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THE ROLE OF NURSING PERSONNEL IN PRIMARY HEALTH CARE

(Presented by the Government of Canada)

Introduction

In 1977, the World Health Assembly resolved that a principle objective of the Member States would be the attainment by all citizens of the world, by the year 2000, of a level of health that would allow them to lead socially and economically productive lives.

In 1978 the World Health Assembly further resolved that the key to the achievement of HFA/2000 was through universal access to primary health care (PHC).

The Region of the Americas formulated its Strategies for HFA/2000 in 1980.[1/] The only mention of nursing personnel in this important document is in Section 4.7, "Training and Use of Human Resources," which proposes:

> "Additional strategies for the development of human resources that would emphasize: ... Recognition of emerging roles in the health sector including, for example, the use of nurse practitioners ... in primary health care."[2/]

PAHO Document CE90/4, ADD. I, dated 8 June 1983, titled "Preliminary Report on the Situation in the Region of the Americas in Regard to the Strategies of Health for All by the Year 2000," notes that there are 461 schools of nursing and 512 schools for the training of auxiliaries in Latin America, and that, in 1980, there were 160,000 nurses and 395,000

1/ PAHO Official Document 173, 1980.

2/ Ibid, p. 54-55 of the Complementary Document.

auxiliaries employed in the delivery of health care. These nurses and auxiliaries represent over 50 per cent of health personnel in the Latin American portion of the Region.

In relation to the development of human resources, the report notes that:

> "Some countries have recently enunciated general guidelines for manpower policies as part of their national health policies. Most of these guidelines ... have little to do with training establishments (universities) ... Today, as the volume of training facilities has grown, the most urgent problem in the Region has become the utilization of (health) personnel and the adjustment of training in response to needs."[3/]

Purpose

The purpose of this document is to review the development of the role of nursing personnel in the delivery of primary health care in WHO and PAHO and to propose, for the consideration of the Directing Council, a course of action that would give greater emphasis to the education, training, development and use of these valuable human resources in the quest for health for all by the year 2000.

Developments in Nursing in PHC

Global Developments

In 1974, the Executive Board of the World Health Organization concluded a study of basic health services, which documented serious deficiencies in essential health services provided to the populations of developing countries.[4/] One outcome of this study was the establishment of the Expert Committee on Community Health Nursing, whose task was to propose ways and means by which nursing could increase its impact on critical health conditions.

In May 1977, the Thirtieth World Health Assembly adopted Resolution WHA30.48 which asked Member Countries to: study the roles and functions of nursing (and midwifery) personnel in PHC; plan to increase the numbers of nurses in accordance with countries' needs for PHC; and involve nurses (and midwives) in the planning and management of PHC, and as teachers and supervisors of PHC workers.

3/ CE90/4, ADD. I, p. 42.

4/ WHO Technical Report Series No. 558, 1974.

In 1978, the Declaration of Alma-Ata[5/] provided a universally acceptable definition of PHC. This was closely followed in 1979 by the adoption of "The Global Strategy for Health for All by the Year 2000" (WHA.34.36).

A meeting of nurses was convened by WHO in Geneva in November 1981[6/], to consider the role of nursing in relation to the goal of HFA/2000. The meeting agreed that while nursing can make an important contribution to health for all, it is not yet geared up to do so.

The major reforms recommended by the meeting included:

- steps to optimize the use of nursing personnel at all levels of health care;
- a shift in the basic approach to nursng education from the hospital to the community;
- necessary legislative reforms to recognize the expanded role of the nurse in PHC and as equal partners in the health care team; and
- operational research to foster effectiveness in the planning, teaching and application of nursing.

The report noted:

> "There is no doubt that nurses will be expected to assume a major role in the implementation of primary health care strategies. It will include such functions as training primary health care workers, establishing educational programs for health workers, helping communities to identify their needs, working as referral agents, managers and team leaders. These activities require new skills and motivation on the part of the nurse which must be acquired now. At the same time, there are forces outside nursing schools and nursing practice which can bring about changes; they include (a) changes in government policy; (b) redefinition of nursing roles and functions; and (c) community needs. It can be expected that the greatest change in nursing practice will occur when all these forces act simultaneously and synergistically."

5/ Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.

6/ Report of a Meeting on "Nursing in Support of the Goal of Health for All by the Year 2000," HMD/NUR/82.2.

In November 1982, the WHO Executive Board considered a discussion paper prepared by the Program Committee on "The Role of Nursing in the Primary Health Care Team"[7/] and emphasized that there is no universal blueprint for a health system infrastructure based on PHC, nor for the manpower component which is the essential ingredient for the proper functioning of the system, and that this lack of universality applied equally to the way in which nursing education and practice were defined, interpreted and regulated. The Executive Board acknowledged that in many countries there is resistance to change, particularly in training institutions and that, on the whole, nursing schools have been slow to respond to the concept of PCH.*

The Committee underlined the fact that PCH concerns the maintenance of health, as well as care of the sick and, thus, a complete redefinition of the types and numbers of health workers is required. The report concludes that it is essential that countries identify the tasks that each member of its health team could face and modify training curricula accordingly.

In 1983, the Thirty-sixth World Health Assembly passed Resolution WHA36.11 with the following operative paragraphs:

1. CALLS UPON nursing/midwifery personnel and their organizations everywhere to support WHO's policies regarding promotion of primary health care and to use their influential position to support training and information programmes relating to primary health care;

2. URGES all Member States to take appropriate steps in co-operation with their national nursing/midwifery organizations to develop a comprehensive nursing/midwifery component in their national health for all strategies;

3. CALLS UPON the international nursing/midwifery organizations to mobilize the necessary resources to support the national organizations so that they can better take responsibility in partnership with national governments for furthering effective nursing/midwifery services, as an integral component of their health for all strategies;

4. REQUESTS the Director-General to ensure that WHO at all levels supports Member States in their efforts to provide nursing/midwifery personnel with adequate training in primary health care, its management and appropriate supportive research so that they can participate effectively in the implementation of national health for all strategies; and to report on the progress made to the Thirty-ninth World Health Assembly.

7/ EB71/5, 11 November 1982, WHO.

* Notwithstanding, it should be recognized that nursing is the only health discipline that has, to date, responded positively to PHC in the context of HFA/2000.

Regional Developments

The countries that make up the Americas have a long history in PHC, that goes back to the traditional medicine of the many groups which contribute to the rich cultural mosaic that characterizes the Region.

The development of commerce, growth of international trade and massive migration of people to the New World, raised concerns over the control of communicable disease, quality of sanitation and protection of the environment. This led to the growth of international cooperation in health and to the establishment, in 1902, of the Pan American Sanitary Bureau (PASB), the oldest international health organization in the world.

In 1947, PASB became the WHO Region of the Americas, and the XII Pan American Sanitary Conference adopted the Constitution of the Pan American Health Organization (PAHO).

During the 1960's, several countries of the Region began experimental programs in community health. These have had a major impact on the development of national health programs. In 1972, the III Special Meeting of Ministers of Health approved a "Ten Year Health Plan" for the Region, that emphasized the need to extend basic local coverage and stressed the development of new components of health care. Aspects of the Plan were subsequently subsumed into the Regional Strategies and Plan of Action for HFA/2000.

In 1980, at its first meeting, the Advisory Committee to the Community Health Training Program for Central America and Panama, approved a plan of action covering nine subprograms. This plan included the production of new models for the extension of PHC coverage, in-service training and the development of educational technology. The main emphasis of the plan is towards the production of intermediate level and auxiliary personnel, in line with the priority components of the PHC approach.

In 1979, a seminar of the Andean Pact Countries noted that the contribution of nursing to PHC programs could be seen as:

1. The planning and programming of health services; training programs for traditional health workers, midwives, and other levels of nursing personnel; and, coordination of health services in health centers as part of a multidisciplinary team;

2. The supervision and evaluation of direct health care, as well as community development and research projects for the study of health services; and

3. Provision of health services with community involvement, especially for high risk groups.

An unpublished PAHO document prepared in Spanish and titled "Forty Years of Technical Cooperation by PAHO in Nursing and Some Notes Concerning Nursing Education in Latin America,"* reviews the characteristics of nursing in Latin America, and the development of technical cooperation in nursing by PAHO. This was prepared as a basic document for use by a Consulting Group on Nursing Education convened by the Director in May 1983 (see Annex I).

Referring to recent developments, the document notes:

> "Nevertheless, during this period one sees a reduction in nursing activities in PAHO in comparison to earlier periods. The number of nurses in PAHO has diminished perceptibly since 1960. ... Moreover, during this period, the proportion of the budget for nursing in relation to the proportion of the budget for the Organization has declined from 3 to 1 per cent."8/

In May 1983, the Director of PASB convened the Consulting Group on Nursing Education noted previously, whose objectives were:

1. To identify trends in the development of critical areas in nursing that influence the educational models in the countries of the Region.

2. To propose the frame of reference of nursing service and education for the analysis of situations and design of strategies of change to be discussed in later meetings of the subregions.**

3. To establish the bases for the coordination of technical cooperation with respect to nursing education.

4. To analyze the achievements of the Textbook Program in the light of the new areas of coverage orientations in nursing, and to propose new mechanisms of collective distribution and expansion of the Program so that it will continue to be an appropriate means of technical cooperation in the countries.

8/ Annex I, page 22 (Spanish text).

*The data and analysis contained in this document is drawn, in part, from Dr. Alina Souza's dissertation, referred to later in this paper.

**The Director has planned a further series of meetings at the subregional level for the purpose of developing medium- and long-term strategies for inter- and intra-country technical cooperation in and between the countries of the Region.

The Consultants' report "Training and Utilization of Human Resources in Nursing to Contribute to the Goal of HFA/2000 in the Americas,"[9/] identifies critical areas, proposed strategies for their amelioration and for technical cooperation, and makes a series of recommendations concerning the training and utilization of nursing personnel in PHC.

The deficiencies identified by the Consultants include the following critical areas:

- Absence, in most countries, of national education and training policies for nursing personnel; and inadequate legislation to allow nurses to play more effective roles in PHC.

- Absence of national associations in the majority of countries that are capable of contributing to planning and decision-making processes required for the training and employment of nurses in the health care system.

- A lack of relationship between the health needs of communities, and the educational and occupational profiles of personnel engaged in nursing.

- Little attention paid to the orientation of nursing professionals to the supervision of nurse education.

- Little evidence of policies for research oriented towards the solution of health problems.

- Insufficient attention paid to the developmental and continuing education needs of nursing personnel.

- Services are generally inadequate to ensure the effective training of nursing personnel in PHC.

- Nursing personnel pay insufficient attention to technical and scientific advances that would better equip them to play a more significant role in the development and conduct of nursing services.

- The main focus of nurse education and training is still, in the majority of countries, directed towards secondary and tertiary levels of health care (i.e., the emphasis is towards treatment rather than prevention).

- A low level of nursing participation in decision-making in the health system.

9/ PAHO Draft Final Report, May 1983.

Notwithstanding these deficiencies, the report notes encouraging signs of progress in many countries and emphasizes that nursing personnel are beginning to play a more proactive role in the development of their national health systems.

A comprehensive review of the development of nursing in Latin America, contained in a dissertation presented by Dr. Alina Souza, B.S., M.P.H., in partial fulfillment of her doctorate at the Ohio State University,[10/] notes that the substitution of national health systems, directly controlled by the government through national health departments or directorates, has affected the practice of all health professions, including nursing. Control of medical care by the state and the medical profession, is perceived by Dr. Souza as the major factor in the process of nursing professionalization and progress. However, in this process, nursing has become increasingly subjected to medical authority, consequently losing some of its independent characteristics.

Dr. Souza notes that Meyer (1980)[11/] estimates that over 80 per cent of practical nurses in Latin America provide direct patient care in hospitals and at community level programs, and that 50 per cent of these personnel have received very little training. Macedo, et al. (1980),[12/] referring to Brazil, notes that the availability of instructors and supervisors provides a major challenge to directors of local programs.

In relation to HFA/2000, Dr. Souza comments that the movement may be seen as a challenge to Latin American governments which, on the one hand, could lead to profound socioeconomic changes and, on the other hand, to the reorganization of the health system in order to extend its services. Moreover, policies to extend health care coverage have prompted a series of recommendations for changes in nursing practice and education that would expand the traditional role of nursing to include actions formally performed by physicians.

Despite the continuous developments taking place in all countries, Dr. Souza notes that the growth of nursing education has not reached a satisfactory level, and the ratio of graduates to population remains fairly static at about 2.0 per 10,000, which compares unfavorably with ratios in developed countries, such as the United States of America, where the 1979 ratio was 50.1 per 10,000 population. However, in light of the current world economic situation, Member Countries may find it difficult to allocate the resources needed to make significant increases to present levels of nursing personnel.

10/ Development of the Pan American Health Organization Nursing Advisory Services; Impact in Latin American Education (1940-1980), Dr. Alina Maria de Almeida Souza, B.S., M.P.H. The Ohio State University, 1982.

11/ Meyer A. y Salud 14:95-105, January.

12/ Macedo, et al., 1980, "Uma experiencia de formaçao de perssoal de Saúde no Brasil", Educ. Med. Salud 14:62-74, January.

Although the Region has made considerable progress in rationalizing the role of nursing personnel, the profession does not, at this time, appear to have the capacity to assume a major role in affecting the changes in the health care system needed to achieve HFA/2000. Freire, in "Pedagogy of the Oppressed," concludes that nursing will have to struggle to determine its space for practice in PHC, noting that the lack of a well organized nursing sector in many countries, and conflicts and contradictions among the various levels of nursing personnel, are hindering the development of more effective nursing roles.

In conclusion, although the Region has made significant strides in rationalizing the role of nursing personnel, such efforts have not always been adequately resourced. This can probably be attributed to a lack of national policies, funding inconsistencies and a lack of guidelines for the employment, education and training of nursing personnel. This is particularly evident with respect to the preparation and employment of nursing personnel in PHC.

Discussion

Nursing Personnel - Definition

In the context of this document the term "Nursing Personnel" encompasses all human resources, both male and female, qualified at the university, diploma or auxiliary levels, who perform functions related to the health care of persons, sick or well, in hospitals, clinics or private offices; or in community or primary health care programs.

Primary Health Care

All countries of the Region have made enormous investments of human and financial resources in hospitals which, overall, account for the employment of well over 50 per cent of health professionals. In Canada, for example, over 80 per cent of nursing personnel are employed in hospitals and similar institutions. This percentage is exceeded in many countries of the Region, leaving relatively few nursing personnel available for employment in PHC. Obviously, countries need to examine the allocation of resources to the various sections of their health sectors and make adjustments to provide adequate financing for community-based PHC delivery.

Because community health attempts to modify behaviour and the environment in which people live and work, it has become a major focus of social action. The objectives of community health are to conserve and promote the health and well-being of the community, prevent disease and assure access to PHC. Community health also focusses on the health maintenance needs of high risk groups. Its emphasis is, therefore, more towards population groups than to individuals.

At the community level, PHC is normally the first point of contact between the individual and the health care system. While it was generally accepted in the past that this first point of contact would be a physician, it is now coming to be acknowleged that the primary care nurse, working as a member of the PHC team, may be a more appropriate point of reference. This change will require a major reassessment of the training of nursing personnel who are placed in a more prominent and responsible role in the health care delivery system.

Community or family-oriented nursing is integral to the Alma-Ata concept of PHC, as it combines the more general concept of public health nursing, with its focus on health promotion and disease prevention, with curative, domiciliary and aftercare. In some countries, the role of nursing personnel has been expanded farther to include mental health, home care of the aged and disabled, and even preventive cancer and cardiology.

Primary health care, with its focus on the community, also embodies the epidemiological function in a manner complementary to the traditional physician/patient interaction; and in remote areas, the PHC team may be the only source of epidemiological data. For example, while the physician records the examination, diagnosis, treatment and rehabilitation of the patient, the PHC team records the status of health of the community, diagnoses the causes of ill health, identifies high risk groups and intervenes on the basis of the health needs of the community. Moreover, surveillance is continuous, rather than episodic. Nursing personnel may require special training to carry out this complementary role, which is an essential feature of the PHC approach.

Greater emphasis on individual and community self-reliance adds to the burden of the PHC team, as it involves participation in decisions affecting the health of individuals, families and the community. A prerequisite for effective participation is knowledge of the relevance of the network of community and family interrelationships, the skills and occupations of the community, its daily activities and its formal and informal leadership structure. The PHC worker must also understand the values of the community, its social mores, beliefs and patterns of behaviour. In many countries of the Region, relatively few nursing personnel have the education, training and experience to function effectively as community participants.

The Team Concept

It is generally accepted that society can no longer limit the provision of health care to the treatment of the sick. However, health care systems have been slow to adjust to the notion that health can be promoted and sustained. Nor is this likely to come about until the emphasis on health care changes from its current preocupation with the treatment of disease to a more holistic approach that places greater emphasis on the maintenance of health and well-being.

This approach to health, emphasizing care as opposed to cure, requires new definitions of health roles, new modalities of health care delivery—especially in the area of PHC—and revision and upgrading of the education and training systems for health professionals, auxiliaries and other members of the health team. New methods of work and service delivery have to be developed, not only for PHC, but also for secondary and tertiary levels of care.

The multidisciplinary approach to PHC requires a reevaluation of traditional relationships within the health sector and the formation of new relationships with the other disciplines that are being incorporated into the primary health care team. Moreover, extending health care into the community also means greater community involvement and the expanded use of health auxiliaries.

These changes to the role and composition of the health team impact on existing hierarchial relationships. Health workers who have traditionally played subservient roles in health care may emerge as the new leaders of the health team. Moreover, because of the health team's multidisciplinary nature, its leadership will not necessarily come from a health professional.

The PHC team approach, with its emphasis on care, can no longer rely solely on conventional referral patterns. Because success depends on the mobilization of all the resources of the community, new linkages, often including other sectors of the economy, have to be developed. This places an added burden on the shoulders of health care providers who are more accustomed to referring patients to higher levels of care.

Community involvement in PHC is a relatively new phenomenon in many countries of the Region. It places demands on the PHC team for which most members have little experience or training. Community participation can challenge conventional wisdom and question stereotyped modalities of health care.

In countries that have aboriginal or isolated rural populations, PHC providers frequently come from cultures alien to the recipients of health care. Linguistic and cultural hurdles have to be surmounted, the problems of social distance and alienation from the community overcome, and team members oriented to differing community social and cultural patterns.

The Emerging Role of Nursing Personnel in PHC

In light of the developments in PHC that are taking place globally, regionally and nationally, as highlighted above, it is expedient to examine in more detail the emerging role of nursing personnel in PHC.

The determination of the role of nursing personnel in PHC will be influenced by the manner in which countries structure their health care system to the Alma-Ata model; as well as by the policies, strategies and plans of action they adopt to implement HFA/2000.

In some countries, the role of nursing personnel will take on new dimensions. In many countries, nursing personnel may be ill-equipped to assume new responsibilities in PHC, responsibilities that could extend their participation in health care delivery far beyond their education and training in preventive and curative medicine. Such new roles may also require legislative changes to allow nursing personnel to perform services which, in the past, have been the exclusive prerogative of licensed medical practitioners.

In the area of social well-being, nursing personnel who have been trained to observe clinical signs and symptoms may have difficulties attempting to assess the over-all social health and well-being of the individual, family or community. Or, they could have difficulty trying to determine the care needed by an individual whose problem is not medical, but economic or social. Clearly, there are no simple answers to these problems and the assessment or type of intervention will depend in large measure on the training of nursing personnel, the composition of the PHC team, and the resources available in the community.

Recognizing that some countries of the Region already assign leadership roles in PHC to nursing personnel, there is a growing need to examine the manner in which they are trained and developed to carry out this function. A starting point for such research could be in those countries that have already established effective nurse-clinician programs.

Many countries of the Region have expanded the role and employment of community or village health workers, especially in rural areas. Nursing personnel, however, are often ill-prepared for the responsibility of training and supervising such paramedical workers and health auxiliaries.

Where traditional medicine is a feature of health care in the community, special orientation of the health members of the PHC team is essential if conflict between traditional and modern methods of health care is to be avoided, and the potential contribution of traditional medicine realized.

Given that these changes are taking place, it is evident that there is a critical shortage of nurses in many countries of the Region and that insufficient numbers of nursing personnel are being trained in disease prevention, public education, community involvement, epidemiology, and in the team concept of PHC delivery.

Determinants of Change

The draft report of the Consulting Group on Nursing Education, convened by the Director in May 1983, identifies many of the issues that inhibit the orderly development of an expanded role for nursing personnel in PHC throughout the Region of the Americas. While some individual countries have already taken steps to provide nursing personnel with an expanded role, progress has been generally slow and lacking the catalytic action needed to generate a more general movement. This catalytic role is one that could be most effectively played or instigated by PAHO.

Dr. Souza makes a critical analysis of nursing in PAHO in her dissertation, noting recent shifts in the orientation of nursing advisory services away from education and more towards service development. She also notes a significant reduction in nursing services in the overall PAHO technical cooperation program over the past 20 years. Dr. Souza makes reference to the broad range of activities which the Organization has conducted in relation to the education, training and development of nursing personnel in the past, and notes the influence exerted by the Organization's 10 year health plans on nursing policies and programs, as well as by recent socioeconomic developments, which have exerted a profound influence on regional health strategies by emphasizing the need for a more simplified and less expensive system of health care delivery.

The movement towards greater integration of medical care and extention of coverage has had a profound effect on PAHO nursing activities, including a general trend towards the reduction of nursing resources at a time when PHC is being promoted as the strategy for the achievement of HFA/2000. Dr. Souza submits that Latin American nursing professionals have been slow to accept change and insufficiently flexible to develop the multidisciplinary and open approaches required to meet new demands in the production of health personnel. Moreover, she believes that the major role in PHC claimed by the nursing profession, is a belief that is not shared by the Member Governments, individually or collectively.

Any concerted efforts to give increased prominence to the role of nursing personnel in PHC will require modifications to the organization and conduct of the Regional Program, in order that: "The Organization (can) fulfill its regional responsibility for monitoring and evaluating progress and serve as a mirror for Member Countries, stimulating the political will to meet the challenge of health for all."13/

The recent changes to the Regional Program, proposed by the Director, focus on health system/infrastructure and health programs development. There is a danger that this could inhibit, rather than promote the evolution of the PHC model, as it appears to create a gap between

13/ Director's Introduction to the Program Budget. Official Document 187.

health systems/infrastructures and health programs that could be difficult to bridge. More often than not, nursing personnel are responsible for the administration of PHC programs. They must, therefore, be able to input to program development and direction. More importantly, they have to be seen as an integral part of such programs and adequately represented in their formulation. In terms of cost-effectiveness, strong arguments can also be made for increasing the presence of qualified nursing personnel in all divisions of the Program. Obviously, PAHO has a unique opportunity to demonstrate, by example, the importance of the role of nursing personnel, not only in program implementation, but also in the development and planning processes.

The role of the Directing Council is, clearly, to give the Director a mandate to focus the attention of the Organization towards the promotion of the expanded role of nursing personnel in PHC within the countries of the Region; assist countries to implement the changes in the health care system that are needed to educate, train and prepare nursing personnel for this expanded role; and to promote the legislative changes needed to give nursing personnel the necessary support to allow them to function in their expanded roles.

At the international level, it is felt that the International Council of Nurses and other international organizations such as UNICEF could play an important role by stimulating national nursing associations to become more proactive in promoting an expanded role for nursing personnel.

Ministries of Health can contribute by interacting with national nursing associations; by involving nursing personnel to a greater extent in the formulation of policies and decisions; and, most importantly, by recognizing the key role that nursing personnel can play in the achievement of HFA/2000 through PHC.

The countries of the Region that have well-developed policies for the employment of nursing personnel could participate bilaterally with countries interested in expanding the use of nursing personnel in PHC delivery through the provision of technical support and advice. Collectively, these countries could provide a powerhouse of knowledge that would obviate the need to continually reinvent the wheel.

There are, of course, many other methods that could be employed by countries to acknowledge the potential that nursing personnel have as prime movers towards the achievement of the goal of HFA/2000.

Conclusions

This brief overview demonstrates that the Regional Strategies and Plan of Action do not provide adequate recognition of the important role of nursing personnel in PHC. For example, the PAHO Plan of Action for the Implementation of Regional Strategies[14/] makes no specific reference to the role of nursing personnel in the sections on Health Infrastructure Development, Increase of Operating Capacity, Sectoral Reestructuring, Planning and Programming of Human Resources, Training in Priority Areas, Utilization of Human Resources or Educational Technology.

The 1977 Resolution WHA30.48 on the Role of Nursing/Midwifery Personnel in PHC has had a relatively minor impact; and the 1983 Resolution WHA36.11, may not provide sufficient motivation to WHO, PAHO or Member Countries to take the prompt action needed to enhance the role of nursing personnel in PHC.

The health conditions and health systems of the countries that make up the Region of the Americas share many common features not found in the other Regions that make up the World Health Organization and many countries have common cultural characteristics which could enhance the Region's potential to develop unique models of PHC, incorporating an expanded role for nursing personnel.

Furthermore, some countries have become pace-setters in the utilization of nursing personnel in PHC delivery and the Region has, therefore, a considerable body of expertise and knowledge--largely untapped--that could be exploited to develop model roles, standards, guidelines, curricula and legislation, and become the focal point for the planning and development of expanded nursing roles in PHC.

PAHO could become the catalyst for motivating countries to reevaluate the role of nursing personnel in their health care delivery systems, and it is submitted that the Directing Council should seriously consider providing the Director with the necessary direction to establish the goal of researching, evaluating and promoting an enhanced role for nursing personnel in PHC.

International and national nursing associations, universities and schools of nursing have all, as yet, largely unexploited potential to be prime movers in the task of reevaluating the roles of nursing personnel at all levels of health care delivery; of contributing to the development of national policies and decisions concerning health care; of adjusting nursing education, training and development to new modalities of care, emphasizing the promotion of health, prevention of disease and incorporating the principles of PHC set out in the Alma-Ata Declaration.

14/ PAHO Official Document 179, 1982.

Finally, it is evident from a review of progress reports on achievements towards the goal of HFA/2000, that many countries have been slow or reluctant to adopt the PHC approach that was unanimously agreed to in 1979 by the World Health Assembly (Resolution WHA32.30) and in 1980 by the PAHO XXVII Meeting of the Directing Council (Resolution XX).

Recommendations

1. In view of the low prominence given to the functions of nursing in the "Regional Program, Headquarters," as evidenced by the diminishing number of posts assigned to nurse advisors and administrators, and their lack of representation in such activities in the Health Programs Development Division as Research Coordination, Maternal and Child Health, Occupational Health, Development of Health Services for the Elderly and for the Disabled, Mental Health, EPI and Control of Diarrheal Diseases, it is recommended that:

a) The Director be requested to ensure that the organizational structure for the development of health programs recognize the key role played by nursing personnel; and

b) Recognize the importance of nursing consultation and advice in these and other critical areas of the Regional Program.

2. In view of the underutilization of nursing personnel in primary health care and inconsistency of their education, training and preparation for participation as members, supervisors or leaders of PHC teams, it is recommended that:

a) The Director be requested to establish a permanent Advisory Committee* to provide consultation and advice on the education, training and development of nursing personnel and to promote their greater use in PHC delivery.

b) The Director be requested to provide the financial resources, technical and administrative support required by the Advisory Committee to properly carry out its role and responsibilities.

c) That the first task given to the Advisory Committee be to research the role of nursing personnel in PHC, develop a series of model guidelines and standards governing their education, training and development; and role models for their employment as members, supervisors or leaders of PHC teams.

d) The Advisory Committee shall submit a report annually to the Directing Council.

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*Proposed Terms of Reference for the Advisory Committee are appended to Annex II.

3. In view of the slow progress being made by some developing countries to adapt their health systems to PHC as the mechanism for achieving HFA/2000; the lack of political will and commitment of some countries to PHC; the unequal allocation of resources allocated to curative care; and the proliferation of new roles in health care delivery, it is recommended that:

a) Member Countries intensify their efforts to adapt the PHC model to their systems of health care delivery; and

b) Member Countries review and adjust the allocation of human and financial resources to PHC, so as to advance progress towards the achievement of the regional baseline targets for priority health conditions.

Annexes

ANNEX I

FORTY YEARS OF PAHO TECHNICAL COOPERATION IN THE FIELD OF NURSING AND SOME NOTES ON NURSING EDUCATION IN LATIN AMERICA

Introduction

In setting up this consultation group, the Pan American Health Organization invites us to reflect on proposals for nursing education in a frame of reference of the health needs and policies of the countries, so that we can ultimately draw up a mediumand long-term technical cooperation program. Achieving that goal will also require looking at the history of this area and the way in which its mission was defined by Dr. Carlyle Guerra de Macedo, Director of the Pan American Sanitary Bureau (PASB) in 1983: ..."it is the work of administering knowledge, in the sense of promoting the creation of knowledge, in the sense of compiling knowledge and in the sense of thinking about it in a critical spirit, disseminating it and helping the countries to use and operate it."

This paper will attempt to offer a critical analysis of the development of PAHO technical cooperation in the nursing field, and add some notes about nursing education in Latin America.*

PAHO began work in the nursing area during the 1940s, when the Institution began to expand its field of action and to define broader health policies that would coincide more closely with actual health practices and policies in the countries. Even before it set up a nursing section or unit, PAHO started to publish a number of papers on nursing in its official journal, El Boletín. Many of these articles discussed the role of nursing in the control of communicable diseases, and the need for programs to train public health nurses. The nursing section was created in 1948, with the intention of "stimulating, promoting and formulating high standards for nursing education and services in all the countries of the western hemisphere through communications, publications, conferences, fellowships, personal services and consultantships" (Boletín of the Pan American Sanitary Bureau, 1948).

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* The data and analysis given in this paper summarize in part the dissertation: "Development of Nursing Services in PAHO: Impact of Nursing Education in Latin America, 1940-1980," submitted by A. Souza to Ohio State University, U.S.A, 1982.

Nursing in PAHO over the last 40 years has experienced some changes in response to the reorganization that has been carried out within the Organization itself, and to the expansion of its specialized services as requested by the countries. These changes are reflected in the nature of the policies and recommendations made by the nursing section for the countries. These can be summarized in a general way into three different phases.*

Nursing in PAHO (1940-1946)

The first six-year period during the Second World War (1940-1946) represented the beginning of PAHO technical cooperation in the nursing field. The special meeting of Ministers of Foreign Affairs that was held in Rio de Janeiro immediately after the attack on Pearl Harbor proposed setting up an Institute of Inter-American Affairs. Such an Institute was to provide international cooperation in the health area, using the "service pattern" which emphasized bilateral agreements between the United States of America and the countries of the Region. PAHO was felt to be an agency that had the competence to coordinate these projects. (Gottas, 1946). Raising sanitary and public health standards in strategic areas as a result of the war was the major objective proposed for the cooperation services, with public health nursing being given prime importance.

It may be said in general that the nursing cooperation services that were begun at that time in PAHO had their roots in and were influenced by two major facts: 1) the development at the beginning of this century in the United States of public health nurse visiting services, and 2) the efforts of the Rockefeller Foundation and other international organizations to set up nursing education and services in Latin America. A summary of those events is given below.

In 1919, a Nursing Division was set up within the U.S. Public Health Service, and at the same time agencies such as the Milbank Memorial Fund, the Rockefeller Foundation and the Metropolitan Life Insurance Company promoted and invested in demonstration projects utilizing public health nurses (Davies, 1980). Davies observed that "trained nurses did not, in the United States, as they did in Britain, find employment in the hospitals." Until the Depression (1929), nurses were largely employed in home nursing services and public health work. This predominant trend in the United States during the first 25 years of this century was also linked to the Rockefeller Foundation's efforts to "modernize" nursing in Latin America in the 1920s.

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* For reasons of space, the first two stages are given in summary form only.

During this period, PAHO's main field of activity was in education. Its cooperation in organizing nursing schools included recommendations on the construction of facilities, curriculum planning, teacher-training and the development of clinical areas for practical work. In general, the curriculum proposals emphasized public health nursing. The projects recommended a pre-clinical period in which an introduction would be given to the physical and biological sciences and to principles of nursing. Clinical and practical hospital and public health work concentrated on the control of communicable diseases, maternal and child health and school health and hygiene. Although the information available on the recommendations made during this period is scanty, we can say that some of Florence Nightingale's proposals, such as an independent program controlled by nursing, were taken into consideration (Matheney, 1973). The recommendations were also based on proposals included in the Curriculum Manual for Nursing Schools published in 1973 by the American Nursing League. According to Matheney (1973), this manual emphasized the system of on-the-job training.

Teacher-training did not mean only fellowships for programs in the United States: it also included teaching and supervision techniques. The teaching techniques focused on how to organize and prepare for individual classes, while instruction on supervision included techniques for the demonstration of nursing procedures and the distribution and monitoring of students. It also covered the organization of libraries and audiovisual materials. These were the patterns of learning for teachers at that period, and can be considered as a support for beginning teaching. As Eisner said (1979), the concern with teaching alone came to be of major academic interest in the 50s when it was redefined to include aspects of the learning process and criteria for achieving specific goals.

The development of clinical areas included studies on the administration and organization of hospitals and public health services. No formal nursing service was organized in PAHO during this period, but the institution coordinated eight projects in different countries on the formation and organization of nursing schools, with the help of about 15 nurses from the United States.

The Nursing Section (1949-1959)

The second stage covers the period from 1949 to 1959, and saw PAHO start to organize its personnel for nursing services. This coincided with the reorientation and reorganization of the institution's activities as a result of the agreement signed between the Pan American Sanitary Bureau (later called PAHO) and the World Health Organization immediately following its creation in 1947. PAHO adopted the WHO Constitution and began to serve as the Regional Office of WHO for the Americas, while still preserving its own identity. Competition between other international

agencies operating in the Americas and the health conditions and socio-economic realities of the Region made it necessary to find new ways of looking at international cooperation on health. PAHO reoriented its policies to give broad coverage to public health, medical care and social welfare. Although the control of communicable diseases continued to be seen as the Organization's central activity, through improvement in the national health services with emphasis on the development of public health programs in health centers, it also began to pay attention to the promotion of medical education and to the organization of hospital services.

At the end of the previous period, nursing in PAHO had been discontinued immediately after the Second World War as a result of the reorganization of the Inter-American Cooperative Services, which turned to bilateral agreements with the countries, coordinating its work directly with them. During the XII Pan American Sanitary Conference (Caracas, Venezuela, 1947), the Director of PASB lamented the lack of funds that had limited nursing activities, and emphasized the Organization's interest in nursing: two of the Area Offices had retained nurses as part of the effort to develop this service.

In September 1947, through a grant from the Rockefeller Foundation, PAHO nursing services began to be reorganized. A nursing consultant was appointed as the head of nursing services in Headquarters in Washington, D.C. During this period, the overall structure of the programs and activities followed the same guidelines as had been developed during the Second World War, in other words, the emphasis on the development of public health nursing and the promotion of basic nursing education.

The nursing section's first endeavor was a study on nursing schools in the Region. This was the first study in the history of nursing in Latin America to bring together data on the number of schools in existence, their programs, technical and physical structures, the number of students, etc. This information would enable guidelines to be drawn up for the advisory services. Five congresses and a number of international seminars were also held. The purpose of the congresses was to bring together Latin American nurses to organize a Latin American nursing federation. They were also an opportunity to exchange views and study the problems of nursing education and practice, and to make recommendations to the governments and to PAHO to help them orient the development of nursing. The seminars promoted nursing education in the areas of supervision and education.

Despite the tiny percentage of the budget allocated to nursing services--an average of 3 per cent of the total PAHO Budget--the number of nurses, programs and specific activities grew rapidly during this period. In 1947, there were two nurses in Washington, D. C., and two in the offices in Peru and Guatemala. Four years later, in 1951, 20 more

nurses had been added to the country activities and by the end of this period, 1959, the section had 43 nurses (the largest number ever recorded in the official documents to date).

There was also a considerable increase in publications on nursing, with substantial contributions by Latin American nurses (see Figures 1-3 and Table 1), and for the first time, specialized literature on nursing was translated into Spanish:

- Principios y Práctica de Enfermería, by Hammer and Henderson;
- Supervisión en Salud Pública, by Hodgson; and
- Manejo de Sala y Enseñanza, by Benet.

FIGURE 1. BOLETIN OFSANPAN: FREQUENCY DISTRIBUTION OF ITEMS ON NURSING (1926-1948)

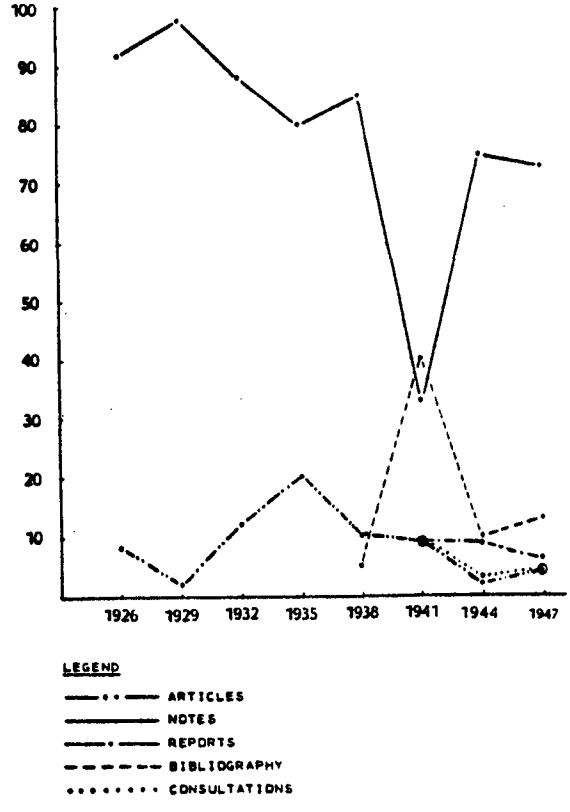
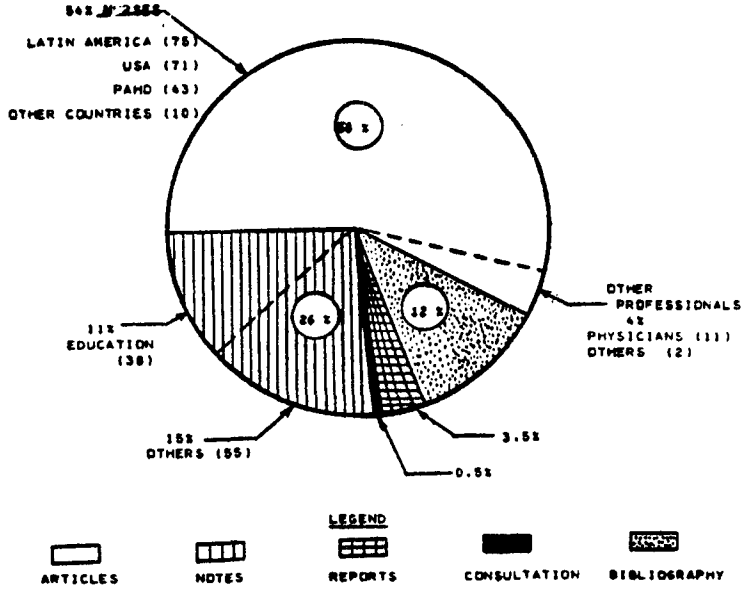
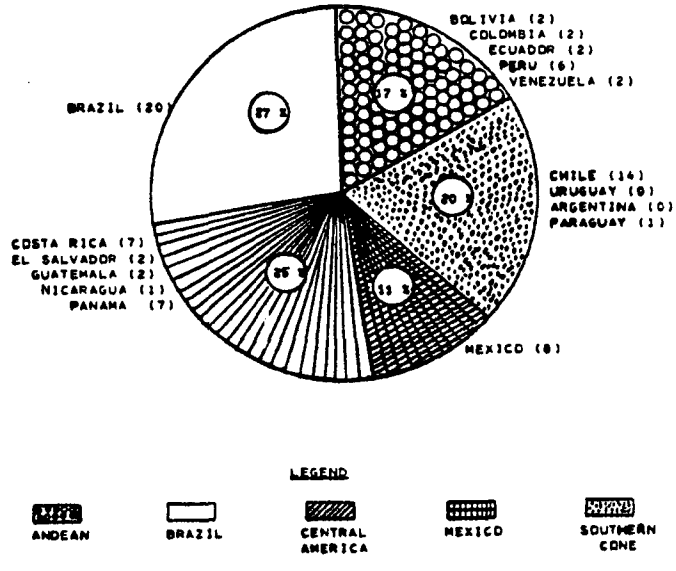


Figure 2. Boletín OFSANPAN: Items on Nursing: Articles (by origin of author), Notes (by type), Reports, Consultations and Bibliographies (1949-1960)



Note: Numbers in parenthesis are absolute figures

Figure 3. Boletín OFSANPAN: Articles published by Latin American nurses according to subregion of origin (1949-1960)



Note: Numbers in parenthesis are absolute figures

Table 1

Boletín of the Pan American Sanitary Bureau
Number of Articles on Nursing by Subject

Years / Article by subject	1949/1951	%	1952/1954	%	1955/1957	%	1958/1969	%
Editorial	3	5	4	7	3	6		
General nursing	15	23	17	28	10	19	16	44
Nursing in DT	10	15	6	10	3	6		
Administrative nursing	4	6	4	7	4	8	1	3
Education nursing	14	21	12	20	9	10	10	28
MED/nursing					2	4		
MCH nursing	3	5	1	2	4	8		
Public health nursing	13	20	9	15	7	13	2	6
Psiquiatry			3	5	3	6		
Auxiliary personnel	2	3	2	3	6	12	2	6
Country situation	1	1	2	3	1	2	1	3
Nutrition	1	1						
Nursing in other articles							3	8
TOTAL	22	100	60	100	52	100	36	100

During this period, the nursing section also sought ways of setting up programs on auxiliary nursing personnel. The problem of the education of nursing personnel is an issue that is still very controversial. During the First Regional Congress (Costa Rica, 1949), the nursing section included discussion of this topic on the agenda, but the lack of agreement among the participants prevented any specific recommendations from being made. The report of the Congress stated: "The Congress is not in a position to make recommendations on this matter until some time has passed." The situation repeated itself at the Second Regional Congress (Peru, 1949), when it was decided that: "each country should consider the training of auxiliary personnel in accordance with its own needs at the most opportune moment for each government." For Chagas (1964), the principal reason why Latin American nurses rejected training for auxiliary personnel was the fear that they might replace graduate nurses. According to Chagas, this fear was greater among nurses from countries where the admissions requirement for nursing school was merely to have completed primary education. Chagas went on to say that in countries where admission requirements were higher than merely primary education, the fear did not exist. That "fear," as explained by Chagas, was based on the fact that a large number of nursing personnel without

formal training were already recognized as "nurses". Naturally, it would be more difficult to make any distinction between personnel with very little training—no matter how short—and three-year trained nurses.

However, these observations look at the problem only from the internal point of view of nurses themselves, which had a contradictory historical perspective. On the one hand, the development of nursing in the United States and Europe had a different history with regard to the education of auxiliary personnel. In both England and the United States, the development of "modern nursing" began with the emergence of clinical medicine in hospitals. At the end of the nineteenth century, most of those practicing nursing had some kind of training and there were standards for the selection and admission of nurses to the various training programs. It was after the Second World War, when there was a shortage of nurses, that the United States organized nursing auxiliary programs for the first time.

But the situation was historically different in Latin America. When nursing training began in Latin America, there were a large number of "nurses" without formal service training. As the nursing schools began to recruit young middle-class women, the gap between them and the practical "nurses", who generally came from a lower social class, became wider. We can therefore see that these events were more directly responsible for the attitudes than the "fear" suggested by Chagas.

The nursing section in PAHO continued to insist on the development of training for nurses aides until it was accepted by the nursing leadership in the Region. It should be noted that there was great interest on the part of governments in training this type of personnel. During this period, PAHO/WHO gave technical cooperation to nine programs for training nursing auxiliaries in the Region, and at the end of this period, had programs in most of the countries.

Another important activity during this period was the awarding of fellowships to Latin American nurses: PAHO gave 402 fellowships to nurses in Latin America. (see figures 4, 5, 6 and 7 on the distribution of fellowships according to duration, country of origin of the recipients, area of study and country in which the study fellowship was used.)

In summary, during this period, the Nursing Section responded to internal demands from PAHO resulting its expanded role in the health field in the Americas by setting up a vast network of nursing advisory services for the Region. It formulated policies and carried out activities that were in general associated with PAHO policies at that time. International development in professional nursing also influenced the Organization's theory about nursing.

Nursing in PAHO (1960-1980)

General characteristics of the period

By the beginning of the sixties, nursing policy at PAHO had changed its central approach from the development of nursing education, which had characterized the two previous stages, to the policy of giving priority consideration to the development of services. PAHO also expanded its policies on medical care, and as a result, nursing began to emphasize hospital nursing rather than the development of public health services, which had characterized the previous periods.

In general, the shift of PAHO's policies toward expansion of medical care was a result of its endorsement of the development model proposed by the Organization of American States at the end of the fifties. The Act of Bogotá (1960) and the Charter of Punta del Este (1961) stated a need for recognizing medical care. Thus, the shifts in nursing policies were related to changes in PAHO itself, which can in turn be associated with changes in social structures in Latin America.

This period is marked by a growing awareness of the role of health in social progress. The Director stated that the Organization had taken "the steps needed to make health a component of development", and considered that planning for the integral development of human and physical resources was a task that needed to be done immediately, in order to achieve the objectives of raising life expectancy at birth and increasing learning and production capacity by improving individual and collective health (PASB, 1962).

Influenced by this broad conceptual view of development and the inclusion of health in social development, nursing at PAHO reoriented and extended its activities.

Nursing Policies

The shift in nursing policies that occurred during this period must be analyzed in light of the changes in the socioeconomic structure of Latin America and the dominant influence of the United States. During this period, most of the countries of the Region were consolidating their industrialization process, which in turn promoted rapid expansion of health services, and particularly of hospital complexes. At the same time, modernization of agricultural production created a demand for rural health services. Although official statements at that time emphasized the humanitarian intent of the social welfare that ought to go hand-in-hand with economic development, the protection of workers' health was the means of ensuring that production would continue. For example, the Director said "...the dominant policy, both nationally and internationally, is to accelerate economic development and abolish the great

disparities in income distribution in order to raise standards of living" (PASB, 1962). However, the fueling of the economy in Latin America by the developmentalist model turned out differently in most of the countries: instead of doing away with unequal income distribution, it accentuated it. The final result was an increase in the very poor, who were more and more dependent on government services and social programs such as health care, thus, prolonging the fiscal crisis and political instability of the Region.

In addition to Latin America's socioeconomic development process, we must also look at the ideological and economic influences that came from abroad. The foreign capital that has been extensively used in the Region has increased dependency and the national debt and sharpened the domestic fiscal crisis. The predominant ideas about health also came through the influential groups. Andrade (1979) reviewed international influence on medical education in Latin America over the last 25 years, and suggested that the influence was continuous and often conflicting. In some cases, it meant that foreign models were adopted.

As an international organization, PAHO was in the vanguard of these processes, reaffirming its role as coordinator of international efforts to publicize the dominant theories in the health area. By adopting the definition of the Economic Commission of the OAS for Latin America on Development, which stated that: "the problem of economic development is essentially that of rapidly assimilating the vast resources of modern technology in order to raise the living standards of the masses", the Organization embarked on the process of technology transfer as a strategy for harmonizing welfare and economic development (PASB, 1962).

Based on the directives of the Charter of Punta del Este, PAHO drew up the Ten-year Public Health Plan, which represented its policies, goals, programs and projects for 1962-1971. In 1972, the Third Special Conference of Ministers of Health of the Americas adopted the Ten-year Health Plan for the following period. These were the major sources for nursing policies during this period.

Alongside this predominant influence, the international nursing movement also helped continue the effort for professional recognition. For example, professional recognition via the strengthening of national colleges and the creation of the Pan American Nursing Federation would persist into the beginning of the sixties as a working goal for nursing at PAHO.

The first Ten-year Health Plan emphasized health planning and programming consistent with the health needs of each country and the availability of funds. Nursing policies therefore promoted the development of national nursing plans. All the countries were encouraged to study existing nursing resources. The recommendations indicated that

Figure 4. Nursing fellowships and Latin American nurses according to duration of program for each sub-region (1950-1959)

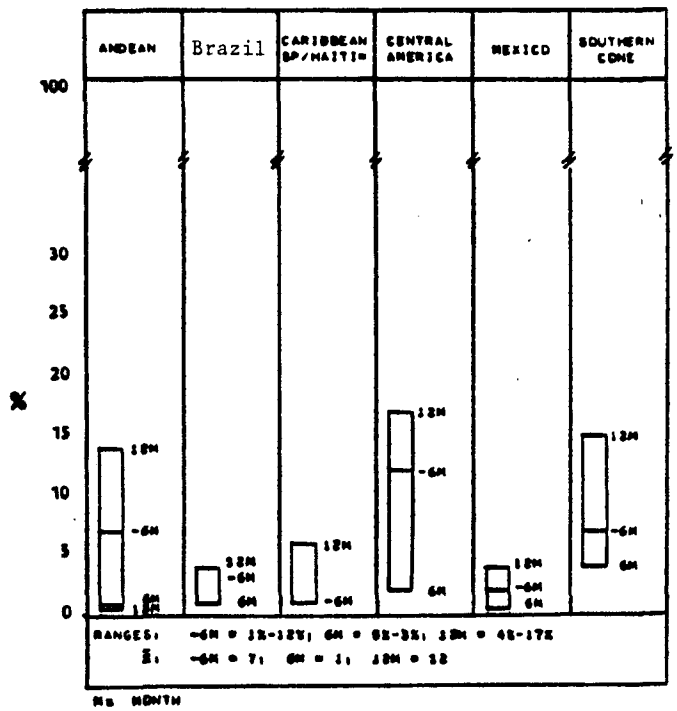


Figure 5. Distribution of nursing fellowships by country within each sub-region (1950-1959)

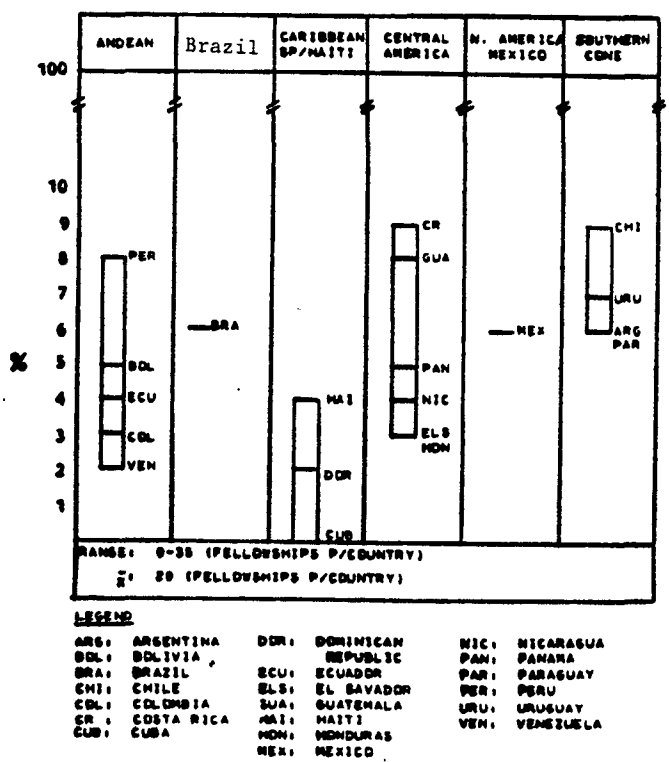


Figure 6. Nursing fellowships awarded to Latin American nurses according to field of study (1950-1959)

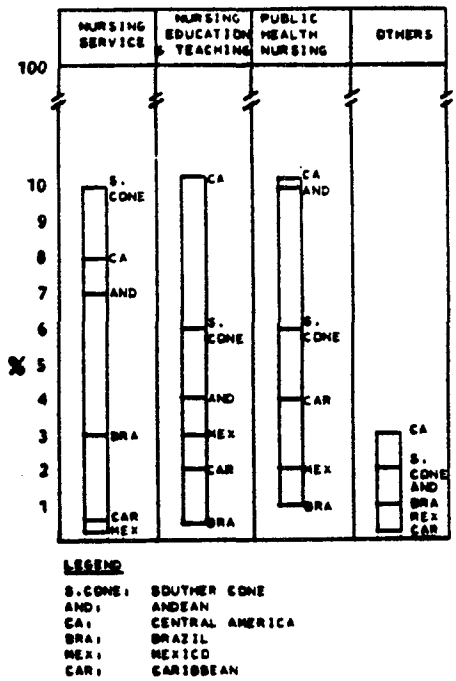
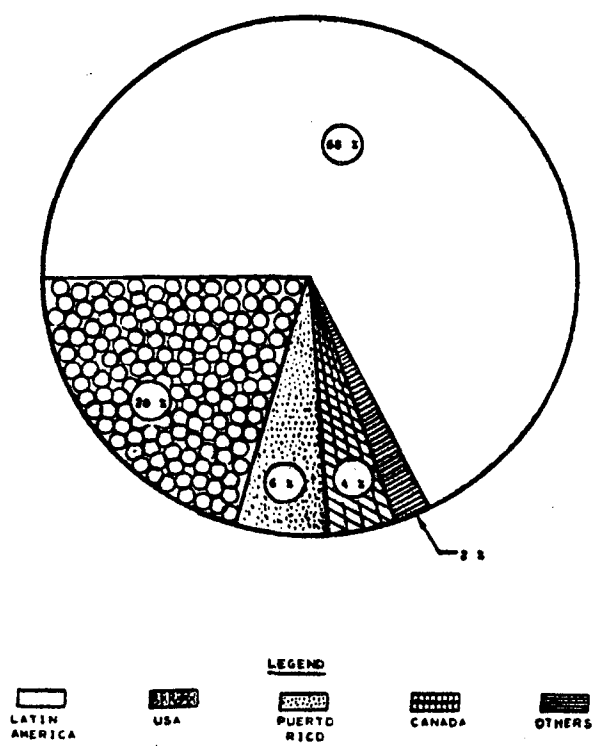


Figure 7. Fellowships awarded to Latin American nurses by region and country of study (1950-1959)



there was a need to develop educational systems for three levels of personnel, and to review the curriculum to enable new ideas to be incorporated and to suit them to the realities and needs of each country.

During the second decade (1970-1980), the world community adopted the New International Economic Order, with reservations by a minority of countries, as a response to the economic crisis. As far as health was concerned, the Second Ten-year Plan for the Americas and later the Declaration of Alma Ata began to emphasize extension of coverage and primary health care strategies as ways of dealing with the crisis, inasmuch as the cost of health care was becoming a overwhelming factor.

During this period, the governments adopted a resolution on nursing for the first time. On the basis of this resolution and for others approved during the decade (1970-1980), nursing at PAHO drew up its program of action. Table 2 gives a summary of five resolutions on nursing adopted by the Governments over the last decade.

In addition to the resolutions on nursing, the recommendations of the First Technical Advisory Committee on Nursing (1969) were a major source of nursing policies at PAHO. That Committee's recommendations are summarized in Table 3. They reinforced the health planning policies that had been adopted by the Organization, and anticipated some of the resolutions that were adopted in the seventies.

In 1978, at the end of this period, the Thirty-third World Health Assembly held in Alma Ata, USSR, adopted the Goal of Health for All by the Year 2000. The Plan of Action and future activities of PAHO/WHO were defined on the basis of this goal, and included primary health care as a basic strategy.

In the following paragraphs, the major policies of the nursing section are identified according to the specific area:

Integrated Health Services. Planning and organization of nursing services in hospitals, including: 1) determination of the adequacy of existing nursing services, and the ratio of nursing personnel to population; 2) organization and strengthening of nursing units, sections or departments at the national level; 3) leadership training for nurses in the Region for administrative and supervisory posts; 4) determination of the duties of nursing personnel at the hospital level, and 5) development of the nursing system.

Education. The new policy on education included: 1) consolidation of three levels of nursing education; 2) reinforcement and inclusion of social and health aspects in nursing programs; 3) strengthening post-basic programs; 4) integrating nursing training with work in educational and welfare institutions, and 5) developing minimum standards for nursing education.

Table 2

Summary of the Resolutions on Nursing adopted by the Member Governments of PAHO between 1970 and 1980

1972	1974	1975
Ten-Year Health Plan for the Americas.		
Accelerate the production of nursing personnel and the establishment of regional centers to prepare nurse instructors, specialists in administration and training of researchers in nursing.	Examine the nursing situation in the countries, provide positions for nurses at all service levels and promote training on direct care of individuals.	Develop a system of information on nursing to determine the number and preparation of nurses and auxiliary personnel necessary to meet the goals of the Ten-Year Health Plan. Reinforce the educational system.

1977	1980
Readjust nursing functions necessary to attain the goals of extension of coverage through primary health care. Focus educational programs on the needs of the services for the extension of coverage. Utilize modern technology of education in all training programs.	Define the role of nurses in primary health care and institutionalize it. Increase the number of auxiliary personnel, mostly in the area of primary health care. Training of personnel (nursing) to assume expanded role required at the first level of care.

Source: Manfredi, M. (1982) Resolutions about nursing during the last decade.

Table 3

Summary of Recommendations Present to the Nursing Services of PAHO by the Technical Advisory Committee on Nursing
Washington, D.C., 18-22 November 1968
(First Meeting)

System of Nursing Personnel	Planning, Research and Investigation	Utilization of Nursing Personnel
Encourage the countries to develop three levels/categories of nursing personnel: High Intermediate Basic High level= university programs Intermediate= secondary school (technical) Basic Level= auxiliary nursing.	Improve abilities of nurses to participate in planning. Have nursing personnel included in manpower studies in the countries. Promote leadership and support investigation. Prepare nurses to develop research.	Support principles of nursing participation in planning at all levels. Prepare nurses for administrative positions. Prepare standards for transfer of medical technical activities to nurses. Promote rationalization of utilization of nursing personnel.

Publications and Textbooks	Additional Recommendations	Nursing Advisory Services (PAHO)
Encourage schools and universities to establish a system to facilitate acquisition of textbooks. Encourage preparation of nursing papers for publication. Establish a textbook program. Promote publication by Latin American nurses. Increase nursing publications at PAHO.	Discuss curriculum of midwifes and nurses midwifes. Promote assistance for students through fellowships and loans. Promote integration of nursing education in the area of health professions. Promote collection of data on nursing for Latin America. Promote continuing education for nurses.	Provide for staff development of nurse advisors. Explore means for better utilization of advisory resources and ways to implement the committee recommendations.

Source: Scientific Publication PAHO No. 180.

Extension of coverage. Organization of community services, and definition of the roles of nurses in primary health care programs.

Education Projects

Basic programs. Technical cooperation consisted basically of training instructors and supervisors. In 1960, PAHO sponsored an international seminar that brought together nurses from 12 countries of the Region, along with educational advisors, to prepare the first manual for Nursing Schools. The fundamental principles of basic education contained in this manual were that nurses should head the schools, and that the schools should be included in the country's educational system, at the proper level. The educational ideas are derived from Ralph Tyler's Basic Principles of Curriculum and Instruction, while the basic nursing principles were those recommended by the International Council of Nursing (ICN). The main features of Tyler's principles are quite well known, and are derived from the theory of educational systems. The ICN nursing concepts are based on humanism and technical training. Both are part of a positivist philosophy.

The manual also contains instructional principles on the selection and organization of educational content and experience. The proposed structure included an integrated core content of biological and social sciences, general education and communication. The manual also suggests strategies for the control of nursing education and schools at the national level, and on their organization, administration and financing.

The need to increase the number and quality of professional nurses was given constant emphasis during this period, while there was a growing awareness that nursing training was out of step with specific health needs in the countries. Studies were conducted in the Region on the nursing education system, the definition of levels and revision of the curriculum. Actual nursing duties became the basis for recommendations on the curriculum. Later, policies on expansion of coverage would also result in emphasis on training nurses to serve in primary care programs.

Post-basic Education. In the area of post-basic education, PAHO continued to support the development of graduate centers. Clinical specialties were promoted, along with public health, supervision and administration.

At the beginning of the sixties, most of the countries of the Region had one or more programs at the post-basic level. The initial programs emphasized teaching and supervision, but later the emphasis shifted to the development of clinical specialization in areas such as maternal and child health, pediatrics, psychiatry, and so forth.

Training of Auxiliary Nursing Personnel. This was the area to which PAHO gave most emphasis and priority during this period. Activities consisted basically of training nurses to head the training programs for nursing auxiliaries, the production of instructional materials and a definition of the duties of this category of personnel.

According to Meyer (1980), Latin America now has more than 300,000 nursing auxiliaries, who are responsible for approximately 80 per cent of direct patient care in the hospitals and community programs. Meyer also commented that around 50 per cent of these auxiliaries had received little training. Despite the fact that the number of auxiliaries increased during this period, the ratio to the number of inhabitants remained constant. Meyer's Table 4 is reproduced here to illustrate this point.

As a result of this, one of the major problems facing the governments of the Region and nursing within PAHO in relation to nursing personnel continues to be the provision of adequate training programs. If training is to be adequate, there must be competent instructors and supervisors. However, as pointed out by the literature on this field, herein lies the greatest difficulty in developing training projects. Macedo (1980), in describing the Brazilian experience with the training of auxiliary personnel for the extension of coverage programs, refers to the availability and quality of instructors and supervisors as the greatest challenge faced locally by the directors of these programs.

Table 4

Number of Nursing Auxiliaries and Ratio per 10,000 Inhabitants in the Region of the Americas - 1964-1976

Region	Nursing Auxiliaries							
	1964		1968		1972		1976	
	Number	Ratio	Number	Ratio	Number	Ratio	Number	Ratio
North America	701,517	34.4	1,132,833	51.5	1,434,062	62.9	1,597,450	67.2
Central America	63,749	6.2	72,926	8.6	60,932	6.6	93,521	9.0
South America	113,988	7.2	151,530	9.0	203,550	10.5	216,539	10.5

Source: Meyer, Alicia. Edu. Med. Salud.

Thus, the training of auxiliary personnel continues to be a complex problem in Latin America. On the one hand, the great differences between candidates' levels of basic schooling have made it difficult to develop educational programs and prepare instructional materials that are in any way adequate. On the other hand, development of these programs has also been hindered by the lack of well-defined duties that are regulated by law.

PAHO has made continuous efforts to give its assistance to the countries in resolving these problems. More than 50 seminars and short courses were given during this period to train instructors and to develop guidelines for the training of auxiliary personnel. In 1964, a guide was prepared on the training of auxiliaries. Cooperation was given to national centers in Argentina, Bolivia, Chile, Guatemala, Panama, Paraguay and Venezuela on training instructors of auxiliary personnel. There were also international seminars to define the functions and roles of such personnel. Despite all these efforts, Latin America has entered the 80s without having resolved this problem; to the contrary, the problem has become worse. The ratio of auxiliary personnel to population has not improved, and in addition, achieving the goal of health for all by the year 2000 will require these auxiliary personnel to develop new abilities and skills, thus creating an additional pressure.

Advisory Committee on Text Books

This Committee held five meetings during this period on the following areas: surgical nursing (1971); maternal and child nursing (1972); introduction to nursing (1973); teaching of community health nursing (1975), and teaching of mental health and psychiatric nursing (1976).

With few variations, the first three committees would follow the same procedure. First, a basic review of the objectives of nursing education and its functions; second, an assessment of the conceptual framework in which the specific area of nursing should be seen; third, a definition of the functions of nursing and of the objectives of the instruction; fourth, the identification of specific content and overall teaching and evaluation strategies. Finally, recommendations were made on textbooks and bibliographical sources and on the overall purpose of education in the specific area. With the exception of two textbooks written by Latin American authors and cited in the bibliography, all the recommended textbooks and bibliography from the first three committees were written in English by North American authors.

The Committee on the Teaching of Community Health Nursing used a different method. It analyzed the specific community health situation in Latin America and examined trends on the delivery of these services in the Region and the implications for community health nursing. The concepts of community health nursing and teaching strategies were derived from this frame of reference. The Committee specified some criteria on the selection of textbooks, and recommended an American textbook.

The last Committee on Mental Health and Psychiatric Nursing considered the overall characteristics and trends of practice in the Region, and recommended an American text.

In short, all the five textbook committees emphasized the need to have education linked to practice in the Latin American context. However, surprisingly and paradoxically, rather than recommending that textbooks be produced by a group of Latin American authors under the sponsorship of PAHO, they selected American textbooks. However, it should be said that at that time, PAHO did not have any real possibility of sponsoring the production of textbooks by Latin American authors. Its only possibility was to include books that had already been published. The lack of textbooks by Latin American authors was at the root of this situation.

A recent piece of research by the Division of Human Resources noted that 66 out of a total of 80 nursing schools use the textbooks program. Table 5 describes how the students used these books. The low rate of utilization of the books by the schools is frequently explained as being due to the socioeconomic level of the students or because of administrative problems in the management of the program. Less frequently mentioned is poor publicity of the program, or unsuitability of the textbooks to the school programs.

Table 5

Utilization of Textbooks by Students, 1982

Percentage of Students	Number of Schools
80% - 100%	12
70% - 40%	36
30% -	19

Table 6

Books from the Expanded Textbook Program not recommended by teachers and not used by students, and reasons, 1982

Book	No. Schools not recommending	Coded Reasons*	No. Schools where students do not use	Code**
Enfermería Maternoinfantil, Kaeder	10	2 - 5 - 6	4	1 - 5 - 6
La práctica de enfermería en salud mental. Morgan Moreno	10	1 - 2 - 5 - 6	4	1 - 6 - 8
Enfermería Médicoquirúrgica, Smith	4	3 - 6	3	1 - 6 - 8
Enfermería Pediatrica, Waechter	3	2 - 5		
Enfermería Práctica, Dugaz-Kozier	10	1 - 2 - 6	2	1
Intervención de enfermería psiquiátrica, Travelbee	7	2 - 5 - 6	3	5 - 6
Métodos para el exámen físico en la práctica de la enfermería, Sana-Judge	5	1 - 2 - 5 - 6	3	1 - 6 - 8
Enfermeria médicoquirúrgica, Brunner	12	2 - 6	9	5 - 6 - 8

*Code:

1. Not relevant to course program
2. Text book content unknown.
3. Inadequate discussion of material.
4. Very complex text
5. Did not arrive on time.
6. Other.

**Code:

1. Not recommended by professors
2. Students do not buy book because of lack of funds
3. Students feel it to be very difficult
4. Do not consider it very interesting
5. Difficult to read
6. Did not arrive on time
7. No time to buy book
8. Other

Table 6 shows the findings on the non-recommendation of books and non-use of them by students.

The most frequent methods of advertising books are posters and talks to groups of students. For professionals, circular letters and pamphlets on the nursing program are often sent out to associations and services.

As regards administration of the program the schools included in this sample most often coordinated the program in isolation or in association with the university.

Educational Technology

Following the recommendations of the Second Ten-year Health Plan, PAHO began to promote educational technology and research on nursing. In 1974 an interregional project was set up in the Latin American Center for Educational Technology in Health, CLATES, in Rio de Janeiro, Brazil, in order to establish educational technology centers in selected schools in Latin America. The program is still operating. Rodríguez, et. al. (1979) reviewed the development of this program and were able to differentiate between three different stages:

First, the production of instructional material centralized at CLATES. This initial phase in reality, never became consolidated. The first activity in Rio de Janeiro was the production of a self-instructional unit, but it soon became apparent that this strategy had limitations insofar as resolving the many different problems of nursing education was concerned. Despite the fact that the quality of the instructional materials produced by CLATES was good, the production instructional packages in a centralized way prevented the nursing schools teachers from adopting this methodology. As a result, it was agreed that teachers would exchange information so as to ensure that instructional materials produced would suit their future needs.

Second, training of nursing teachers in the national centers through the production of instructional materials. During this phase, five centers were set up in Brazil, Chile, Ecuador, Costa Rica and Venezuela. Each center began to prepare its own materials in a series of workshops on instructional methods. Drawing on this experience, the centers were able, after two years, to question the school's capacity to produce quality instructional material and the possible role of educational technology in maintaining traditional concepts. The program was revised in view of these considerations.

Third, it was proposed that technical cooperation be given on the basis of a diagnosis of educational needs in each school, and that the program be established accordingly.

In this phase, the verticality of the program disappeared, and it became based on local needs according to available resources. Six new centers were created on the basis of this new idea, in Mexico, Brazil (2), Cali, Bogotá and Peru. Each center developed a network of sub-centers in the schools in their area of influence.

Up to 1979, this program had trained 1,250 nurses in various aspects of educational technology, and had produced 275 modules and other instructional materials.

Research:

Nursing research in Latin America through PAHO projects did not begin to develop until the sixties, although some projects had been done earlier at the country level. The Organization has no specialized nursing research staff, and has always used the services of short-term consultants.

An interregional research program began in 1972 in some schools of the Region. It has promoted the training of nurses in the scientific method and has given each school a small grant.

Manfredi (1982), addressing a research group in Honduras, said that research needed to be done in the area of nursing practice and its relationship with the educational process. Research on nursing practice and its implications for the improvement of health is an area that will be important for PAHO in the future. The result of this type of research could be to provide a better understanding of the future role of nursing in health care in Latin America.

However, nursing activities at PAHO declined during this period in comparison with the previous period. The number of nurses at PAHO fell notably after the sixties. Figures 8 and 9 give this information. Not only did the total number of nurses decline, but also the consultants in education projects were fewer. The amount of the nursing budget in relation to the Organization's total budget also fell from an average of 3 per cent at the beginning of the period to 1 per cent at the end.

Figure 8. Number of nursing advisors (total), Number of advisors from Latin America, United States of America and other countries (1958-1980)

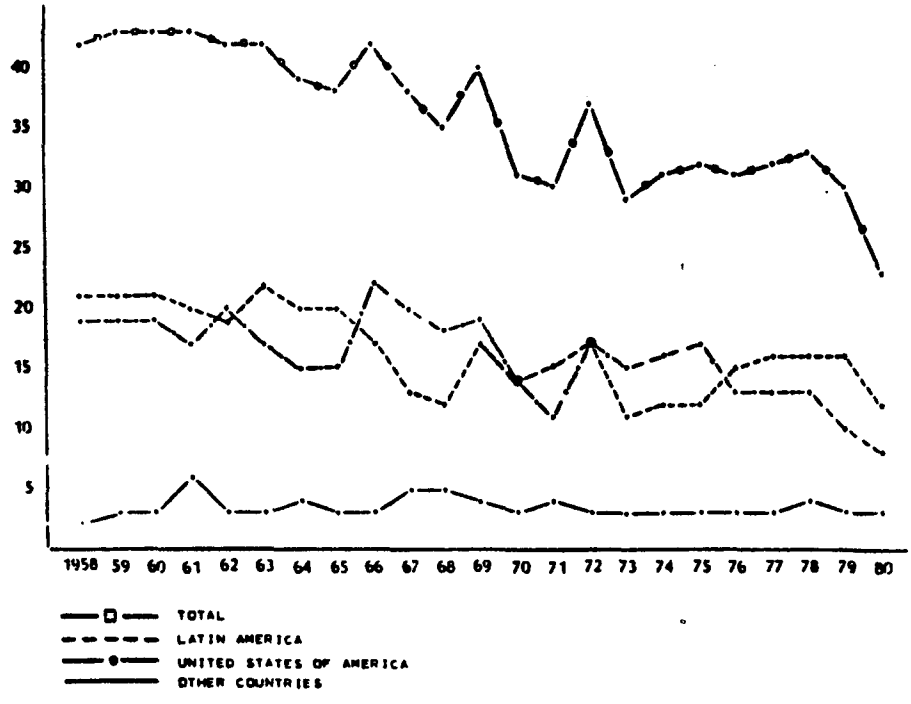
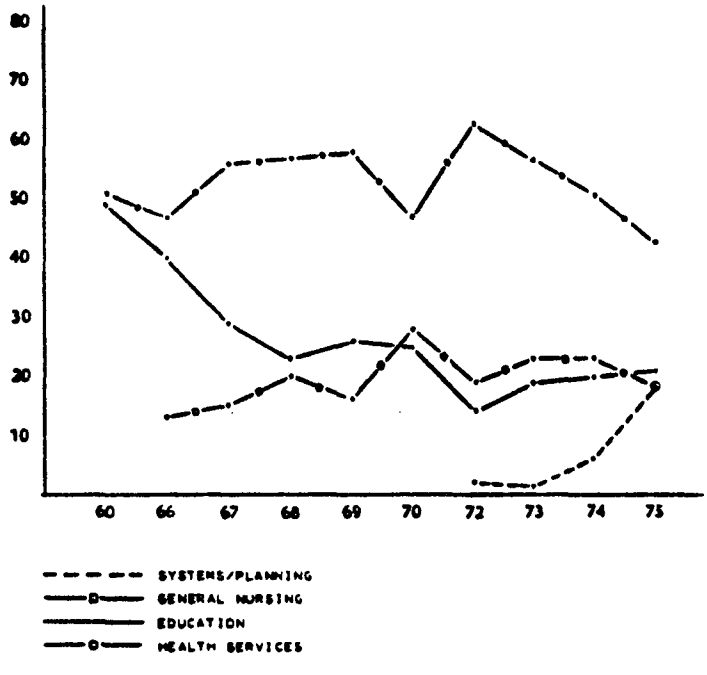
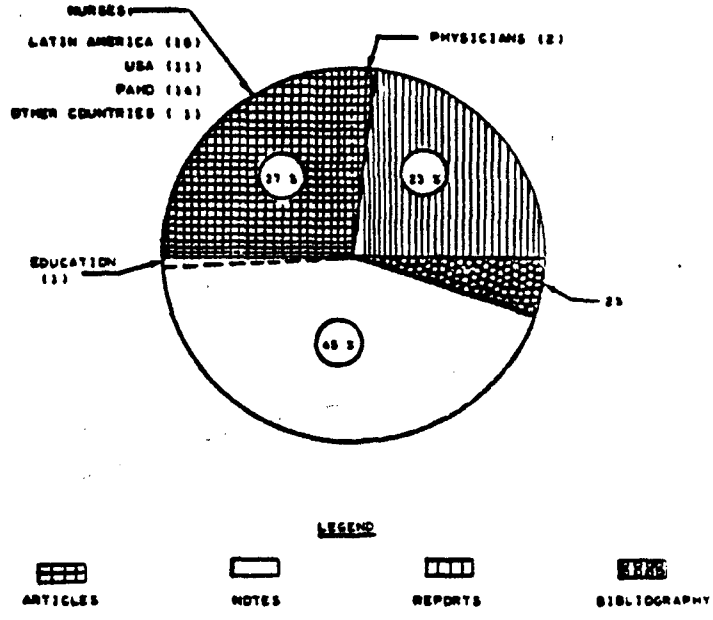


Figure 9. Distribution of nursing advisors by projects (1960-1975)



Publications in the Boletín also fell, although literature on nursing was found in other PAHO publications during this period. The most representative of general nursing trends during this period were the scientific publications and reports on nursing. Most of the scientific publications dealt with educational issues, with emphasis on structuring the curriculum to enable it to respond to new demands for services and the integration of community health services. Figures 10, 11 and 12 show the status of publications in the Boletín of the Pan American Sanitary Bureau during this period.

Figure 10. Boletín OFSANPAN: Items on Nursing: Articles, Notes, Reports and Bibliography (1960-1980)



NOTE: NUMBERS IN PARENTHESIS ARE ABSOLUTE NUMBERS.

Figure 11. Boletín OFSANPAN: Articles published on nursing - Classified by subjects (1960-1980)

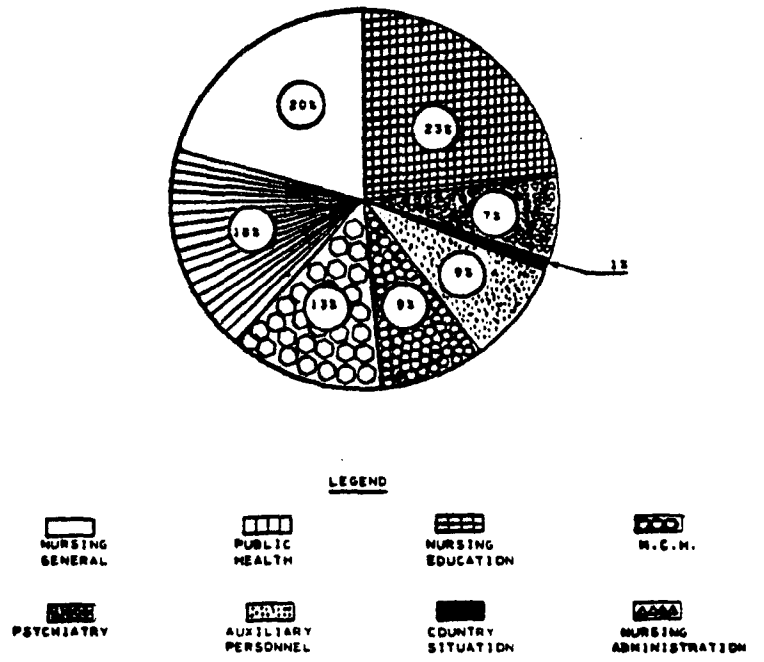
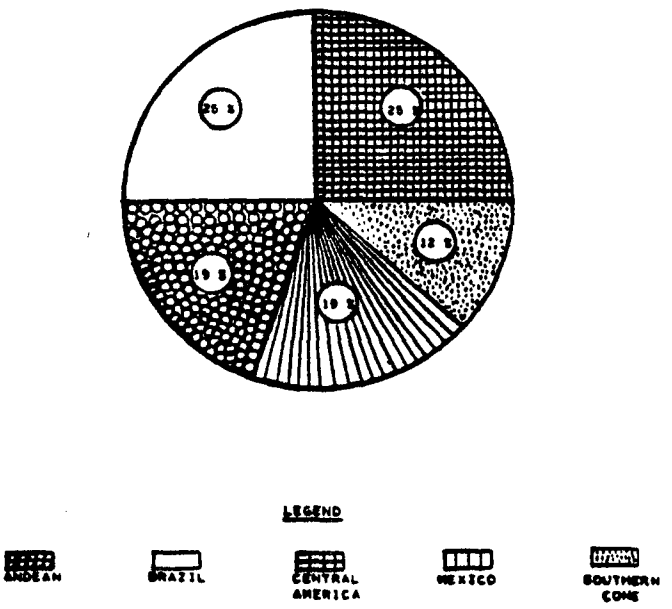


Figure 12. Boletín OFSANPAN:: Articles published by Latin American Nurses by sub-region (1960-1980)



The fellowship program also continued to encourage nursing training in the Region. In general, the number of fellowships rose and the opportunity was taken up by most of the countries. The general trend in this period was to give short-term fellowships for programs in Latin America. Figures 13, 14, 15 and 16 show the distribution of the 1,771 fellowships awarded by PAHO during this period.

Figure 13. Nursing fellowships by duration of program and sub-region (1960-1980)

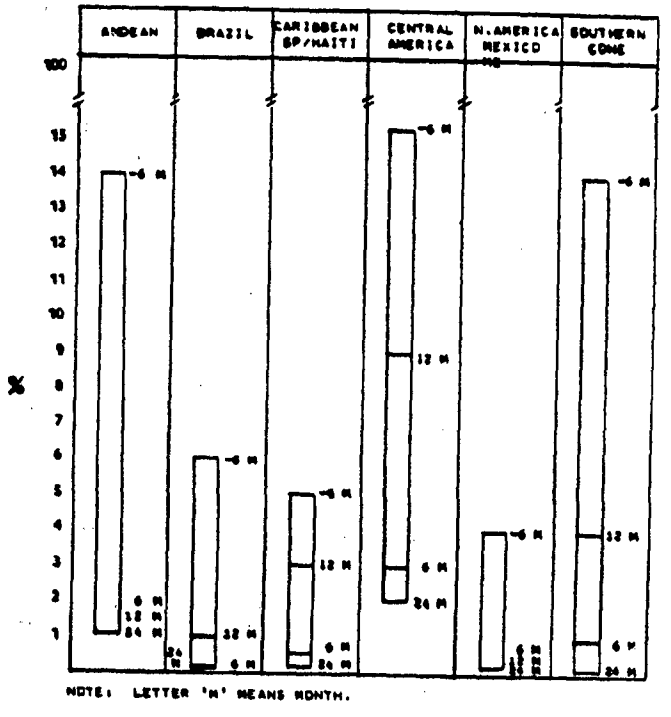


Figure 14. Nursing fellowships awarded to Latin America by sub-region (1960-1980)

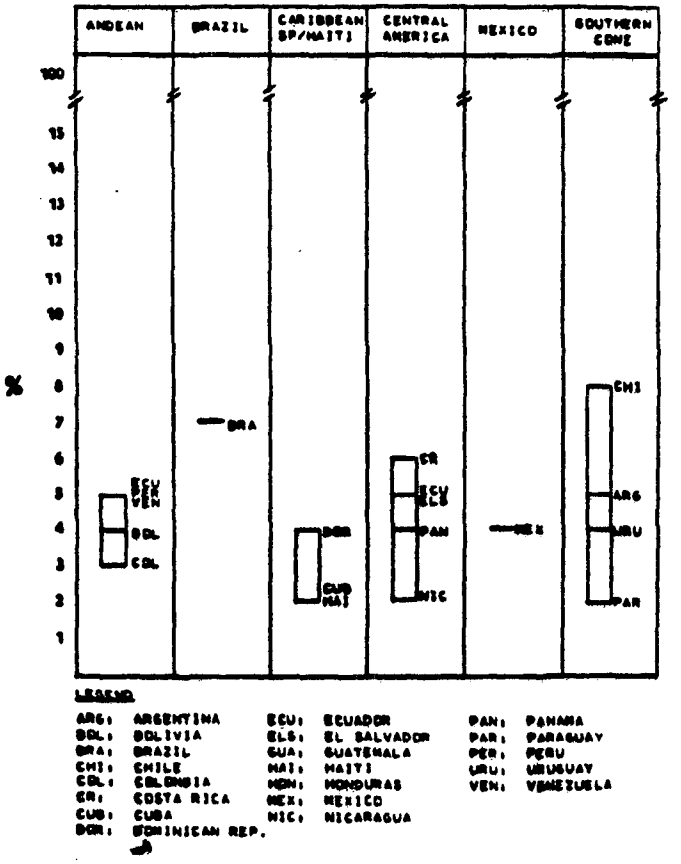


Figure 15. Nursing fellowships to Latin American nurses according to field of study (1960-1980)

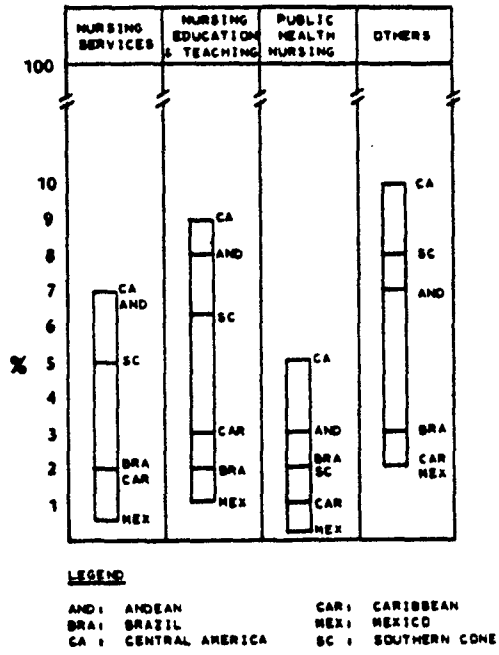
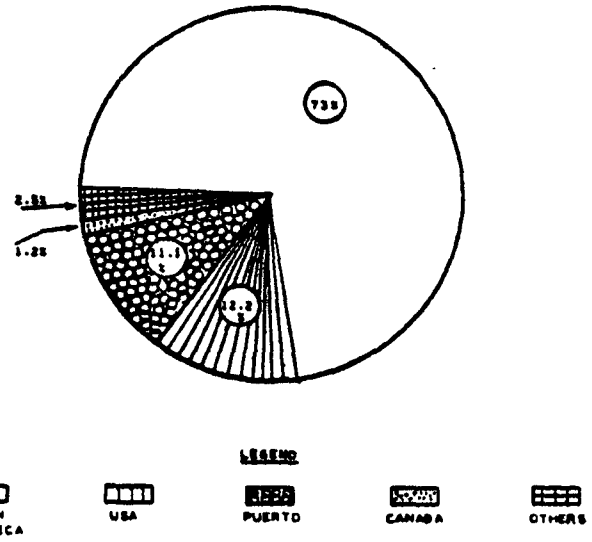


Figure 16. Nursing fellowships awarded to Latin American nurses according to place of study (1960-1980)



The decline in nursing activities during this period raises an important question which is not easy to answer because of the very many factors that came into play. The question is: why is it that during the second half of this period, we see such a rapid decline in nursing activities at PAHO, at a moment when the institution was adopting primary health care as its central strategy for achieving the goal of Health for All by the Year 2000?

It is paradoxical since nursing has always had an important role to play in this area. The inference might be that the budget resulting from the economic crisis is limiting the growth of certain programs, and in some cases making for zero growth. However, it is difficult to accept that budgetary constraints are exclusively responsible for the disappearance of resources for nursing. In searching for an answer, we must look at more substantive aspects of the problem. It might be suggested that the profession is considered to be slow in accepting change and not sufficiently flexible in developing the multidisciplinary approach needed to meet the new demands for health personnel, and that the major role the nursing profession claims for itself is a belief not shared by the Member Governments, individually or collectively.

SOME NOTES ON NURSING EDUCATION IN LATIN AMERICA

The development of nursing in Latin America was in three major stages. First, the secularization policies that came along with the modernization and increased use of technology in medical care were responsible for the development of educational programs at the end of the last century and at the beginning of this century. With the exception of Mexico and the countries occupied by the United States at the beginning of this century, however, these policies were not fully established in most of places. Thus, the training of lay personnel for nursing care was limited to in-service training of auxiliaries under the direction of nuns. As a result, nursing care in most of the countries remained in the hands of Catholic religious communities.

The few nursing schools founded at the end of the last century and at the beginning of this were somewhat unstable and made no impact on the number of graduate professionals. Most of these schools were promoted by doctors who had studied in Europe and who had seen the "modern nursing" movement led by Florence Nightingale in England. Some exceptions could be seen in Chile, for example, a country that had a well-developed economy and was able to maintain a continuous development of its nursing services. In Argentina also, nursing schools were important to the development of technical nursing, although the number of students graduating at the period was very small.

Initially, the programs were based on patterns of in-service training, following the model of the English "probationer", whose very rigid disciplinary rules made it difficult to develop leaders. Nursing education was dominated by physicians who emphasized the need for training in accordance with American and English patterns derived from the Nightingale reform. In England, the probationer system was used in

Victorian times when the professions were developing among the expanding middle classes. (Baly, 1980); but in Latin America, capitalist formation did not promote the expansion of the middle classes, and nor did it create the bases of an educational system that would encourage women to obtain basic education or work in the professions. Recruiting middle-class women for nursing in Latin America was thus a problem. The literature of the time refers to the need to recruit women of high "moral character", and references to Grierson, Pullen and Adams indicates that it was necessary to stress the cultivation of moral qualities for nurses.

Mexico was perhaps an exception to that situation. After the Mexican Revolution, the policies on the secularization of medical care encouraged middle-class women to go into the professions. Although discipline and morality was part of the idea of nursing, the principal emphasis was on the development of technical abilities. Thus, it was easier to recruit nurses in Mexico than in other countries of the Region. The number of nursing students in Mexico has grown continuously, and currently, almost one fourth of all nursing students in Latin America are in the 123 Mexican schools. In short, the development of nursing education in Latin America at the beginning of the century made no significant changes in nursing practice. The number of schools and students was limited and only a few more stable programs have continued through to the present. (Table 7 gives a summary of the development of educational programs in some countries during this period.)

Second, the public health movement became an important element in the promotion of nursing education after the first 25 years of this century. Nursing schools were founded in countries which had not had them before them, and new schools were set up and some of the existing programs were reorganized in countries that had already started nursing programs.

The Rockefeller Foundation played an important role at the beginning and throughout this entire period. In the early 1920s, the Foundation began cooperative services in Brazil and founded the Ana Nery School; it also helped in introducing public health programs in Chile, Panama and Argentina. A similar project was conducted in Colombia and Venezuela in the 1930s, and finally, during the Second World War, the Rockefeller Foundation sponsored programs in cooperation with the Institute for Inter-American Affairs and PAHO.

The role of PAHO and of the Institute for Inter-American Affairs was also of great significance. PAHO continued technical assistance for a long time, and the Institute for Inter-American Affairs created an extensive network of public health services in the Region, thus creating the conditions for field work in public health nursing.

The number of schools and students in the Region tripled during this period in comparison with the previous period. The findings of PAHO studies given in Table 8 show these observations. Nursing education in Latin America continued to be limited and inadequate, with an effect in practice only on large urban centers.

Table 7

Number of Nursing Students Graduating from Programs in Selected Countries (1886-1949)

Country Students	Number of students enrolled	Number of nurses graduating	No. of nurses graduating per year
Argentina (1 school, 1892-1909)	1,360[a/]	148	9
Brazil (2 schools, 1918-1940)	-	461	21
Chile (1 school, 1924-1940)	-	261	16
Colombia (1 school, 1935-1940)	-	37	6
Cuba (6 schools, 1900-1928)	112[b/]	84	3
Mexico (1 school, 1925-1928)	935	-	-
Panama (1 school, 1908-1940)	-	382	12
Peru (1 school, 1915-1917)	14[c/]	12	6
Venezuela (1 school, 1934-1940)	-	192	32

Source: C. Grierson (1910); Estudio de Enfermería en Brasil, 1963, Boletín of the Pan American Sanitary Bureau; H. Pedraza (1954); F. Peña, (1980)

a/ Estimate based on the number of applicants for one year, 1908.
b/ Candidates for 1928.
c/ Candidates for 1915.

Third, the massive extension of nursing schools to the universities after the 1960s was another important element in nursing education. According to a study on university schools conducted by PAHO in 1976, 61 per cent of the new schools were established as university programs, and 70 per cent of the schools already organized had extended into a university. Still, the problems persisted. On the one hand, wider educational opportunities for women encouraged them to select other professions such as medicine, engineering, etc., whose professional status was higher and where working conditions were better. In countries where examinations were not required because of the places available in other professions, nursing was selected as the third option.

Table 8

Number of Schools in Latin America by Country, and PAHO Criteria for the study of nursing in 1959

Country	Total	More than six years of primary education and three of nursing	Less than six years of primary education and less than three years of nursing
Argentina	150	9	141
Bolivia	2	2	-
Brazil	39	39	-
Chile	5	5	-
Colombia	6	6	-
Costa Rica	1	1	-
Cuba	5	2	3
Dom. Republic	1	1	-
Ecuador	4	4	-
El Salvador	2	2	-
Guatemala	2	2	-
Haiti	1	1	-
Honduras	2	2	-
Mexico	50	10	40
Nicaragua	4	4	-
Panama	1	1	-
Paraguay	3	3	-
Peru	9	9	-
Uruguay	2	2	-
Venezuela	5	5	-
Total	294	110	184

Source: PAHO, Study on Nursing Schools, 1959.

Moreover, prospects in the profession are limited. Nurses' salaries are low, working conditions are poor, and technical or scientific development is not available to most nurses. The number of applicants for nursing schools in Latin America thus continues to be a challenge to the development of the profession. Table 9 shows the number of nursing schools according to the institutions that maintain them.

Table 9

Number of nursing schools in Latin America sponsored by institutions and countries
1980

Country	Institutions Total	University	Ministry of Education	Ministry of Health	Other
Argentina	69	12	37	20	-
Bolivia	5	3	-	-	2
Brazil	57	40	1	3	13
Chile	14	14	-	-	-
Colombia	22	13	9	-	-
Costa Rica	1	1	-	-	-
Cuba	29	1	-	28	-
Dom. Republic	2	2	-	-	-
Ecuador	7	7	-	-	-
El Salvador	3	1	-	2	-
Guatemala	3	-	-	3	-
Haiti	3	-	-	3	-
Honduras	3	2	-	1	-
Mexico	123	99	15	-	9
Nicaragua	4	-	-	4	-
Panama	2	1	-	1	-
Paraguay	3	2	-	-	1
Peru	25	14	-	6	5
Uruguay	1	-	-	1	-
Venezuela	35	3	24	8	-
Total	411	215	86	80	30

Source: PAHO Files.

The most recent data indicate that there are 151,573 nurses per 10,000 inhabitants in Latin America (4.2), and 387,379 nurses aides per 10,000 inhabitants (10.8) (Manfredi, 1982).

There are currently four levels of nursing training in Latin America: 512 programs for nursing auxiliaries; 243 programs for general nursing; 163 undergraduate degree programs; 39 programs for mid-level technicians and 19 for senior-level technicians. It is estimated that 22,570 auxiliaries and 16,158 nurses graduated in 1982, of which 3,616 are mid-level technicians, 6,663 are general nurses, 2,015 are senior-level technicians and 3,864 have university degrees in nursing (Manfredi, 1982).

In conclusion, the development of nursing education reflects the uneven, heterogeneous socioeconomic development of the countries. As a result, neither the in-service training program begun in the early part of the century nor the subsequent creation of an institutional system of nursing education has created the conditions necessary for growth of the profession.

We give below some of the preliminary findings of the survey conducted in 1982 by what was then the Division of Human Resources and Research and is currently the PAHO Program on Health Personnel.

1. Administration

The study covered 82 nursing schools whose questionnaires had been received by the Division of Human Resources and Research before the last week in December 1982. The questionnaires had been sent to all nursing schools in Latin America in 1980, in other words, to 411 schools. Table 10 shows the distribution of schools according to country, and the number of schools.

The schools included in the study are shown in Table 11 according to the year in which they were founded. Five schools did not report the year in which they were founded, and it can therefore be seen that more than 50 per cent of the sample schools were founded after 1960.

Table 10

Number of schools in Latin America, by country
Number of schools included in the study

Country	Number of existing schools	Number of schools included	Percentage
Argentina	69	16	23.19
Bolivia	5	5	100
Brazil	57	13	22.81
Chile	14	6	42.86
Colombia	22	12	54.54
Costa Rica	1	1	100
Cuba	29	1	3.45
Ecuador	7	1	14.29
El Salvador	3	-	-
Guatemala	3	3	100
Haiti	3	-	-
Honduras	3	1	33.33
Mexico	123	7	5.69
Nicaragua	4	-	-
Panama	2	-	-
Paraguay	3	2	66.66
Peru	25	13	52
Dominican Republic	2	1	50
Uruguay	1	-	-
Venezuela	35	-	-
Total	411	82	19.95

Table 11

Year of foundation of the schools included in the study

Decade	Number	Accumulative
1910 - 1920	7	7
1921 - 1930	-	7
1931 - 1940	4	11
1941 - 1950	11	22
1951 - 1960	11	33
1961 - 1970	15	48
1971 - 1980	27	75
1981 -	1	76

Seventy-one (74.38 per cent) of the schools form part of public education institutions (Ministry of Education and State Universities), thirteen (15.85 per cent) are schools administered by the Ministry of Health and eight (9.75 per cent) are private institutions.

Currently, most of the schools (70 or 85.4 per cent) require graduation from secondary school as an admission requirement.

Of the 57 (69.51 per cent) university schools in the sample, 17 are independent academic units, 5 are departments within the health sciences schools, and 23 have some other type of administrative relationship to the university.

The basic subjects in the health sciences in the pre-professional cycle are given by specific academic units in 63.38 per cent of the schools affiliated with the universities, while in the remaining schools (36.62 per cent), these subjects are taught by the nursing school itself.

Most of the schools (90.24 per cent) are headed by a nurse; only five are headed by physicians and three by other professionals. In 1907, the schools began with nurses at their head; however, by 1958, only 50 per cent had achieved this ambition that was so much emphasized by the leadership of the nursing profession throughout the world.

2. Objectives of the Schools

A majority of the schools (68) said that their most important objective was the delivery of services (direct care); equal in second place are the delivery of services (administration) and community-centered education (29); and in third place is education for the community and research (20 and 18). Table 12 shows the data.

Table 12

The three objectives considered most important by the schools

Objectives	Number of schools Classification 1	2	3
Delivery of services			
direct care	68	3	4
administration	8	29	11
Research			
scientific method	12	13	18
research	2	13	11
Education			
community	15	29	20
staff training	7	11	12
Clinical specialization	6	8	5
Specialization in public health	9	3	
Specialization in administration	1	4	8

Only 35 schools offer specialization in specific areas of nursing, with surgery, obstetrics and public health being the most frequent. Specialization began in the 1930s, but 50 per cent of the schools that offer this kind of teaching began it in the 1960s. Table 13 shows these data.

Table 13

Specialization offered by nursing schools according to average starting year and number of schools offering these programs

Specialty	Starting Year	Range	No. of schools
Surgical nursing	1970	1936 - 1982	35
Pediatric nursing	1967	1939 - 1982	22
Obstetrical nursing	1967	1939 - 1982	28
Maternal and child nursing	1972	1962 - 1982	24
Psychiatric nursing	1967	1939 - 1982	22
Public health nursing	1968	1948 - 1982	29
Nursing administration	1969	1948 - 1982	22
Nursing education	1972	1964 - 1982	17

3. Plan of Studies Curriculum Reform

In general, the number of changes in the curriculum is associated with the length of time the institution has been in existence. Curriculum changes were more frequent after the 1940's. Table No. 14 shows the number of changes in the curriculum observed in the sample.

More than 50 per cent of the schools reported that they had made up to three changes in the curriculum (62.18).

Generally speaking, changes in the curriculum were made for a combination of reasons. The most frequent of all reforms indicated came from proposals made by teachers in connection with curriculum evaluation studies. Other reasons were curriculum change in the country, proposals by students, and finally, proposals initiated by international consultants.

The proportion between theory and practice did not vary greatly throughout all the curriculum changes: the observed average was 33 per cent theory and 57 per cent practice in the oldest curricula, with a slight increase in the amount of theory in current curricula.

Table 14

Number of curriculum reforms per school

No. of Reforms	No. of Schools	Percentage	Cummulative
0	9	10.97	10.97
1	13	15.85	26.82
2	11	13.41	40.23
3	18	21.95	62.18
4	10	12.19	74.37
5	6	7.31	81.68
6	2	2.43	84.11
7	5	6.09	90.20
8	3	3.66	93.85
No information	5	6.09	99.95
TOTAL	82	100	100

In general, the ratio in current curricula is an average of 40 per cent theory and 60 per cent practice. (see Table 15: Average annual hours of theory and practice in the current curriculum).

Table 15

X annual hours of theory and practice in the curriculum per academic year

Activity	X First year	X Second year	X Third Year	X Fourth year
Theory	588	464	378	257
Practice	349	631	683	697

This ratio is not uniformly distributed: there is a higher proportion of theoretical activities in the first academic year, while starting in the second year, the amount of time devoted to practice increases progressively until the fourth year, when it represents almost 80 per cent of the curriculum.

Practice in in-patient services is most frequent in state hospitals, while ambulatory practice is more frequent in health centers. Table No. 16 shows the average year in which practice began, and the number of schools using each of the institutions.

Table 16

Facility in which practice is conducted, by X starting year, range, and number of schools using each of the institutions

Facility	Starting Year	Range	No. of Schools
In-patient			
University hospital	1965	1906 - 1982	29
State hospital	1963	1906 - 1982	64
Social Security hospital	1970	1949 - 1982	44
Private hospital	1967	1908 - 1981	38
Health Center Ambulatory	1967	1940 - 1981	37
University hospital	1966	1939 - 1982	20
State hospital	1963	1915 - 1982	44
Social Security hospital	1970	1950 - 1982	28
Social Security hospital	1967	1938 - 1980	20
Health Center	1966	1927 - 1981	59
Health Post	1971	1943 - 1982	40
Community	1971	1947 - 1981	34

Public health activities began in 1901, but it was only in 1970 that 50 per cent of the schools included these activities in their study plans.

Public health activities most often included home visiting, health education, immunizations and control of communicable diseases.

The average number of hours per year devoted to public health activities in the current study plan are shown in Table 17. These activities represent 24 per cent of the average time devoted to theory, and 34 per cent of the average time devoted to practical work. Currently, activities are most often maternal and child nursing, community development, control of communicable diseases and home visiting.

Table 17

X hours per year devoted to public health activities

Activity	X First year	X Second year	X Third Year	X Fourth year
Theory	588	464	378	257
Practice	349	631	683	697

Table 18 describes the training activities in the area of independent nursing actions to develop primary care programs. Although the techniques of taking case histories and giving physical examinations were introduced early, independent nursing consultations were introduced only after 1970, and only 50 per cent of the schools conducted this type of activity.

Table 18

Activities related to independent nursing practice, average starting year, range and number of schools

Facility	Starting year	Range	Number of schools
Adult case history	1971	1915 - 1982	65
Child case history	1971	1939 - 1982	62
Pregnancy case history	1970	1940 - 1982	64
Physical exam., adult	1974	1945 - 1982	61
Physical exam., child	1973	1939 - 1982	65
Phys. exam., pregnancy	1971	1940 - 1982	63
Indiv. Nurs. Cons. adult	1977	1963 - 1982	28
Indiv. Nurs. Cons. child	1974	1952 - 1982	42
Indiv. Nurs. Cons. pregnancy	1974	1954 - 1982	38

Indiv. Nurs. Cons. = Individual Nursing Consultation

The teaching method for practical work in the schools is based on traditional teaching practices, but there is still a group of schools that has not introduced educational technologies (see Table 19).

Table 19

Educational technologies used by the schools, average year of introduction and number of schools

	X Year of Introduction	No. of Schools
Programmed instruction	1975	39
Modularized teaching	1978	37
Simulation	1970	58

4. Professors:

Table 20 shows the number of professors, according to the length of time they work.

Table 20

Number of nursing professors and other professionals according to the hours they work

Contract	Professors	
	Nurses	Other professionals
Full-time (40 hours)	1141	132
Part-time (20 hours)	298	42
Less than part time (12 hours)	82	107
Work by the hour	189	916
TOTAL	1710	1197

Table 21 shows the level of academic education achieved by nursing professors.

Table 21

Number of nursing professors according to academic level achieved

Academic Education	Number	Percentage
General nursing	157	9
B.A. Degree (B. Sc.)	663	39
Specialization	573	34
M.A. Degree	282	16
PhD. Degree	35	2

Most of the graduate courses were taken in the country itself (80 per cent), followed by Latin America (12 per cent), U.S.A. (5 per cent) and other countries (3 per cent).

The distribution of nursing professors according to the area of specialization or graduate degree is shown in Table No. 22.

Table 22

Number of professors according to area of graduate specialization

Academic Education	Number of professors
Surgical nursing	196
Obstetrical nursing	104
Pediatric nursing	77
Nursing education	332
Maternal and child nursing	77
Public health nursing	238
Psychiatric nursing	90
Nursing administration	125
Independent practice	39

Observation: Some professors have more than one area of specialization.

Most of the schools report that the professors participate in practical work as supervisors and instructors (73 and 75), while only 39 and 41 respectively from the health institution team do so, with an average participation of 11 hours a week.

5. Students

The number of graduates per decade rose slowly through the 1970s, when the number of schools in the sample also increased. Also in the seventies there was a significant increase in the number of university enrollments in Latin America. Table 23 shows the number of graduates per decade. The number of students enrolled in 1982 is shown in Table 24.

Table 23

Number of students enrolled in 1982 by academic year and sex

Academic Year	Sex	
	F	M
First year	5471	610
Second year	4240	314
Third year	3695	256
Fourth year	2928	236
TOTAL	16334	1416

Table 24

Number of graduates per decade by sex

Academic Year	Sex	
	F	M
1900-1920	879	48
1921-1930	378	57
1931-1940	643	45
1941-1950	2082	54
1951-1960	3878	75
1961-1970	4973	133
1971-1980	19176	601

If the student body is maintained at this level throughout the eighties, the number of graduates will be double that of the previous decade.

6. Agreements with PAHO

The first agreement was signed in 1952, immediately after the Nursing Section was set up at PAHO. Only 45 schools out of the sample have signed an agreement, and only 31 indicated the date and purpose of it. Table 25 shows the number of agreements on textbooks.

Table 25

Number of agreements with PAHO, by school

Number of Agreement	Number of schools
0 - 3	23
4 - 6	4
7 - 9	2
10 - 12	2

The agreements are most often to train professors in different areas of nursing, to develop curricula, including the design, implementation and evaluation; and to develop courses, workshops and seminars. Agreements have also been signed to introduce educational technology, and to conduct projects on school reorganization and on training nursing aides at various levels.

7. Advisory services received from PAHO without agreements

Twenty-eight schools in the sample said that they had received advisory services from PAHO. Advisory services began in 1959, and were thus a little later than the agreements. Table 26 shows the number of consultations given per school.

Table 26

Number of schools having received advisory services from PAHO

No. of consultations	No. of schools
1	11
2	5
3 - 4	5
5 - 7	6
8 - 10	1

The most frequent purpose of the advisory services is curriculum development, courses, workshops and seminars, and teacher training. Advisory services were also given for the introduction of educational technology, training for nursing auxiliaries, development and evaluation of clinical fields, school reorganization and development of research projects.

Impact of technical cooperation on nursing education in Latin America

The exploratory study by Souza (1982) on PAHO's impact on curriculum innovation used the same sample as the study above, and covered 45 nursing schools in Latin America. The study allows us to indicate some trends as to the role of PAHO technical cooperation.

Four recommendations are identified as being the most important for nursing education: 1. introduction of public health into the curriculum (in the 1950s); 2. improvement in the level of education as a result of introducing nursing specialization into the curriculum and improving the standard of teachers of nursing through graduate programs in education (in the 1960s); 3. the development of abilities and skills to take on the extended role of nursing in primary care functions (in the 1960s and 1970s), and 4. the introduction of educational technology and teaching methods (in the 1970s). Six indices were selected on the basis of these recommendations:

1. Time of introduction of public health and practice into the curriculum.

2. Period of introduction and kind of nursing specialization introduced into the curriculum.

3. Number of teachers with graduate education.

4. Ranking of objectives of nursing education.

5. Number of programs for the development of abilities and skills to perform the expanded role of nursing.

6. Number of schools using educational technology.

On the hypothesis that contact with or exposure to PAHO technical cooperation was a possible indicator of impact, the sample was divided into two groups: linkage with PAHO and no linkage with PAHO.

1. Introduction of public health nursing into the curriculum

Independently of direct assistance from PAHO, schools founded after the 1960s already included this area of study in their curricula when they opened. The general trend among schools founded before the 1960s was to have begun to include public health after the first five years. Table 27 gives this information.

These findings appear to indicate that public health generally appears in the curriculum as a result of internal demand from the countries, thus demonstrating that PAHO's influence depends on how far it is in line with national health policies.

Table 27

Introduction of Public Health Nursing in the Curriculum of the 45 schools included in the study, broken by linkage with PAHO, and by founding date of the school

Introduction of Public Health	SCHOOL							
	Linkage with PAHO				No linkage with PAHO			
	1		2		1		2	
	No.	%	No.	%	No.	%	No.	%
At time school opened	4	33.30	7	70	3	37.5	10	66.70
After school opened	8	66.70	3	30	5	62.5	5	33.30

1 = Schools founded between 1900 and 1960
2 = Schools founded after 1960

The content and duration of public health training varies little among the groups: Table 28 shows that it is mostly concentrated in the fourth academic year, and that schools without links to PAHO have a slightly higher tendency to offer more hours of training at this level.

Table 28

Average time of public health training in the schools included in the study, by academic year and by linkage with PAHO

Academic Year	X Hours of public health training			
	Schools with links to PAHO		Schools without links to PAHO	
	Theory	Practice	Theory	Practice
First	75	78	75	75
Second	63	134	98	131
Third	73	176	90	185
Fourth	92	414	158	501

Nursing Specialization Programs

Schools with links to PAHO show a greater tendency to have nursing specialization programs, as shown in Table 29. The percentage of schools offering specialization is higher when they receive assistance from PAHO, and they also introduce the specialization earlier.

Table 29

Number of schools included in the study that offer Nursing Specialization Programs, by links with PAHO, and decade in which they were introduced

Decade in which specialization was introduced	Linked with PAHO		Not linked with PAHO	
	No.	Percentage	No.	Percentage
1950	3	23.00	1	12.5
1960	5	38.50	-	-
1970	5	38.50	7	87.5

Note that 59.10 per cent of the schools receiving assistance from PAHO offer specialization programs, but only 34.78 per cent of schools without links to PAHO offer such programs. Schools with links to PAHO have a higher proportion of teachers educated at the graduate and specialization levels. This group has 54.70 per cent of its teachers with an academic higher than basic nursing, while the group without PAHO links has 46.70 per cent. If we differentiate only by graduate work, the difference between the two groups increases (see Table 30).

Table 30

Number and percentage of professors in the two groups of schools included in the study, by level of education

Educational level attained by professors	Number of Professors			
	Schools linked to PAHO		Schools without links to PAHO	
	No.	Percentage	No.	Percentage
Basic	134	21.50	95	22.90
B. A. (B. Sc.)	148	23.80	126	30.40
Specialization	126	20.30	128	30.80
M. A. Degree	194	31.20	62	14.90
PhD Degree	20	3.20	4	1.00
Total	622	100.00	415	100.00

Skills and abilities in the expanded role of nursing

The data on the introduction of training in skills and abilities for the expanded role of nursing show that there are no significant differences between the two groups. Table 31 shows that the development of independent nursing activities is distributed almost equally between the two groups. It is noted that the schools founded after the seventies were more likely to introduce these innovations. Such schools are located in countries that adopted expansion of coverage policies prior to the 1970s, such as Colombia and Chile.

Table 31

Activities on expansion of the role of nursing in the two groups of schools included in the study

Type of expansion of the role of nursing	Links with PAHO		Without links to PAHO	
	No.	Percentage	No.	Percentage
No activities	5	22.80	6	26.60
Full activities	14	63.60	11	47.80
Only with children	1	4.50	1	4.30
Only with pregnant women	-	-	1	4.30
Adults and children	-	-	1	4.30
Adults and pregnant women	-	-	1	4.30
Children and pregnant women	2	9.10	2	8.80

The number of nursing teachers trained to teach the expanded role of nursing differs slightly: 2.60 per cent in the group with links to PAHO, and 0.60 per cent in the group without links to PAHO.

Objectives of nursing education

The fact that all the schools included in the study report that they have written objectives that conform to the general guidelines recommended by PAHO in 1961 may indicate that formally at least, PAHO has influenced all the schools of the Region without distinction. This may be because PAHO publications are widely distributed and read, regardless of whether the links are direct or indirect.

However, the schools included in the study differ in how they categorize the first three objectives of nursing education, in terms of the emphasis assigned to them. Schools with links to PAHO rank their objectives as follows:

1. direct care
2. research
3. community education, and

schools without links to PAHO:

1. direct care
2. community education, and
3. administration of health care.

It would seem that schools that have direct links with PAHO feel research to be an area of particular interest, although this has not been a policy to which PAHO has given priority. Both groups emphasize community nursing.

Despite these differences, it was not possible to identify any substantive differences in the curricula of these schools. The course content and duration of the program, the theoretical and practical experiences, show no essential differences in the two groups. Table 32 shows the data on the length of the programs.

Table 32

Hours per year of theory and practice in the two groups of schools included in the study

Activities	Links with PAHO		Without links to PAHO	
	No.	Percentage	No.	Percentage
Theory	466	42	461	42
Practice	629	58	639	58

These differences need to be investigated more thoroughly. The course content must be examined in order to reach conclusions about the relationship between the ranking of teaching objectives and the structure of the curriculum. While the present analysis did not explore the course content in detail, no such relationship was observed: regardless of how the two groups of schools ranked their objectives, their curricula are not notably different.

Introduction of educational technology

No differences are observed between the two groups as regards the introduction of educational technology. In the group with linkage to PAHO, 90.30 per cent of the schools have incorporated one or more types of technological innovations, while 87.00 per cent in the group without links to PAHO have also done so. When examined in detail, the small difference between the two groups is accounted for by the utilization of modular instruction, which is a basic proposition of PAHO's educational technology project (see Table 33).

Table 33

Number of schools included in the study that offer modular instruction, by linkage with PAHO

Modular Instruction	Linkage with PAHO		No Linkage with PAHO	
	No.	Percentage	No.	Percentage
Yes	12	54.50	10	43.50
No	10	45.50	13	56.50

It is also important to remember that PAHO's educational technology project proposes the creation of national centers for educational technology for nursing, which should in turn create a network of subcenters within the school's area of influence. This may be grounds for a favorable conclusion about PAHO's influence in this area. However, we must proceed with caution before coming to a final conclusion, and the status of the development of educational technology and policies of each country in this area must be investigated first.

The conclusions of the study indicate that there is a need for further research in this and other areas to discover more about PAHO's influence mechanisms and thus improve technical assistance.

CONCLUSIONS AND GUIDELINES

This analysis of the development of nursing in PAHO has demonstrated its internal relationships and how it relates to the international context. The development of nursing in PAHO reflects all the complexity of an international organization whose principal role has been to circulate and publish some of the dominant ideas about health and innovations in the health area.

In these final comments, we shall briefly discuss some of the implications of this study for the future of nursing education, and propose recommendations that could be relevant to nursing within PAHO.

The future of nursing in Latin America must be seen in light of the goals of Health for All by the Year 2000 and strategies for achieving it. The Division of Health and Manpower Development of the World Health Organization (WHO) organized a conference on "Nursing in Support of the Goal of Health for All by the Year 2000" in November 1981. The report of the Conference points out the need for nursing to give careful consideration to the approaches to health care indicated in the WHO document "Global Strategies for HFA/2000". It considers the following to be particularly important for nursing practice in primary health care:

> "1. Commitment to primary health care requires a fundamental reorientation from the present, increasingly expensive service providing sophisticated technology for the cure of the few to a more widely-available service, built around and responding to the health needs of the people.
>
> 2. The health systems of the country must be based on the principles of primary health care.
>
> 3. That care must be directed to the whole population instead of only to certain segments.
>
> 4. Technology used must be appropriate, scientifically sound, adaptable, and acceptable to those for whom it is intended and to those who apply it. It must be selected so as to be affordable within available resources.
>
> 5. Self-reliance and social awareness are the key factors in health development, hence community participation is vital.
>
> 6. Intersectoral action and adequate community involvement are prerequisites in shaping and controlling the health system."

Based on these general premises, the Conference arrived at the following conclusions:

"1. Nursing has the ability and responsibility to make radical change in the health care system to advance HFA/2000. This change depends on the full implementation of primary health care concepts and on carefully formulated strategies appropriate to all levels of care and within the health development perspectives of the country concerned.

2. The paramount change needed in nursing is the expansion of traditional roles in diagnostic, therapeutic and rehabilitative functions required by the prevailing health and social problems of the country.

3. Basic to the expansion of those roles is the development of tenacious attitudes and aggressive plans to make primary health care available to all populations as quickly as possible through the use of technologies and patterns of health manpower development appropriate to the specific country.

4. Commensurate with the above, and of equal importance, is the concentration of intervention techniques at the community level, including community involvement in all phases of health planning, delivery and evaluation, with emphasis on prevention at all levels, and focused on groups at high risk of illness, injury and disability.

5. Acceleration of the impact of nursing on community health requires dramatic change in practice and in the education of nurses throughout the educational system. Change in basic nursing education is of prime importance to the development of future generations of practitioners. Change in postbasic and continuing nursing education is fundamental to the reforms required in basic programs, especially as they pertain to the practice of nursing students. Consequently, change in one is an integral part of change in the other, and they must be planned in concept."

Although there is no doubt that nursing will be required to assume an important role in the implementation of the strategies to achieve the goal HFA/2000, we may question the capacity of nursing to play a major part in making the changes that will be needed in the health care system if this goal is to be achieved in Latin America. The long history of limited professional power which Torres (1982) describes as "oppression", in the sense used by Freire in his book "Pedagogy of the Oppressed", points to a more secondary role, in which nursing will have to struggle to stake out its territory. The absence of a well-organized nursing sector in most of the countries, together with growing, ongoing conflict and contradictions between the various levels of professionals, is making it difficult for the sector as a whole to take an objective position.

However, we must look at the health sector as a whole. For example, we see in some countries a significant growth in private health services, which the governments are using increasingly to meet demand at the second and third levels. In general, these services have not incorporated nursing as a sector at all staffing levels, because they are not inclined to pay competitive salaries. The quality of the nursing care is frequently low. Thus the problem of nursing practice and education goes beyond the questions raised in relation to primary health care.

If radical changes in nursing practice and education are expected, the first step would be a critical examination by nurses and nursing personnel of their professional development in Latin America. Such an analysis could lead them to a better understanding of the relationship between their religious and their military roots, and between dominant health practices, which are determined ultimately by the political and economic structure of society. An understanding of these relationships should, in turn, make for the formulation of new goals for nursing practice and education. It should also lead to the formulation of new strategies for integration and coordination of the nursing sector.

In Latin America, auxiliary personnel with little and sometimes no training continue to constitute most of the labor force. The nursing education system's capacity for training all the personnel needed to achieve the goal of HFA/2000 is limited, which suggests that a number of untrained nursing personnel will continue to engage in nursing work in the future. This will certainly continue to present a challenge for nursing leadership and require a redefinition of roles and responsibilities for all levels of nursing personnel. Creativity and utilization of all trained nursing personnel in the development of manpower for primary health care must be taken into consideration if service to people, both individually and collectively, is the true concern of nursing.

Apart from these internal considerations about the nursing profession, it is important to bear in mind that the success of the strategies to attain the goal of HFA/2000 is conditional upon Latin America's fiscal crisis. For dos Santos (1979), the present economic crisis, with its rising inflation and high rate of unemployment, will go on for a long time. What, then, are the real possibilities open to the countries to expand their health services? Governments will undoubtedly adopt the least costly alternatives, which will necessarily include utilization of an increasing number of less qualified personnel. The limitations do not come solely from the internal problems of the nursing sector.

One conclusion is apparent from this discussion. Future nursing practice in Latin America, with the new perspective of HFA/2000, will continue in the hands of personnel with less training. Nevertheless, the

role of nursing leadership in providing a new view of nursing should not be forgotton. A different approach based on more critical models of interpretation of national realities could guide the educational sector in formulating more integrated and coordinated programs for all levels, as well as a more efficient allocation and utilization of funds. Future nursing practice will have an important impact on attainment of the goal HFA/2000, if instead of striving for professional status, following the footsteps of the medical profession, professional nurses were to join with all levels of personnel in the pursuit of better services for individuals and the community.

The following premises proposed by Cerezo (1979) for nursing education could represent a strategy for a new approach to nursing in Latin America and could allow for the reorganization of services and the integration of nursing personnel:

- "It means achieving more than merely a modification of teaching methods: it will mean arriving at a clear definition of the theoretical methods of teaching as a science.

- Fundamental changes will be required in the conceptualization of the educational process, which should favor the development of plans and study programs in harmony with the reality and future needs of the country.

- A plan of studies that is centered on the community and on the health services shall be established, which will develop a coherent relationship between the process of health and illness and the socioeconomic and environmental conditions.

- A nursing practice will be defined which will emphasize primary rather than secondary prevention; collective rather than individual prevention; polyvalent rather than specific prevention, and greater focus first on the healthy family in its social and community life, then on illness, handicaps and social disability, and finally lead to treatment and rehabilitation.

- There will be an effort to structure health services so as to make them broader than current agencies and foster the integration of the well with the sick and the community with the health services.

- An attempt will be made to bridge the gap between science and professional practice, by means of study plans which lead students early on into research activities favoring improvement of the educational process of professional practice and social practice.

- Continuing education will be established by means of study and participation in scientific research in the therapeutic, epidemiological and social fields. Naturally, this proposal is incompatible with an individualist approach to the profession."

Given these new perspectives, nursing in PAHO will also have to be reconsidered. PAHO's recommendations in the area of nursing education were based on nursing experience in the developed countries, and took their inspiration from an "ideal" international model of nursing patterned on the ideas of the International Council of Nursing. But social realities in Latin America need to be taken into account. Although the recommendations have been revised over the course of time, they have not be sufficiently powerful to produce changes. Importance must be given to alternate ways of looking at the social process, particularly those that have influenced adoption of international recommendations. An understanding of nursing practice and education based on a critical analysis of the relationship that this sector has with the rest of society ought to improve the adequacy of recommendations and strategies for their implementation.

The strategy by which PAHO could establish an ongoing analysis of the health sector and nursing in the Region and in each individual country must necessarily include social research, taking into account the theoretical as well as the empirical work done by local researchers.

Consistent with this perspective, recommendations for innovations in nursing education should be based on actual experience in Latin America. We also believe that integration and coordination of the nursing sector at all levels must be examined in much more detail.

In conclusion, in its broadest sense, nursing in Latin America needs to engage in ongoing, constructive and vigorous debate, the fundamental purpose of which should be to bring new dimensions to health care policies so that the professionals may more fully realize their professional commitment to a better quality of life for the peoples of Latin America.

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ANNEX II

PROPOSED TERMS OF REFERENCE

ADVISORY COMMITTEE ON THE EDUCATION, TRAINING, DEVELOPMENT AND EMPLOYMENT OF NURSING PERSONNEL

Preamble

The Thirtieth World Health Assembly decided in 1977 (Resolution WHA30.43) that the main social target of the Governments and the World Health Organization in the decades ahead should be: "the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life."

The Declaration of Alma-Ata, USSR, in 1978, emphasized that: "primary health care is the key to attaining this target as part of general development, in the spirit of social justice."

In 1980, the Pan American Health Organization adopted its Regional Strategies for the attainment of health for all by the year 2000 (Official Document 173); and in 1982, approved the Regional Plan of Action for the Implementation of Regional Strategies (Official Document 179).

Concern over the slow pace of development of the role of nursing personnel in Primary Health Care (ACT) prompted the XXX Meeting of the Directing Council to establish a permanent committee to advise Member Countries and the organization on the education, training and development of nursing personnel (Resolution .....).

Although the main focus of attention of the Advisory Committee is towards the employment of nursing personnel in PHC, it will also concern itself with the broader issue of nursing education, training, development and employment at all levels of care.

In view of trends and developments toward a more multidisciplinary approach to care, the Advisory Committee should include in its membership, not only representation from nursing and other health disciplines, but also representation from the managerial and social sciences. Consequently, the Director may request certain Member Countries to appoint technically qualified representatives from other than nursing disciplines to the Advisory Committee.

It is confidently expected that the work of the Advisory Committee will make a significant contribution to the development of the role of nursing personnel at all levels of care; stimulate technical cooperation among developing countries (TCDC); foster bilateral consultation; and

encourage the development of a more uniform and consistent approach to the education, training, development and employment of nursing personnel with the Region.

Objectives

The objectives of the Advisory Committee on the education, training and development of nursing personnel are:

1. To consider new developments in the roles and utilization of nursing personnel.

2. To act as a source of technical consultation and advice on the education, training, development and employment of nursing personnel at all levels of health care delivery, but with special reference to the preparation and utilization of nursing personnel in primary health care.

3. To identify critical areas in the education, training, development and employment of nursing personnel.

4. To conduct or stimulate the conduct of research into the critical areas noted in 3 above, for the purpose of establishing standards; identifying roles; developing appropriate curricula, methods and procedures; setting goals and monitoring and evaluating performance.

5. Upon invitation, to assess the status of nursing in countries of the Region and make recommendations to enhance the utilization of these valuable human resources in the provision of health care.

6. To report annually to the Directing Council on its work and on the status of nursing in the Region.

Terms of Reference

Composition of the Advisory Committee

Each country elected to the Executive Committee of the Organization may nominate a technically qualified member to the Advisory Committee. The term of appointment to the Advisory Committee will coincide with the term of office of the Executive Committee member.

The Organization may nominate three members to the Committee representing the Regional Program (Headquarters), Regional Program (Field), and the Centers. Observer status may be extended to the International Council of Nurses and other appropriate international agencies.

Election of Officers

The members shall elect a Chairperson, Vice Chairperson and Secretary, who shall serve for a period of one year, and shall constitute the Executive Officers of the Committee.

Rules of Procedure

The Advisory Committee may establish its own Rules of Procedure, which should generally follow the Rules of Procedure of the Organization, laid down in Official Document 188 (Basic Documents of the Pan American Health Organization, 14th ed.).

Frequency and Duration of Meetings

The Advisory Committee will meet in March and November of each year for a period of five working days, at a time and place selected by the Director, and at such other times as may be necessary to meet its objectives.

Administrative Support

Financial and administrative support will be provided by the Secretariat, except that this shall be provided in conjunction with the host country when meetings are held in a location other than Washington, D.C.