about how to incorporate this particular focus into coursework that nurses, if we're talking about nurses, that nurses might take. I know lots of times the coursework is a little inflexible or very rigid. So, looking for opportunities that can be fit into maybe existing courses rather than creating new courses, might end up being important" (Jo).

More targeted content of the training that covers more issues inherent to the home visiting practice

Central to adequate preparation is not only the provision of training, but also the provision of education and training that is more targeted to the scope of practice and covers more issues inherent to the home visiting practice. Three of the interviewees mentioned that there are gaps in preparation in terms of the content of the training – which is more focus on illness rather than on public health and more general and that the specialization of different cadres is key.

Ch described their efforts towards that end:

"But we as an institute are trying to influence that at the moment. We would like to see some new entry gates, because if somebody ... if you wanted to become a health visitor, you would have to train for three years as a nurse, and then one year, 45 weeks, as a health visitor to become a health visitor, which one can argue, isn't that madness? If you really want to be a health visitor, you don't want to be a nurse, you want to be a health visitor, but you have to train as a nurse or midwife to become a health visitor. And we would like the training in the future where the individual goes through the nurse training, however, they would only do the pieces that they need, the experiences that they actually need for health visiting, so they would learn about medicine and illness and infection and so on. They would learn about the surgery from the point of view of the healing process, the effect of shock on the body and so on. They would learn about the very sick child in pediatrics, but probably not very much because there aren't many really sick children who go into hospital. Pediatrics in the community and special needs is much more important than the very sick child in hospital. They would do quite a lot of mental health, because mental health is a big component. You can't escape mental health. And they would do quite a lot on the maternity experience and the effects on the body of the maternity experience. Pregnancy, the baby, the fetus, the development of the fetus, the effects of, I don't know, alcohol, smoking on the fetus, and moderating those. So, we would change the curriculum and we would make it more public health focused and less illness focused" (Ch).
Jo also suggested:
"Well, I don't want to sound too much like a broken record, but I do think being able to work with higher education systems to be able to view home visiting, to create for example, maybe even just a certification program for home visiting or to create it as a particular service track that people who are in nursing or in social work or in a kind of a human services degree can actually engage in, so that they can say that, that's part of their educational processes. They're moving them towards this field. I think that would be really helpful" (Jo).

Continuous learning – ongoing professional support

Three of the interviewees stressed the importance of continuous learning and ongoing professional support:
"I think in a way, health is just learned all the time, because suddenly you're faced with a family who are managing, I don't know, perhaps a baby with a condition that you haven't seen before, so you need to learn about that condition to be able to help them. So, the learning is continuous once they're trained, but I think 45 weeks is a very limited preparation, certainly for what we expect" (Ch).
"And I think we need to develop better ongoing professional support for who are on for basically on the job training that they're getting" (Jo).
El also stressed the importance of mentorship and follow-ups:
"Then the second priority, second priorities would be to ensure that there is mechanism for mentorship and follow-ups of frontline worker. Mentorship and follow-ups" (El).

National standards about the profession and the training

As seen in the challenges section each service provider emphasizes different aspects to a different extend. So, it is important to have national standards and every practitioner should be trained to the same level at issues that are central to their practice: According to Ch:
"So, for instance, parenting would be in the training, but one provider might do half a day on parenting, another might do a whole module on parenting. And to me, this isn't acceptable. We have an evidence base, babies are born okay into different circumstances, but every baby needs staff or health visitors supporting them, helping them who have a core set of skills, which should be the best possible skills according to the evidence and need. And then obviously if you're a baby who's born into, I don't know, a Romani community or a homeless community or a whatever community, the staff working in those environments need additional suitable skills. But every health visitor should be trained, for instance, to

the same level around breastfeeding, around mental health, around nutrition, skin diseases, and so on" (Ch).

Sv also mentioned that Maternal and Child health nurses are obliged to implement all these things that they learn during the training in their daily practice:
"*It's a legal thing, so they're obliged to provide all these activities now…. It is part of the system of the home visiting system in the country?... They have to provide all these activities what we learn them during the trainings. All this assessment of comprehensive family needs, counseling, modeling, referral, to all these topics which I mentioned earlier"* (Sv).
In addition, El stressed that it is important to have in place a systematic way in order to monitor that the skills learnt during the training are really practiced by the practitioners after the training:

"I would say yes, and the first thing, like I talk about resources. When you have done a training, for example, there should be a way, a systematic way of ensuring that whatever you have trained the provider on is actually being practiced. Probably, now that there's advanced technology, if there is a way you could monitor this through probably a software or something, that would I'm sure improve their competency in that particular area, because you can do what we call drills, and you get to identify the gaps, the weaknesses, and you help to strengthen, without calling the provider to come where you are" (El).

Having recognized legal status of the practitioner role

According to Ka:
"*One of the things that we have lost in the UK is that we used to have the title of health visitor legally in statute within our nurse and midwifery council. We lost that about 15 years ago. That has made a big difference to the visibility of the role within policy because the legal stake is actually there… If you take the approach of a general nurse and apply it in health visiting it wouldn't work because general nursing is an illness model, whereas we take a health-creating model. Having recognized legal status of the practitioner role, I think, is important*" (Ka).
The need for the recognition of the profession and practitioners' role was also mentioned by Sv.

Filtering system: Recruit and train people with the right attributes or who lack training

Two of the interviewees highlighted the need for a filtering system being in place so as to support the recruitment and training of people with the light attributes or who lack training. According to Ch:
"*and what they realized was that it's not enough just to train anybody, you've got to have people who have* ***the right attributes****. Their approach, and so attributes really, it's their approach. So, they themselves are professional, they will focus on the person, they're self-aware, they know when they're crossed the line. They're open, they listen, they're positive. They're curious. They are accepting of people's differences, and they're tolerant of differences*" (Ch).

She also stressed:
"So, in other words, for us, that is a starting point. And when we recruit new health visitors, they have two interviews. One interview is for their ***personal attributes and their suitability****. Would they fit in? Would they operate in the right way in a family's home? And then the other interview is an academic one. Do they have the* ***academic ability*** *to get through the training?"* (Ch)
Ch mentioned that this filtering system is very important because health visitors go into every home, and it's just so important that they have the personal abilities to be able to form relationships and to work with families. And also, the personal confidence to be able to deal with whatever they find behind that door.

El also mentioned that they use a filtering system, when selecting the practitioners that they will be trained and from an inventory that they are having they choose those who do not have the skills, have not been trained in a certain skill.

Preceptorship phase and field experience

Taking into consideration the fact that the training is not long enough and it cannot cover all that the Maternal and Child health nurses need to know and practice, a good preceptorship program can help manage those challenges. According to Ch:

"So, if you focus on, I don't know, say domestic violence, you'll come out quite well-informed on that. Or breastfeeding or something, but you'll have a lot of gaps as well. But I think that's the challenges, yeah, it's the length of time. I mean, I think it can be managed by a good preceptorship program" (Ch).
In addition, a **preceptorship phase** might also address challenges related to preparation and field experience. During this phase the practitioner:
"will need to get additional skills and knowledge, and they will be more specific things that probably won't have been taught in that year. For instance, assessing hearing. Assessing vision. Family planning. Mental health, working with mental health. Nutrition. Just much more detailed courses tend to be then bolted on" (Ch).

In addition, the preceptorship phase is important in order for students to have the support they need when they take over a caseload of families in the beginning. With this, they gain the field experience and they have the ability to implement the theory into practice, but they also have the support they need to work with these families:
"So, when they go out into practice, they feel all their learning really starts when they're given a caseload of families to look after. They feel very ill-prepared, actually, which is a reason why we can lose health visitors in the beginning. If they're given a sort of inner-city caseload with a lot of safeguarding issues, they can really struggle with that in the beginning if they're not well-supported. So, the preceptorship element is really, really important that they have the support after their training" (Ch).

Ka also mentioned the importance of a preceptorship phase:
"It's a period of time that recognizes that they're newly qualified in their role so they're still novices. Well, they're qualified and they're competent, but they're still novices, I suppose, as qualified practitioners. So, they have this recognized period. It's been recommended that it should be six-months long by the Institute of Health Visiting, but actually, I think if they do get it offered, it's normally only three-months long. It's where they're meant to have extra clinical supervision and opportunity to be in a learner role, still, even though they're qualified. They're given a bit less responsibility and maybe a reduced caseload during that period of preceptorship, as a way of easing them into that role" (Ka).

(Effective) supervision and mentorship

Al mentioned that providing Maternal and Child health nurses with supervision and having a practice teacher going at home with them in order to observe their practice is an effective way of addressing existing challenges.
Ch highlighted that:

"A good employer will provide weekly supervision, which could be by a manager or it could be by a senior health visitor, and as a result of that supervision, will respond to gaps in training and offer additional courses" (Ch).

Jo also stressed that practitioners need:
"they need a regular place to be able to process and talk about the relationships that forms with families, with a supervisor who knows their job and understands basically what the home visitor is going through. I think again, talking about asking home visitors still to watch their practice and reflect on their practice, is important because I think there are these fundamental kind of communication skills or strategies that home visitors can do in working with families that facilitate the development of these responsive partnerships. Basically, like being able to ask open-ended questions, being able to incorporate what the parent says into their response back"

Mi also stressed that practitioners need a supportive practice teacher and a supportive team, a welcoming team. Practitioners need to feel part of this team and open lines of communication should characterize that team.

Finally, cascading and mentorship on the job, was also referred by El as effective ways in order to address financial constraints and low numbers of workforce:
"Yeah, I'm seeing that as a priority, though I know it is a bit challenging. When I talk about mentorship, I'm looking at the opportunities that are available now. You find, like in my country today, most donors come in to supporting capacity building. We call people in hotels. They stay there for five days. We train them. That is just removing the minimal resource from their place of work to keep them in a hotel, and I'm proposing mentorship, such that we only have regional mentors. If it is a case of emergency obstetric care, just build the capacity of various regional mentors, and cascade, let them cascade the knowledge. Go to the rural facilities where these people, the practitioners, are, and do a mentorship on job while they're doing their job. That is for low resource setups, where even the workforce is very low. It's very thin. Yeah, so that's what I would advocate for" (El).

Autonomy of the practitioner

Ka stressed that practitioners should be autonomous in their practice, so as to have the flexibility to tailor their approach depending on the needs of the family, to be able to determine the caseload and how to manage it. Autonomy can also support practitioners to work based on the principle of progressive universalism. According to Ka:
"Probably, thirdly then, as part of that, is allowing the practitioner sufficient autonomy so that they can apply their professional knowledge so that... The practice really is... and I've not mentioned this already. Another key feature of practice is to be able to tailor your approach so that they're not using the same approach with every single family. They can most definitely tailor how they behave, what they offer, depending on the circumstances of each family in each situation. Because again, if they offer this one size, same-founded approach to absolutely everybody, then very quickly the families will feel that the service isn't relevant to them and they won't trust it. That level of autonomy is really important to be able to... The health visitor needs the family to trust them, but the employers need to trust the health visitor to be able to make their professional decisions. Maybe have governance checks, you know, peer review, to double-check that they aren't spending too much time on the wrong things, but allow them to use their professional judgment about whether families do or don't need contacts or need extra support, rather than just a very strict list of five contacts and then no more. There will always be circumstances where some families need less and some families need more, and you only know that when you're operating at an individual level and you're able" (Ka).

Models of effective modalities

Experiential learning is one of the most effective ways of training. Coaching and working in one-to-one basis or in small groups is also very important. We should also be able to see videos of what

Maternal and Child health nurses do in their practice. In addition, we need models of coaching. According to Jo:
"the thing that has to happen now, is that we need to have really good models of what this coaching should look like. So, we can say that this is an effective way to do it and we can kind of prove its effectiveness, and I think it will spread once we are able to do that one" (Jo).

El stressed the importance of incorporating <u>on-line components</u> to training and why this is important: "*What I'm saying, that, moving forward, I think adopting use of technology, that is digitalizing most of these trainings, and also mechanisms or follow-ups, can really be useful. For example, having an online <u>... Online mechanism of engaging</u> the ... es. I was saying, if there is a way that courses, some short courses can be developed, that can be used to engage practitioners every other time regularly, so that you just remind them of a particular, they can be in form of drills. You remind them of a particular case, and you show them how to manage them. Then you give them an exercise, and they do. I think that interaction is necessary on a regular basis, just to keep people updated of the management of various key cases that come. And also pegging that to their CPDs, so that they always want to be part of it. You peg that to their professional development points"* (El).

Communities of practice and peer-to-peer support

Communities of practice and peer to peer support are considered as helpful in addressing existing challenges. According to Ka:
"Sometimes they're referred to as communities of practice, but essentially it is a small grouping of them getting together on a regular basis, where they each have an opportunity to share maybe a challenge they're facing with a family, to have the benefit of the dialogue with the rest of the group to be able to work out solutions and how to move forward. So that's like peer support in many ways… The university doesn't get involved in any of that support because it's as if our contract is finished, once they graduate as students. It would be nice if...No, I was going to say it would be nice if we could continue with that, but if it happens, it's very informal" (Ka).

Jo also highlighted:
"I also think being able to do creating kind of like <u>peer learning communities</u> can be really helpful. So, the opportunity for home visitors to get together, and be able to share their practice and learn from each other. There's a little bit of emerging research that shows that, that is something that can be really helpful to home visitors' practice. But again, there aren't a lot of examples of that happening" (Jo).
Jo also mentioned an effective model **of communities of practice**: ": *I think, there is a community of practice model that I liked that was developed by [Laurie Roggeman 00:15:42], I don't know if you've heard that name being mentioned and her team, she's developed an observational measure of home visiting and she's now developed a way of training home visitors on its use and using what she calls it a community of practice, where home visitors get together and they share segments of video recorded home visits and have discussions about it…..she shows at least some self-reported gains in knowledge and comfort in the practice. She's shown some improvements in their actual behaviors on home visits... But I think the evidence that she's presenting suggests that this is a pretty good model of working with home visitors to provide feedback to them*" (Jo).

However, Ka stressed that peer (lay) support is not enough but it should be provided along the best professional practice. According to Ka:
"*I think if there can be models that incorporate lay people as peer supporters working alongside health visitors. I think it's always a mistake to do a complete replacement of professionals in their roles because, as I've just explained the role to you, it is highly skilled. Actually, I think you can have peer support, lay home visiting services but they will not achieve the same thing. Whilst the people involved*

in doing them think they're very happy and they're safe and there's no problem, there's things that they won't necessarily recognize that are problematic. The very professional nature of the role of the nurse means that everybody is entitled to it. If it's a peer or a lay supporter, then the lack of professionalism would challenge the equality and, I think, the equity of service provision. You will get in groups and out groups. People talk about just needing to be friendly. Well, it's far more sophisticated than just being friendly because sometimes you have to also point out the very difficult things for the sake of protecting the safety of the child. So, I think services that can combine the best of peer support and the best of professional practice is probably the way to go, to make it both relevant to families, accessible, but at the same time quality controlled and equitable as well" (Ka).

Training of trainers

In their majority interviewees highlighted that in order to address existing challenges there is a need to train not only practitioners, but also the trainers of trainees:
"I think supervisors have their own need for training and professional development. People often become supervisors because their supervisor quit, and they can graduate into that role, but then they don't quite know, even though they might be an experienced home visitor, but they don't know how to provide supervision to support staff. So, I think there's basic kind of training and supervision and administration that program leaders need. And I think we need to develop better ongoing professional support for who are on for basically on the job training that they're getting" (Jo).
"*I think there should be resources available to agencies at the kind of, on the ground level where they can learn particular coaching strategies for how home visitors can work with families. I think supervisors need to learn how to incorporate guided observation into their work with home visitors. So, I know supervisors will sometimes go on home visits with their home visitors to observe them in practice, but there's now opportunity for self-reflection"* (Jo).
"*It might be that videoing interactions when practicing and peer observation, I think, in the real world. But then that is skilled as well so you need to have very skilled peer-reviewers to feedback to the practitioner, because at the same time we don't to undermine the confidence of the practitioner because sometimes the work is very hard anyhow, and if we then have peer-reviewers that criticize then that wouldn't be helpful. So that as well has to be carefully managed*." (Ka).

Also, it is stressed that it is important to have a cohesive team at the level of the training institute:
"I think, there are a number of things that are effective. We have a very cohesive team here, we're a team of four lecturers and we... When I was program manager, I was very keen to involve us all in the whole program, we've all taught on all of those modules, we've all assessed all of those modules so we've got a good grasp of the intensity of each of those modules. I think that really helps our students. I think our student support is excellent, last year we actually won an award, for the post registration education provider of the year by the Student Nursing Times, which is a U K based award… And I think that's testament really, to how supportive and innovative we are within the program really. We're really passionate, you can probably tell by the way I'm speaking. We're really passionate about engaging with our students and we do that from day one of the program. We don't let things drift; we respond to them. If a student emails us, we don't wait weeks to respond, we email back within 24 hours. We tell them we will do that and if not our out of offices will be on. So, I think our ethos is that we're passionate and we are engaging, and we try and be innovative as possible and work in partnership with our students." (Mi)

"*And as university lecturers, trying to keep up to date and being as current as possible, being involved in our own research. We can involve our students with that, getting them to becoming a little more academic in their work, be more critical, it's a level seven, so we very much talk about them, critically analyzing and critically analyzing practice, asking lots of questions, why is this behavior this way? So, what I suppose, we'd say, "So what? You're giving me this point, so what? How is this developed in*

practice? Why is that mother smacking your child? What does the law say about smacking?" As an example, so building their experience, their critical practitioners and their questioning, but for the good of the child and families that they're looking after" (Mi)

El mentioned that the first training they offer is very expensive because they have to train facilitators. <u>For the second training they offer she mentioned that they train mentors to train their providers within their facilities and this is not that expensive</u>: "*Now, this is fairer, because it can be done locally with the local available resources, so we try to train, like what we have done is to train mentors who now train the other healthcare providers within their facilities without bringing them to our hotel, because it is expensive*" (El).

Work in partnership with the trainees/students and with other institutions/official bodies

Both Mi and Jo highlighted the need to work in partnership with the trainees and with other institutions/official bodies. That collaboration builds on bottom-up approaches and ensures that trainees' needs are taken into account when the training is developed and delivered. For example, Mi mentioned that for changes they need a majority consensus from students and practice teachers and that they changed the assignments after they consulted with the students:
"*We changed the assignments and again, we worked with our students, we consulted our students, we consult our students before any change because we need a majority consensus that that's okay for it to change, and we brought our practice teachers in as an example, I took them through that change process and actually gave them the theory behind what was expected of them, it's in relation to health promotion and health promotion models and psychological theory, which our practice teachers now look at within the practice area. And some of them said, "We need an update on this." So, we brought them in and we actually did a training session with them. We've done that over a couple of issues. We've got a change now in the assessment of our students, which has been led by the Nursing and Midwifery Council. So again, we're meeting regularly with our practice teachers to implement that change. We do engage with our students and practice teachers to implement anything and keep them updated. Any policy changes we're going to have now, hopefully"* (Mi).

In addition, Mi mentioned that the success of their program may attributed among other to the fact that they are working in partnership with their health boards and their practice partners who have been involved in the development of the program and also its users so that they have got this robust program and it's just the best support network for their students. Drawing form her experience, Mi suggested:
"I just think it's a collaborative process. I would really recommend that you get a whole range of opinions. You're looking at perhaps students, service users and practice areas working with you as an education institution. I think the key is partnership where we can open lines of communication and engaging with your participants, your students, your service users, et cetera. I think engagement and partnership working is absolutely key in the development of any curriculum or any nursing program, although it's very time-consuming, it pays dividends in the end because you have almost like a student service led curriculum. Even though you have criteria to meet from your statutory bodies and from your university quality assurance processes, an engaged process offers a richer program. Meeting those students' needs and primarily meeting the needs of the children and families in our case, or patients because that's what we're striving to do, offer an excellent service for our service users. So, engagement and collaboration are key" (Mi).

Jo also stressed the importance of taking into account Maternal and Child health nurses' training needs annually:
"I think what happens is, at the field level, if the agency where home visiting is administrated, if it's a very well run program, they will have a kind of a system set up for professional development where,

for example, if they undergo a yearly review, part of that review will be asking the home visitor to identify the areas where they feel like they need to focus their content knowledge and the skill development, and then help them identify opportunities to do that. What I know about different training institutes that have been set up by some of the larger program models in the US, I feel like that does not happen as much. It doesn't happen that often, and it is something that they could probably, I think listening to at home visitors say, they need help with ... Is something that would probably be beneficial to the field" (Jo).

How challenges can be tackled: Synopsis

Interviews revealed a number of suggestions about the ways that can be used in order to tackle existing challenges. These include:

- **Longer training** in order to ensure the expected results are achieved
- Having practitioners who are adequately prepared and their **preparation and training is in line with the context of their practice**
- Central to adequate preparation is not only the provision of training, but also the provision of **education and training that is more targeted to the scope of practice** and covers more issues inherent to the home visiting practice. Three of the interviewees mentioned that there are gaps in preparation in terms of the content of the training – which is more focus on illness rather than on public health and more general and that the specialization of different cadres is key
- **Continuous learning and ongoing professional support**
- **National standards**: every practitioner should be trained to the same level at issues that are central to their practice
- Having **recognized legal status** of the practitioner role
- Need for a **filtering system** being in place so as to support the recruitment and training of people with the light attributes or who lack training
- Taking into consideration the fact that the training is not long enough and it cannot cover all that the Maternal and Child health nurses need to know and practice, a good **preceptorship program** can help manage those challenges
- Providing Maternal and Child health nurses with **supervision and having a practice teacher** going at home with them in order to observe their practice is an effective way of addressing existing challenges
- Practitioners should be **autonomous in their practice**, so as to have the flexibility to tailor their approach depending on the needs of the family, to be able to determine the caseload and how to manage it. Autonomy can also support practitioners to work based on the principle of progressive universalism
- **Models of effective modalities**: Experiential learning is one of the most effective ways of training. Coaching and working in one-to-one basis or in small groups is also very important. We should also be able to see videos of what Maternal and Child health nurses do in their practice. In addition, we need models of coaching
- **Communities of practice and peer to peer support** are considered as helpful in addressing existing challenges
- In their majority interviewees highlighted that in order to address existing challenges there is a need to **train** not only practitioners, but also **the trainers of trainees**
- **Need to work in partnership with the trainees and with other institutions/official bodies**. That collaboration builds on bottom-up approaches and ensures that trainees' needs are taken into account when the training is developed and delivered

Practitioners' perspectives

The home visiting program

Duration and modalities

In Serbia, the family has the right to five days of visits. The Maternal and Child health nurses, in collaboration with the family, discusses how it is best to use those visits. The visits take place every second day, usually. In case of families with problems, the Maternal and Child health nurses might visit the family more than five times.

In the Netherlands, the service is the preventive care for children for zero until four years. It's on a free base, but when a child is born, then the family gets a letter from the service and they will go on a home visit. In the first few months, the family will come like every month to the service, and when the child is getting older, the time between appointments is a few months to a year.

Focus

In Serbia, Kri mentioned that the idea of the visits is:

"*to teach them how to do some basic things but it's mostly to see how are they taking a role of parent. So, we are trying to be with them as long as we can" (Kristina). Specifically, in each visit the home visitor discusses different things with the family: "So we can help family to have that first needs satisfied financially or in some goods but we can't go out from the family not doing nothing, to do nothing. It's something that's not moral. After that we have five visits or six or seven. After that we have two visits until the child is one year old. We usually do that visit at four months, we talk about nutrition, we talk about development and that visit is usually used to motivate them if they are not vaccinated. We usually motivate them why, is that important and how to do that and we are friends of family and they usually trust us. So that's the good way to say some message that country or our health system wants to say. That's the best way how you're going to say that to the families. After that, we go and child is usually seven months old and we again talk about development, we are trying to see again how is the relationship parent-child going, we talk about oral hygiene, we talk about lots of things*" (Kri).

In the Netherlands, according to Ve:

"The home visit, we do it in the 10th until 14th day after the birth. Then we talk about the pregnancy and delivery, and we answer some questions from parents about breast feeding, growing up, vaccinations, everything that has to do with the child and family. Besides that, we also look at the environment of the family, like the financial state. Does the family have enough support from family? Do they need any more help? To me, look at the baby. Is it growing well? Are there things we have to pay attention on? If there's anything we can help them with, then we can ... Well, I can do not really much things with the families, because mostly I'm in front… We also have a program for parents who need a little bit more help. It is called [foreign language 00:06:19], like strong parenting. Then a nurse especially trained for those house visits. They make an appointment in a few weeks to talk about the things their family is worried about, or where they can help with. Then it's every few weeks the nurse come back until the parents say, "Well now it's enough. I can do it on my own." (Ve).

Profile of the Maternal and Child health nurses

In Serbia, according to Kri there is not specialized training for Maternal and Child health nurses but they have a basic education for nurses that lasts four years and after that home visitors need to have three more years of education. According to Kri:

"We hold at high nurses. We also have our schools; our high school is having ... It's college basically for nurses. It lasts three years after high school, sorry. We have basic school, high school, basic school,

everybody is the same in Serbia. High school, you have a specific, we have medical high school finished and those are clinical nurses. After that, if you want to work in home visitor service you need to finish three more years. It's like college but different name in our country, with my bad English, it's not good at I translate it or say and [inaudible 00:14:01] it's a course. But we also have specialization or for public health. It's not specifically for home visitor but it's something that's more attached to our job in basic but it's not necessary to have specialization but it's necessary to have finished college, I mean, these three years after high school. Also, it's not the same in entire Serbia, I'm not going when somebody who have just high school comes to talk to me and wants the job, I'm not going to give him because we don't want to, how do you say, I don't want to change the rules. I really think that if you want to work in home visitor service, you need to know more. I don't want to take a nurse with high school. Unfortunately, we in Serbia have 50% nurses that are working with just high school finished in home visitor services because we don't have a lot of nurses that are educated" (Kri).

Kristina also referred to older nurses that are tired and cannot do home visits but they are working at the phone services available:
"So, we have a list of women with address and phone numbers and we call them. We have nurses that are doing these things they are calling checking address. Those are old women, that are not for, how do you say, they don't have anymore strength or they're sick and they can go to home visits. They can do on field. But they can do, we use their experience like this, so they work on phone and their job is to answer on phone, they give advises to the families and to check to call pregnant ladies to explain them how is the home visitor service functioning and to check, is the address correct, is the phone correct and then they're giving data to the home visitors considering the address that they're living on. Every nurse is having her own part of our city that she is working" (Kri).

In the Netherlands, too, practitioners are nurses. According to Ve:
"The nurses do all the home visits, and at the [foreign language 00:05:45], we also have doctors and assistants…. We also have a program for parents who need a little bit more help. It is called [foreign language 00:06:19], like strong parenting. Then a nurse especially trained for those house visits" (Ve).

Collaboration with other services

Both practitioners mentioned that the service and the Maternal and Child health nurses collaborate with other services especially when they detect problems in the family. According to Kri:
*"Home visitors when they detect some risks about family, we have a chance to contact other services. We usually collaborate with, how do you say, center for social well-being. We usually collaborate with them when it's really, really bad conditions in family" (*Kri).

Ve also mentioned that they cooperate with other services: *"If there's some problem, I will have to, yeah, to lead them to another organization who can help the family. We work with a lot of organizations in Róterdam. We have a lot of contact with them also*" (Ve).

Also, Ve mentioned: *"We look at the bigger picture. If there are some problems in the family and they can solve it themselves, then for me it's okay. Of course, we will monitor it. But if I think the family is, they are solving their problems, then I do a referral to another organization. But it's always, the parents have to agree"* (Vera).

The home visiting program: Synopsis

Duration and modalities

In Serbia, the family has the right **to five days of visits**. The Maternal and Child health nurses, in collaboration with the family, discusses how it is best to use those visits. The visits take place **every second day**, usually. In case of families with problems, the Maternal and Child health nurses might visit the family more than five times.

In the Netherlands, the service is the **preventive care for children for zero until four years**. It's on a free base, but when a child is born, then the family gets a letter from the service and they will go on a home visit. In the first few months, **the family will come like every month to the service**, and when the child is getting older, the time between appointments is a few months to a year.

Profile of Maternal and Child health nurses

In Serbia, there is not specialized training for home visitors but they have a basic education for nurses that lasts four years and after that Maternal and Child health nurses need to have three more years of education. **In the Netherlands, too, practitioners are nurses.**

In-service training and mentoring available to nurses

In Serbia

In Serbia, Kri mentioned that when they are hired nurses participate in in-service training and mentoring:

In-service training in the beginning:
Kri mentioned that when nurses are hired, they participate in in-service training for one month, during which they learn:
"When she's first hired, we have a month of her monitor working but she's learning. We are having these modules that we had from UNICEF…. She needs to learn; she needs to read all the modules. She needs to learn all of our procedure, how do we do things and then she's going with her mentor on field. She doesn't do anything in home visits in first week or two. After that, she's just looking how is it done, after that she works things with mentor, mentor is looking and when it's finished, mentor gives me a report, is she ready to go on field by herself or not. If she's not, her mentoring is continuing but if she's ready she's going on her own. After that, a week after when she's going on work on her own, a week after that the, how do you say main nurse, main home visitor?" (Kri).

Mentoring and supervision:
In terms of mentoring and supervision Kri mentioned that in the beginning, when they are hired, the main Maternal and Child health nurses, goes to monitor how the nurse is working by herself and she is giving the report also. After that initial phase, they have some type of monitoring and supervision, "*but it's some things that they can use, they have opportunity to call mentor every time when something is not how do you say, but I am not sure in some things. She can call mentor in for me or she can call main home visitor"* (Kri).

In addition, Kri mentioned that they are having a meeting once per month in order to discuss various things that happening in practice:
"So, we went one step further, but let me go back one step, when we have some really, really bad things that happened in family and home visitor is saw that and did some things, we have our meeting once a month. The 52 home visitors of Novi Sad on one place and this is the time when we discussed about these bad cases because we don't have to learn from our own experience, we can learn some things from other people's experience. So, when these home visitors tell what are the steps that he has made, then it's easier when somebody had when someone is going to have some similar situation, he's going to know how he needs to done some things. Are those meetings once per month ... During those meetings once per month do you discuss only difficult situations or everyone that, for example, can I come and say, "Oh, I don't know how to say to a family the X thing. I don't know how to communicate, how I can address their specific needs" (Kri)

Other types of in-service training:
In terms of other types of in-service training, Kri mentioned that they run workshops on specific subjects: For example, last year they had two workshops about breastfeeding *"and it's good under that way we are expanding our knowledge and we walk"* (Kri).

In the Netherlands

In-service training:
In the Netherlands, Ve refereed to a specialized in-service training available to nurses so as to be able to support and help better the families:

“It's an in-service training, I guess from two days. It's not a really big training, but you get a little bit more information and advice how to help the parents” (Ve).
Ve also referred to the many different in-service training opportunities available to nurses in the Netherlands. These trainings are in their majority obligatory when the nurses start to work in the service and some of them, such as the training in breastfeeding, nurses have to repeat the training in five years. Trainings are mostly a half or one day. It's not very long and are offered by experienced nurses or doctors in their organizations. Sometimes, they have a guest to do the education. For most trainings there is not a test at the end. Trainings are offered four times a year. In their majority, trainings are theoretical, using power point presentations, whereas she mentioned that there are also e-learnings available.

Mentoring and supervision in the Netherlands:
Ve mentioned that they do not have a supervisor neither other mechanisms are in place to ensure practice change and sustainability.

Participants’ experiences and reactions to the in-service training they have received

Kri described the in-service training that she received and she characterized it as a very interesting and effective training that it supported her to learn many new things and to change herself and her practice. Kri mentioned that an effective training is short, but comprehensive and is not characterized by lecturing but rather follows a workshop style. It also addresses many different topics inherent to practitioners’ everyday practice:

“They organized training of master trainers Belgrade 2018, I think. No, no, sorry, '16. They trained us; we went through all the modules. Training lasts three days and I think that that was the best training that I ever had about home visitors…. Three days is quite enough, it was it wasn't long. It was concrete, how do you say it was, it was basic, we really learned about the core of our work they ... Oh, really, how do you say that, they considered every subject that we are having problem with and the language was easy. The work was easy and it was training, it wasn't classic education, it wasn't, how do you say when person stands and talk, talk, talk, talk, talk…. It wasn't [inaudible 00:36:47] it wasn't lecturing, [inaudible 00:36:52] is done like that. And it's boring and usually people don't learn anything. So, when we have it and I had experience with training, I was thrilled. It was excellent for me. I learned a lot of things and it wasn't long so it was just how it needs to be done…. It was workshop. It was ... We discussed about role of home visitor, about importance of early childhood development, role of father, how to, I don't know, safety, neglect of child, parents’ well-being. I don't know, I can't remember some everything for now, just a little bit. I have them. How to collaborate with other services and things that we, we have done that. But problem is that we'd never had any written rule, how are you going to do that and this is the first time that we have written rule and that was great…. They gave us some [inaudible 00:39:29] role, for example, for every subject. During the module of children's well-being on safety, we talked about every city that was in that room because there were cities from lots of different parts of Serbia. We went, I went only four. Only I went from Novi Sad, that was Kragujevac, Petrovaradin. A lot of cities. And we had assignments to showcase about collaboration with the center of social well-being. Where was involved children that's neglected and how have we finished that case or situation. Every city has shown how they are doing things. So, our trainer just had a job to comment things. We had the opportunity to exchange information, we had the opportunity to see how some things are differently done in the other cities. So, I think that's the only training that I went that people was honest and they honestly said, "Okay, we are not doing that." (Kri).

On the other hand, Ve mentioned that she has participated in many different in-service trainings, but only limitedly reached their goals as they were primarily based on lecturing:

"I *have followed a training for bonding. There, they teached a little bit about the background about bonding, what kind of signals they have to worry about. So, you see then what kind of things can you do to help the parents and the child with the bonding. Then I had a training- Yes. Videos they use. Role playing, not that much. We had one training with role playing. It was with aggressive behavior of parents, and how to react, so that was really interesting. But most of the time, it's just sitting there with a PowerPoint, and listen what they have to tell"* (Ve).

Other training in which she participated are the following: "*Yeah, well I had a training about breastfeeding. Some problems with breastfeeding and how to solve, but if there's a really big problem with breast feeding, I cannot solve it, and I have to refer to a professional who has learned a few years, I guess, for solving the problems with breastfeeding. I had a training for the development investigation. It is called [foreign language 00:32:35], and in that schedule, yeah, there are some subjects you have to, or a child has to do at a specific age. For example, when they are two years old, they have to make a tower from a tool blocks, or they have to draw a straight line. That kind of things for the ... How do you say? For their motor skills and also their language skills… What other training did I have? A training about vaccinations. What kind of vaccinations do we give? Why do we give the vaccinations? What if we do not give the vaccinations? Let's see. We also have a few e-learnings about ... There are a lot of, yes, how to say? A lot of guidelines for a lot of subjects, like eating, sleeping, the growth. And there are a lot of e-learnings about them"* (Ve)

In-service training and mentorship available to nurses and personal reflections on the training: Synopsis

- In both countries, **nurses have access to in-service training opportunities**.
- **In Serbia emphasis is placed in in-service training and mentoring when practitioners are recruited** and are starting work in the field.
- **In the Netherlands** on the other hand, **practitioners are having access to a more coherent and systematic training system but no supervision** is available to them.
- As far as their personal experience from trainings is concerned, although **Kri was enthusiastic about the content and modalities** used during the training she has attended, **Ve stressed that the training was theoretical, it did not achieve fully its aims and she welcomed the opportunities for peer learning** provided during the training.

Challenges at service level

Quality is dependent on the person

Kri mentioned that the quality of the services and the quality of the training and the supervision is dependent on the individual:

"Oh, trust me, I don't know. You need to have, chief of home visitor services needs to be more opened for education, how to implement these things. Basically, when we finished practice in Belgrade and came back to our facilities, it was depending of people, is these things are going to change or not. I have done a lot of things in my home visit service and it can be done. But it definitely depends of person" (Kri).

She also stressed that: "*We decide what are the needs of family. Not that's good because we depend of how is home visitor, how I am like nurse educated, do I love my job, because if I don't love my job, I'm going to go five times never mind about the risks or anything with the family"* (Kri).
Thus, Kri mentioned that: "*We need some rules that will be obligated to all home visitors because now we have that problem that, if I am a good person first of all and I want to help family, I'm going to do some things. If I don't want to help family, I'm not going to do anything and it's going. The wheel is turning around and that's not good"* (Kri).

Finally, Kri also mentioned that it is important to be a good human:

"I'm proud. I learned that I don't know a lot of things, that I need to learn a lot more. I learned that if you're good man and you're good to people, they're going to give you back with good usually. I learned that if you show people respect, they're going to do the same thing with you. I learned that I'm good chief, I learned that also. I don't know, I learned that you can be human and in these our specific work, if you're not human with people, you're not going to do anything. You're not going to achieve anything" (Kri).

Lack of standards and rules

Kri mentioned that there is a lack of standards and the quality of the services is dependent on the characteristics of the individual practitioner. If the practitioner is not good then he/she will not support and help adequately the family:
"We do six, seven visits. Still, we don't have control they're letting us to ... We decide what are the needs of family. Not that's good because we depend of how is home visitor, how I am like nurse educated, do I love my job, because if I don't love my job, I'm going to go five times never mind about the risks or anything with the family. So, we need to find the way how are we going to, oh, please help me… We need that someone says in this case you do like this. If you see this, this, this, you need to go six, seven, eight time until this happens. We need some rules. Yes rules, I wanted to say rules. We need some rules that will be obligated to all home visitors because now we have that problem that, if I am a good person first of all and I want to help family, I'm going to do some things. If I don't want to help family, I'm not going to do anything and it's going. The wheel is turning around and that's not good. Home visitors when they detect some risks about family, we have a chance to contact other services. We usually collaborate with, how do you say, centre for social well-being. We usually collaborate with them when it's really, really bad conditions in family".

Kri also referred to the lack of standards about when they are supposed to call the center for social wellbeing and this lack of standards creates sometimes bigger problems: *"Well you have situation that when you go to the informal, a place that is very, very poor and it's very, very dirty, you always have problem what is the limit, when are you going to call center of social well-being because every family in that part of the city is living very, very poor and very dirty. What is the limit, when do I need to react*

and we all the time, basically we have problem with that. If we call the center of social well-being, they said I'm sorry, they're living like that but if we don't call, we have its moral obligation. What if something is happening, what is going to happen with that. We also have always problem when ... What is the limit when we need to call again social well-being in regular families? What is that limited it says, okay, now this is the thing that it needs to be. Because when every time when we write a report or call center of social well-being, they're not critical, they're going to do everything. But if social worker goes to field and said, okay, the home visitor reported to us, then we're having problem to go again in that house. So, we are always measuring, what are we going to achieve. It's not good to all the time involved center of social well-being because sometimes they are more, how they say, they are making more damage than help… Okay, if I continue to [inaudible 01:00:57] that family, maybe I'm going to achieve some results, maybe they're going to be more careful, more kind, more gentle with their child. But if social worker closed door for me, then we are all in problem. These are some of the problems, for example, we don't have that, how do you say, basic problem is lack of supervision." (Kri).
Ve on the other hand mentioned that they have common standards of practice.

Lack of supervision and monitoring system: Emphasis on the number of visits but not on the quality of visits
Kri mentioned that there is no supervision and monitoring in her country and the emphasis is paid on the quantity of visits rather than on the quality.

"No. Unfortunately in our country there is none of supervision and I am very sad about that. I do not have anybody above me who can tell me how I can do things properly because in our country, we have some, I told you what number of visits we need to do. But quality of those visits, you don't have instrument to measure because in our country when I go to family, I see that they are really, really bad things are going on and I call a center of social well-being, a social worker comes ... I spend my time on that family but I can't show anywhere what have I done because my country does not ask for me to show that. They don't care. They are care only about the number. Until we change that, it's not going to be better" (Kri)

Kri also mentioned that there is no monitoring of whether they have delivered training to practitioners: "*But they haven't asked any reports from us of have we done some training for home visitors. No. It was, how do you say when, if I'm okay want to share knowledge, I'm going to do that, if I'm not, I'm not going to do that"* (Kri).

Finally, she mentioned that even she, as a chief of the service, would welcome some supervision, as sometimes she does not know what to say to her practitioners:

"These are some of the problems, for example, we don't have that, how do you say, basic problem is lack of supervision. Sometimes I don't know what to say to my nurses. I'm thrilled to have some supervision above me. The call to say, we had problem, for example, we have problem of child delivery in home. It's not legal in [inaudible 01:01:46] country. But we have problem that woman that had child delivery in her house illegal, she called us and she wants the home visitor to go to visit and do things with child and help her" (Kri).

Variation across regions
Kri mentioned that there is variation across regions, in terms of the services are provided: *"I told you about those percents about visiting, entire Serbia have obligation to visit pregnant women. Some local communities don't do that at all. Some health services center, home services don't do that at all. Their explanation is that they can't make it. They just [inaudible 00:22:58] can't do that. So, we don't have same, how do you say when this is how it's going to be done and everybody needs to done like that"* (Kri).

Ve also referred to the variations among cities and she pointed that although there are some good sides in that there are also some negative aspects: *“Now it's for the townships, and it's not in every township the same services they offer. I think on one side, it's a good change, because the [foreign language 00:23:34], or the township then will get more financials for the real problems in that city. But otherwise, it is difficult for parents, because if they move from one city to another city, then the service can be really different from the service they had in the other town. That's one thing”* (Ve).

Not a progressive universalism approach

Kri mentioned that all families have access to the same number of visits, even if some families have some problems and they need more help.

Challenge at training level

Practitioners, during the trainings, do not seek help or state that they do not know how to do something

According to Kri: *“Yes, they can say that but they're not going to do that. You know, because on those meetings, when you have 52 persons involved, you're not going to ... It's in my home visitor service like that, she's not going to stand up and say, "Okay I don't know how to do this."* (Kri).

During trainings some practitioners (mainly older ones) dominate

Kri mentioned that during the training older and more experienced practitioners tend to dominate and younger ones do not discuss or express their perspectives:

“But we had one problem, we have dominating, how do you say dominate, we had some persons that are dominated in home visitor service. And when we share them in groups, they started to do things like that that's that person that wants to do that and it's dominates, he does the task and report in the name of the group and the others don't do anything. So, I stopped doing that, it's not good. I want to hear voice of every of them. So, we right now finding some way, how are we going to do that but definitely we need the 52 persons on one space is very much and it's not good. But definitely we are considering the way how are we going to do that with smaller groups” (Kri).

She also mentioned: *“We need a younger nurse to put on the same room with just one old nurse who had experienced because if they are much experienced nurses, then these young nurses don't have opportunity to say anything, they're shy they are afraid to say something wrong. So, we need to change that way”* (Kri).

The training does not affect all participants

According to Kri not all participants are affected by the training and we need to find ways to resolve that problem:

“I used that meeting to share with them knowledge that I have get on some others, education programs etc, etc. This is the way how I made them then they must come, they must listen. So, but definitely we need to change something about that because it's fun, it's good but I think that it's not getting effect on every one of them” (Kri)

Ineffective types/modalities of training:

Kri referred to a training her practitioners participated and she mentioned that it was too long and it involved lots of lecturing that it was boring and ineffective since practitioners kept nothing at the end: *“My nurses were involved in project of UNICEF, that was involving also families with children in early development period…. And it lasts two year and they had a lot of education during that period. They went to Belgrade; I think about 11- or 12-times entire day they stayed there. And when they went first*

time, it was thrilled, allows extra. Knowledge is great, everything is great. Second time they were tired. Third time, it was really sick to them, how can I explain when something last long and forever and it's not good. Knowledge, did they get during that project, their education is the same that I have passed during three days, only worked slow. They worked with specific details and it was involved lots of others lecturing and it was boring. They haven't [inaudible 00:44:15] nothing. Unfortunately. Nothing stayed after" (Kri).

Ve also referred to the fact that in their majority trainings are about *"it's just sitting there with a PowerPoint, and listen what they have to tell"* (Ve).

Challenges at workforce level

Lack of educated staff and/or staff committed to life-long learning
Kri mentioned that the country lacks enough educated and qualified nurses, and that 50% of the nurses are working with just high school. According to Kri:

"Unfortunately, we have experienced that some of the nurses, however are the clinical nurses or ... I noticed that it's not important, some of the nurses after finished school, they don't even open the book. And that's the problem. So, it's why we are important that they have much more knowledge than clinical nurses because it's easier. It's no communication, they need to know what are they going to advise family because family trusts them. If I don't have knowledge about debated, help me please, diabetes, then I'm not going to be the proper [inaudible 00:18:46] family and we are going to be in problem. That's why it's important. She needs to have skill to trans ... How do you say that? She needs to know how to say family things, how to adjust things that she's saying particularly to that family. And she's not going to learn that in our high school, she is going to learn that in College" (Kri).

If practitioners are very young, they might face parents' reservations
Ve mentioned that the fact that she is very young makes parents question her ability to support them:

"Yeah, I find it a difficult question, but every day I'm trying to do my work better, because I'm still very young, and some parents, they look at me and they think, "She's a young girl. She doesn't know anything about parenting. Do I have to take advice from her?" That's for me a really important thing, to let them see that I know a lot, and that I'm also able to help the parents with their problems unless I'm just very young" (Ve).

Challenges at family level

Service delivery and take-up decline after some time
Kri mentioned that when women go back at work, service take up declines and they do not do many visits after the child turns 3 or 4-year-old.

Parents are not aware of the services provided or they have a negative image of the services
Ve mentioned that in some cases parents do not know what are the services available or that they have a negative image of the services:

"And in the beginning of the [foreign language 00:21:06], it was a lot of advice, and they point with the finger from, "Well, you're not doing it right," and that ... But a lot of parents do think about [foreign language 00:21:27] that way. I think there has to be a change, so the parents know more about our services, because it's very difficult, because a lot of parents talk about our services maybe in a negative way, but they don't know really what we have to offer. I don't know how to change, but I know that is a big problem at the moment for a lot of parents. Is that something?" (Vera).

Variability among families

Ve mentioned that even if a colleague suggests a way to tackle the problem, there is a great variability among families that it does not mean that since it worked in one family it will worked in all families: *"It's difficult, because they tell you about it, and every parent is different. If it works with one parent, it doesn't have to mean that it works with another parent. So, you just have to try. But when they tell you what they did, it's not very specific step-by-step, but only the problem a little bit about what they advised, and then the outcome with the way ... Yeah. During the advice, and to support the parents. Well, sometimes they are not really mentioned" (*Ve).

Difficulty in communicating to parents the "correct" approach

According to Ve:

"Sometimes, you know what the best ... For example, a parent comes to me with a problem with sleeping from this child. Then I already have a solution to solve the problem. I'm not the one that has to solve the problem. The parents have to solve the problem. I can tell the parent how to do, but the parents, they are more worried about the child's ... They do not want to let it cry during the night, because they are worried that the child is going to be angry with them. Yeah, well then, I know that that is the right thing to do, but you also have to tell the parents why that is the right thing to do. Sometimes it's a very difficult conversation with the parents, because they are at another level than I am" (Ve).

A type of service that points the finger instead of support the parents

According to Ve, the rationale behind the services used to be advice-oriented and "*they point with the finger from, "Well, you're not doing it right," and that ... But a lot of parents do think about [foreign language 00:21:27] that way.*" (Ve).

Difficulty in identifying women that are pregnant and they can receive the service

Kri mentioned that it is difficulty especially in some parts of the country, to identify the pregnant women and to deliver the services: *"the only thing that we need to know is that they exist. If I don't have information that woman on this address is pregnant, I'm not going to visit her" (Kristina).*

Key challenges across levels: Synopsis

- Interviews revealed a number of challenges at the *service, training, workforce and family levels.*
- At the ***service level,*** challenges include: quality of services is dependent on the person and on the attributes and experience of the practitioner; lack of universal standards and rules for the practice; lack of supervision and monitoring system and the fact that emphasis on the number of visits but not on the quality of visits; variations across regions; lack of a progressive universalism approach.
- At the ***training level***, challenges include: practitioners, during the trainings, do not seek help or state that they do not know how to do something; during trainings some practitioners (mainly older ones) dominate; the training does not affect all practitioners; ineffective types and modalities of training.
- At the ***workforce level*** challenges include: lack of educated staff and/or staff committed to life-long learning and practitioners' age, meaning that if they are very young they might face parents' reservations.
- Finally, at the ***family level*** challenges include: service delivery and take-up decline after some time, variability among families, difficulty in communicating to parents the "correct" approach, parents are not aware of the services provided or they have a negative image of the services, difficulty in identifying pregnant women and a type of service that points the finger instead of support the parents.

Success factors

Practitioners' characteristics

Interviews revealed a number of characteristics and competencies that should be in place. These are briefly presented below:

College graduates / educated and specialized practitioners

Kri mentioned that highly educated and specialized practitioners are the key to the quality of services, as they need "*to know how to say family things, how to adjust things that she's saying particularly to that family. And she's not going to learn that in our high school, she is going to learn that in College"* (Kri). She also stressed that college is important as education during colleagues moves beyond treating illness to the more social aspects of health:

"*Yes, we have some practice that consider work, especially in primary health care. We don't have that in our basic education. In basic education, you learn about sickness, about functioning of humans' body and that things. But on college we do learn about how does every part of our health system function, what are the subject primary health care. One year I learned how does the primary health care function in our country, what does the home visitor needs to do, what does the preventive center needs to do and we learn about prevention more. And prevention is core of our work"* (Kri).

Communication skills: Practitioners who know what to ask and how and work in cooperation with the families so as to solve the problem

Ve stressed the importance of communication skills, that enable practitioners to resolve problems in cooperation with families rather than judging parents or solving problems for them:
"I think it's important that you're there to ask a lot, because most of the times, people are scared to ask about financial status, or violence in a relationship. But if you ask it in a, well normal way, and without an opinion about it, they will, yeah. I'm trying to say ... They will achieve your goal better. And, it's really important to do it together with the parents. Not just me solving a problem. Because if I solve the problem, the parents don't know what I did, and they have to move on, and I am just out of the family. Then after a year or so, the same problem is there again, and then I have to solve it again. It's important to let the parents solve their problem. A lot of communication skills are really important, I guess" (Ve).

Practitioners with an aptitude for life-long learning

Kri stressed that in order to be effective Maternal and Child health nurses need to know everything about everything, as it is a wide field and they have to have the energy that they want to learn. They should be committed to life-long learning, they need to want to improve yourself, they need to want to learn after they finished school.

Reflective practitioners

Reflecting on their practice is an important characteristic for effective practitioners, according to Ve:
"That's a very good question. I guess in the first place, your experience. Sometimes it goes wrong with a family and then you ask yourself, "Okay, where did it go wrong? What did I have to do better?" It's important that you can admit that you made a mistake, and also to the parents maybe, so an open conversation is very important. But a lot of practice is ... Yeah, I think that's the most important thing" (Ve).

Service and training characteristics

Mentorship

Kri stressed the importance of mentorship and how this supports newly qualified practitioners to learn on the job and how observing the practice teachers supports practitioners.

Documentation and training on the documentation procedures

Kri mentioned that she developed tools that her Maternal and Child health nurses can use to document and support their practice and that she run specific trainings on how to use those documents/tools that were developed:

"During those projects, they had some, it was made instruments of checking some things, for example, we had [inaudible 00:45:20] of first parts of the question and it's something that they went the project. They listened a lecture about post postpartum depression, but they didn't know what to do with that piece of paper after this project. So, when I had the training three days that last, I used all those instruments, put them in our computers, so every [inaudible 00:45:59] have approach to them and can use them in their everyday work. So, we have a parallel with that I can't just say, okay, you have this instrument and you're going to use it. I had to do of course shorter version of workshop about post postpartum depression and baby blues and the parents well-being after giving a child. So, they know what to do with that instrument" (Kri).

Effective and supportive supervision and supervisor

According to Kri supervision is central to the sustainability of good practices. She also stressed that supervision should not be about observing practitioners but about helping and supporting them. Supervision is not about controlling practitioners. She stressed that Maternal and Child health nurses need supportive supervision and not a strict one:

"First of all, in home visitor services, you can't be directive. You need to make good atmosphere so if you want to see results. So, you can't have the person that's running home visitor services that's going to be strict and going to bully workers. Definitely not. Because work of home visitors, how can I say, it's really tight attached with will to work and will to help. So, if you have unhappy home visitor, you're not going to do anything. You're just bullying him and bullying yourself. This kind of work is good" (Kri).

Finally, Kri described the way she supports her Maternal and Child health nurses. She mentioned that her nurses can call her from the field whenever they have a problem and this makes them feel safer and stronger:

"And they're calling me whenever they have some situation that's need to be, how I can do this or that and what is the best, we think about it together and we find together some practice solution about that. Are we going to involve the social well-being or not, are we going to send them here or there…? Sometimes and this is good. My home visitor is happy because of that practice because they are feeling stronger and safer. It's not her decision only but she's discussing about that with someone" (Kri).

Later on, she mentioned:

"*We have problems, always, all the time, it's normal. We are big service and always there is something, some issues but they also know that they have opportunity to call me in every part of day. Whenever they have some problem, whenever they need something to consider about or talk about or I talk about work, not about private issues. They need support. They need one person, at least one person. When they are not sure what to do, they can call her and ask her and that person needs to be, how do I say when it's available, available every time that they are called when they have problem"* (Kri).

In the same line, Kri mentioned that it is important for practitioners to be praised for their work as it makes them feel that they are working in safe environment and that their supervisor takes care of them, is there for them. Also, this makes them feel that someone is seeing things that they are doing and it's really important in this job. According to Kri:

"If I do great and nobody say, "Great. You're super." Then after some while I'm going to stop trying. But if somebody recognize, okay, you done dead good, maybe you try this thing like this, then it's different. They're feeling like they are, how do you say, when your worth to me when you are a core of this disservice. They're feeling like important part. [inaudible 01:09:59] of that service. They are feeling like important part of this facility and society at all. They are feeling like they are doing a good thing. They are proud of the things that they are doing" (Kri).

Kri also mentioned that overall people in her country are tired, but when they are given credit for something that they are doing then they want to do and learn more:
"*You need to have energy; you need to have people who is going to be proud of every ... You know in our country it's; I don't know, people are tired. They don't want to learn a lot but when you give them credit about something, they're happy and it give them motivation to do next thing better and next thing and next thing and I work like that."* (Kri).

Opportunities for peer-learning
Ve mentioned in different instances that she is trying to learn from her colleagues: *"Every day, I learn from my mistakes, and I ask my colleagues if I don't know what to do, and they give me some advice, and then I will try. I'm not walking away if it's getting difficult"* (Ve).
She also mentioned that it would be very effective if they had the opportunity to observe other colleagues during their practice and learn from them:
"I think that you can learn a lot more if you go together with the colleague to a family where there are problems which you find difficult to solve together with other families. There you kind of share with your colleague, what is she doing? How is she doing it? Then you can learn from your colleague during the practice" (Ve).

Thus, she highlighted that trainings should also give them the opportunity to learn from their colleagues:
"During the trainings, if there's time or if it's one method of the training, then I think the practice during training with other colleagues, and we'll tell each other about things they have done to help families. Most of the time, it's experience from my colleagues that help me. But then I have to do it myself, and then sometimes it's difficult, because you hear what your colleagues say, and then I think, "Oh, that's a good idea." But to do it yourself is sometimes difficult. I don't know" (Ve).

Kri also referred to the importance of sharing with colleagues, so as for the one to learn from the other:
"How do you say that when you ... We started last year, for example, no, not last year, two years before this. They called me, one nursed called me, she said I have problem, we talked about that we said okay. I asked her, "Is there any chance that she can stand up in front of the 50 nurses and speak about her experience." And she said, "Okay." And then they, 50 of them was seeing how she is doing that. Next time it was some other nurse, next time it was some other nurse. When we have these things, then they realized how important is to talk about it. When we discussed together at least 10 of 50 is going to say something. She's going to give some comment about that case. Others are listening and then they realize how much is important to talk about the things" (Kri).

Also, Kri mentioned that they are having a meeting once per month and this is important because practitioners learn from other people experiences:
"So, we went one step further, but let me go back one step, when we have some really, really bad things that happened in family and home visitor is saw that and did some things, we have our meeting once a month. The 52 home visitors of Novi Sad on one place and this is the time when we discussed about these bad cases because we don't have to learn from our own experience, we can learn some things from other people's experience. So, when these home visitors tell what are the steps that he has

made, then it's easier when somebody had when someone is going to have some similar situation, he's going to know how he needs to done some things" (Kri).

Video-feedback

Kri referred to how effective and important is video-feedback for the nurses:

"And then we tried, UNICEF gave us standards and we tried to give, we asked families, can they give us signs. Can they sign [inaudible 01:16:45] form, that they are consent to a video home visit. They don't want to do that and my nurses don't want to do that. I had at least 10 of them that says ... 10 of them I tried. They're asked to do. Of them 10, three of them have taped the video and we sit and we watch the video and they were thrilled about how that was, how they saw themselves, how are they doing some things. They are giving feedback to themselves. They realized it. They said to me, "Okay, I done this here maybe I should." It was really helpful to them and to me. So, I think that we definitely need and every country needs to develop supervision thing, video, home visiting [inaudible 01:17:59] visit and we need to learn on different kind of ways, not like this" (Kri).

e-services and phone-services

Ve mentioned that the last years, they provide online services and they have created an e-culture. According to Ve the e-services provided has helped her to focus more on the families who have more serious problems:

"What about the e-cultural thing, and all the other things online? I have more time for people who really need it, because last year we went on a house visit, for example, with every child which is born in Róterdam, but now we also have the opportunity to call the parents and do the house visits by phone, when we know it's a second or third child, and everything is going okay in that family. So, I'm not working one hour with the family, but maybe half an hour, so I get more time for other things that are important" (Ve).

Good reputation

Kri mentioned that it is really important to have good reputation as a service and your Maternal and Child health nurses to be well-known and have a good reputation too:

"*So basically that's ... I'm definitely proud of ... Speaking now with own aspect of chief, I'm proud of my home visitors in the service. I am proud because I really can say that we have moved a lot. I think that… I just hope that I'm not, how do you say, when I think [inaudible 01:12:13]. Definitely my nurses are, because of the knowledge and thinks and information and things that how is done in our facility, whenever they go to some meeting with other cities or some education with our societies, they are proud and they are proud when they say, we are from Novi Sad. And other home visitor services are having some kind of respect for [inaudible 01:12:52]"* (Kri).

She also mentioned that people say good things about her services and that when people say good things, then she says good things to her practitioners:

"In city of Novi Sad, when you say home services, everybody knows about us. And they are saying the good things about us. And when they say good things about us, then I say good things to my nurse. And they're doing the best, how can I say that, I know that they're trying to do the best thing that can be done" (Kri).

Success factors: Synopsis

- Interviews highlighted that ***success is dependent on the characteristics of the practitioners and the characteristics of the services and the training***.
- In terms of *practitioners*, a number of characteristics and competencies should be in place. These are:
  1. practitioners should be college graduates / educated and specialized practitioners;
  2. practitioners should have good communication skills: Practitioners who know what to ask and how and work in cooperation with the families so as to solve the problem;
  3. practitioners should have an aptitude for life-long learning;
  4. practitioners should be reflective.
- On the other hand, *successful trainings and services* have the following characteristics:
  1. they provide mentorship;
  2. they support documentation practices and training on documentation;
  3. provide effective supervision and an effective and supportive supervisor;
  4. provide opportunities for peer learning;
  5. use modalities such as video-feedback;
  6. offer alternative types of services such as e-services and phone services; and
  7. have good reputation.

Suggestions for improvement at service level

Common standards

Kri mentioned that there is a need for common standards/rules who should apply for all Maternal and Child health nurses, so as to deliver the same services, irrespectively of their quality as professionals:

"We need that someone says in this case you do like this. If you see this, this, this, you need to go six, seven, eight time until this happens. We need some rules. Yes rules, I wanted to say rules. We need some rules that will be obligated to all home visitors because now we have that problem that, if I am a good person first of all and I want to help family, I'm going to do some things. If I don't want to help family, I'm not going to do anything and it's going. The wheel is turning around and that's not good" (Kri).

Kri also mentioned that it was great that they had the opportunity to introduce some written rules about what practitioners need to do.

Monitoring system

Kri mentioned that in her country they care about the number of visits but not the quality of the visits and she stressed that: *"Until we change that, it's not going to be better"* (Kri). In addition, she mentioned that without a monitoring system, which will enable them to show to other how to do things right, having only individuals doing things rights, does not help sustain change:

"But if I do things good and I don't have way to show you, how can you do things good then it's not something that's going to last. In our health home services, they call me from field" (Kri)
In addition, she mentioned that there is a need to introduce a training/module about monitoring and supervision. She said:

"but there is something that needs to be more specific definitely and one module we didn't have and it's particularly that supervision. We didn't have that. I think that's the key that's missing. If you don't supervise my work, how do you know that I will work correctly" (Kri).

Autonomous practice

Kri mentioned: *"I'm not somebody that is going to put his hand on the table and say okay that's enough. I think that we need to give freedom, home visitor, I need to feel respected, I need to feel that I have freedom to do in that family things that I consider that needs to be done"* (Kri).

Monitoring parents experience from the service

Ve stressed that it would be important to monitor parents' experience about the services they receive:

"Yeah, well maybe the experiences of parents, because I think we do not have to forget how it's been for parents to accept the help, and what they struggle with. Most of the times I will think, okay, well if I'm going to do this, what will a parent think? I think that if you invite a parent into a training where it's relevant, and then yeah, it can be very helpful" (Ve).

Progressive universalism

Kri mentioned: *"We have that opportunity to do six or seven visits when we have some that detect some risk, but country says everybody are the same, everybody has same right and everybody have same number of visits. Country said like that. They need to develop and we need to developed different packages for those who are at risk, for those who are not and like some basic support, some advanced support, something like that. That needs to be done in our country"* (Kri).

Cooperation with gynecologists in order to identify pregnant women

Kri mentioned that in her region they have cooperated with gynecologists in order to identify pregnant women:
"But we have, it's not the same in entire Serbia, I have to say. We know it's hard, I went to meetings with gynecologists and we have improved agreement that every woman that comes to our facility to say that she's pregnant and go to, how do you say gynecologist, obstetrician. Do you say it like this on English. And she went to doctor about pregnancy, he's going to tell home visitor about that woman. So, we have a list of women with address and phone numbers and we call them. We have nurses that are doing these things they are calling checking address" (Kri).

Suggestions for improvement at training level

Practice during training in a safe environment

Ve mentioned that just sitting in front of a ppt and listening to what they teachers want to say is not effective and that practitioners need to practice in a safe environment:
"I don't think it's the most effective way to learn, because you only sit there and you hear what they have to say. You learn a few things, but I think it's important to practice there in a safe environment. So, you can try some trying, what's going to work, what is not going to work. Without the parents, we will be very angry if you say something. So, I think that the trainings, yeah, they can improve the trainings. But I don't know how many time and money we have to improve the trainings" (Ve).
She also mentioned that as delivered now training do not reach their full objectives, since you are learning some things but you can learn more and this could change by incorporating more practice during the training.

Having smaller groups during training, with more younger nurses and only one older nurse

Kri mentioned that they would like to have smaller groups during the trainings, so as to avoid having some practitioners dominating and some not talking at all. In this sense, she mentioned that it would be better if they had more younger nurses in the group and only one older-more experienced nurse so as for the younger ones to talk:

"Right now, we are going to share them on smaller groups and like that we are going to try to do with smaller groups everything. We need younger nurses to put on the same room with just one old nurse who had experienced because if they are much experienced nurses, then these young nurses don't have opportunity to say anything, they're shy they are afraid to say something wrong. So, we need to change that way. I'm planning to do some meetings of workshops that I'm going to have at least five younger nurses and just one experienced nurses" (Kri).

Shorter training

Kri referred at different instances about the importance of having shorter trainings that are not boring.

Suggestions for improvement: Synopsis

- Interviewees stressed that there are a number of factors that need to be in place so as to ensure that the *services and the training are effective*.
- In order for **services to be effective**, interviewees highlighted:
    1. Need for common standards/rules who should apply for all Maternal and Child health nurses, so as to deliver the same services, irrespectively of their quality as professionals
    2. Without a monitoring system, which will enable them to show to other how to do things right, having only individuals doing things rights, does not help sustain change
    3. Enhance practitioners' autonomy
    4. Ensure bottom up approaches by monitoring parents' experiences from the services
    5. Provision of services that build on the progressive universalism approach
    6. Cooperation with other professional groups so as to identify families
- **At the training level**, the following suggestions were formulated:
    1. Provide opportunities for practice in a safe environment
    2. Having smaller groups during training, with more younger nurses and only one older nurse
    3. Shorter training

Discussion

Strategies and processes that need to be in place in order to successfully achieve a practice-change among nurses

In order for practice change to be achieved a number of strategies and processes need to be in place. Although participants in the research come from different geographies and despite the fact that the systems in which they operate vary considerable, interviews highlighted many commonalities.
Practice-change is inseparably linked to the system in which practitioners operate. One of the most frequently referred to necessary elements is the recognition of the field itself, as well as the wideness of the field. That means that in order to achieve practice change it is important to recognize the importance of the field as well as the uniqueness of this field. Linking home visiting to treating illness does not support practice change. On the contrary, in order to achieve change we need to focus on the social aspects of health and move beyond hospital-oriented practices and theory.

In addition, it is important to understand that the everyday practice is so unpredictable and so wide that it is challenging to prepare practitioners to adopt all these different roles they have to play every day and to know all those things that are inherent to their everyday practice.
This fact calls for more innovative, practice-based approaches and experiential learning. All interviewees, both training providers and practitioners, highlighted that practitioners learn best through practice, by observing more experienced colleagues and practice teachers. Thus, the need for common standards of practice and common standards among training providers is profound in order to ensure that all practitioners working in the field have a shared understanding of different aspects central to their practice.

Experiential learning and observation were also mentioned as a response into how we can support practitioners develop skills “that cannot be taught”. For example, all interviewees mentioned that communication skills and confidence are the main competencies of an effective Maternal and Child health nurse. Yet, those competencies and skills cannot be easily taught. However, observing other colleagues and practice teachers can support them in building these competencies. Thus, interviewees stressed that as such “inherent” abilities are linked to the quality of services, a filtering system would be advantageous. That means that in-service training should be primarily addressed to those practitioners who already possess certain attributes.

In addition, it was stressed that the unpredictability of the profession raises the need for supportive supervision. Practitioners need to feel safe, need to feel that they work in a supportive environment and that they can call for help and advice when they have to deal with situations for which they do not feel adequately prepared. In order to feel that safety, some interviewees also stressed that supervision should be on a one-to-one basis and should not be addressed only to those practitioners who work with families with problems but universal for all practitioners.

Thus, taking into consideration the fact that practitioners need to constantly learn about new things the importance of continuous professional development was also raised. However, in their majority participants highlighted that the workforce has limited access to CPD opportunities and those opportunities are limited. In fact, participants stressed that there is no type of communication after the training and although it would be beneficial to continue the communication this is primarily unofficial, when it takes place.

Finally, in terms of the characteristics of the in-service training is concerned, interviewees highlighted that they need to be bottom-up and they need to build on the needs of the practitioners, the needs

of the profession and the needs of the families. The needs of the professionals include but are not limited to:

a) Building their confidence
b) Enhancing their skills and capacities
c) Peer learning and sharing
d) Grow practitioners into adult learners

Thee needs of the profession, on the other hand include:

1) Having the right people with the right attributes
2) Practice change
3) Influencing and shaping policy
4) Intersectoral collaboration
5) Re-conceptualizing the social aspects of health
6) Giving voice to the field
7) Having unified standards and practice

Strategies and processes that need to be in place in order to successfully achieve a practice-change among nurses: Synopsis

- Practice-change is inseparably linked to the system in which practitioners operate.
- In order to achieve practice change it is important to recognize the importance of the field as well as the uniqueness of this field.
- We need to focus on the social aspects of health and move beyond hospital-oriented practices and theory.
- It is important to understand that the everyday practice is so unpredictable and so wide that it is challenging to prepare practitioners to adopt all these different roles they have to play every day and to know all those things that are inherent to their everyday practice.
- This fact calls for more innovative, practice-based approaches and experiential learning.
- Thus it calls for common standards of practice and common standards among training providers in order to ensure that all practitioners working in the field have a shared understanding of different aspects central to their practice.
- Experiential learning and observation were also mentioned as a response into how we can support practitioners develop skills “that cannot be taught”.
- Thus, since such “inherent” abilities are linked to the quality of services, a filtering system would be advantageous.
- Need for supportive supervision: Practitioners need to feel safe, need to feel that they work in a supportive environment and that they can call for help and advice when they have to deal with situations for which they do not feel adequately prepared.
- The importance of continuous professional development was also raised.
- Finally, in terms of the characteristics of the in-service training is concerned, interviewees highlighted that they need to be bottom-up and they need to build on the needs of the practitioners, the needs of the profession and the needs of the families

Common elements among successful programs

Interviews highlighted a number of success factors among effective programs. One of those success factors is when the training is obligatory and part of the CPD opportunities available to the workforce. In addition, the training should combine theory and practice. Theoretically-oriented programs are not considered effective, but although participants stress the importance of practice, they also acknowledge that practitioners need the theory that will support them to back up that practice. In addition, continuity in the process was mentioned as important. That means that the communication should not stop with the training, nut it should continue after that, too.

Taking into consideration the wideness of the field, two of the interviewees stressed the importance of intersectoral training. Thus, effective programs equip trainees with the monitoring tools they need to monitor their everyday practice. Also, most of the interviewees mentioned that effective trainings build on the principles of adult learning and on experiential learning. Specifically, four interviewees highlighted that coaching and supervision as well as the use of modalities such as practice portfolio and video feedback are elements of a successful training program.

Finally, peer support was stressed as important both from training providers and practitioners. An effective training gives the opportunity to trainees to discuss with colleagues and to observe colleagues and brings people together so as to form a community of learners.

Common elements among successful programs: Synopsis

- Training obligatory and part of the CPD opportunities
- Training that combines theory and practice
- Continuity in the process - the communication should not stop with the training
- Intersectoral training
- Effective programs equip trainees with monitoring tools
- Effective trainings build on the principles of adult learning and on experiential learning
- Coaching and supervision as well as the use of modalities such as practice portfolio and video feedback are elements of a successful training program
- An effective training gives the opportunity to trainees to discuss with colleagues and to observe colleagues and brings people together so as to form a community of learners

Barriers and challenges in program implementation

As mentioned previously one of the key challenges that all stakeholders (e.g. practitioners, training providers, managers in the services) phase is the unpredictability of the profession. This is a key challenge as it makes difficult the overall preparation of practitioners for all the situations they might have to deal with. In addition, as it was stressed although initially, we do not expect practitioners to have many skills later on we expect that from them. However, if we do not start building their capacities early on, during initial preparation, an in-service training cannot cover all the gaps. Participants further elaborated on this by mentioning that another key challenge is the lack of direct entry in the profession and the lack of specialized training on home visiting, from the beginning. This lack of a higher education system for Maternal and Child health nurses, across countries, is inseparably linked to how the field is viewed and its status. Specifically, in many cases home visiting is not legally in statute. All these interfere with knowledge and skills development and retention. The above also have implications about the stability of initial training. The lack of standards characterizes not only the professional practice, but also the provision of training. Thus, it characterizes opportunities for field experience. In fact, it was stressed that when opportunities for field experience are available, there are not in place quality assurance mechanisms and the quality of the practice is dependent on the quality of the practice teacher.

In terms of the lack of field experience, it was stressed that in many cases practitioners do not have the opportunity to practice the knowledge they have gained and this knowledge is lost since without practice you cannot enhance your skills.

As such, there is wide variability in terms of initial training, with each training institution assigning different importance and time in different theoretical aspects inherent to the home visiting practice. This creates, however, instability in the abilities and competencies of the workforce and when in-service training is provided the academic background of the practitioners varies a lot. This is also true, about the experience of the trainees. However, this variability in terms of previous experience, affects among other things the time trainees need in order to master the skills the training targets. Yet, although trainees may need different time to master certain skills, based to their academic background and experience, there is not an individualized approach which takes into account the needs of each practitioner. Thus, there is consensus that practitioners' needs are not taking into account most of the times, when we design and deliver training programs.

Another issue raised was about the duration of the training. Two of the interviewees working on university-based training institutions mentioned that taking into consideration what we expect from the trainees, the training is short and does not go in-depth but rather it gives trainees only the starting points of the key topics and also does not allow to go far from the theoretical part. Other participants on the other hand, mentioned that the training is so long that trainees lose interest. Finding the right balance, based on trainees' needs and background is of high priority.

Cost-related challenges were also mentioned by various interviewees. For example, it was stressed that financial constraints do not allow to provide the training to all practitioners, that they cannot provide field experience or that budget constraints lead to shortage of staff and in that case existing practitioners cannot participate in training due to their workload. Other cost-related challenges that were mentioned, include but are not limited to: failure to select influential types of training, as they are more expensive; failure to train the facilitators; variability among regions as there is not a universal funding.

Finally, some of the barriers come also from the practitioners' side. For example, two interviewees stressed that some practitioners show resistance to change and to some modalities, such as video

feedback. Other interviewees mentioned that for practitioners, especially senior ones, is difficult for them to back to the role of the student. Others on the other hand are so much practice oriented that it is difficult for them to bother with reading and research. Have workloads, intense paperwork, vicarious trauma and burnout were mentioned as challenges from practitioners' perspectives.

Barriers and challenges in program implementation: Synopsis

- Unpredictability of the profession
- Although initially we do not expect practitioners to have many skills later on we expect that from them
- If we do not start building their capacities early on, during initial preparation, an in-service training cannot cover all the gaps
- Lack of direct entry in the profession
- Lack of a higher education system and specialized training on home visiting, from the beginning
- In many cases home visiting is not legally in statute.
- All these interfere with knowledge and skills development and retention.
- Lack of standards for the professional practice and for the provision of training.
- When opportunities for field experience are available, there are not in place quality assurance mechanisms and the quality of the practice is dependent on the quality of the practice teacher.
- Lack of field experience - in many cases practitioners do not have the opportunity to practice the knowledge.
- Wide variability in terms of initial training, with each training institution assigning different importance and time in different theoretical aspects inherent to the home visiting practice
- Instability in the abilities and competencies of the workforce and when in-service training is provided the academic background of the practitioners varies a lot.
- This variability in terms of previous experience, affects among other things the time trainees need in order to master the skills the training targets.
- Practitioners' needs are not taking into account most of the times, when we design and deliver training programs.
- Duration of the training.
- Cost-related challenges.
- Barriers from practitioners' side (e.g. resistance to change, resistance to some modalities, difficulty in assuming again the role of the student, heavy workloads, intense paperwork, vicarious trauma and burnout).

Conclusions

In order to achieve practice-change it is important to acknowledge that challenges are stemming from all levels and that we need to start by re-considering the status of field itself. Establishing universal national standards of practice, having recognized legal status of the practitioners' roles, allowing practitioners to be autonomous are the starting point for practice change. Central to enhancing and improving the system level is to provide adequate and content-specific preparation before the entry in the profession, by establishing a higher education system that specifically addresses the needs of the home visiting profession. Three of the interviewees mentioned that there are gaps in preparation in terms of the content of the training – which is more focus on illness rather than on public health and more general and that the specialization of different cadres is key. Finally, at the service level it is important for practitioners to have access to continuous professional development opportunities and supportive supervision.

Turning to the in-service training programs, in order to practice change to be achieved they should provide a combination of theory and practice. Thus, effective modalities, rather than lecturing and power point presentations, should be employed, such as videos, role play, experiential learning, coaching and working in one-to-one basis or in small groups, online components, labs, portfolio, etc. In addition, both training providers and practitioners highlighted the importance of peer-support and communities of practice. In addition, programs should consult with the trainees in order to ensure that they meet their needs. Finally, special attention should be given to the competencies of the training providers and master trainers, as the overall quality of the program is inseparable linked to their quality.

Appendix 1. Consent Form

Interview Consent Form

Research Project Title: Literature review – implementing practice change in Maternal-Child Health Nursing services to enhance children's outcomes

Research investigator: Dr. Maya Yaari, Head of Research and Evaluation, Goshen - Community Child Health and Wellbeing

I. The Project

We invite you to participate in the research "Literature review – implementing practice change in Maternal-Child Health Nursing services to enhance children's outcomes" undertaken by ISSA for Goshen Institute. This research aims at informing and guiding the development of a National Program to Strengthen the Capacity of "Tipat Halav" nurses in working with parents to advance the developmental outcomes and well-being of young children and families in Israel.

II. Procedures

Upon your consent to participate in this research, you will be invited to an **interview**. The interview will last approximately 45 minutes and the exact day and time of the interview will be set according to your schedule. The interview will be conducted online, using the GoToMetting web-hosted service, by one of the members of the research team. Notes will be taken during the interview. The interview will be **recorded** and an audio tape of the interview and a transcript will be produced.

Your participation in this research is **completely voluntary**. There is no explicit or implicit coercion whatsoever to participate. You have the right not to answer questions. If you feel uncomfortable in any way during the interview session, you have the right to withdraw from the interview and ask that the data collected prior to the withdrawal will be deleted.

Your **confidentiality** in this study remains secure. All the information and data that will be collected will remain confidential and will be used only for research purposes. At no time will your name or personal details be revealed. Thus, in any report on the results of this research, or direct quotations from the interview, that are made available through academic publication or other academic outlets, your identity will remain **anonymous**. Subsequent uses of records and data will be subject to standard data use policies which protect the anonymity of individuals.

The transcript of the interview **will be analysed** by Dr. Konstantina Rentzou and Goshen institute's research unit members, as research investigators. **Access to the interview transcript** will be limited to the Principal Investigator, Dr. Konstantina Rentzou and one researcher of the Goshen institute's research unit members.

We don't anticipate that there are any risks associated with your participation, but you have the right to stop the interview or withdraw from the research at any time.

III. Consent

This consent form is necessary for us to ensure that you understand the purpose of your involvement and that you agree to the conditions of your participation. Would you therefore read the information and then sign this form to certify that you approve the conditions.

By signing this form, I agree that:

1. I am voluntarily taking part in this project. I understand that I don't have to take part, and I can stop the interview at any time;
2. The transcribed interview or extracts from it may be used as described above;

3. I have read all the information included in this form;
4. I don’t expect to receive any benefit or payment for my participation;
5. I can request a copy of the transcript of my interview and may make edits I feel necessary to ensure the effectiveness of any agreement made about confidentiality;
6. I have been able to ask any questions I might have, and I understand that I am free to contact the researcher with any questions I may have in the future.

You will obtain a copy of this consent form co-signed by the interviewer

____
Participant’s Name

___________________________________ ______________________
Participant’s Signature **Date**

___________________________________ ______________________
Researcher’s Signature **Date**

What if I have concerns about this research?
If you are worried about this research, or if you are concerned about how it is being conducted, you can contact
Dr. Maya Yaari
Head of Research and Evaluation
Goshen - Community Child Health and Wellbeing
E:mayay@goshen.org.il
https://gadalta.org.il/
+972-2-6285891

Appendix 2. Interview protocol for training providers

Key Informant Interviews – Guide for Training Providers

INTRODUCTION & BACKGROUND

- Hello, my name is _______and I work for_____________. Thank you so much for your willingness to speak with me. We appreciate your time and value your experiences and opinions.
- As part of the Review conducted by ISSA for Goshen Institute, my colleagues and I are trying to understand how to train nurses in their work with parents in a way that will ensure a sustainable practice change. More precisely, we aim to map:
    - The strategies and processes that need to be in place in order to successfully achieve a practice-change among nurses
    - What are the common elements of successful programs?
    - What are the barriers and challenges in implementation of such programs?
- We will use this information to:
    - Inform and guide the development of a framework to Strengthen the capacity of Tipat Halav" nurses in working with parents to advance the developmental outcomes and well-being of young children and families in Israel. .
- As part of this work, we are interviewing key stakeholders across middle-high income countries.
- Do you have any questions before we begin?

To get started, we would like to hear a little bit more about you and your role.

Demographic information

1. Could you tell us some things about you and your academic background? (Position, Academic background, Working experience – years and contexts, Where do you work)
2. Could you tell us about your role and responsibilities within the organization that provides the training program?
3. Can you please describe briefly your organization?
    a. the type of the institute (e.g. university, NGO, etc.)
    b. the location of the institute (e.g. urban, rural, remote)
    c. the focus of the training program (e.g. health promotion, research, management)
    d. the way it is offered (e.g. is it free of charge, subsidized, to all nurses, etc.)
    e. How are trainees recruited?
    f. the demographic characteristics of the trainees (e.g. age, learning needs, professional role, local trainees or international trainees)

Now I would like to ask some questions about the in-service training program you provide

4. Can you please tell me about the training program you offer?
    a. Structure (length, frequency), modalities (lectures, group learning, field practice, e-learning, peer-learning, role-playing, etc.), main goals, curriculum focus areas and main subjects taught
        i. Are leadership competencies targeted with the program?
        ii. To what extent, if any, do you support trainees to work effectively and in collaboration with parents? How? What types of collaboration are targeted?
    b. What types of equipment, supplies and resources do you provide to the trainees?
    c. Are there in place elements of ongoing implementation and sustaining the change (e.g. supervision, coaching, video feedback)?
    d. Are there any other complementary supports available to trainees (e.g. network and alumni activities, etc.)?

e. How do you help trainees learn new practices and how do you keep them engaged and excited about implementing new practices?
f. Are subjects and modalities informed by a research-based needs assessment? Do you support trainees to implement research results into everyday practice - to work towards sustainable practice-change in their practice context? If so, how? Are there in place any ongoing continuous activities to support implementation and sustainability, after the end of the formal training?
g. How was the program developed?
    i. To what extent, if so, were different stakeholders (e.g. practitioners, students, parents etc.) involved in the process of developing the curriculum and the strategies?
    ii. In case the program has been adopted from another context / country, ask what procedures have been followed so as to be culturally-responsive.
h. To what extend does the program achieve its goals and how "success" of the program is defined and measured?
    i. Do you have an estimation of the outcomes of the program at different levels (e.g. practitioners, parents, children, organizations, etc.)?
i. What is the most effective element of the program? What are the most useful skills and competencies that the program helps trainees to develop?
j. What is the least effective element of the program? What necessary skills and competencies does it fail to develop?
k. What changes would you like to see in the program in terms of content, strategies, processes, etc.?

5. How do the learnings from a structured in-service training program translate to the unpredictability and complexity of the day-to-day work in health centers?
6. If you were to visit an MCH setting in which a nurse was implementing "faithfully" the content/philosophy of the program, what would you expect to observe?
7. What might you observe that would lead you to conclude "that is not what we intended when we developed our training program"?
8. To what extend do you seek trainees' feedback in order to identify your limitations and areas that you need to improve?
9. Overall, what other countries/institutions might learn from your training program?
    a. What is the innovation?
    b. What are the potential benefits of adopting that model?
    c. What are the costs?
    d. Is it compatible with other countries/organizations? How? Why (not)?
    e. What changes do they have to make before adopting the model?
    f. What are the ingredients of success?

Finally, I would like to discuss with you about your perceptions about effective practice and practice-change processes

10. What are the essential skills and qualities for an effective MCH nurse?
    a. How do you support them to acquire those skills and use them in their routine practice beyond their primary training?
11. What is the current state of nurses' knowledge about effective MCH practice?
    a. How well prepared are they?
    b. What are the most significant gaps in preparation?
    c. What needs to change and how do you redesign it?
    d. How should goals and plans for change be developed?
    e. How do we bring nurses into the process?

12. How well-prepared nurses are to achieve practice change? Who can support them in this role? How?
13. What are the primary challenges that MCH nurses face? How the training addresses those challenges? Are there any challenges that cannot be overcome?
14. What are the main limitations or deficits that inhibit nurses to improve their practice to meet current standards using evidence-based practice or best-practice standards?
15. What is required so as to be able to alter the practice environment?
16. What are the skills and competencies nurses need so to act as full partners with other health professionals in redesign and reform efforts across the health care system?
17. Overall, what are the facilitators and barriers to practice-change in terms of the clinical skills of the nurses?
18. What would be your top 3 priorities to address in planning for and preparing the future nursing workforce?
19. Can you please describe the best practice-change experience you had until now?
    a. What practice/behavior was it changed?
    b. Why did you feel the need to change the practice/behavior?
    c. When did you start working towards changing the practice/behavior?
    d. What did you do to address the challenge and to alter the practice environment?
    e. How did you involve nurses and other professionals and / or parents in the process?
    f. What did you do to keep others motivated, especially when things did not go as planned?
    g. What were the results?
    h. Were there any obstacles to the change process? Were you able to address them? How?
    i. Describe how you felt at the end of the experience that you just described.
    j. What were the two or three major lessons about practice-change that you learned?

Before we close, I was wondering if you

20. know any approaches – such as initiative, activity, etc., that have been implemented to support the MCH workforce to lead practice change and you think could be useful for other countries /institutions?
    a. If so, what are these approaches
    b. Can you describe the X approach and what it entailed?
    c. When and where was this approach introduced?
    d. Why was it introduced?
    e. Who developed it?
    f. What changes, if any, have been achieved since introducing this approach?
    g. What have been the successes of this approach?
    h. What have been the challenges of this approach?
    i. What lessons might this approach offer to other countries/institutions?

Thank you so much for your time today. I understand how busy you are and appreciate you taking time to discuss this important issue with me.

Appendix 3. Interview protocol for practitioners

Key Informant Interviews – Guide for nurses

INTRODUCTION & BACKGROUND

- Hello, my name is _______and I work for_____________. Thank you so much for your willingness to speak with me. We appreciate your time and value your experiences and opinions.
- As part of the Review conducted by ISSA for Goshen Institute, my colleagues and I are trying to understand how to train nurses in their work with parents in a way that will ensure a sustainable practice change. More precisely, we aim to map:
  - The strategies and processes that need to be in place in order to successfully achieve a practice-change among nurses
  - What are the common elements of successful programs?
  - What are the barriers and challenges in implementation of such programs?
- We will use this information to:
  - Inform and guide the development of a framework to Strengthen the capacity of "Tipat Halav" nurses in working with parents to advance the developmental outcomes and well-being of young children and families in Israel.
- As part of this work, we are interviewing key stakeholders across middle-high income countries.
- Do you have any questions before we begin?

To get started, we would like to hear a little bit more about you and your role.

Demographic information

21. Could you tell us some things about you?
    a. Age
    b. Field of expertise – what did you study
    c. Working experience – years and contexts
    d. Where do you work
22. Could you tell us about your role within your context of practice?
    a. What are your main responsibilities in this role?
    b. Can you tell us a bit about your background before this role?

The context of practice

23. Can you please describe briefly your context of practice?
    a. the type of practice setting (e.g. clinical care, management, administration,)
    b. the location of the practice setting (e.g. urban, rural, remote)
    c. the way services are provided (e.g. are services available and accessible to all families; are they free of charge; on what basis do families attend – one-time, standard schedule, etc.)
    d. the characteristics of families (e.g. health status, their age and their children's age, specific needs)
24. Is there a clear scope of practice?
    a. What does it include? What is the focus of practice (e.g. health promotion, research, management)
25. To what extend is practice autonomous?
26. Are there opportunities for professional development and in-service training for you and for the rest of the staff?

    a. Can you please describe briefly those opportunities? (e.g. requirements, content, delivery service, hours, etc.)?
    b. What are the aims of professional development?
7. Is supportive supervision carried out?
    a. How regularly?
    b. What it includes (e.g. provide feedback, coaching, problem solving, skill development, data review, etc.).
8. To what extend parents' feedback is sought to identify limitations of the services and areas that need to be improved?
9. To what extend parents' feedback is sought in order to identify practitioners' limitations and areas that they need to improve?

Interviewee's perceptions about effective practice and practice-change processes

10. What are the essential skills and qualities for an effective MCH nurse?
11. How do nurses acquire these skills and how they use them in their routine practice?
12. How do you approach the practice-change process?
13. Can you please describe the best practice-change experience you had until now?
    a. What practice/behavior did you change?
    b. Why did you feel the need to change the practice/behavior?
    c. When did you start working towards changing the practice/behavior?
    d. What did you do to address the challenge and to alter the practice environment?
    e. How did you involve nurses and other professionals and / or parents in the process?
    f. What did you do to keep others motivated, especially when things did not go as planned?
    g. What were the results?
    h. Were there any obstacles to the change process? Were you able to address them? How?
    i. Describe how you felt at the end of the experience that you just described. Can you please describe how it has changed you at a personal level? Did it change the way you perceive yourself, the way you perceive your job, your sense of competence? What have you learnt about yourself from this process?
    j. What were the two or three major lessons about practice-change that you learned?
14. What are the main limitations or deficits that inhibit you to improve your practice to meet current standards using evidence-based practice or best-practice standards?
15. If staff is involved in practice-change:
    a. How do you involve them?
    b. How do you support them learn new practices?
    c. How do you get them engaged and excited about implementing new practices?

Overall, what are the facilitators and barriers to practice-change in terms of the clinical skills of the nurses?

In-service training programs

16. Have you participated in any type of in-service training program? Can you please tell us about the training?
    a. What were the goals and objectives of the program?
    b. Which subjects were included and which key behaviors were targeted?
    c. What was the structure of the training program (length, frequency, etc.)?
    d. What were the main modalities of training and learning (lectures, group learning, field practice, e-learning, peer-learning, role-playing, etc.)?
    e. Were subjects and modalities informed by a research-based needs assessment? Were you supported to implement research results into everyday practice? If so, how?

f. Were there in place elements of ongoing implementation and sustaining the change (e.g. supervision, coaching, video feedback)?
g. After the end of the formal training program, were there in place some ongoing continuous activities to support implementation and sustainability?
h. To what extent did the program achieve its goals? How did it achieve these goals?
i. What changes would you like to see in the program in terms of content, strategies, processes, etc.?
j. What was the most effective element of the program? What are the most useful skills and competencies that the program helped you develop?
k. What was the least effective element of the program? What necessary skills and competencies did it fail to develop?

17. How did you integrate the information from this program into your everyday practice and leadership style?
18. Have you seen any organizational improvements after participating in the program?
19. How do the learnings from a structured in-service training program translate to the unpredictability and complexity of the day-to-day work in health centers?
20. What challenges do you face in your everyday practice and how the program supported you in overcoming and addressing those challenges? What challenges cannot be overcome?

Promising approaches

21. Are there any approaches – such as initiative, activity, etc., that have been implemented in your country/institution to support the MCH workforce to lead practice change and you think could be useful for other countries/institutions?
    a. If so, what are these approaches
    b. Can you describe this approach and what it entailed?
    c. When and where was this approach introduced?
    d. Why was it introduced?
    e. Who developed it?
    f. What changes, if any, have you seen since introducing this approach?
    g. What have been the successes of this approach?
    h. What have been the challenges of this approach?
    i. What lessons might this approach offer to other countries?

Thank you so much for your time today. I understand how busy you are and appreciate you taking time to discuss this important issue with me.