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SPECIAL FEATURES : EDUCATION

A European Union and Canadian Review of Public Health Nursing Preparation and Practice

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ABSTRACT ***Objective:*** This study explores the preparation and role of the public health nurse (PHN) across European Union (EU) countries (Finland, Sweden, and the United Kingdom) and Canadian provinces (Alberta, New Brunswick, and Prince Edward Island). ***Methods:*** A literature review including relevant peer reviewed articles from 2000 on, in conjunction, with critical debate was undertaken. The results were considered in relation to the three essential areas of PHN practice, outlined in the World Health Organization (*Moving on from Munich: A reference guide to the implementation of the declaration on nurses and midwives: A force for health*, 2001b) recommendations, family oriented care, public health action, and policy making. ***Results:*** The major challenge the review revealed across a variety of international education and practice environments was the lack of consistent preparation for and engagement with leadership and policy making in practice.

Key words: curricula, education, policy, public health nursing.

Background

From 2005 to 2008, a transatlantic exchange program took place involving nursing students from the three EU countries of Finland, Sweden, United Kingdom, and in the three Canadian provinces of Alberta, New Brunswick, and Prince Edward Island. Two aims of the project were to explore the academic preparation and subsequent role of the public health nurse (PHN) as the exchange students worked alongside public health nurses. During the project, it became clear that there was no uniformity of preparation or role for the PHN. The aim of this study is to critically examine the preparation and role of the PHN across three EU countries and three Canadian provinces. This study presents a comparison of the preparation and role of the PHN and then a review of research from the year 2000 focused on an analysis of practice roles and educational preparation in light of the recommendations from the World Health Organization (WHO) (2001b)11 years after the publication of this key policy.

In June 2000, the second WHO Ministerial Conference on Nursing and Midwifery held in Munich provided a starting point for strengthening the contribution of nurses and midwives to achieving the goal of "better health for all". The Munich Declaration which emerged from this conference, Nurses and Midwives: a Force for Health (WHO, 2001a,b) underlined that the nursing and midwifery workforce globally represent a priceless intellectual and practical capital asset for health and social care

systems, particularly in relation to policy development and implementation. The PHN has an unmatched knowledge of people's lives and the social determinants of their health. A need to make the best use of this asset is acknowledged in the published literature, however, there is a major challenge to achieving this due to the diversity of curricula and practice roles that public health nurses undertake globally (Chavasse, 1998; Petrakova & Sadana, 2007; Sadana, Mushtaque, Chowdhury, & Petrakova, 2007). This article defines policy "making" as legislative and executive processes in which nurses may play both direct and indirect roles. Policy development is seen as including leading, influencing, and lobbying for policy improvement or for policy change.

Methods

A literature review including published articles and policy documents from 2000 onwards, relevant to each of the countries under study, undertaken by the transatlantic project team. The databases searched included BNI, CINAHL, and MEDLINE. The search terms used were public health nursing, curricula, education, preparation, role, practice. The studies included were published in English, Swedish, and Finnish. The findings were then considered critically through each country/province team which undertook a narrative review of the relevant articles and then considered their findings in the light of the three areas of practice outlined by the World Health Organization (2001b) as essential for an effective public health nursing role, see below.

- Family oriented care—The focus is on meeting individual and family needs for care and treatment carried out with an awareness that comes from a careful assessment of the social and economic circumstances and overall living conditions of families.
- Public health action—This requires a wide range of social, political, and economic knowledge, as well as knowledge and skills in health protection and health promotion. Leadership and advocacy skills are also needed to be effective in community development and involvement work. For the purposes of this study, health protection is defined as (Health Protection Agency, 2009) "protecting people, preventing harm and preparing for threats", whereas health promotion is defined as "the process of enabling people to increase control over their health and its determinants, and thereby improve their health" (WHO, 2005).
- Policy making—The WHO recommendations (WHO, 2000) clearly state that nurses must have the ability to influence decision making and manage change. An understanding of politics as a social process and a capacity for strategic thinking is needed. Diplomatic, networking, and negotiating skills to work with many diverse groups are essential.

Each team mapped the PHN roles that existed in their country or province. The findings from this mapping exercise are presented in the table below. The results from this mapping integrated with current public health policy development within each country are then enlarged upon under the following headings, PHN preparation and role. The current issues and research on the preparation and role of PHN relevant for each country are then considered within the discussion section.

Results

The table shows an overview of different types of PHN role within each country, including qualifications, client group, place of work, and employer. This table helps to illuminate the scope of public health nursing internationally. The differences in preparation are apparent with Canada and Finland subsuming the PHN qualification within their initial nursing degree program and other countries requiring further specialist post registration study.

The results from the review for individual countries will now be presented under the headings of preparation and roles to further expand on the details presented in the Table.

Public health nursing in the EU—UK

Preparation. Historically, many different 'categories' of Specialist Community Public Health Nurses (SCPHN) have evolved in the United Kingdom, although all these different categories have been registered on what is commonly referred to as the 'third part' of the U.K. Nursing and Midwifery register (NMC) from 2004 (under the title of SCPHN). Each category has developed their own

distinct qualification client group and area of practice (see Table). Currently, in the United Kingdom, nurses are required to complete a specialist qualification post registration to practice as a SCPHN. Academic preparation for this role is either at graduate or post graduate level and the different categories share some common education with focused practical learning on their specific role within public health.

The role of the PHN in the United Kingdom. This division has meant that the role of nurses in this area may have evolved to provide health care services in a reactive way rather than focusing on local health needs and the reduction in inequalities. These nurses have been employed through health services and by individual general medical practitioners as well as by organizations outside state health services which has led to greater fragmentation and lack of overall focus over time. The role of the Health Visitor has been predominantly engaged with primary prevention of ill health with a particular focus on children (under 5) and families. Although across all categories of SCPHN knowing about your local population has not been a priority and capacity development in relation to public health skills including policy development and leadership has been limited (Butt, 2007; Lowe, 2007; McMurray & Cheater, 2003, 2004; Poulton, 2009).

The U.K. government has commissioned an extra 4,200 training places for health visitors by 2015 as part of their strategy to reduce inequalities in health and offer early intervention support to low income families (DOH 2011, Cowley, Caan, Dowling, & Weir, 2007). However, it is currently unclear what impact this may have on the effectiveness of their role in this area as will be discussed in more detail within the discussion section of this article.

Public health nursing in Sweden

Preparation. In Sweden, all nurses wanting to work in public health or District Nursing (DN), as it is known as, are required to graduate from a university or college with a bachelor degree in nursing followed by clinical experience as an Registered Nurse for 1–2 years. After that, these graduate nurses have to complete a specialist qualification at post graduate level, either post graduate diploma or masters degree to practice as a public health nurse.

The role of the PHN in Sweden. The PHN or DN can work in the community with children <6 years of age and their families, at schools as a school nurse and with adults and elderly (Table). Traditionally, these nurses work to a greater extent with programs specific to health promotion and illness prevention within a geographic area in Sweden. However, the work of the DN in the community has changed due to changes in the health care organization (Lindstrom, 2007) where the DN is no longer responsible for a geographic area. From working in their own surgery, now these nurses most often belong to a larger organization which employs other professionals at the health center (except for the school nurse). The latest national competency description for district nursing includes fields from caring, medical, public health, and behavioral sciences (Distriktssköterskeföreningen i Sverige, 2008).

Public health nursing in Finland

Preparation. Nursing education in Finland is a 4-year bachelor preregistration program and incorporates PHN registration.

The role of the PHN in Finland. The legislation in Finland necessitates municipalities and municipal boards for social welfare and health care for the provision of free or low-priced community services for their citizens. Consequently, the PHN is working with people over their whole life span from maternity to old age involving the whole family in the health promotion process. In the health centers, these nurses work as practice nurses or home health nurses with general medical practitioners, as maternity and child health nurses, as school nurses or student health nurses among students of higher and vocational education. The PHN may practice as an occupational health nurse as all Finnish employers must provide free occupational health services to their employees, often produced by the private sector.

Public health nursing in Canada

Preparation. Canada's federal, provincial, and territorial governments are responsible for the delivery and maintenance of public health care services to Canadian citizens living in urban, rural, or remote areas. Even though the public health system varies from one province or territory to another,

the public health service is delivered through regional health authorities (RHA), while each province or territory issues its own legislation and regulations defining the services provided by health professionals. The Canadian PHN is baccalaureate degree prepared and works with populations implementing health promotion programs in community health centers, street clinics, schools, youth centers, and through nurse-led services.

The role of the PHN in Canada. According to Battle Haugh and Mildon (2008), a public health nurse is "a community health nurse who synthesizes knowledge from public health sciences, nursing science and the social sciences, in order to promote, protect, and preserve the health of populations" (p. 43). A PHN according to the Canadian Community Health Nursing (CCHN) standards focuses on "promoting, protecting and preserving the health of populations by linking health and illness experiences of individuals, families and communities to population health promotion practice". These nurses recognize that the health of a community is closely linked with the health of its members and is often reflected first in individual and family health experiences (Community Health Nurses Association of Canada, 2008, p. 8). Currently, there are five categories of nurses working in community health (Table 1).

The primary focus of public health nursing in Canada is on populations and healthy communities, whereas the primary focus of home health nursing is on individuals and families. The role of the PHN includes visits to families and individuals in need of assistance with health-related problems; participating and cooperating with other divisions and government departments as well as voluntary agencies in health promotion activities in accordance with health education programs; disseminating health literature for public use; and implementing immunization programs.

Discussion

This article will now focus on each country and consider critically current policy issues and research focused on PHN preparation and practice roles.

Current government policy in the United Kingdom provides both challenges and opportunities for public health nursing (Butt, 2007; Nursing & Midwifery Council, UK, 2010), as policy change has provided the potential for nurses to practice independently and for their services to be commissioned for a specific geographical area focused on local health needs. This policy change has also opened up the potential for private providers to take over providing services previously provided by the National Health Service. Although overall this commissioning system is new, some pilot "practices" have been set up providing nursing services to particular localities (DOH 2011). However, it remains unclear at present how these changes will impact on the ability of nurses to influence policy and practice in response to local health needs.

The U.K. government has commissioned an extra 4,200 training places for health visitors by 2015 as part of their strategy to reduce inequalities in health and support low income families (DOH 2011). However, it is currently unclear what impact this may have on the effectiveness of their role in this area as a study in 2009 (Poulton) described a theory practice gap in public health nursing which suggests that these new students will not experience practice focused on local health needs, public health action, and policy making (WHO, 2001a) and that there is a lack of leadership to enable the role to change (Poulton, 2009). It has been recognized that there is a lack of academic development and debate focused on public health nursing in the United Kingdom (Hoskins 2009 & Poulton, 2009). 3
Indeed, in a recent study (Lindley et al. 2011), con- 4
sidering education challenges for public health nursing the three areas outlined by the WHO, family oriented care, public health action, and policy making are not mentioned at all and the importance of leadership skills is mentioned once briefly. In a review (Hoskins 2009) it was suggested that a radical rethink of the role of public health nurses and their ability to implement it was needed. The U.K. Public Health Association has advocated divorcing public health nursing from health services to enable it to leave behind its narrow medical role and focus on health needs and working with local communities.

In Sweden public health policy (SNIPH, 2005, 2010), health promotion and prevention of ill health are currently target areas to improve the health of Swedish populations. This provides an opportunity for public health nursing to move

TABLE 1. *Public Health Nursing, Title, Study (Qualifications), Client Group, Place of Work, and Employer by Country*

Title	Country	Visiting Nurse (Victorian order of nurses, VON)	District Nurse Home Health Nurse	UK: Health Visitor (family nurse Scotland), Canada: PHN. Sweden: District nurse/Child health nurse Finland: Maternity and Child Health Nurse	Health Protection Nurses	School Nurse	Occupational Health Nurse	Sexual Health Advisers
Study	United Kingdom			R.N.[b] + Specialist Practice Training	R.N. [a]may have further Specialist Training	R.N. [a]may have further Specialist Training	R.N. [a]may have further Specialist Training	R.N. [a]+ Specialist Training
	Sweden		R.N.[a] + Specialist Training in Public Health Nursing	R.N.[a] + Specialist Training in Pediatric Nursing or in Public Health Nursing		R.N. [a]+ Specialist Training in Pediatric Nursing or in Public Health Nursing		
	Finland		B.N. (R.N.)[ab]	B.N. (R.N.)[ab]	B.N. (R.N.)[ab]	B.N. (R.N.)[ab]	B.N. [a]+ Post Graduate Specialist Course	
	Canada	R.N.[b]		B.N.[a]	B.N. & Graduate Certificate or Master's Degree or Ph.D.		R.N. [b]& Certificate in Occupational Health Nursing or B.N.[a]	
Client group	United Kingdom			0–5 years other groups at their discretion	All ages	School age + attending school	Employees	Adults and Young People
	Sweden		All ages	Families with children 0–6 years, School children		School age/ attending school		

TABLE 1. *Continued*

	Finland		Elderly people needing home health	Pregnant families and families with children under school age 0–6	All ages	School age children 7–17 Students of higher or vocational education 17+	Work age population	
	Canada	All ages		All ages, but the focus is on child, adolescents, and family care	All ages		Employees	
Place of care/work	United Kingdom		Client's home/ G.P. [c]surgeries	Client's Homes/ G.P.[c] Surgeries or other Community Sites	G.P.[c] practices	School	At work	N.H.S./ Charities
	Sweden		District nurse Surgery, Child Health Center, Schools, Health Center, G.P. [c] surgeries, Client's Home	Child Health Center, Schools		Schools		
	Finland		Clients' Homes	Maternity and Child Health Clinics	G.P.[c] practices	Schools Students' Health Clinics	Occupational Health Clinics	
	Canada	VON clinics Homes Workplaces Home Care Agencies		Clinics, Schools, Universities, Homes, Workplaces, Hospitals	Physicians/ Family Practice Center, Community Center, Hospital, Nursing Homes/ Residential Care		Industries, Business, Schools, Universities	
Employer	United Kingdom			N.H.S.[d]	Health Protection Agency	N.H.S.[d]/ Private or State School	Company/ Institution employing nurse	N.H.S.[d]/ Charities

TABLE 1. *Continued*

Sweden		County Council, Municipality, Private Companies	County Council, Municipality, Private Companies		City Council/ Municipality, Private Schools	
Finland		Municipality/ Social and Health Center	Municipality/ Social and Health Center	Municipality/ Social and Health Center	Municipality/ Social and Health Center	Private Company/ Occupational Health Clinics
Canada	Regional Health Authority, Industries, Private Nursing Agency, Individual Client		Regional Health Authority, under the Health Department	Regional Health Authorities, Physicians Clinics, Community Health Center, Nursing Homes, Self-Employed		Industries, Business, Universities, Government

Note. Blank boxes indicate this role does not exist in this country or is not classified as a public health role.
[a]B.N. stands for Bachelor in Nursing. [b]R.N. for Registered Nurse. [c]G.P. for General Medical Practitioner. [d]N.H.S. for National Health Service.

beyond basic approaches which focused on individual behavior change toward a broader community health endeavor through partnerships with other disciplines as well as the recipients of health programs. This activity currently takes place in family centers where staff from a variety of disciplines work together with families, preschool teachers, social workers, midwives, and the district nurse (PHN) working within child health care, other professions may include psychologists or family therapists. While, the national guidelines from the National Board of Health and Welfare (2011) focus on individual behavior change, they also mention that the prevention of high-risk health behavior is a crucial goal for everyone in society.

Public health roles in Sweden are now based within local authorities (The Public Health Policy Report, SNIPH, 2010). The county councils and regions can primarily contribute to future public health by developing health promoting public policy. Obstacles to this are short-term budgetary plans and organizational structures that do not promote cooperation or collaboration. The National Board of Health and Welfare (2011) has recently introduced national guidelines for disease prevention to help support individuals to change their health behavior. The focus is on tobacco use, alcohol consumption, inadequate physical activity, and unhealthy eating. The earlier role of the district nurse (PHN) is now being further challenged by rapid organizational change toward more privatization in the health sector. It is not yet clear if the private sector is likely to promote health in a community or geographical setting and/or advocate equality of health for all citizens. Both of which aims should be a key part of the role of the PHN as outlined by the WHO recommendations.

The role of the Finnish PHN has changed over the past 30 years. In 1950–1980 the role required more independent practice and home visits particularly in remote areas of Finland (Oinas, Nikkonen, & Pietilä, 1999). Since then the number has decreased and clinics in several fields of health care have taken the place of home visits. The role of public health nurses is viewed as important in the early identification of health and social problems for diverse client groups.

Recent studies of the role of the PHN in Finland report a lack of sensitivity and skills in recognizing complex physical and psychosocial problems in the population. Pirskanen (2007) points toward the need for developing public health nurses' early identification and leading intervention skills for substance abuse by school-age children and students. Sirviö's (2006) research revealed the need for more client centered interaction among public health nurses. In her study, the contact between the nurse and families with children was dominated by professional-centered actions and the interaction was neither strengthening the participatory role of the families nor involving them. Also discussions on family health were based on a traditional problem or disease centered approach and not a family centered approach or one which considers the social dimensions of health and partnership working. Peltonen (2009) suggested a potentially more effective model for municipal social and health centers which would facilitate the collaboration between community and specialized hospital service sectors and improve client participation. Peltonen (2009) proposed that public health nurses would practice in social and health centers either in general medical practitioner partnerships or in a team, would have independent nurse-led clinics, would write prescriptions, and would have good decision making, leadership, and policy development skills.

The National Development Plan for Social Welfare and Health Care in Finland (KASTE Programme, 2012–2015) is a strategic policy to reform social and health care practice. The key targets of the program are to reduce inequalities in health and well-being and to increase client involvement in service structure and provision. The targets will be met through six subprograms where the PHN is seen as a potential leader of effective policy development, these include inclusion, well-being, and health for high-risk groups; effective services for children and families; improved services for older people; a new and more effective primary service structure; and improved information and data systems. It is not yet clear how effectively nurses will engage with their potential as leaders within these developments in social and health care practice.

According to Stanhope, Lancaster, Jessup-Falcioni, and Viverais-Dresler (2008), the PHN in Canada should be distinguished by their emphasis on populations living in the community and the delivery of public health programs and services with the broader goal of improving the whole population's health. This is known as thinking upstream

where the immediate needs of individual clients or families are met as well as addressing the broader socioenvironmental determinants of health and root causes of health issues in individuals, families, and communities (Cohen, 2008). A study published in 2005 focused on whether PHNs in Canada were "thinking upstream" and using or leading a multidisciplinary approach focused on social justice and participation. The conclusion was that the biomedical approach still dominated practice and an approach focused on influencing policy and participation was not used consistently. In 2008, the Public Health Agency of Canada published core competencies which represent the essential knowledge, skills, and attitudes necessary for public health practice in Canada which include population health assessment, surveillance, disease and injury prevention, health promotion, and health protection. They are organized under seven categories: public health sciences, assessment and analysis, policy and program planning, implementation and evaluation, partnerships, collaboration, and advocacy. All professionals working in the public health arena must integrate those competencies in their practice. This newly remodeled health care system requires investment in terms of continuous professional development for current staff in order for the role of the PHN to be developed to contribute to policy development (Cohen, 2008). Over the past 10 years, the potential role of the PHN has changed, with the policy intention being that the PHN becomes a leader of partnerships, collaboration, and advocacy; however, this change has not been reported in studies to date (Cohen & Reutter, 2007; Falk-Rafael, Fox, & Bewick, 2005; Schofield et al., 2011). A further challenge for the public health system in Canada and globally is the shortage of nurses in rural communities to develop and lead public health initiatives (Schofield et al., 2011).

In relation to the three areas outlined by the WHO (2001b), it would appear that policy making and influencing is the one that public health nurses across these different countries appear to be the least likely to be prepared for and lead in practice. The WHO (2001b) recommendations mentioned that nurses must acquire the ability to influence decision making and manage change. An understanding of politics as a social process and a capacity for strategic thinking will be needed. Diplomatic, networking, and negotiating skills to work with many diverse groups will be essential. It appears that since these recommendations in 2001, these developments in preparation and practice may not have occurred. It is also apparent that the policy direction within the countries included in this review support the development of the PHN as a leader in policy and practice development within communities and across agencies and services.

Nursing authors have suggested that nurses do not hold power within a health care context in many instances (Christensen & Hewitt-Taylor, 2006; Falk-Rafael et al., 2005), and that this would suggest that if nurses are to achieve a change in power and status they must be prepared to take leadership roles in local areas and engage in political debate, seeking to change their public and political status. Villeneuve (2008) viewed this process as having the potential to occur at both the micro and macro levels. At the micro level nurses may offer leadership and influence policy with individuals or communities, however, Villeneuve (2008) argued that this micro level process cannot occur without macro level engagement of nurses as the largest work force for health globally. This process of engagement and development of skills for nursing students and those in the work force is essential to enable nurses to influence the planning and provision of health promotion and health care and to influence the social determinants of health in their local community. The public health nursing workforce is a critical contributor to primary health care reforms as mentioned in the WHO Report (Primary Health Care Now, 2008). Significant investment in change is needed, however, to empower staff to become team players combining biomedical and social perspectives toward the process of reform. The report emphasizes that: "Without investing in their (nurses) mobilization, they can be an enormous source of resistance to change, anchored to past models that are convenient, reassuring, profitable and intellectually comfortable" (WHO, 2008b, p. 110).

The policy developments occurring across different countries discussed here provide an opportunity to work differently to influence policy and practice. These international policy priorities give nurses the opportunity to lead practice with populations in geographical locations/settings (such as local areas, schools, or work places). It would appear that across governments there is an active

move to enable poorer areas (where there have been problems in attracting primary care practitioners) to be better served by new market entrants in new and innovative ways. Public health nurses can potentially be part of, or lead these developments as independent practitioners commissioned to provide health care services in localities working to overcome health-related disparities, which may otherwise be lost as a priority within these policy changes.

Implications for nursing preparation and practice

This study would suggest that if all public health nursing curricula engaged with the WHO three key areas of practice (family oriented care, public health action, and policy making with a particular focus on inequalities in health), then this would start to ensure that nurses going into practice globally have these as key areas on which to focus their practice. In addition, if the area of leadership and policy making/influencing was assessed in practice, it may become more of a focus for both students and practitioners. The opportunity to exert influence at work and in social and political settings is dependent on education and professional standing. The European office of the WHO (2001a,b) acknowledges that in many countries currently government ministers consult physicians' associations regularly and nursing associations only in periods of crisis. They acknowledge that consensus building on policy issues and lifting morale in the health sector would be much better served if all professions enjoyed ministerial confidence. However, if this is to happen, nurses need to understand political processes and political and business language as well as how to "influence" others effectively. A key part of preparation for this area of practice should occur within education and training programs. Public health nursing students need to be exposed to role models who are effectively involved in policy making at all levels. Indeed, the WHO (2001b) calls for nurses and nurse educators to disengage from what is familiar and habitual; give up the protection of institutions and clinics and their structures of routines and management hierarchies for more autonomous and self-directed roles, particularly in primary care. In future, it would seem if nurses want to create better health for all, they must learn to engage with policy makers and strategists, and to act as advocates to enable the involvement and engagement of the local people whose health they are trying to improve.

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During the copy-editing of your paper, the following queries arose. Please respond to these by marking up your proofs with the necessary changes/additions. Please write your answers on the query sheet if there is insufficient space on the page proofs. Please write clearly and follow the conventions shown on the attached corrections sheet. If returning the proof by fax do not write too close to the paper's edge. Please remember that illegible mark-ups may delay publication.
Many thanks for your assistance.

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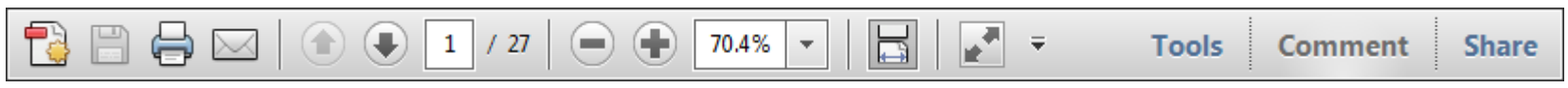
WILEY-BLACKWELL

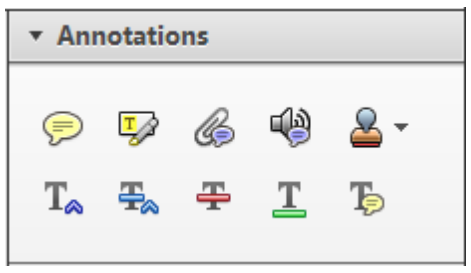
USING e-ANNOTATION TOOLS FOR ELECTRONIC PROOF CORRECTION

Required software to e-Annotate PDFs: Adobe Acrobat Professional or Adobe Reader (version 7.0 or above). (Note that this document uses screenshots from Adobe Reader X)
The latest version of Acrobat Reader can be downloaded for free at: http://get.adobe.com/uk/reader/

Once you have Acrobat Reader open on your computer, click on the Comment tab at the right of the toolbar:



This will open up a panel down the right side of the document. The majority of tools you will use for annotating your proof will be in the Annotations section, pictured opposite. We've picked out some of these tools below:

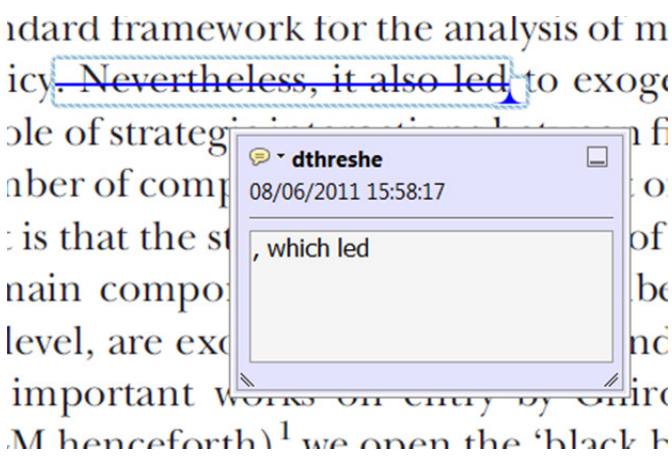


1. Replace (Ins) Tool – for replacing text.

Strikes a line through text and opens up a text box where replacement text can be entered.

How to use it

- Highlight a word or sentence.
- Click on the Replace (Ins) icon in the Annotations section.
- Type the replacement text into the blue box that appears.

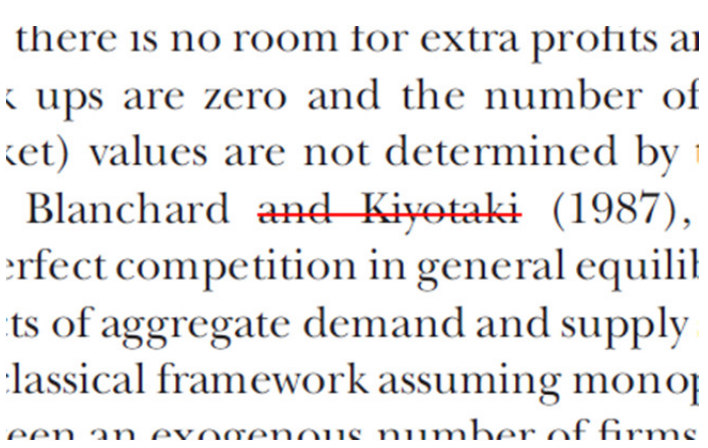


2. Strikethrough (Del) Tool – for deleting text.

Strikes a red line through text that is to be deleted.

How to use it

- Highlight a word or sentence.
- Click on the Strikethrough (Del) icon in the Annotations section.

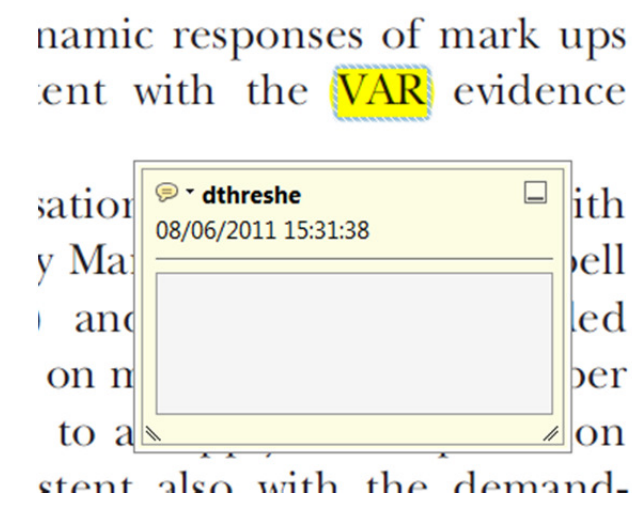


3. Add note to text Tool – for highlighting a section to be changed to bold or italic.

Highlights text in yellow and opens up a text box where comments can be entered.

How to use it

- Highlight the relevant section of text.
- Click on the Add note to text icon in the Annotations section.
- Type instruction on what should be changed regarding the text into the yellow box that appears.

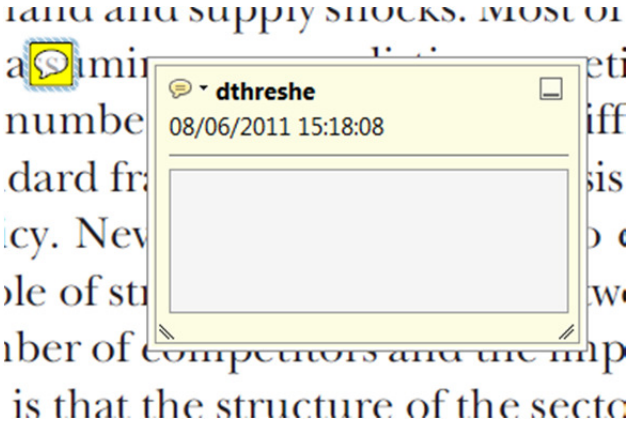


4. Add sticky note Tool – for making notes at specific points in the text.

Marks a point in the proof where a comment needs to be highlighted.

How to use it

- Click on the Add sticky note icon in the Annotations section.
- Click at the point in the proof where the comment should be inserted.
- Type the comment into the yellow box that appears.



WILEY-BLACKWELL

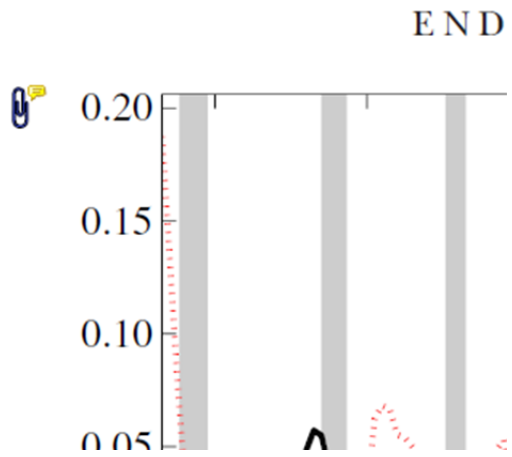
USING e-ANNOTATION TOOLS FOR ELECTRONIC PROOF CORRECTION

5. Attach File Tool – for inserting large amounts of text or replacement figures.

Inserts an icon linking to the attached file in the appropriate pace in the text.

How to use it

- Click on the Attach File icon in the Annotations section.
- Click on the proof to where you'd like the attached file to be linked.
- Select the file to be attached from your computer or network.
- Select the colour and type of icon that will appear in the proof. Click OK.

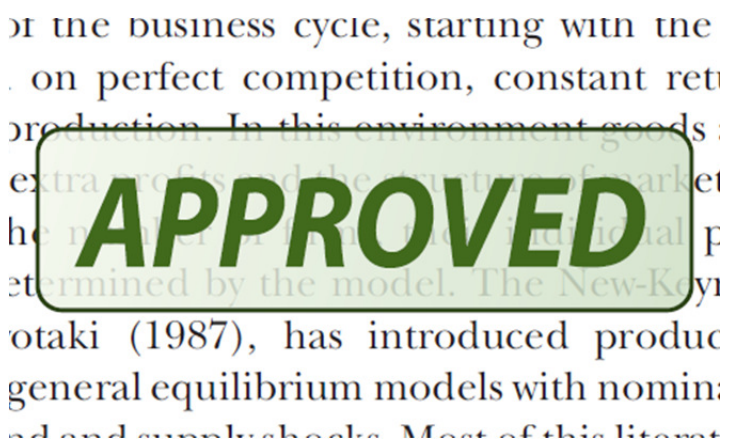


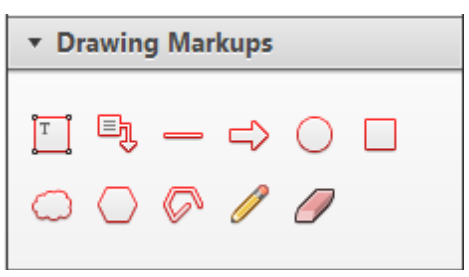
6. Add stamp Tool – for approving a proof if no corrections are required.

Inserts a selected stamp onto an appropriate place in the proof.

How to use it

- Click on the Add stamp icon in the Annotations section.
- Select the stamp you want to use. (The Approved stamp is usually available directly in the menu that appears).
- Click on the proof where you'd like the stamp to appear. (Where a proof is to be approved as it is, this would normally be on the first page).



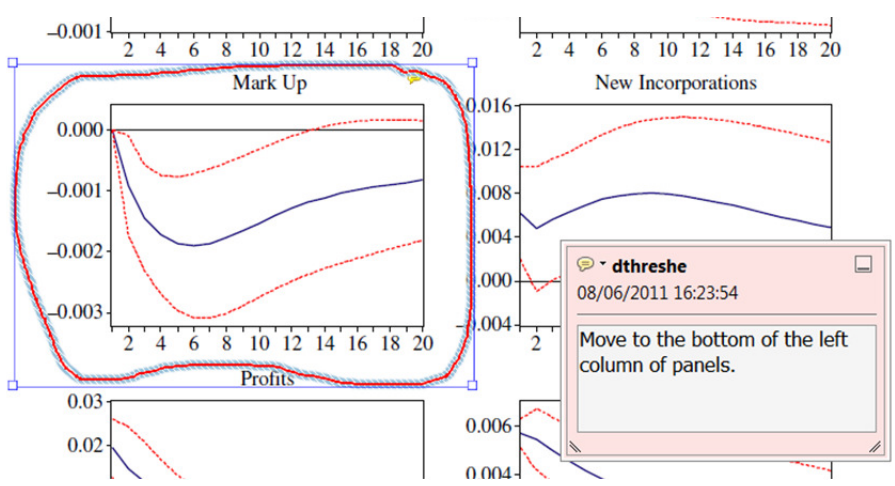


7. Drawing Markups Tools – for drawing shapes, lines and freeform annotations on proofs and commenting on these marks.

Allows shapes, lines and freeform annotations to be drawn on proofs and for comment to be made on these marks..

How to use it

- Click on one of the shapes in the Drawing Markups section.
- Click on the proof at the relevant point and draw the selected shape with the cursor.
- To add a comment to the drawn shape, move the cursor over the shape until an arrowhead appears.
- Double click on the shape and type any text in the red box that appears.



For further information on how to annotate proofs, click on the Help menu to reveal a list of further options: