PUBLIC HEALTH NURSING IN RURAL AREAS: A BROAD PERSPECTIVE

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Every nurse contributes to the public health in some way, either by example or precept. The public health nurse, however, is especially trained for this type of activity and devotes full time to it. She is better known in many urban and rural areas as the "visiting" nurse.

Public health nurses are to be found in every climate and in every region—in the valleys and in the mountains, in the arctic and in the tropics—walking, bicycling, riding horseback or muleback, paddling canoes up tropical rivers, riding planes into the "bush" country, dog-sledding across frozen wastes, driving an automobile on a well-paved highway, or just working in a public school or clinic. Notwithstanding the fact that she seems to be everywhere, there are still large expanses of territory where a public health nurse has never been seen.

There has been much talk about the serious shortage of nurses in the United States, but many people do not know that one-half the nurse population of the world is to be found in that country. Nevertheless, there are regions in the United States where public health nurses are scarce or not known, and health conditions are deplorable. Under the circumstances, how well off can other countries be? The following are the approximate nurse-population ratios of several countries:

United States of America	1 for	270	people
Canada	1 "	330	"
Sweden	1 "	580	"
Ceylon	1 "	6,500	"
Haiti	1 "	10,500	"
Brazil	1 "	25,000	"
India	1 "	45,000	"

These figures include all graduate registered nurses, both active and inactive.*

How important are public health nurses to rural areas and what do they do? Public health nurses are so important to rural areas that without them large sections of the population would probably receive no hygenic advice of any kind. Many communicable disease cases would never be discovered, mother and child care would be neglected, advice on sanitation, adequate nutrition, care of the sick, prevention of mental

* The ratios were determined from figures secured from "1949 Facts About Nursing," published by the American Nurses' Association, 1790 Broadway, New York.

as well as physical disease, correction of defects, etc., would be unavailable.

When one mentions public health nursing *in rural areas*, the impression of unattractive, poverty-stricken, isolated regions may be gathered. This is not altogether true. While some rural regions are isolated, they are far from unattractive. While some regions are unattractive, they are far from isolated. Then again, they may be both. On the other hand, there are many attractive, populated areas that are considered rural. For example, there is an island populated with the estates of wealthly people and their retinues. While the wealthy themselves may never see a public health nurse except in the case of a reportable disease, the children in the public schools and the household entourage will, for they have health problems and need advice. The tradesmen in these regions have families who need advice also. It is evident, therefore, that at one extreme of rural nursing lies the attractive, fairly well populated area and at the other end the poor, unattractive and isolated region.

Programs Based on Social Needs and Available Resources

Looking over the entire area of rural public health nursing, the whole subject might be presented more comprehensively from the point of view of four levels or stages of public health development based on social needs and available resources:

1.—The highly progressive area where all needs, both physical and mental, are being met by official and non-official agencies.
2.—The less highly progressive area where most physical needs are being met by official and non-official agencies.
3.—The mildly progressive area where critical needs only are being met either by official or non-official agencies (rarely by both).
4.—The unprogressive area where public health activities are virtually unknown and where federal governments, and perhaps, international or missionary organizations, recruit teams for the purpose of initiating programs in basic sanitation, vaccination, mother and child care, etc.

A word on official and non-official agencies may be in order. Official agencies are government agencies organized on local, county, state or federal levels. They may have generalized or specialized programs (usually generalized in rural areas), and are concerned with all problems bearing on the public health. They work closely with all tax-supported institutions and with voluntary agencies.

Non-official agencies are those supported by voluntary contributions, insurance funds, or by large industrial enterprises. They usually supplement or complement the work of official agencies where both are in the same field. Both employ public health nurses, the voluntary agency generally carrying a large program which provides for bedside care in the home.

Nursing in Well Developed Areas

The well developed area is also a highly progressive one and as the term would indicate, has well-organized health services with administrative and professional functions clearly defined, a complete staff of well-qualified persons to meet all needs, and community resources sufficient for all purposes. The area may comprise a small or large section of a political unit of a state, or the entire unit depending on its size. The families in this area are probably well-to-do professional and business men with country estates, alert to their physical needs, and able to pay for medical service and advice. The responsibilities of the nurse are well-defined. She rarely must use her initiative in meeting problems, since her work is carefully outlined for her. The duties of the nurse from the official agency are chiefly in the field of health education (particularly mental health). They may concern: the problem child, education of the exceptional child, or rehabilitation of the handicapped. She may assist with research and investigation in poliomyelitis, cancer, heart disease, or other conditions. The nurse from the voluntary agency complements this work with bedside care in the home when needed. Both have ample opportunity to further their knowledge in new fields, such as atomic medicine and bacteriological warfare. The nurse-population ratio in this section may be 1–2,500 or 1–4,000 depending on the area to be covered and its density. Automobile transportation is generally provided, the geographical area offers no barriers, and the salary compares favorably with that of women in other professions.

Nursing in the Less Well-Developed Areas

In these areas the organizational structures of health services may follow the recommended patterns, with administrative and professional functions defined, but because of economic and other reasons, such as insufficient community resources to meet the needs of the population, it may be impossible to develop the program to its fullest extent. As in the first case, the area may comprise a small political unit, or a section of it, populated with well-to-do farmers. These people work hard and long on the land and do not have much time to consider other than acute physical needs, the cost of which they can perhaps readily defray. While the responsibilities of the nurse in this set-up are defined, she must at times use her own initiative in meeting unexpected situations. For example, in the absence of a physician to make a diagnosis, she may find it necessary to give diphtheria anti-toxin to a child, who in her opinion presents strong evidence of being acutely ill with the disease. (Of course precedence has usually been established in what is known as the "standing order".) The duties of the nurse from the official agency are chiefly in the field of education, although she may be called upon occasionally for home care. She will spread the gospel of frequent medical and dental examination, immunization, and take an active part in edu-

cating families to the correction of physical defects in children not only for physical improvement but as a mental hygiene measure. The latter is probably one of her most important problems, for buck teeth, crossed eyes, club feet, severe acne, etc., may lead to serious maladjustments in later life. Community resources are taxed to a greater extent as farmers are often unable or unwilling to pay for the correction of handicaps. Here the nurse must use a great deal of tact and ingenuity in stimulating parents to action. She may assist also in school health programs with research investigation in polio, cancer, heart disease, and perhaps Rocky Mountain spotted fever. Here, too, the nurse from the voluntary agency will complement this work with bedside care in the home when needed. Both nurses often have the opportunity to further their knowledge in the newer fields.

This nurse generally has automobile transportation provided to her and while her territory probably covers a large area because of the distances between farms, there are no unusual geographical problems and the population served by one nurse may be 1–2,500 or 1–5,000. Her salary compares favorably with the nurse in the first category and she is just as well prepared.

Areas Where Health Problems Are Acute

It is in the last two categories that public health nurses face their most difficult problems. Only nurses with a pioneering spirit and an unswerving faith in mankind, can be recruited to face them, and only those who can face these problems as a challenge to their ingenuity and resourcefulness should seek posts in these areas. Moreover, there is often little financial remuneration and even less recognition, but they will be repaid in personal satisfaction.

Nursing Where Only Critical Needs Can Be Met

In the less progressive areas in any country, organization for public health activities, as is to be suspected, follows the general pattern of slow development in other fields. However, there are probably some provisions for basic sanitation, which include some method of water supply and for the disposal of excreta. The workers might be tenant farmers, share croppers, migratory workers, ranch hands, miners, fishermen and others, often illiterate and ignorant. In this group, superstitions, religious beliefs and social customs play an important role, and the nurse must keep these constantly in mind in her approach to the problems. The area may be flat or mountainous, easy, or difficult of access because of poor roads or no roads at all. Transportation for the nurse may be provided or can be had by special arrangement. The bicycle, the horse, the mule, the automobile, the jeep, or just walking will help her to reach her destination.

There may be a full or part-time health officer in charge in the province,

county or state, but the public health nurse may be the only person working full-time in the region assigned to her, which means that she must survey the situation carefully and proceed cautiously. She will need statistics on morbidity and mortality for the district in order to determine what the critical needs are. She will frequent places where groups are apt to meet, such as churches, market places, and local fairs, for the opportunity to appraise visually the state of health of the population. She will talk to clergymen, school teachers, the local constabulary and others for further orientation. If the greatest need is for smallpox vaccination, she will start with that. Tuberculosis and venereal disease may be acute, but she may need to recruit assistance to handle these problems. No doubt the infant and maternal mortality rates are high, and that may be her next program. Many times an appeal for the care of the infant will set the foundation for teaching basic sanitation, personal hygiene and the prevention of communicable disease. Her job, as can be seen, will be a big one, and she should not attempt to cover a large area without assistance, especially if the terrain is difficult. She can train auxiliaries to work with her to take over some of the simpler duties and teach untrained midwives the fundamentals of good midwifery.

Of course this is the way she will *proceed to plan* her program, but there will be many setbacks. Once she has gained the confidence of the people, the sick may call upon her for spiritual consolation and guidance, as well as for physical care. She may have to devote a good deal of time to teaching families to look after their own sick, if she is to have sufficient time for other duties. One of the nurse's biggest problems may be to get patients requiring surgery, those acutely ill with tuberculosis, and the obviously psychopathic, into hospitals or state institutions. In teaching care for the sick in the home, this nurse must be extremely resourceful when there is no money with which to buy much needed equipment. If she has had a good course in public health nursing, she will have learned a good deal about improvisation with chairs, ironing boards, crates, boxes, newspapers and the like, although very often in individual situations she will have to tax her ingenuity to its utmost.

Because of the pressure of her work, the most she can contribute to research will be the statistical records which she keeps. Recognizing the magnitude of her problems, she may wish to pursue advanced study, but more likely she will not have the courage to leave her job, particularly if she cannot be replaced.

Nursing Where Public Health Activities Are Unknown

Because of the absence of organizations of any type, care in unprogressive areas can be supplied only by federal governments, or international or missionary organizations in an economic position to recruit

teams for the purpose of initiating programs in basic sanitation, vaccination, mother and child care, etc. These areas are frequently remote and inaccessible, at least in certain seasons, although this is not always true. The deplorable sanitary conditions found are almost always due to the extreme poverty of the people, ignorance, lack of technically trained personnel, and the social barriers of one type or another which contribute to the isolation of the region. The inhabitants may eke out a precarious living from the soil. Economically, such regions cannot hope to improve their standard of living, chiefly because of the absence or lack of development of natural resources, and the low productivity of the soil in inverse proportion to the number of people to be fed. One or more families (and several domestic animals) may live in a one-room hut or shack. As can be expected, parasitic infestation is high, communicable disease rampant, malnutrition severe, and infant and maternal mortality rates shocking. In addition, climatic conditions may be rigorous, and educational opportunities non-existent. Superstition plays such an intimate part in the daily lives and cultures of the people that our own precepts of sanitation are often in distinct contradiction to their beliefs. For a long time missionary organizations have worked with many of these backward peoples, and more recently, official agencies have planned world-wide programs of basic assistance to underdeveloped areas.

Where such conditions prevail, the public health nurse usually enters as part of a team consisting of a physician, sanitarian, and possibly an epidemiologist and social worker. In some cases she may train a corps of "auxiliary nurses" to assist her. The latter are young women recruited from the district to be served, who are given a six to eight months' course in the basic essentials of vaccination, domestic sanitation, personal hygiene, infant care and the fundamentals of good nutrition. Frequently, they are taught elementary care of the sick in the home, since there are no community resources for hospitalization. The auxiliary nurse may either return to her own district to live and practice, or work out of the health center which has been set up in a strategic section, and travel to the "interior" at frequent intervals. The public health nurse supervises her work and makes routine "check" visits.

Other nurses are not so fortunate as to have an auxiliary service and must carry most of the nursing load themselves. The basic essentials of sanitation such as the boiling of water and milk, the disposal of excreta, refuse and garbage, ridding the body of parasites and the necessity for frequent bathing and washing of clothing, are only a few of the lessons to be taught. Some problems are not easily solved. The nurse knows that she must teach something of the elements of good nutrition, but more often than not, basic foods are not available in any form. A baby must have milk, if the mother is unable to nurse it, and so must all small

children and ailing individuals. Where milk can be secured, is frequently a hopeless question. Some nurses have evolved formulas for making soya or peanut milk which is satisfactory from a nutritional point of view (1). Kitchen gardens have been encouraged, but the lack of protein foods (especially those of animal origin) is a problem of no small magnitude, even for large world organizations.

These forgotten people must be taught the essentials of the transmission of communicable disease, and the need for cooperation in vaccination programs. The ubiquitous untrained midwife requires basic instruction, and very often the nurse will be acting as midwife herself.

The public health nurse will have to care for and give instruction in critical illness. Isolation of acute communicable disease cases, and segregation of the obviously leprous or tuberculous are no small tasks. To say that she will have to rely on her ingenuity and resourcefulness to meet these needs is an understatement.

The excerpts which follow will serve to illustrate the types of problems which nurses have had to confront and how some of them have been met.

A public health nurse in refugee Pakistan describes her isolation unit:

"The 'Khanewal Refugee Isolation Hospital'—an elegant name for the servants' quarters of a once-grand house occupied by five hundred refugees—had mud walls, mud floors and a mud roof supported by inadequate wooden beams. It had no window glass—iron bars were set at six-inch intervals across the window frames—no lights and no latrine except a fenced off corner of the compound. The liquid excreta drained into the sand at a safe distance from the well and the solid portion was swept into a basket (by a sweeper) and buried in the desert sand, which stretched away into the distance outside the door.

"The beds were low wooden-framed, rope-strung charpoys; the only bedding available was native cotton quilts and army blankets from America. There were no sheets, no cloth, no rubber sheeting; drugs were limited in variety, penicillin was especially scarce, but the sulfa drugs sufficient. DDT spray was used on walls and bedding to reduce the fly population.

"Only twenty-five patients with smallpox came under my care. The oldest was 18 years of age. The deaths, caused chiefly by secondary infection of the pustules, occurred in the twelve to eighteen month age group; the death rate was 8% . . . .

". . . . Isolation of an infected patient from the healthy members of the family is not only a violation of social custom in this part of the world, where smallpox is regarded by certain groups as a sign of approval from God, but represents a threat to the already precarious emotional balance of refugees. It is understandable in the light of their recent experiences that families refuse to be separated, and when ignorance of the dangers of a communicable disease is added, it is surprising that it was possible to allow only one member of the family to be admitted with each patient. The relative was inoculated at once,

if he had not had smallpox, and then was not permitted to leave the walled enclosures around the hospital rooms until the patient was discharged . . . ." (2).

From a nurse in China we hear:

". . . . As the civil war closed in on us in 1947, the hospital—with patients, staff, and equipment—moved farther and farther back into the hills. At last, after we had crossed the Yellow River, we came to rest on a hillside . . . . There in a series of caves hollowed out of the hill's face, we set up our hospital.

"One hundred and sixty-four patients were put to bed in these primitive dwellings which the villagers had vacated to make room for us. In each cave we found a "kang," a smooth waist-high platform built of stones, wood, and clay . . . .

"When we took over the caves the kangs became hospital beds; on them, two to six patients were placed, depending on their size. Each kang was covered with a woven mat made of the rushes that grew in the valley . . . . A sack filled with seed, a bundle of clothing tied firmly together, or a brick, served as a pillow . . . ." (3).

The following is from a nurse in India:

"Nurses, I learned, are even more scarce than doctors in this land where cholera strikes swiftly, where malaria is universal and deadly, where beriberi and scurvy follow in the wake of habitual undernourishment and recurring famines. Moreover, in India public health and sanitation measures, such as we know . . . . are unheard of even in most urban centers, to say nothing of the swarming villages where 85 percent of India's people live. It was only later, when I visited these rural areas, that I began to appreciate the courage of the young women who decide to train for a nursing career in India.

"Nurses get involved in all sorts of tasks. They are almost sure to be called upon for midwifery. It is all in a day's work to deliver a baby with the mother lying on the earthen floor of a windowless mud hut, without benefit of any sterile equipment or supplies except what the nurse is carrying in her kit.

"Before she completes her visit to the village where she has acted as midwife, she may be advising the head men of the community that they must board up their well to prevent unsanitary ground drainage and that they may have the water tested to be sure it is fit for people to drink. Or she may be showing the women how to plant a kitchen garden to provide the variety of foods their children need to keep healthy; or explaining the advantages of having cattle housed in a building separate from the family dwelling. She may try to persuade a victim of leprosy to submit to voluntary segregation at night for the protection of his family; or to suggest to parents afflicted with leprosy that they send their as-yet-unafflicted children to an institution where they will not be in constant danger of contracting the disease and where they may be under observation for early symptoms . . . ." (4).

A nurse in Bolivia solved a problem in this fashion:

"This particular baby had the bad judgment to arrive in his cold, high altitude home two months too soon . . . ." The two nurses went to the infant's

home and set up their incubator. It was just a box from the grocery store in which the baby was placed, surrounded by hot water in bottles. They swaddled the baby in cotton and, using a medicine-dropper, they began to feed him mother's milk fortified with vitamins. They taught the father and the grandmother how to feed him, how to manage the incubator, and how to follow a carefully planned, 24-hour schedule .... She returned to the baby's home again and again to take care of him and to help the father and the grandmother. And the child lived!...

"In the small homes in the back streets of Cochabamba, the kitchen is frequently a pot over a fire outside the door, with perhaps a tarpaulin rigged up as a roof. The woman of the house wears her traditional hat as she kneels on the ground to poke the fire or to stir the beans in the pot...." (5).

And this last letter from a nurse in Formosa who returned to her country after taking advanced public health work in the U. S.:

"The hospital has half a century's history in an old tradition which allowed to nurses only an inferior functional position. I found a mere 40 nurses and 120 attendants serving over 300 doctors, 500 in-patients, and daily clinics of 6–800 out-patients. Nurses were the immobile property of the various departments and were very unequally distributed. To transfer or rotate them was possible only with the permission of the department chiefs. Nurses on night call were not in actual attendance but had to be called from their bedrooms in the wards by the patients or their relatives when needed. The number of patients' relatives in the wards at all times considerably exceeded the number of patients, and they did their cooking there as well, on small charcoal stoves. The relatives included children of all ages, and the cooking of course necessitated the keeping of live chickens and ducks in the wards....

"The cleaning of the wards, the introduction of strictly observed visiting hours, the assignment of nurses for day and night duty, the use of sterile gloves in operating, the elevation of patient's beds to standard height, and many similar innovations amounted to an Americanization of the hospital which was unwelcome in quite some quarters. After eight months of persistent effort most of the resistance has been overcome. The hospital now employs 6 highly qualified supervisors, 20 competent head nurses, 110 regular nurses, and 110 attendants. The nurses are rotated in shifts and assigned for duty by a newly established Nursing Department. The Department has set up a Central Supply Room and manages housekeeping which has resulted in considerable economy to the hospital. It has taken over and completely reformed the diet kitchen and will soon take charge of the Admission Office and the hospital laundry...." (6).

These stories can be readily multiplied and many more details can be added. However, they should suffice to show that the problem of adequate nursing for millions is acute. So is the problem of adequate hygiene, adequate medical care, adequate hospitalization, adequate nutrition, adequate social and psychological guidance. Yet the picture is

not all black. Definite progress has been made, and it is hoped that soon the world-wide movement to improve the living standards of underdeveloped areas will become a reality. Such programs should contribute immeasurably to the health and welfare of millions of unfortunate people.

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ENFERMERÍA SANITARIA RURAL (*Sumario*)

Las enfermeras de salud pública que realizan labores específicas y valiosas en las zonas urbanas, se hacen aún más necesarias en las regiones rurales que por localización, falta de medios o de interés de la población, reciben una limitada asistencia médica o ninguna.

En las regiones rurales es, seguramente, donde la enfermera de salud pública debe usar todos sus recursos personales y profesionales porque su tarea allí es múltiple y concreta y comprende además de otras actividades: el reconocimiento de enfermedades infecciosas que no habrían sido conocidas sin su presencia en el lugar, dar adecuada atención materno-infantil, dar consejos e instrucciones sobre saneamiento, enseñar las condiciones o requisitos que exige una alimentación adecuada, cuidar de los enfermos, prevenir afecciones físicas y mentales, buscar los medios de corregir defectos y evitar futuras inadaptaciones de los miembros de sus familias, preparar personal auxiliar, etc.

Los programas de enfermería de salud pública de las zonas rurales deben basarse en primer término en: las necesidades sociales y los recursos de que dispone la región. Esto significa que es necesario conocer previamente el terreno en el que se desarrollará el programa. El programa en conjunto será más comprensivo si se analiza desde los cuatro niveles o estados en que se desarrollan los programas de salud pública rural, a saber:

1.—Las zonas o regiones altamente progresistas donde todas las necesidades de salud, físicas y mentales, están bajo control de organismos estatales y privados.

2.—Las zonas menos progresistas donde las necesidades físicas son atendidas por organismos estatales y privados.
3.—Las zonas poco progresistas donde las necesidades urgentes de salud son realizadas por organismos estatales o privados (rara vez por ambos a la vez).
4.—Las regiones no progresistas donde las actividades de salud pública son prácticamente desconocidas y donde el gobierno federal, y tal vez, organizaciones internacionales o misiones religiosas contratan equipos técnicos con el propósito de iniciar programas de saneamiento básico, inmunizaciones, atención materno-infantil, etc.

Las funciones de la enfermera de salud pública que trabaja en cualquiera de estos programas son completamente distintas en cada situación.

1.—En las regiones rurales progresistas sus funciones están claramente definidas y planeadas y tiene siempre la cooperación de un equipo eficiente, además, de la ventaja de una población consciente y alerta a las necesidades de salud. Sus actividades se limitan a un campo de acción específico, puede o no ayudar en investigaciones especiales, y, la que pertenece a organizaciones privadas complementa su tarea en la asistencia de enfermos en el hogar.

2.—En las zonas menos desarrolladas el programa no se efectúa en toda su extensión por limitación de recursos comunales; la enfermera de salud pública debe entonces usar, de vez en cuando, su iniciativa para resolver problemas de emergencia en ausencia de médico. En estas zonas rurales en que las familias son reacias o lentas en comprensión la enfermera de salud pública debe usar de extraordinario tacto, ingenio y delicadeza para conseguir la cooperación de la familia para los efectos de exámenes médicos periódicos, inmunizaciones, corrección de defectos, etc.

En las dos últimas categorías las enfermeras de salud pública tienen que afrontar serios problemas y es en Enfermería de Salud Pública Rural donde necesitan poseer fe inquebrantable en la humanidad y espíritu de misioneras para predicar la nueva doctrina de salud y realizar la inmensa tarea con recursos propios, lo que a veces proporoiona sólo satisfacción personal.

3.—En las zonas rurales poco progresistas sólo existen organizaciones de salud pública en ciernes y sus únicas actividades son provisión de agua potable y disposición de excretas. La población de estas zonas compuestas generalmente de pequeños parceleros, mineros, pescadores, emigrantes y obreros son en su mayor parte analfabetos e ignorantes. En estos grupos las enfermeras de salud pública tienen en su contra los prejuicios, los sentimientos religiosos y las costumbres raciales o sociales que les impiden a veces alcanzar los objetivos de su programa. En estos casos, la enfermera de salud pública debe tener presente sus creencias para plancar su contacto con ellos.

En estas zonas suele ser la enfermera de salud pública la única persona a cargo del programa de salud, y, sus medios de transporte variarán de una mula, caballo o "jeep" hasta la caminata por senderos apenas trazados. Sus actividades se desarrollan en un plan generalizado de enfermería de salud pública que incluye atención de enfermos y estadísticas de morbilidad y mortalidad. Su contacto con la población la llevará a los lugares en que pueda obtener un índice aproximado del estado de salud de sus habitantes—plazas, mercados,

ferias, iglesias, y tendrá que informarse en más detalle conversando con sacerdotes, profesores, autoridades locales y líderes de la comunidad.

Su plan de trabajo se realizará a base de las necesidades sociales más urgentes y tendrá, si es necesario, que recurrir a la preparación de grupos locales para solucionar emergencias de tipo sanitario tales como inmunizaciones, vacunaciones. La fundación de su programa será, naturalmente enseñanza de saneamiento básico, higiene personal, prevención de enfermedades transmisibles además de atención materno-infantil, incluyendo preparación de parteras. Es natural que a medida que gana la confianza de la población irá aumentando sus actividades tales como cuidado de enfermos, enseñanza para cuidado del paciente en el hogar, obtener atención médica adecuada en casos de cirugía, tuberculosis graves, enfermedades venéreas, enfermos mentales, etc. Sus recursos personales los probará al improvisar equipos para pacientes cuando no hay dinero, ni posibilidades de adquirirlos.

La enfermera de salud pública de esta zona no podrá hacer investigaciones sino llevar un buen control estadístico de su población.

4.—Otras zonas rurales, remotas e inaccesibles en algunas estaciones del año, son alcanzadas sólo por organismos internacionales, misioneros y organismos estatales.

Las deplorables condiciones sanitarias en que se encuentran se deben fundamentalmente a la extrema pobreza de la gente, a las barreras sociales y físicas y a la pobreza de las tierras o recursos naturales que impiden la elevación del standard de vida.

Como es de esperar las parasitosis son altas, las enfermedades transmisibles están en estado floreciente, la desnutrición está avanzadísima y la mortalidad materno-infantil es impresionante. En general, el clima suele ser inclemente y las oportunidades de educación no existen; es natural esperar que las supersticiones, creencias y costumbres estén en pugna con la civilización.

A estos lugares donde vive gente olvidada, han estado llegando periódicamente misioneros y en el último tiempo organizaciones internacionales cuyos objetivos primarios son elevar el standard de vida de estas poblaciones.

Cuando la enfermera de salud pública llega a estos lugares forma parte de un equipo que consta de un médico sanitario, un epidemiólogo y una trabajadora social.

En estos casos ella entrena personal auxiliar para su labor; generalmente son personas de diversos sectores de la región que reciben en 6 u 8 meses conocimientos esenciales de vacunas, higiene, nutrición y cuidado del niño. Luego la auxiliar se va a su distrito o sector y sirve a la enfermera de salud pública de informante de lo que ocurre allí. La enfermera de salud pública por su parte, hace visitas frecuentes de control. Su actividad profesional es siempre a base de necesidades locales con énfasis en principios esenciales de saneamiento. Muchas veces tendrá problemas serios tales como falta de leche y tendrá que buscar el substituto adecuado.

La prevención de enfermedades transmisibles y cuidado de los pacientes infecciosos, su aislamiento y la atención a embarazadas, son sus serios problemas ya que deberá hacerlo personalmente o por medio de personas preparadas por ella.

Muchos heroicos y anónimos ejemplos están dando las enfermeras de salud pública rural y es necesario que su ejemplo sea como un llamamiento a otras enfermeras de salud pública que deseen ayudar y hacer feliz a la gente olvidada del mundo: la que vive en lejanas regiones rurales.

SEMINARIO DE ENFERMERÍA EN CHILE

Bajo los auspicios de la Oficina Sanitaria Panamericana y del Gobierno de Chile se realizó en la ciudad de Viña del Mar, Chile, del 10 de julio al 19 agosto, 1950, un Seminario Educativo sobre problemas de enfermería sanitaria, administración, supervisión y métodos de enseñanza.

Las labores de este Seminario se prolongaron hasta el 19 de agosto y en él participaron educadoras, administradoras y profesoras de enfermería sanitaria de las escuelas de enfermería de Argentina, Brasil, Chile, Colombia, Panamá, Perú y Uruguay.

Los trabajos del Seminario se refirieron al estudio y solución de los problemas que diariamente se presentan en este campo, y a la discusión e intercambio de ideas sobre la materia. Hubo sesiones generales en las que se discutieron problemas comunes y reuniones especiales de grupos más pequeños, en las cuales se trataron problemas específicos y consultas individuales. Para tal propósito participaron especialistas en todas las fases de educación de enfermería y de la enfermería sanitaria.

La Directora del Seminario fué la señora Agnes Waddell Chagas, Jefe de la Sección de Enfermería de la Oficina Sanitaria Panamericana, asesorada por las señoritas Elfleda Sprague y Frances Fell, Consultoras en Enfermería de la misma Oficina, así como por la doctora Verna White, Profesora de Educación de la Universidad de Syracuse.

Además del Servicio Nacional de Salubridad de Chile, cooperaron en el desarrollo de este Seminario el Instituto de Asuntos Interamericanos, la División Internacional de Protección Infantil del Servicio de Salúd Pública de los Estados Unidos y la Fundación Rockefeller. Actuó como coordinadora, a la vez que como miembro del cuerpo de profesoras, la señora Sofía Pincheira de Ehrenberg, asesora Jefe de las Enfermeras Sanitarias del Servicio Nacional de Salubridad de Chile. Fueron también profesoras en este Seminario, la señorita Gladys Peake Guevara, Directora de Enfermeras de la Beneficencia de Concepción; la señorita Catherine Kain, Enfermera Consultora del Instituto de Asuntos Interamericanos; la señorita Caroline Russell, Consultora de la Sección Materno-Infantil de la División Internacional de la Oficina do Protección Infantil del Servicio de Salud Pública de los Estados Unidos; la señorita Mary Elizabeth Tenant, Directora de Enfermería de la Fundación Rockefeller y la señorita Esther Mary Hirst, Enfermera Consultora para Sud América de la misma Fundación. Además participaron en el desarrollo del Seminario mencionado distinguidos profesionales, médicos y educadores

SEMINARIO DE ENFERMERÍA EN CHILE

Grupo de la facultad en reunión preliminar. De izquierda a derecha: Miss Frances Fell, Miss Caroline Russell, Dr. Verna White, Mrs. Agnes Chagas, Srta. Eugenia Gaete y la Sra. Sofía Pincheira de Ehrenberg.

Otro grupo de la Facultad en una discusión. De izquierda a derecha: Sra. Rosalba Flores de Fernández, Sra. Sofía Pincheira de Ehrenberg, Miss Elfleda Sprague, Miss Catherine Kain.

El cuerpo docente y las alumnas del Seminario de Viña del Mar, Chile. Aparecen en el grupo el Dr. Nacianceno Romero, Director General de Sanidad y el Sr. Chattey del Servicio Cooperativo Interamericano en Chile.

Graduadas de la Escuela de Enfermeras de São Vicente de Paulo, Fortaleza, Ceará, Brasil, recibiendo sus diplomas.

chilenos. El informe completo de este Seminario aparecerá en uno de los próximos números del *Boletín*.

DISTRIBUCIÓN DE ENFERMERAS PROFESIONALES EN LOS ESTADOS UNIDOS*

En la primavera de 1949 había 506,050 enfermeras profesionales con licencia para ejercer (registered) en los Estados Unidos y sus territorios. El 59 por ciento de esta cantidad se encontraba desempeñando servicio activo de enfermería. El mayor número de enfermeras en servicio activo estaban empleadas en hospitales y otras instituciones; a éstas le seguían el grupo menos numeroso de las que se dedican al servicio particular.

El número más grande de enfermeras se encontraba en el estado de Nueva York donde había 68,250 enfermeras profesionales con licencia, de las cuales 44,163 estaban en servicio activo. El estado de California ocupaba el segundo lugar con 58,577 enfermeras, de las cuales 32,707 estaban en servicio activo. En tercer lugar estaba el estado de Pensilvania con 45,280 enfermeras, 23,252 de éstas estaban en servicio activo.

El número de enfermeras profesionales con licencia y en servicio activo que eran casadas, era sólo ligeramente menor que el número de las solteras: 42 por ciento en comparación con 46.3 por ciento, respectivamente. Por otro lado, entre las enfermeras que no estaban en servicio activo, el 86.9 por ciento eran casadas, y sólo el 8.3 por ciento eran solteras. Entre las enfermeras menores de 30 años de edad, las que estaban en servicio activo eran ligeramente más numerosas que las que no estaban en servicio; mientras que entre las que tenían de 30 a 39 años de edad las inactivas eran apreciablemente más numerosas que las activas.

Estos datos están basados en un Inventario de Enfermeras Profesionales con Licencia, el cual fué realizado por la Asociación Americana de Enfermeras a principios de 1949. La información se obtuvo mediante un cuestionario que se envió por correo a las enfermeras profesionales con licencia en cada estado o territorio. En estos cálculos no se han tomado en cuenta el número de enfermeras profesionales sin licencia en estado o territorio alguno.

La Oficina de Mujeres de la Secretaría de Trabajo de los Estados Unidos ("Women's Bureau of the U.S. Dept of Labor") ha calculado que para mantener las normas actuales del servicio de enfermería en 1950 se necesitarán 409,700 enfermeras profesionales con licencia. Este número incluye aproximadamente 109,000 enfermeras más que el número que estaba empleado en servicio activo de enfermería en la primavera de 1949. En 1955 se necesitarán 477,700 enfermeras, y en 1960, 554,200. Los hospitales no federales necesitarán el mayor número de enfermeras profesionales, al igual que sucede hoy en día. En los últimos diez años las necesidades en el campo de salud pública aumentaron hasta 164

* "1949 Facts about Nursing," American Nurses Association.

por ciento, mientras que las necesidades de los hospitales no federales aumentaron sólo 34 por ciento.

Las tablas siguientes dan una idea de la distribución de enfermeras graduadas en los diversos campos de actividad, así como un cálculo aproximado de las necesidades futuras:

Número de enfermeras profesionales, con licencia y en servicio activo en los Estados Unidos y sus Territorios, por campos de enfermería, en 1949

Campo de Enfermería	Número	Porcentaje
Total	300,533	100.0
Hospitales y otras instituciones	141,882	47.2
Escuelas de enfermería	7,839	2.6
Hospitales y escuelas de enfermería	4,044	1.3
Salud pública	28,930	9.6
Salud pública y escuelas de enfermería	272	.1
Servicio particular	65,032	21.6
Industrial	13,113	4.4
Oficina	26,444	8.8
Otros	1,371	.5
Sin clasificar	11,606	3.9

Cálculo aproximado de necesidades de enfermeras profesionales con licencia para 1950, 1955 y 1960

Campo de Enfermería	1950	1955	1960
Total	409,700	477,700	554,200
Hospitales no federales	234,900	272,400	315,700
Servicios federales	32,800	35,300	36,800
Servicio particular	100,000	100,000	100,000
Salud pública	29,000	50,000	76,700
Industrial	13,000	20,000	25,000