INFORMATION TO USERS

This reproduction was made from a copy of a document sent to us for microfilming. While the most advanced technology has been used to photograph and reproduce this document, the quality of the reproduction is heavily dependent upon the quality of the material submitted.

The following explanation of techniques is provided to help clarify markings or notations which may appear on this reproduction.

1. The sign or “target” for pages apparently lacking from the document photographed is “Missing Page(s)”. If it was possible to obtain the missing page(s) or section, they are spliced into the film along with adjacent pages. This may have necessitated cutting through an image and duplicating adjacent pages to assure complete continuity.

2. When an image on the film is obliterated with a round black mark, it is an indication of either blurred copy because of movement during exposure, duplicate copy, or copyrighted materials that should not have been filmed. For blurred pages, a good image of the page can be found in the adjacent frame. If copyrighted materials were deleted, a target note will appear listing the pages in the adjacent frame.

3. When a map, drawing or chart, etc., is part of the material being photographed, a definite method of “sectioning” the material has been followed. It is customary to begin filming at the upper left hand corner of a large sheet and to continue from left to right in equal sections with small overlaps. If necessary, sectioning is continued again—beginning below the first row and continuing on until complete.

4. For illustrations that cannot be satisfactorily reproduced by xerographic means, photographic prints can be purchased at additional cost and inserted into your xerographic copy. These prints are available upon request from the Dissertations Customer Services Department.

5. Some pages in any document may have indistinct print. In all cases the best available copy has been filmed.
Souza, Alina Maria de Almeida

DEVELOPMENT OF THE PAN-AMERICAN HEALTH ORGANIZATION
NURSING ADVISORY SERVICES: IMPACT IN LATIN AMERICAN
NURSING EDUCATION (1940 - 1980)

The Ohio State University  Ph.D.  1982

University Microfilms International  300 N. Zeeb Road, Ann Arbor, MI 48106
PLEASE NOTE:

In all cases this material has been filmed in the best possible way from the available copy. Problems encountered with this document have been identified here with a check mark √.

1. Glossy photographs or pages _____
2. Colored illustrations, paper or print _____
3. Photographs with dark background _____
4. Illustrations are poor copy _____
5. Pages with black marks, not original copy _____
6. Print shows through as there is text on both sides of page _____
7. Indistinct, broken or small print on several pages _____
8. Print exceeds margin requirements _____
9. Tightly bound copy with print lost in spine _____
10. Computer printout pages with indistinct print _____
11. Page(s) _______ lacking when material received, and not available from school or author.
12. Page(s) _______ seem to be missing in numbering only as text follows.
13. Two pages numbered _______. Text follows.
14. Curling and wrinkled pages _____
15. Other _________________________________________________________
DEVELOPMENT OF THE PAN-AMERICAN HEALTH ORGANIZATION
NURSING ADVISORY SERVICES: IMPACT IN
LATIN AMERICAN NURSING EDUCATION
(1940 - 1980)

DISSertation

Presented in Partial Fulfillment of the Requirements for
the Degree Doctor of Philosophy in the Graduate
School of the Ohio State University

by
Alina Maria de Almeida Souza, B.S., M.P.H.

The Ohio State University
1982

Reading Committee: 
Dr. Gregory Trzebiatowski
Dr. Gail McCutcheon
Dr. Richard Pratte

Approved by:
Dr. Gregory Trzebiatowski
To the nursing personnel of

Latin America
ACKNOWLEDGEMENTS

I wish first of all to give testimony of my gratitude to the W.K. Kellogg Foundation, the Federal University of Rio de Janeiro, Brazil, and the Pan American Health Organization. All have contributed with their institutional support to making possible this dissertation.

To the W.K. Kellogg Foundation and its staff, I am grateful for having defray the cost of my studies; for having been sufficiently flexible to extend the duration of my fellowship beyond the established institutional norm, but above all for the encouragement and kind support received from Karen during these years away from home.

My employer, the Federal University of Rio de Janeiro and my colleagues at the Center of Educational Technology for Health who have patiently and graciously accepted the burden of my absence, carried the share of my contribution and encouraged the pursuit of my academic work.

The Pan American Health Organization welcomed me at its headquarters in Washington, D.C. The staff of the Division of Human Resources Development and Research facilitated the search for
information and made available all physical facilities required. I am deeply thankful to Maria Teresa, and her colleagues in the Library, Susana, Estela and Quintana. To Amanda, Olga, and Rosita without whose support and assistance my work would have been much harder, I wish to say "muito obrigada". In addition, I wish to thank all the technical personnel who kindly helped with their advice, information and personal reference for this work specially Lydia, Teruel and Jorge.

My professors present and past, I am thankful too for their guidance and encouragement; I wish to make special mention of Dr. Trzebiatowski, my major adviser, and the teaching staff of the Department of Research and Foundation in Education, specially Dr. McCutcheon and Dr. Pratte. Dr. "T" took a genuine interest in the subject of my dissertation and in the region of the world where I come from, and he also helped and guided me during my entire Ph.D. program at Ohio State, I extend my gratitude to Sally, his Secretary, who also helped and cooperated with my work a great deal; Dr. McCutcheon and Dr. Pratte who were very much responsible for my understanding of the theoretical foundations of knowledge, thus making possible the formulation of the conceptual framework of this dissertation.

Writing this dissertation without the love, comfort and help of my friends - here and at home - would have been an almost impossible task for me to accomplish. Cesar, Noni, Eleuterio, Maricel, Pat, Aracely, Gustavo, Violeta, Beth and Pete, all are very dear and special people.
Cesar, the "mestre e amigo" somehow always found time in his already heavy schedule of assignments to discuss my problems. No one has been closer to this dissertation than Cesar. He shared with me his knowledge of Latin America and views on social research as well as provided ideas and helpful criticism of my work.

Noni, the best friend in these days of tensions and worries. She encouraged me, gave continuous love and shared her concern about conditions of health in Latin America. She several times put aside her own work and family to undergo the arduous task of improving my written English. I also wish to extend my gratitude to her family: Bill, her quiet and patient husband, who perceived the need for her late hours and weekends away from the family. Teffy, Mark and Julie, her children, who shared with me the cheerfulness of their lives, and, D. Lucina and D. Ruben, the parents who with patience and understanding helped their "adopted daughter", D. Lucina had dinner ready every night, and D. Ruben helped with some graphic work.

Eleuterio my dear friend in Brazil, who helped me develop a clear work perspective, and continuously encouraged my personal development.

Maricel, always willing and available to share her time to discuss and provide information on Latin American nursing, a subject she so well knows.

Pat, Araceli and Gustavo also took of their precious time to help in the English editing. I am specially grateful to Pat, for her patience in trying to understand the structure of my own language and
read my thoughts in order to better express them in English - we built a friendship over our work together.

Violeta has been a patient and joyful typist to work with. She never questioned the numerous drafts, worked nights and weekends with dedication and love until the completion of the final draft.

Beth and Pete who gave me their time, friendship and a break from my work pressure to regain strength to continue - one week of no worries in a time of despair.

Neuza and Dinha my beloved sister and brother, my nieces and nephews, - Karina, Suzana, Priscila, Alina, Ray Neto, Roberto and Guiga for their particular ways of loving, their constant presence and dedication to my wellbeing, even from distant Brazil.

Finally, and above everyone else I wish to express eternal gratitude to my parents, even though they are no longer with me - they made possible the continuation of their lives through me and my brothers and sisters. Through them I acknowledge to all my relatives and the entire human family, the gift of life, and the possibility of living under conditions which in the end have made possible the development of this work.
VITA

September 13, 1941 .................. Born - Santo Antonio de Jesus, Bahia, Brazil.

1960 ............................ B.S. Nursing. Universidade Federal da Bahia, Salvador, Bahia, Brazil.


1973 ............................ Psychologist. Universidade de Brasilia; Brasilia, D.F., Brazil.

1967 - 1975 .................... Head nurse of the Public Health Services of the University of Brasilia.

1975 - 1980 ..................... Assistant professor, Núcleo de Tecnologia Educacional para a Saúde. Universidade Federal do Rio de Janeiro; R.J., Brazil.

PUBLICATIONS

FIELDS OF STUDY

Major Field: Education

Education for the Health Professions. Dr. Gregory Trzebiatowski

Philosophy and Foundations of Education. Dr. Richard Pratte and Dr. Gail McCutcheon
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEDICATION</td>
<td>ii</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>iii</td>
</tr>
<tr>
<td>VITA</td>
<td>vii</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>xii</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>xvi</td>
</tr>
<tr>
<td>LIST OF ABBREVIATIONS</td>
<td>xviii</td>
</tr>
<tr>
<td>Chapter</td>
<td></td>
</tr>
<tr>
<td>1. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Footnotes</td>
<td>22</td>
</tr>
<tr>
<td>2. CONCEPTUAL FRAMEWORK</td>
<td>24</td>
</tr>
<tr>
<td>Dominant Theory of Social Change</td>
<td>25</td>
</tr>
<tr>
<td>Historical Time - Periodization</td>
<td>29</td>
</tr>
<tr>
<td>Periodization of Latin American Social</td>
<td></td>
</tr>
<tr>
<td>Formation in the Nineteenth and Twentieth</td>
<td>35</td>
</tr>
<tr>
<td>Century</td>
<td></td>
</tr>
<tr>
<td>Periodization of Nursing Development</td>
<td></td>
</tr>
<tr>
<td>in Latin America</td>
<td>38</td>
</tr>
<tr>
<td>General History</td>
<td>38</td>
</tr>
<tr>
<td>Criteria for Periodization</td>
<td>42</td>
</tr>
<tr>
<td>Periodization for Latin American Nursing</td>
<td>45</td>
</tr>
<tr>
<td>Nursing in Latin America Social Structure</td>
<td>48</td>
</tr>
<tr>
<td>Footnotes</td>
<td>55</td>
</tr>
<tr>
<td>3. NURSING EDUCATION IN LATIN AMERICA</td>
<td>57</td>
</tr>
<tr>
<td>General Framework of Nursing Education</td>
<td></td>
</tr>
<tr>
<td>in Latin America</td>
<td>59</td>
</tr>
<tr>
<td>Secularization and Modernization of Medical</td>
<td></td>
</tr>
<tr>
<td>Care</td>
<td>59</td>
</tr>
</tbody>
</table>
### Table of Contents (Cont'd)

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health Movement</td>
<td>63</td>
</tr>
<tr>
<td>University Programs</td>
<td>69</td>
</tr>
<tr>
<td>Nursing Educational Development</td>
<td>72</td>
</tr>
<tr>
<td>Group 1: Argentina, Chile and Uruguay</td>
<td>72</td>
</tr>
<tr>
<td>Group 2: Brazil</td>
<td>79</td>
</tr>
<tr>
<td>Group 3: Bolivia, Ecuador and Peru</td>
<td>84</td>
</tr>
<tr>
<td>Group 4: Mexico</td>
<td>90</td>
</tr>
<tr>
<td>Group 5: Colombia, Venezuela, Paraguay and Centro America</td>
<td>95</td>
</tr>
<tr>
<td>Group 6: Panama</td>
<td>102</td>
</tr>
<tr>
<td>Group 7: Cuba, Dominican Republic, Puerto Rico and Haiti</td>
<td>104</td>
</tr>
<tr>
<td>Conclusions</td>
<td>108</td>
</tr>
<tr>
<td>Footnotes</td>
<td>116</td>
</tr>
<tr>
<td>4. NURSING IN THE PANAMERICAN HEALTH ORGANIZATION</td>
<td>117</td>
</tr>
<tr>
<td>A Beginning of Nursing in PAHO (1940 - 1946)</td>
<td>119</td>
</tr>
<tr>
<td>Program, Budget and Personnel</td>
<td>131</td>
</tr>
<tr>
<td>Summary</td>
<td>133</td>
</tr>
<tr>
<td>The first 13 years of the Nursing Section</td>
<td>134</td>
</tr>
<tr>
<td>Initial Activities</td>
<td>137</td>
</tr>
<tr>
<td>Regional Congresses</td>
<td>142</td>
</tr>
<tr>
<td>Policies and Recommendations</td>
<td>149</td>
</tr>
<tr>
<td>Program and Budget</td>
<td>151</td>
</tr>
<tr>
<td>Personnel</td>
<td>160</td>
</tr>
<tr>
<td>Publications</td>
<td>162</td>
</tr>
<tr>
<td>Fellowships</td>
<td>169</td>
</tr>
<tr>
<td>Summary</td>
<td>173</td>
</tr>
<tr>
<td>Nursing Section 1960-1980</td>
<td>174</td>
</tr>
<tr>
<td>Policies and Recommendations</td>
<td>176</td>
</tr>
<tr>
<td>Programs and Budget</td>
<td>186</td>
</tr>
<tr>
<td>Services Projects</td>
<td>186</td>
</tr>
<tr>
<td>Education</td>
<td>188</td>
</tr>
<tr>
<td>Research</td>
<td>198</td>
</tr>
<tr>
<td>Budget</td>
<td>200</td>
</tr>
</tbody>
</table>
Table of Contents (Cont'd)

Personnel .................................. 202
Publications ................................ 209
Fellowships ................................ 213
Summary .................................... 217
Footnotes ................................... 219

5. IMPACT OF PAHO ON CURRICULUM'S INNOVATIONS
   OF SELECTED LATIN AMERICAN NURSING SCHOOLS .... 224
   Questions and Definitions .................... 226
   Methodological Considerations ............... 231
   Variables and Measures ....................... 231
   Instrument .................................. 232
   Statistical Treatment of the Data ........... 233
   Results ..................................... 234
   General characteristics of the
   Schools Included in the Study .......... 234
   Distribution of the Six Indicators
   for the Dependent Variable ............... 238
   Homogeneity of Groups ...................... 243
   Relationships Between PAHO's Linkage
   and Curricular Innovations ............... 245
   Conclusions ................................ 254
   Footnotes ................................... 258

CONCLUSIONS .................................. 259

LIST OF REFERENCES .......................... 268

APPENDIXES
A. Directory of Nursing Schools in Latin America . 283
B. List of Scientific Publications on Nursing .. 314
C. Questionnaire used in the Exploratory Study .... 318
D. List of Nursing Schools Included in the
   Exploratory Study .......................... 341
LIST OF TABLES

<table>
<thead>
<tr>
<th>TABLE</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of Nursing Schools in Argentina by Year of Foundation and Sponsoring Institutions. 1868-1940.</td>
<td>75</td>
</tr>
<tr>
<td>2. Number of Nursing Schools in Argentina by Sponsoring Institutions and Location. 1980</td>
<td>76</td>
</tr>
<tr>
<td>3. Nursing Schools in Chile by year of Foundation and Sponsoring Institutions. 1900-1940</td>
<td>78</td>
</tr>
<tr>
<td>4. Number of Nursing schools of Brasil by Year of Foundation and Sponsoring Institutions. 1890-1950</td>
<td>83</td>
</tr>
<tr>
<td>5. Nursing Schools in Bolivia by year of Foundation and Sponsoring Institutions. 1930-150</td>
<td>87</td>
</tr>
<tr>
<td>6. Nursing Schools of Peru by Year of Foundation and Sponsoring Institutions. 1904-1942</td>
<td>90</td>
</tr>
<tr>
<td>7. Nursing Schools of Mexico by Year of Foundation and Sponsoring Institutions. 1895-1940</td>
<td>93</td>
</tr>
<tr>
<td>8. Number of Nursing Schools in Mexico by Sponsoring Institutions and Location. 1780</td>
<td>94</td>
</tr>
<tr>
<td>9. Number of Nursing Schools in Colombia by Year of Foundation and Sponsoring Institutions. 1903-1940</td>
<td>98</td>
</tr>
<tr>
<td>10. Number of Nursing Schools in Central America by Country and Sponsoring Institution. 1980</td>
<td>102</td>
</tr>
<tr>
<td>11. Number of Nursing Students and Graduates from programs in Selected Countries. 1886-1940</td>
<td>110</td>
</tr>
<tr>
<td>12. Number of Nursing Schools in Latin America by Country and PAHO's Criteria for the 1959 Nursing Study. 1959</td>
<td>112</td>
</tr>
</tbody>
</table>
List of Table (Cont'd)

<table>
<thead>
<tr>
<th>TABLE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Number of Nursing Students per 100,000 Inhabitants of Countries from the Schools that Responded the 1949 and 1959 PAHO's Survey and Followed the Established Criteria in 1959</td>
<td>114</td>
</tr>
<tr>
<td>14. Number of Nursing Schools in Latin America by Sponsoring Institutions and Country. 1980.</td>
<td>115</td>
</tr>
<tr>
<td>15. Regional Congresses: Participation and Summary of Recommendations from Third, Fourth and Fifth Regional Congresses of Nursing</td>
<td>145</td>
</tr>
<tr>
<td>16. Total Budget and Allocated Budget for the Nursing Section. (1947-1949)</td>
<td>159</td>
</tr>
<tr>
<td>18. Bulletin OFSANPAN: Number of Articles on Nursing by Subject. 1949-1960</td>
<td>164</td>
</tr>
<tr>
<td>20. Summary of Nursing Resolutions Approved by Member Governments of PAHO Between 1970-1980.</td>
<td>182</td>
</tr>
<tr>
<td>21. Summary of Recommendations Presented to the Nursing Services of PAHO by the Technical Advisory Committee on Nursing. Washington, D.C. 18-22 November 1968 (First Meeting)</td>
<td>184</td>
</tr>
<tr>
<td>22. Number of Nursing Auxiliaries and Ratio Per 10,000 Inhabitants in the Region of the Americas. 1964-1976</td>
<td>192</td>
</tr>
<tr>
<td>23. Seminar and Short Term Courses Held in Latin America for Preparation of Auxiliary Nursing Personnel. 1960-1980</td>
<td>194</td>
</tr>
</tbody>
</table>
List of Table (Cont'd)

<table>
<thead>
<tr>
<th>TABLE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>24. Total PAHO Budget and Allocated Budget</td>
<td>201</td>
</tr>
<tr>
<td>for the Nursing Section. 1960-1979</td>
<td></td>
</tr>
<tr>
<td>25. Distribution of Nurse Advisors by</td>
<td>205</td>
</tr>
<tr>
<td>Latin American Countries. 1950-1980</td>
<td></td>
</tr>
<tr>
<td>26. Number of PAHO/WHO STC Consultants</td>
<td>207</td>
</tr>
<tr>
<td>27. Comparative Distribution of Grade and</td>
<td>209</td>
</tr>
<tr>
<td>Salary for Nurses and Engineers 1981</td>
<td></td>
</tr>
<tr>
<td>28. Number of Student Enrolled in the</td>
<td>235</td>
</tr>
<tr>
<td>Schools Included in the Study by</td>
<td></td>
</tr>
<tr>
<td>Academic Year and Sex</td>
<td></td>
</tr>
<tr>
<td>29. Distribution of Schools According to</td>
<td>236</td>
</tr>
<tr>
<td>Linkage to PAHO by Countries. 1982</td>
<td></td>
</tr>
<tr>
<td>30. Number of Schools According to Kind</td>
<td>237</td>
</tr>
<tr>
<td>and Number of Assistance Received form PAHO</td>
<td></td>
</tr>
<tr>
<td>31. Average Time (in hours) of Public Health training in the</td>
<td>239</td>
</tr>
<tr>
<td>45 Schools Included in the Study by</td>
<td></td>
</tr>
<tr>
<td>Academic Year</td>
<td></td>
</tr>
<tr>
<td>32. Number of Specialized Nursing Programs</td>
<td>240</td>
</tr>
<tr>
<td>Offered in 21 of the Schools Included in the Study, According to</td>
<td></td>
</tr>
<tr>
<td>Decade of Introduction</td>
<td></td>
</tr>
<tr>
<td>33. Number and Percentage of Teachers from</td>
<td>240</td>
</tr>
<tr>
<td>the 45 Schools Included in the Study</td>
<td></td>
</tr>
<tr>
<td>According to Level of Academic Preparation</td>
<td></td>
</tr>
<tr>
<td>34. Number and Percentage of Nursing Professors from the</td>
<td>241</td>
</tr>
<tr>
<td>45 Schools Included in the Study</td>
<td></td>
</tr>
<tr>
<td>According to Field of Specialization and Graduate Education</td>
<td></td>
</tr>
</tbody>
</table>
List of Table (Cont'd)

TABLE PAGE
35. Distribution of the 45 Schools Included in the Study by Linkage with PAHO and Decade of Foundation of the School 244
36. Distribution of the 45 Schools Included in the Study by Linkage with PAHO and Country of Location of the School 244
37. Distribution of the 45 Schools Included in the Study by Linkage with PAHO, Duration of Program, Linkage with University and Academic Admission Requirements 245
38. Introduction of Public Health Nursing in the Curriculum of the 45 schools Included in the Study by Linkage with PAHO and Period of Inauguration 247
39. Average Hours of Public Health Training in the Schools Included in the Study According with Linkage with PAHO and Academic Year 247
40. Number of Schools Included in the Study that Offers Specialization in Nursing by Linkage with PAHO and Decade of its Introduction in the Program 248
41. Number and Percentage of Teachers from the two Groups of Schools Included in the Study by Level of Academic Preparation 249
42. Activities of Expanded Role of Nursing in the Two Groups of Schools Included the study 250
43. Average Annual Hours of Theory and Practice in the Two Groups of Schools Included in the Study 252
44. Number of Schools Included in the Study which Offer Modular Instruction by Linkage with PAHO 253
<table>
<thead>
<tr>
<th>FIGURE</th>
<th>DESCRIPTION</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Boletin OFSANPAN: Frequency Distribution of Items on Nursing (1925-1948)</td>
<td>123</td>
</tr>
<tr>
<td>2.</td>
<td>Boletin OFSANPAN: Articles and Notes on Nursing by subject (1925-1948)</td>
<td>129</td>
</tr>
<tr>
<td>3.</td>
<td>Boletin OFSANPAN: Items on Nursing: Articles (by Origne of Authors), Notes (by Type), reports and Consultations, and Bibliographies. (1949-1960)</td>
<td>164</td>
</tr>
<tr>
<td>4.</td>
<td>Boletin OFSANPAN: Articles Published by Latin American Nurses According to Sub-region of Origen. (1950-1959)</td>
<td>166</td>
</tr>
<tr>
<td>5.</td>
<td>Nursing Fellowships According to Duration of Program for each sub-Region. (1950-1959)</td>
<td>170</td>
</tr>
<tr>
<td>6.</td>
<td>Distribution of Nursing Fellowships by Country within Each Sub-Region. 1950-1959</td>
<td>170</td>
</tr>
<tr>
<td>7.</td>
<td>Nursing Fellowships According to Field of Study. 1950-1959</td>
<td>171</td>
</tr>
<tr>
<td>8.</td>
<td>Nursing Fellowships According to Place of Study. 1950-1959</td>
<td>172</td>
</tr>
<tr>
<td>9.</td>
<td>Number of Nursing Advisors (Total), Number of Advisors from Latin America, United States of America and other Countries. 1958-1980</td>
<td>203</td>
</tr>
<tr>
<td>10.</td>
<td>Distribution of Nursing Advisors by Projects. 1960-1975</td>
<td>206</td>
</tr>
</tbody>
</table>
## List of Figures (Cont'd)

<table>
<thead>
<tr>
<th>FIGURE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Nursing Fellowships by Duration of Program and Sub-Region. 1960-1980</td>
<td>214</td>
</tr>
<tr>
<td>15. Nursing Fellowships Awarded to Latin American by Sub-Region. 1960-1980</td>
<td>214</td>
</tr>
<tr>
<td>17. Nursing Fellowships According to Place of Study. 1960-1980</td>
<td>216</td>
</tr>
</tbody>
</table>
LIST OF ABBREVIATIONS

2. HFA/2000 = Health for All by the Year 2000.
3. ICN = International Council of Nursing.
4. OAS = Organization of American States.
5. PAHO = Pan American Health Organization.
8. WHO = World Health Organization.
Chapter 1

INTRODUCTION

Research on the development of nursing in general is in a state of reconceptualization. Previous research has tended to be characterized by an historical approach, offering primarily a chronological description of key events and influential persons as well as promoting the idea of professional progress. In relatively recent years a new generation of scholars has been urging prospective researchers to depart from this approach, and have been calling for a more critical analysis of the determinants of nursing development. This critical analysis involves the acknowledgement of the whole social context in which this profession has developed. (Davies, 1980; Abel-Smith, 1960; Almeida et al. 1981; Baly, 1980).

The purpose of this dissertation is to analyze critically the development of the Nursing Advisory Services of the Pan American Health Organization (PAHO) and to explore the impact of its policies and recommendations on nursing education in Latin America. The analysis of the nursing advisory services of PAHO first needs to be placed within the broad context of the development of the Organization itself.
The creation of the Pan American Health Organization as reported by Howard-Jones (1980), resulted from the growing concern of the United States with outbreaks of cholera brought over by European immigrants and yellow fever introduced by maritime commerce with South and Central America during the late 1800's.

As early as 1851 several European countries held a series of International Sanitary Conferences attempting to reach agreement on international quarantine regulations. The United States did not participate in these conferences until the Fifth International Conference was held in Washington, D.C. in 1881. Twenty-six countries participated, including for the first time countries of South and Central America. This served as a forum for the exchange of information and the debate of strategies for quarantine regulations as well as the discussion of information of a scientific nature. For instance, it was during this conference that Carlos Finlay first publicly discussed his theory of an intermediate agent as a necessary element in the transmission of yellow fever. Twenty years later, in 1901, a recommendation was presented to organize a permanent executive board comprised of members of the Union of The American Republics (now Organization of American States). This recommendation initiated the Pan American Sanitary Bureau (PASB). In 1949 in agreement with the World Health Organization (WHO) the Pan American Sanitary Bureau became the Regional Office of WHO for the Americas, identified as the Pan American Health Organization (PAHO). A such, it continues to be recognized as an Inter-American Specialized agency for the Organization of American States (OAS).
This brief description of the origins of the Pan American Health Organization demonstrates its close relationship with the specific interests of the countries relevant to international economic interchange. The international trade of raw materials and food products from the producer countries of Central and South America was faced with the problem of food-borne and product borne diseases that impede the continuity of trade. In addition, the existence of other diseases affecting the workers in these areas was also a factor resulting in decreased productivity. It is possible to conclude that as knowledge became available on the transmission and control of the major quarantinable diseases, an international organization would serve the purpose of disseminating the knowledge through the formulation of sanitary agreements and regulations. Several authors have recently interpreted and described the articulation of Latin American social formation in this way. (García, 1981; Verderese, 1979; Almeida et al, 1981).

During the first thirty years of existence the basic concern of PAHO was to control communicable diseases, and one of its main activities was the organization of The International Health Conferences. However, according to Bustamante (1952) from 1910 onward the focus of the discussion in the Conferences started to shift from quarantine measures to other aspects of communicable disease control, such as:

"...vaccination against smallpox; eradication of malaria and tuberculosis; need for centralization of national sanitary policies; development or research on tropical disease with emphasis on parasitology and pathology anatomy; development of laboratories, not only for the diagnosis of diseases but, also to develop research in
the field of tropical medicine and general pathology according with recommendations judged adequate by sanitary authorities."

However, it was not until the 1930's that PAHO started to act upon the recommendations of the Conference discussions and broaden its scope of concern and action. In 1931 Doctor Hugh Cummings, at that time Director of the United States Public Health Service, stated that:

"...the nature of the work of the Organization is such that it would be capable of achieving considerable enlargement. Furthermore the International Conference of the American Republics and the Pan American Sanitary Conference imposes on it additional responsibility. There is also a tendency on the part of other international organizations, the work of which is somewhat similar to that of PAHO, to amalgamate themselves with PAHO...(PASB, 1930)."

It is important to note that at this time significant social and economic transformations were also taking place in Latin America. The Great Depression in the United States and later the Second World War brought about significant changes in the economic order. Inhibition of international commerce, to a certain extent, contributed to the growth of national industry and the expansion of an internal market in Latin America. This process of industrialization, brought new demands for health services, i.e., the development of individual to care to protect the health of local labor forces.

The organization of individualized health services, forged the development of the hospital industry in Latin America since the 1930's. Not only was the existing system modernized but new complexes were constructed. The complexes were sponsored by Ministries of Health, Social Security Institutions, and Universities. However,
interest in communicable disease based on incidence and prevalence ratios in the Region still persisted. Consequently, public health services assumed both the curative and preventive aspects of health care.

The perception of Cummings in making the aforementioned comments, reflects the need for PAHO as an international organization to adjust its conceptual framework according to a new social reality of Latin America and at the same time assure the continued success and leading reputation of the Organization.

In fact, it is observed that six years after Cummings suggestions PAHO began to broaden its scope of activities. During the International Conference of Ministers of Health held by the Bureau in 1936, not only were the traditional subjects with regard to communicable diseases treated but also other matters such as:

"workers hygiene, maternal and child health, development of institutes to study by the problems of health, related to the life in high altitudes; and, the need to establish special technical services to study sanitary problems, unify the national health actions, and the development of units of services in urban and rural areas with the participation of specialized personnel on a full time basis" (PASB, 1937).

It was within this context of expansion of activities at PAHO that nursing services started to be developed. Prior to the actual utilization of nurses in the early 1940's, however, the official monthly publication of PAHO (Boletín de la Oficina Sanitaria Panamericana) published several nursing papers. Many of its articles on nursing discussed the role of nurses in the control of communicable
diseases and the need to create educational programs for the training of visiting nurses. In 1948 a technical nursing section was created at the Organization. Its purposes were:

"...to encourage, to promote and to formulate high standards of nursing education and nursing services in all the countries of the western hemisphere through communication, publications, conferences, scholarships, personnel services and advisory services (Boletín Oficial de Salud Pública, 1948)."

During the last forty years PAHO's nursing services have undergone changes in accordance with the restructuring of the Organization itself and the expansion of its own specialized services based on the demand of the countries. These changes are reflected in the nature of the policies and recommendations formulated throughout the years. For instance, while in the early 1950's major emphasis was on the strengthening of nursing education, in the 1960's it was on nursing service development. In addition, the Nursing Unit continuously organized conferences, seminars, and conducted studies of issues relevant to Latin American nursing and promoted the production of specialized literature.

The development of nursing education in Latin America followed different roads, reflecting the internal development processes and the current state of health care in the countries. Formal training was established for the first time in a few countries at the end of the nineteenth century. Secularization associated with modernization of medical care, and a more technical approach to health care, on the one hand, and a close relationship with nursing education programs in the United States of America, on the other, are among the major factors
which resulted in the early introduction of nursing schools throughout the Region.

The early development of nursing education was very slow, due to the existing health care conditions in the Region, and the utilization of untrained personnel in providing nursing care. Until 1949, when the first survey of nursing schools in the Region was conducted by PAHO, there were only 57 nursing schools and the number of graduates was 6,235 (Chagas, 1950).

The rate of development was accelerated by the public health movement, which since its beginnings in the United States of America in the early 1900's, had contributed to the growth of public health nursing in this country. International agencies, such as the Rockefeller Foundation, exerted great influence on nursing education by sponsoring projects for the creation of nursing schools in Latin America.

Despite continuous development in all countries, the trend of growth of nursing education has not reached a satisfactory level. The number of schools in 1980 was 411, however the ratio of graduate to population has remained very low, being maintained, with very few exceptions, at a low nurse to population ratio of 2.0 per 10,000 inhabitants, if it is compared with ratio of developed countries such as the United States of America where the ratio nurse/population for 1979 was 50.1 per 10,000 inhabitants.

The general framework of nursing education followed the traditional Nightingale system of curriculum organization, in which practical training, as well as the development of abilities and skills
focus on hospital care. However, the formulation of the policies for extension of medical coverage and primary health care, nurses have begun to recognize the need to change the focus of their training programs (Cerezo, 1979; Godoy, 1951; Roberts, 1980). However, the expansion of nursing roles has created conflicts. Some nursing educators are struggling to maintain the traditional, so called "independent role of nursing". For example, Oliveira (1968) in a seminar on nursing curriculum stated:

"...the true nursing function, the one related to patient care independent of any other professional authority, gives the specific character to the profession...while the medically, delegated functions that nurses are assuming in the face of scientific and technological advances of medicine...do not constitute a specific field for nursing."

Nevertheless, students as well as practitioners began to demand more training to assume this new role, and further, to demand its legitimization. Primary health care practice was viewed as the true avenue for the development of nursing practice and also as a new space in which the professional nurse could acquire control over health care. In several articles that appeared in the "Boletín de la Oficina Sanitaria Panamericana", nurses from various schools exposed their faith in this strategy for the future development of nursing practice. (Godoy, 1951; Roberts, 1979; Cerezo, 1979).

Certainly the debate over the new role in primary health care has advance changes in curriculum and the definition of new educational goals. A survey of 17 countries conducted by PAHO in 1975, the results of which would be used for the preparation of the nursing goals for the decade in 1975, indicated an increase in number as well as emphasis
on community oriented programs.

Separate from the training of nurses at higher levels of education, training programs for auxiliary nursing personnel have been continuously implemented. Originally these programs were developed in the form of in-service training, based on actual demands for personnel, but later, were institutionalized. Nurses initially were against this institutionalization, but gradually came to recognize the need for this type of personnel and to control these educational programs.

These programs, much like the ones implemented at higher level, were not able to prepare the growing number of professionals needed by the health sector. Thus, recruitment of personnel without any formal training continues to be the major source of labor in the Latin American Region. (The word Region is used from now on to indicate Latin America).

GENERAL PURPOSES AND HYPOTHESIS

By and large "advisory services" are a mode of professional practice which aims at the development of policies, recommendations and/or guidelines directed at a specific type of public. It is claimed that advisory services as a form of professional practice embodies two distinctive areas of knowledge: (1) the advanced scientific and technical knowledge of a substantive discipline, i.e. medicine, nursing, administration, etc. that allows for the identification of specific solutions for specific situations; and (2) the recognition of characteristics and needs of prospective users.
Within the nursing profession neither one of these two areas of knowledge is neutral. In the context of this analysis, neutrality refers to an absence of or a distance from the political and/or social determinants that influence knowledge and practice in any given discipline. The structure of nursing practice and the history of its development clearly show the ideological influences responsible for the transformation and production of new knowledge, and reflecting the historical changes in the socio-economic modes of production. The medical and nursing professions have been viewed as purely technical and apolitical. Donnangelo and Pereira (1976) dispute this view, pointing out the scientific and technological basis of these professions, as well as the purpose and characteristics of their practice may give an appearance of neutrality; nevertheless, they are far from being isolated from the political and social realities of the times.

In addition, any assumed knowledge about the characteristics and needs of prospective users of advisory services presupposes abstractions of social realities. Consequently any dominant ideology has an important influence on the providers of advisory services.

The development of PAHO's nursing advisory services is viewed as a social practice inserted in a defined context: an international organization. As such, it bears PAHO's political framework and follows its general policies.

Since the organization of PAHO's nursing advisory services, there has been a continuous development of knowledge and services in almost all areas of nursing, even though education and organization of services in public health has been the main emphasis.
PAHO's nursing section has also experienced a continuous and dynamic process of change, which purportedly reflects the changing needs and expectations of the member governments of the Organization as indicated in the resolutions proposed and adopted at the quadrennial conferences and annual councils. However, the actual adoption of these resolutions at the country level seem to be influenced by factors other than the simple reflection of their needs and expectation.

A closer look at this phenomenon suggests that two levels of complex interactions are at work. Firstly there are internal interactions which involve the relationship between the conceptual and organizational structure of the Organization and its nursing service. Secondly, there are also external interactions which involve the relationships among countries and their role in the process of determination and adoption of international policies.

Given the broad scope of these relationships, the examination of nursing development and the impact of PAHO's educational policies and recommendations during the last 40 years in Latin America will be addressed through the following specific objectives which are:

- To analyze the relationship of PAHO's health concepts with dominant health concepts of society.
- To analyze the relationships between PAHO's health concepts and its nursing educational policies.
- To analyze the development of nursing education in Latin America.
To point out relationships between PAHO's nursing education recommendations and curriculum changes in Latin American nursing schools.

The analysis of these relationships is conceptualized according to a specific view of change, in which certain internal factors are perceived as having primacy in the determination of such change. This framework also assumes that there are dominant social forces, which foster specific concepts about health care and nursing care. It also assumes that these concepts eventually shape the dominant characteristics of health care practice.

Consequently, the proposed conceptual framework for the analysis of nursing in PAHO and its impact on Latin American nursing education includes the articulation of nursing practice and nursing education within society as a whole, focusing on the social formation of the Region as an ultimate determinant of the dominant professional practice.

Society is viewed as an integrated whole in a permanent and dynamic process. Changes are to be understood in the light of its structural interrelationships. Empirical reality is not a straight forward phenomenon, any particular view or conceptualization of the world plays an important role in its definition. In this sense the results presented in this dissertation stem from a concept based on a critical view which involve the articulation of the internal determinants of nursing development.

Based on the aforementioned theoretical position on change, the following hypotheses were formulated to guide the analysis:
1. Observed changes in PAHO's nursing educational policies are determined by the general conceptions of health adopted at a given time by the Organization.

2. The impact of PAHO's nursing recommendations on Latin American nursing education depends upon their degree of congruence with internal societal realities.

3. The impact of PAHO's recommendations depends upon the formal linkage of the nursing school with PAHO's nursing services.

It is assumed that the first hypothesis includes a broader one which serves as the context for its examination: PAHO's health policies are determined by the characteristics of society in which dominant social economic relations of production plays a major role.

RESEARCH PROCEDURES

Considering the specific objectives and hypothesis of this study two methodological approaches were used: The first approach is a historical research of the development of nursing education in Latin America and of PAHO's Nursing Services. This method of research does not have mechanisms to control the phenomena under observation; control being understood in its widely used sense in experimental research. (Gay, 1976). Furthermore, this first method involves a systematic examination of PAHO's nursing services and Latin American nursing education according to historical periods of Latin American socio-economic development and its critical analysis in order to test
the previously stated hypotheses.

The second approach is an exploratory study to analyse the impact of PAHO's recommendations on Latin American Nursing education. It is felt that his exploratory study would increase the investigator's familiarity with the phenomena under observation, facilitate the development of appropriate measures and methodological strategies for future research. (Selltig et. al., 1959).

For the historical research the following procedures were established.

**Definition of Variables, Measurement and Data Collection**

Based on the stated hypotheses the following broad category of variables were identified as: a) Latin American's dominant relations of production; b) Pan American Health Organization policies; c) Pan American Health Organization nursing policies; d) the internal social reality within countries.

**Latin American Dominant Socio-economic Relations of Production**

Dominant relations of production in Latin American are defined here as the central socio-economic activities developed to produce wealth.

Taking three distinctive periods of Latin America social formation since the last beginning of century the dominant relations of production are characterized, and, the factors which more directly affect the establishment of dominant health practice are thus identified. The analysis of these relationships is detailed in Chapters 2 and 3.
Pan American Health Organization Health Policies

Health policies are directives or plans for action by the Organization. In the process of policy-making the Organization undergoes a rational choice in face of different alternatives.

The constitution of the Pan American Health Organization states as its purpose "the promotion and coordination of efforts of the countries in the combat of disease, lengthening of life and promotion of physical and mental health of people". Its membership is open to all American states and territories within the Western Hemisphere. Its organs comprise the Conference, the Council, the Executive Committee and the Bureau.

The Conference is thought of as the supreme governing authority of the Organization. It has among its functions the determination of the Organization's general and financial policies. All the other organs within the institution have been vested with authority to perform some of these policy-making functions in one way or another as follows: The council has been delegated to act on behalf of the Conference between its meetings; the Executive Committee considers and submits to the Conference or to the Council as appropriate the program and budget proposed by the Director of the Bureau; and the Bureau performs technical activities required to achieve the Organization's purposes. It is within this context that health policies of the Organization are conceived. The Sanitary Code is used as the basis or guide for the interpretation of the health realities of the member countries (PAHO, 1973).
The Bureau and the Conference play a major role in the definition of health policies within the Organization. Hence, it is necessary to give some consideration to the internal and external mechanisms which determine the dominant influence on health concepts. On the one hand, the technical staff of the Bureau have a specific ideology derived from their individual and collective visions of the world. Dominant practice of health, and the development of scientific knowledge and health legislation, among other factors, make up the concrete social reality from which health concepts are abstracted; these are the elements that the staff of the Bureau utilizes. On the other hand, the Conference embodies the political interests of the governments represented. Health policies at the country level are in turn a consequence of local social conditions and international relations. 3

Consequently, the health policies of PAHO are determined by this consubstantiation of the internal health ideology of the Bureau and the governments political interests. These policies are materialized into programs and the budget of the Organization.

Data for this study were taken from the written programs and budgets of the Director of the Bureau, as well as other official documents of the Organization dealing with these matters.

**Pan American Health Organization Policies on Nursing**

Nursing policies are those directives which embody specific nursing content. They are determined on the basis of the general directives adopted by the Organization and they are developed through the same process described above, for the Organization as a whole. They are also materialized as programs and budgets.
Besides the official documents of PAHO enumerated in the previous section, the sources of data used to analyze PAHO's nursing policies are specific documents on nursing, nursing advisory reports, and publications included in PAHO official journals.

**Internal Social Realities Within Countries**

In the context of this study internal social realities within countries is defined with regard to the historical transformation of the process of economic production in each country. In this way its definition coincides with the one proposed for the variable Latin American dominant socioeconomic mode of production. However, its scope is viewed in terms of individual countries instead of Latin America as a whole. Furthermore, it measures and some of the information are the same as the ones stated above under Latin America dominated socioeconomic relations of production.

**Design**

Internal and external relationships of PAHO development as well as Latin American nursing education, were examined according to historical periods of Latin American social formation. Three historical periods marked by different social formation characteristics since the beginning of the last century are identified. Factors which affect the establishment of dominant health practice in each one of these periods are consecutively analyzed in their relations to PAHO's and Latin American nursing education development.

The general strategy used for the historical analysis of PAHO's advisory services consisted of selection of data from PAHO's archives and library which dealt with policies and recommendations on nursing.
Based on the analysis of these policies and recommendations major categories were established and subsequent information on specific plans, programs and projects were identified further for analysis. Within this framework five basic categories were established for each period: (1) policies and recommendations, (2) programs and budget, including service and education programs and research; (3) personnel; (4) publications, and, (5) fellowships.

For the study of the development of nursing education in Latin America data for each country was obtained and classified according to historical periods and analyzed on the basis of three dominant elements which forged changes in the dominant health practice in the Region thus allowing for changes in educational development. These elements were secularization of medical care, the public health movement and the advance of medical specialization as well as the technological advance of individualized medical care.

Source of data

The selection of sources of data was based on relevance of information. Primary sources were the main ones utilized. The relevance of the material was determined through the utilization of the following criteria based on Van Dalen (1973):

1. Is the material an official document of PAHO?

2. If the material is not an official document, is the author a staff member?

3. Is the author an accepted and competent authority in the specific area?
4. Do other accounts by other independent, competent observers agree with the report?

The methodology for the exploratory study is fully detailed in Chapter 5. The major steps followed consisted of:

Definition of Variables

PAHO's linkage to nursing schools, as defined by the existence of formal assistance of PAHO to the schools is conceived of as the independent variable of the study. Adoption of PAHO's recommendation for curricular innovations by the schools the dependent variable.

Measurement

For the independent variable the measure consisted of the dichotomization of the sample into two groups according to linkage or lack of linkage with PAHO. The measures for the independent variables were derived from the analysis of PAHO's recommendations. Four major recommendations were identified and six measures were defined; these measures are fully addressed in Chapter 5.

Instrument for collection of data

A questionnaire for self administration was designed and sent to nursing schools in Latin America. These questionnaires were also part of a research of the Division of Human Resources and Research of PAHO which sponsored and coordinated its administration.

The Division of Human Resources and Research of PAHO included in its plan for 1982 a study of the nursing schools of Latin America. Its main purpose was a follow-up of the previous studies conducted by PAHO on nursing education in the Region and an evolution of the Text-Book Program. Taking into account the interest of the Division of
Human Resources and Research in the present dissertation and the need to avoid repetition of questions to the nursing schools a decision was made to use one questionnaire that could serve the interest of both: the Division of Human Resources and Research and the present study. As a result a questionnaire prepared by the author of the dissertation was adapted to PAHO's needs and sent to 363 (85.6%) of the nursing schools of Latin America.

Sample

Forty-five schools from which the responses were received by the Division of Human Resources and Research of PAHO up to the first week of September, 1982, were included in the study.

Design

The treatment of the data consisted of the comparison between the two group of schools — according to linkage with PAHO and the measures of curriculum innovation, using what Dixon (1970) has defined as less efficient statistic: means, deviation and proportions.

Based on the foregoing the dissertation has been structured in the following manner.

Chapter one is a statement of the problem of conceptualizing the relationship between society and nursing development. According to what we consider the most central argument: the primacy of changes in the social formation of Latin America and methodological strategies for their examination.

Chapter two summarized the conceptual framework for the study of the relationship between society and nursing development in Latin America, several contributions along this line are analyzed and
attempts are made to set forth the conceptual basis for the analysis of nursing development from a perspective of change which assumes the primacy of internal factors in its determination.

Chapter 3 and 4 analyses the development of nursing education in Latin America and PAHO's nursing services. Three periods of Latin American social formation marked by different social formation characteristics are analyzed. And the exploratory study analyzing the impact of PAHO on Latin American nursing education is summarized in Chapter 5. Chapter 6 covers the conclusions based on the arguments and the findings along with suggestions for future research in this field.
Footnotes for Chapter 1

1. Summary of historical bibliography of PASB/PAHO: First established in 1902 with the following members of a Directing Council: Dr. A.H. Doty (USA), Dr. Juan Guiteras (Cuba), Dr. Juan J. Ulloa (Secretary, Costa Rica), Dr. Walter Wyman (President, USA), Dr. Eduard Laceaga (Mexico); Dr. Eduard Moore (Chile); Dr. Ruth Goode (USA). In 1905 the Directing Council recommended the establishment of a presidency to assure the continuity of the Bureau's activities. Dr. Walter Wyman (USA) was then nominated, he was at the time also the Surgeon General for the USA Public Health Service. Dr. W. Wyman stayed in this position until his death in November of 1911. The second president also the Surgeon General of the USA Public Health Service was Dr. Rupert Blue. His period covered from 1912-1920. In 1920 Dr. Hugh S. Cumming who succeeded Dr. Blue at the USA Public Health Service also became in-charge of the PASB. Dr. Hugh S. Cumming's period inaugurated the institutional organization of the Bureau since the Directing Council and the President only dealt with the organization of the Sanitary Conferences up to this time. During the Sanitary Conference in Montevideo (1920), Dr. Hugh S. Cumming was elected the first Director of the Bureau and Dr. Pablo García Medina was elected honorary Director. Dr. Cumming was the Director of the Bureau for 27 years (1920-1947). In 1947 Dr. Fred L. Soper was elected the new Director of the Organization. It was also in 1947 that the PASB started to reorganize its structure, the Constitution was revised and steps were taken for the Agreement with the World Health Organization. Dr. Fred Soper was reelected for three consecutive periods, staying in office for eleven consecutive years (1947-1958). In 1958 Dr. Abraham Horwitz, from Chile, was elected for four consecutive periods (1958-1974). In 1974 Dr. Hector Acuña (Mexico) was elected and reelected in 1978 for another four years period. In September 1982 the Pan American Sanitary Conference elected Dr. Carlyle Guerra de Macedo (Brazil) for the next quadrenium (1983-1987). For further detail on PASB/PAHO history see: Bustamente. M. "Los Primeros Cincuenta Años de la Oficina Sanitaria Panamericana." Bol. Of. Sanita Panam. Vol 33 No. 6 Dic 1952. and Howard-Jones, N. "The Pan American Health Organization: Origins and Evolution (1) and (2) WHO Chronicle, 34:367-375; 419-426, 1980.
2. N. Howard Jones' paper on the origins and evolution of PAHO considers the work of the Organization previous to the agreement with the World Health Organization (WHO) as limited to the promotion of International Health Conferences for the hemisphere which focused the discussion on regulations of quarantinable and transmissible diseases.


4. Modes of production. The concept of mode of production has been considered a very useful abstraction for the analysis of basic aspects of society, by scholars in all fields of social research. García, 1980; Estrella, 1980; Navarro, 1978; Elling, 1978; and Verderese, 1979; are examples of scholars that have utilized it in social research in the field of health. Modes of production is defined by three basic elements: The economic or infrastructure, the political and the judicial and the ideological. The latter two constitute the supra-structure. Mode of production, thus, considers these societal structures in their dynamic interrelationships.
Chapter 2
CONCEPTUAL FRAMEWORK

Having established in general terms the framework and hypotheses in the Introductory Chapter, questioning basically the issues of either externally or internally motivated changes in Latin American nursing education, we can move to identify and discuss the basic concepts, theories and principles involved in the process of change.

Currently changes in professional practice are more often seen as a result of the continuous evolution of scientific knowledge and technological advances. Nursing literature frequently attributed nursing's professional development and progress to the scientific and technological advances of medicine and health related sciences.¹ (Dock and Stewart, 1938).

These assumptions about the impact of scientific and technological advances on nursing progress are largely influenced by theories of innovations and modernization which are considered a major impetus for change. Innovation and modernization theories hypothesize that the introduction of an external unknown element into a given system will promote change under certain conditions.

Changes in Latin American nursing education, for instance, are mostly attributed to educational innovations imported from countries...
where nursing is considered to be in a more advanced stage. Very little consideration, if any, has been given to the role played by internal social elements which might have shaped nursing education and practice in this Region.

In this chapter, then, the major characteristics of different sociological approaches to explain social change, analyzing its conceptual basis as well as the methodological elements involved, are outlined.

DOMINANT THEORY OF SOCIAL CHANGE

The mainstream of thought on social change is firmly based on the theoretical framework of functionalism and general systems theory. As Lilienfeld (1978) suggests, both concepts are similar enough to be grouped together.

Change in the functionalist view, is explained as an initial state of equilibrium which is altered by the introduction of new unknown elements into the system. The new element acts as a disturbance factor that prevents the system from attaining its initial goal and in turn promotes a differentiation process towards the reestablishment of a new state of equilibrium.²

A system is analyzed as being in a state in which all its subsystems and elements are harmoniously integrated and their functional goal is being met. Change in such a system occurs when disturbances between or within the subsystems and elements are introduced. Disturbances to the initial state of equilibrium can be endogenous,
exogenous, or a combination of both. The emergence or introduction of a new qualitative elements imposes changes in the mechanisms that regulate its reproduction. Goal attainment and integration are mechanisms most affected by interfering in the relationship between input and output, and thus preventing the attainment of the system's goals. As a result, the system changes its goals and defines a new state of equilibrium in which new elements are incorporated and legitimized within the system. In this process it is assumed that the system undergoes a move from a more simple structure to a more complex and differentiated one. In this sense, change is conceived as structural differentiation of the system. (Parsons, 1954 and 1961; Bertalanffly, 1977; Taylor, 1979).

In reviewing this basic framework, we see that disturbances indicate the de-stabilization of a given state of equilibrium and that the mechanisms of reintegration result in a new state of equilibrium. The movement is oriented by a readjustment of the system's goal to its environment at a new and more specialized level, with an increased adaptive capacity as compared to the previous state. Differentiation and reintegration correspond to the need for adaptation to the system's environment. (Hagerstrand, 1968).

At the theoretical level the major problem concerning this framework is the lack of explanation for causation of change. The disturbances, either exogenous or endogenous, are not conceptually defined. (Taylor, 1979). The theory focused on the processes of response of a system to disturbances under an assumption of initial equilibrium which is not proven. (Lilienfeld, 1978). Elements of
disturbances are taken as given; their causes are not theorized and the only approximation is to explain differentiations which has occurred in other systems. This situation leads to a description of change rather than an explanation of cause. (Taylor, 1979).

Lacking the capacity for a theoretical explanation, the functionalist theory of social change can not enable the derivation of conclusions which can be generalized from one social system to another or the prediction of future directions of change. (Taylor, 1979; Lilienfeld, 1978).

Despite these inadequacies functionalism became the dominant social theory of change and has laid the foundations for the theories of modernization and innovation developed after the Second World War. These theories have been widely utilized in the third world societies under the assumption that development in these societies is a question of modernization. Innovations are the motivating elements which trigger the mechanisms of change and enable the transformation of traditional societies into modern ones. The interrelated elements of a system through a process of increasing differentiation, attain "modern" characteristics as innovations are integrated into the system.

Since internal elements are not taken into consideration, modernization theory provides a ground for empiricism. Only the existence or absence of innovative elements are assessed without further consideration about the social forces, power, and contradictions present within a given society. As a result, the application of modernization theory to a particular area, such as nursing, has promoted an encapsulated view of the profession within the health care system as opposed
to a dynamic vision of its interrelationships with the whole social structure.

For instance, Ferreira-Santos (1973) concluded that nursing as a professional category in Brazil is in a state of role change to adapt to the modern requirements of hospital structure and society. She focused on the process of de-stabilization and the need for reintegration based on the idea of innovations introduced into the health care system. In describing the inconsistencies and maladjustments of nursing to the health care system she fails to explain the underlying conflicts and contradictions within the profession, its structure of power in relation to the dominant structure of power in the health care system and in society as a whole.

The theoretical position or approach selected for the purposes of this dissertation is one which analyzes change from a historical perspective but recognizes the social, political and economic variables which influence and effect change in societal structure. According to this approach, social change is conceptualized in terms of the transformation that occurs in the inner and more profound structures of society. Change is viewed as the result of struggle for power among different groups or classes. (McLeish, 1969). Thus, the introduction of new elements in a society is regarded only as a form of pressure utilized by the dominant group to reinforce or maintain societal structure. Consequently innovations are introduced only at the suprastructure level and cannot be considered as a fundamental change.
As Castellano (1982) observes, propositions for innovations emerge from the internal contradictions within the old and traditional, therefore it is an internal process referenced by the dominant relations of power.

Consequently, in order to be able to explain nursing development in Latin America it is necessary to view the process of change beyond the premises of modernization. It is necessary to identify and analyze the forms of articulation of nursing and society as a whole.

HISTORICAL TIME - PERIODIZATION

The first step in the analysis of the forms of articulation of nursing and society as a whole is to characterize the Latin American social structure within a historical perspective of its social formation. However, prior consideration must be given to the question of historical periodization in order to set the stage for the analysis of social formation. As Carr (1961) observes, if fact and its interpretation can be related to the past, present and future within the entire historical context, it is possible to claim objectivity in history.

Periodization or the division of history into time periods has posed a series of polemic questions among scholars in the field. There are two major positions: realistic and conventional (Kula, 1974). Kula (1974) considers that in the realistic approach, the need for periodization stems from the very object of historical investigation; and, in the conventional approach the need for periodization is posed
by an outside concept imposed on reality. In the realistic approach, periods are inherent to historical reality. If this conceptual approach is to be considered, the researcher must identify critical points at which qualitative transformation has occurred in history. Thus, the criteria for periodization are internal to the phenomenon under observation. In this sense, historical periods can only be defined in one way, that is, within the context of the historical phenomenon itself.

In contrast, the conventional approach considers the continuity of history as a given principle and periodization as a methodological instrument that facilitates the isolation of historical facts for heuristic interpretation. The criteria utilized for periodization are then external to the phenomenon under observation. In this case, the researcher is free to establish and define any division of time which might suit his pragmatic needs at a given time.

In addition to the problem of realism and conventionalism, Kula, (1974) discusses the philosophical question of knowledge of the whole vs. knowledge of the parts in relation to historical periodization. Basically, he notes that there are two major philosophic positions with regard to theoretical considerations on this question of knowledge of the whole vs. knowledge of the parts: positivist or non-positivist.

It is not the purpose of the present review to analyze the question of knowledge under either assumption. The point to consider here can be summarized as how differently knowledge of reality under each assumption is conceived. In the positivist framework knowledge of elements or small parts are summarized to give a broader picture of
reality, however, knowledge of total reality is unattainable. Meanwhile, non-positivist approaches present a more complex view. Even though facts and elements of a totality are considered pertinent objects of research, without knowledge of the totality it is impossible to know these parts or elements in their entirety. It is through the confrontation of parts to the whole that the entire reality can be uncovered. Therefore, in the non-positivist approaches there is a dialectical relationship between knowledge of the whole and knowledge of the parts. (Kula, 1974; Semo, 1977).

To illustrate the use of non-positivism it could be said that knowledge about the conceptualization of poverty and the development of poor laws, as unrelated as it may appear, is essential to understanding the changes in nursing practice which occurred in mid-nineteenth century in England and initiated the movement of modern nursing development in the world. For instance, Dean and Bolton (1980) stated:

"The system of the new nursing practice and the terms in which reforms were made existed within a common discourse based on the transformation of pauperism by specific principles of sanitation and institutional commitment and a specific view of how the poor ought to behave, whether in their own homes or as patients in the hospital.

To understand these features it is necessary to return to the discourses in which nursing reform and practice are delineated and situate these in the wider context of the formulations of poverty and its means of administration. In this way we can reconstruct the aim, and means of nursing practice and situate it in the attempts to forge forms of administrative apparatus, types of intervention, and a new specific relation to the poor to the state."
Thus, in addition to a realistic or conventional position, periodization of history can be approached from a dialectic or non-dialectic perspective. Considering the juxtaposition of these four philosophical principles: realistic, conventional, dialectic and non-dialectic, the researcher takes a position with relation to historical time. The non-dialectic conventional approach results in an abstract construct that hinders the analysis of the relationship between elements of social reality and its totality.

Conversely, the dialectical-realistic approach allows for the identification of the position and relationship of each part or element under observation with respect to the totality. Through a dialectical realistic approach it is possible to consider each phenomenon in its different manifestations according to its position in a given society (Kula, 1974; Semo, 1977).

The other possible alternatives -dialectical conventional, non-dialectical realism- may also be considered. If a dialectical perspective is taken along with externally defined criteria, analysis of the relationship between the parts and the whole may be difficult, basically resulting in modifying the criteria itself. While a non-dialectical realistic approach, an alternative widely used by researchers, as pointed out by Kula, results in the definition of discontinuity in time which can be considered a "good breaking point but lacks the perspective of globality" (Kula, 1974).

Either as a working hypothesis or a general framework, periodization in the dialectical realistic approach should be considered as
inherent to historical research. For Semo (1977) periodization reflects the uniqueness and the diversity of the historical process:

"(it reflects) time delimitation of the successions of events which are qualitatively different, (it reflects) socio-economic formations, (it reflects) stages of evolution and revolution, (it reflects) the discontinuities which signals the birth, disappearance or qualitative transformation of phenomena. In summary, periodization is an essential part of historical phenomenon."

In reviewing the basic literature on the question of periodization and assuming a dialectic-realistic perspective, one can conclude that each historical period is characterized by the specific social formation prevailing in a given time and place.

The concept of social formation can be understood as a synthesis of all social structures, in which the economy (the mode of production) is a determinant of all others: state, law, and ideology. (Taylor, 1978, Estrella, 1976). This definition embodies a complex totality which for Althusser (1970) represents a number of different social practices, such as economic, political, ideological, and theoretical. For Althusser (1970) each one of these social practices requires a specific way of transforming raw material into a specific output. The transformation is carried out by a specific activity or labor that utilizes different means of production in accordance with each practice. The economic practice, however, determines and structures the others, even though they are relatively autonomous.

Conceptualization of historical time is thus a question of concern in the characterization of a given structure of social formation. On the one hand, it is feasible to consider instances in the social formation which can be completely characterized by the domi-
nance of a specific mode of production. This approach considers mainly the historical time of consolidation of a dominant mode of production in the social formation. On the other hand, the characterization of historical time may consider equally consolidations and transitions of a dominant mode of production. Characterization of transitional periods may be important for the analysis of the determinants of social change in a given society, most particularly third world societies which have undergone a very heterogeneous process of social formation (Cueva, 1978).

For the present purpose, the adoption of a dialectical realistic perspective is indicated. Firstly, history should not be considered as a continuous unfolding of events in time that may be broken at leisure for heuristic analysis, as has been traditionally practiced within the framework of positivism. It should instead consider the discontinuities in continuity. As Balibar (1968) notes "the concept which fragments the line of time, thereby finding the possibility of understanding historical phenomena in a framework of an autonomous totality". Secondly, there is also a need to be congruent with the position adopted in relation to the question of change. The dialectical method is inherent to the position adopted, when discussing the dominant theory of social change. Emphasis is given to the characterization of transitional as well as consolidated periods in Latin America history.

In addition, the question of periodization has to be focused in accordance with, at least, the two major areas from which the hypothesis of this study stems. These areas are: 1) Latin America
socioeconomic development which ultimately serves as the background or scenario of the totality to allow for the analysis of nursing education policies in PAHO as well as its development in the region, and, 2) the development of the nursing profession to permit the analysis of its articulation with the totality of Latin American development.

PERIODIZATION OF LATIN AMERICAN SOCIAL FORMATION IN THE NINETEENTH AND TWENTIETH CENTURY

Several Latin American scholars have treated periodization from a dialectical realistic perspective within a framework of economic history. Periods thus reflecting economic formation instead of cultural or educational formation have been more widely utilized. For instance, Frank (1979) and Pereira (1970) among others have identified three periods within capitalistic formation: merchant capitalism, liberal or monetary capitalism, and monopolistic or neocapitalism. Cardoso and Faleto (1979), and Sunkel and Paz (1970) in considering the question of dependency and development have linked the stages of development of Latin America with the central nations or so called developed countries. They have also considered three periods: export economies (liberal trade regimes), internal industrial development (formation of internal market), and dependent authoritarian capitalism (neo-liberal trade regimes).

Other authors have also considered political instances of Latin American social formation together with economic formation. Donghi (1972) uses this strategy considering four basic stages: a transitional
stage between colonial dependency and the formation of politically independent states; a new colonial stage dominated by liberal trade economy; a stage of maturity of new colonial states in which the dominant economic formation is the development of internal market; and, a stage of crisis of neocolonial states dominated by economic crises in important sectors of the economy. Cueva (1978) describes the structure of Latin American society in three major economic and political stages.

Precapitalistic or Anarchical Stage

This stage is mostly characterized by an economic situation in which there is no accumulation of capital, as compared with capital accumulation in the world system during the same period and is further characterized by political instability which followed independence. This period covers most of the two middle quarters of last century.

Capital accumulation or dependent oligarchy

This is characterized by capital accumulation associated with the imperialistic phase of capitalism development predominantly in the "developed" world. International trade is the dominant economic activity for capital accumulation. At the state level the national dependent oligarchy consolidates its political powers. This stage covers the last quarters of the nineteenth century and first of the twentieth.
Industrialization or Liberal Oligarchy

This stage is characterized by the transformation of the old oligarchical state into a liberal oligarchy and the emergence of industrialization as the main economic activity. General crisis of the system, political as well as economic, have been observed in the late 1950s and up until the present. This stage is consolidated after the first quarter of the twentieth century in some Latin American countries; industrialization began earlier in a few countries before the period in question and in others it never actually began.

The general thesis of Cueva is one of heterogeneity of structural changes in which an accumulation of contradictions is a basic element in the process of Latin American entry into the capitalistic world system and which entry led as a result to the present economic and political crisis observed throughout the Region. Also, the focus of his discussion is that of transitional periods marked by the coexisting presence of different modes of production.

Cueva's conceptualization of historical time in Latin America will be initially utilized to develop the analysis of nursing educational policies of PAHO and nursing education development in Latin America. His conceptualization offers two very important approaches for analysis: his view of the relationship between economic and political factors and his understanding of the transitional periods of economic development. Both of these factors, but particularly the political one, affects or is more directly related to health policy development and thus to nursing.
PERIODIZATION OF NURSING DEVELOPMENT IN LATIN AMERICA

Before making an attempt to devise realistic periods for nursing history in Latin America it is necessary to present an overview of how this question has been approached by scholars in general nursing history. This is important in order to uncover the criteria used and point to a direction which may be helpful for our present purpose.

**General History**

Periodization in nursing history has in general followed the characteristics of the conventional and nondialectical position. The criterion most widely used is the traditional history of western civilization. Dolan (1973), Goodnow (1950), Jamieson and Sewall (1966), Pavéy (1951), Savard and Gagnon (1970) and Sanner (1975) are authors of a nursing history which attempt to coordinate nursing into the ancient, medieval, and modern periods of the history of Western civilization.

Austin (1957), Bullough and Bonnie (1969), Dolan (1978), Dock and Stewart (1938) and Stewart and Austin (1962) combine the criteria of Western civilization with professionalization. They describe early stages of nursing practice within the primitive practice of health care in the ancient history, consider the rise of nursing as an occupation during the medieval period, and note the development of nursing as a profession in the modern period.
Sister Frank (1953 and 1959) considers nursing in the broad framework of western civilization and the development of Christianity. She analyses nursing in the context of healing arts in the primitive era, both remote and in proximity to Christianity. Then she analyzes nursing in the Christian era in the light of medieval and modern periods of Western civilization.

Nutting and Dock (1907-1912) used, in a parallel manner, Western civilization criteria with geography or regionalization. Up to the medieval period they treat nursing history within the broad framework of health care in primitive, ancient and medieval societies. In the modern period they consider nursing development in different geographical regions.

Seymer (1957) and Paixao (1960) consider the development of Western civilization and nursing biographies. They approach the early stages of nursing in connection with health care in primitive and ancient societies and from the medieval period on, they bring forth names of deaconesses and nurses who have contributed outstandingly to the development of nursing.

Shryock (1959), and Robinson (1946) studied the history of Western civilization in connection with the development of medicine.

Abel Smith (1960) in the History of Nursing Profession in England has approached periodization from a realistic perspective, positing that internal logic for periodizations the power relationship between elite groups in the process of professionalization. The periods take the form of prenightingale, postnightingale and postregistration (Maggs, 1980).
Through this brief review of periodization utilized by different scholars in nursing history it becomes evident that, although nursing as an organized occupation only appeared during the medieval period of the history of human civilization in Western Europe, there is an attempt to trace origins of nursing practice in primitive and ancient societies.

The development of nursing as an occupation is traced to the military, regular and secular orders, that dominated health care during the medieval period as a consequence of the influence of religion. The Protestant Reformation movement is then considered detrimental to nursing development. Most of these scholars mentioned this phase as the "dark age of nursing" making a close relationship with the so called "dark age" of the history of western civilization during the prereformation and reformation that occurred during the medieval period. This association basically connotes the idea of early secularization of nursing care. With the closing of churches, monasteries and hospitals in the countries that experienced Protestant Reformation, lay personnel started to be appointed into nursing care positions. This new incoming personnel were distinctly from lower classes. As Griffing and Griffing (1973) notes:

"The Protestant Church abhorred cloisters and religious institutions and did not feel the same responsibility to the sick that had characterized the early Catholic Church. Nurses were drawn from among the discharged patients or from the lower strata of society—woman who could no longer else out a living from gambling or vice often turned to nursing".

The emergence of the so called modern nursing is treated as a reformation movement which occurred in England under the leadership of
Florence Nightingale. In conclusion, all the authors, with the exception of Austin, Bullough and Bonnie, Dolon, Dock and Steward, and Stewart and Austin, who integrated history of civilization and professionalization to characterize nursing in modern time, thus using a realistic approach to characterize phases of nursing development, have utilized external criteria and based their historical analysis under the assumption of a linear and evolutionary process of development.

Bellaby and Oribabor (1980) taking a dialectical realistic approach have tentatively divided the history of nursing care practice in England into three phases. In the first phase, nurses are considered hospital housekeepers, integrating a disciplinary nonprofessional group whose functions were not directly subordinated to doctors. The Nightingale reform is considered in this phase.

The second phase is inserted in the period between the two world wars. It is marked by the contradictions between the development of nursing structure and the emergent curative model of medical care. Nursing became subordinated to medicine within a technical division of labor.

The third phase began during the Second World War, and it is marked by state intervention and development of managerial nursing. The criteria of Bellaby and Oribabor’s for periodization are obviously internal to nursing care development in England.
Criteria for periodization

Taking into account the approach of these authors, it is possible to conceive professionalization as a meaningful internal criterion for the periodization of Latin American nursing development.

The question of professionalization within nursing has been of great concern to the nursing leadership for a long time. The main issue is centered around the problem of characterizing nursing as a profession in accordance with a set of discriminating criteria or variables generally utilized to study professions and the professionalization process. While in most nursing literature professional status is considered fully established, sociological reviews on professions tend to place it as a semiprofession seen by some authors as being viable to fully become a profession and by others with no possibility to ever attain this status. (Katz, 1969; Goode, 1969; Turner and Hodge, 1970).

Nevertheless, this polemic should not affect the consideration of professionalization as a criterion for periodization of nursing development in Latin America. A particularly important perspective has emerged in the sociology of professions, that is, the questioning of the utility of the traditional taxonomies to differentiate professions from nonprofessions. The new focus is placed on the factors that are affecting the power of the practitioners "to manipulate the social position of their occupations" (Klegon, 1978). As Klegon further observes, the question needs to be shifted from "What are the essential traits of true professions?" to a more significant one which, according
to Jackson (1972), must be "What are the means by which an occupational status becomes rectified and expanded into wider social significance?" These questions, according to Klegon (1978), would promote a sociological inquiry of how professional status is or is not maintained and what are its consequences, thus permitting a better understanding, for example, of the social conditions that allowed occupations to claim, from a historical perspective, a unique body of abstract knowledge and to maintain this claim throughout time.

The adoption of this perspective permits a more realistic and critical approach to the examination of the relationship of the occupation and its practitioners to other aspects of the social structure. (Klegon, 1978). In other words, it is possible to identify the strategies utilized by a professional group to gain professional status.

Klegon further observes that the social influence of an occupation presents both external and internal dynamics. The internal dynamic consists of all the work developed by the practitioners of a given occupation to raise its status. The external dynamic refers to the conditions prevailing in the social structure which may enhance or hinder the social significance of a profession; in other words what power does an occupation have to control its social significance. (Johnson, 1972; Klegon, 1978).

The traditional trait or classification system for determination of professional status as observed by Klegon (1978) presents two set of problems. The first one relates to the identification of professional
traits and its empirical application in the definition of professions. The second deals with the question of value orientation.

Neither the several lists of traits and attributes are compatible among themselves or are easy to apply in the appraisal of occupations. To illustrate this point Klegon (1978) shows how lists differ among six different authors in the field. Nevertheless, systematic abstract knowledge seems to be present in all of them and is considered a key trait in the determination of the status of a profession. In addition to the problem of inconsistency in the definition or value judgment of traits, their concrete application seems to be a more critical problem. Klegon demonstrates how even authors who are proponents of traits criteria such as Wilensky and Hall have failed to clearly define the boundaries for consideration of the existence of an abstract, theoretical knowledge base. He concludes:

"Thus, there are several difficulties in applying the criterion of an abstract theoretical knowledge base. Practitioners may be able to manipulate the nature of their occupational knowledge, similarities between the knowledge characteristics of occupations considered professions versus nonprofessions exist, and important differences in the type of knowledge utilized among even the established professions are evident."

Therefore, in studying nursing it seems necessary to adopt a more critical view and utilize the alternative theoretical perspective proposed by Klegon. As a result attempts for status definition should be substituted by an analysis of the strategies utilized by nursing within a given social context to obtain and maintain professional status; in other words, the internal and external dynamics of practice.
Periodization for Latin American Nursing

As Maggs (1980), points out "...identifying important and significant periods which take to this alternative concern into account is a difficult and evolving task: difficult because, until more detailed research has been carried out which looks at these issues and those 'ordinary' people, definite eras cannot be established".5

Based on these perspectives we can, as a first approach, consider three major phases in the development of nursing in Latin America. The first covers all of the colonial period and extends itself to the time of independence up to almost the end of the nineteenth century. It is characterized by the organization of nursing under the control of religious orders which provided the great majority of health care for sectors of Latin American population since colonial times. It may be seen as a mere extension of nursing in the central European nations, where it is confined to hospitals and its practitioners are nuns or lay persons, mostly women from lower social classes who at one time might have been patients themselves. Nursing functions are related to patient support and hygiene in terms of prevailing religious concepts as well as housekeeping chores (Nutting and Dock, 1912). It is necessary to bear in mind that this phase corresponds to the emergence of the so-called traditional professions in Western Europe, and also the rise of nursing as a structured and independent occupation. In addition, Latin American social formation during this period does not reveal any substantial degree of autonomy from the European nations. Consequently, nursing, although an orga-
nized occupation in Latin America, did not attempt to use any strategy to raise the power and prestige of its practitioners as compared with the European movement which resulted in the 'Nightingale' reform.

The second phase was marked by the movement toward professional development and progress. It started in a few countries in the Region late in the nineteenth century and extended up to the beginning of the Second World War. Its main characteristics are the development of institutional education and public health practices. Nursing development is mostly promoted by the state, as it acquired control over health care and initiated the process of secularization. This process of change is heterogeneous in the Region. It is mostly dependent on the articulations between church and state within each country. International influence also marked this period. In all Latin American countries the effort to organize a system of education and service was based on the presence of either European or North American nurses through agreements with international organizations such as the Red Cross and the Rockefeller Foundation.

This period is characterized by the struggle of practitioners to raise their status by different ways and means. In some countries of the Region professional associations were organized, practitioners started to gain control over nursing recruitment and preparation, and some schools began to be directed by nurses, and above all, legislation was adopted.

The third phase is marked by complete incursion of nursing in the professionalization process. This phase, which started with the
Second World War extends itself to the present time. Control of education and practice came under the responsibility of nurses in most of the Region.

As a consequence of a further division of labor within the health area, the category of practical or auxiliary nurses is institutionalized and the nurse assumes leadership of their training and control. Specialization, similar or parallel to those developed for medicine, emerges and is developed as an attempt to claim an abstract and scientific body of knowledge which would lend credibility to the emerging profession.

In all countries legislation in support of education and the practice of nursing is a complete reality. Nursing enters the system of higher education, and in all countries the educational process has defined policies. National organizations control the practice and nurses are increasingly mobilized into professional organizations and unions to struggle for better salaries work conditions, following to a certain extent the international trend guiding professionalization since the Second World War. (Katz, 1969).

Having discussed the question of historical periods we can turn to a closer examination of the articulation between health practice and nursing in Latin American social structure. A general overview is considered here and in chapters three and four, where the development of nursing education in Latin America and PAHO's nursing advisory services are examined in more detail from this perspective.
NURSING IN LATIN AMERICAN SOCIAL STRUCTURE

As we have noted previously the period that runs from the end of the eighteenth century to 1880 is marked politically by atomization of power which characterized the state in this transitional phase of constitution of an independent nation. The economy is based on export of agricultural and mining products. During this period the articulation of health practice with the social structure presents two distinctive aspects which influenced nursing. The first is the development of public health services controlled by the state and directly tied to the dominant form of economic production. Port surveillance of quarantinable diseases and control of communicable diseases are the focus of public health activities. Garcia (1981) observes that this public health development "represented a substantive transformation in the role previously played by the national state." In most countries the colonial and locally controlled health system is substituted by national health systems directly controlled by the government through the newly established national health departments or directorates.

This change affected the practice of all health professions including nursing. For the first time the state introduces and promotes nursing visiting services based on North American models. Argentina, Mexico, Chile, Uruguay, and Brazil, for instance, are countries that had thid kind of service in the early 1900's. Furthermore, these are the countries which in this period developed an earlier export type of economy and central control of public health (Garcia, 1981). In addition, development of nursing in some of these
countries is tied to the public health development of this period. This issue is treated in further detail in the next chapter.

The second aspect that has an influence on nursing is medical care or curative medicine. By and large, medical care during this period maintained its colonial structure of services. These services have traditionally selected and differentiated according to the social class structure. The dominant classes received care through independent and private medical services; the emerging working classes received care on a very limited basis from a few industrial health services connected with the mining and agricultural private enterprises, the lower and poor classes received charity medicine practiced in asylums and hospitals under the control of religious orders. However, in a few countries, medical attention to the lower classes began to be transformed. One of such transformation resulted in the emergence of the professionalization process of nursing.

Thus, nursing professionalization in this period may be best explained by the secularization of medical attention. For instance, the first attempt to establish a nursing school in Brazil in the year 1898 was promoted by the state when it took control of psychiatric care. (Pullen, 1940).

Nevertheless, it is important to note that other than the few isolated attempts at professionalization, nursing practice remained almost unchanged in the majority of the countries, reflecting the general trend of medical care prevailing in the period -early 1900's.

The period between 1930 and the end of the 1960's is marked by the consolidation of political power into liberal oligarchic states and
the emergence of industrialization as the dominant economic activity. These structural transformations led to substantive changes in the health area. On the one hand, the administrative structure for delivery of medical care is reorganized under a new conceptual framework. Individualized care becomes the focus of service development, bringing with it the emergence of the hospital "industry". Progressively the state begins to control the care of the working classes through the development of social security systems as well as the care of lower class patients through social welfare systems. (Verderese, 1979; García, 1981). On the other hand, the structure of public health services is expanded. Health education, maternal and child health programs and urban sanitation programs, among others, are introduced shifting the previously dominant focus of activities centered around port health surveillance. Special public health services are also created during Second World War in strategic areas where either mining or agricultural activities had a certain degree of importance for the United States and European nations. These services received financial and technical support from the Institute of Inter-American Affairs. (PASB, 1942).

Changes in both areas of medical care and public health influenced nursing during this period (1930-1960). Control of medical care by the state and the medical profession, however, are the major factors which intervened in the process of nursing professionalization and progress. In this process nursing becomes increasingly subjected to medical authority, consequently losing some of its independent characteristics as well as its housekeeping functions.
At the end of this period all countries in the Region had established a nursing education system. The number of schools grew steadily and rapidly. In ten years (from 1949 to 1959) the number of schools doubled from 54 to 115. Brazil, for instance, experienced a dramatic growth of 1150 percent creating 21 new schools in only one decade. (Chagas, 1952, PAHO, 1962). Professional organizations were established in 12 countries, and nursing legislation was initiated. During the centennial anniversary of the University of Chile in 1942 the national nursing association organized the first Pan American Nursing Congress. One of the resolutions of this international meeting was related to the organization of a Pan American nursing publication and annual meetings suggesting an embryonic stage for the establishment of a Pan American Nursing Association that was to be consolidated soon thereafter.

Nursing practice is concentrated in hospitals; more than 80 percent of the professionals are employed by these institutions. With the expansion of hospital industry the number of auxiliary personnel increased to a higher proportion as compared with professional nurses. As a result, professionals started to assume administrative positions and became responsible for the supervision and training of these auxiliary personnel.

Public health practice encouraged independent participation of nursing in the delivery of maternal and child health care, industrial work, and communicable disease control.

From the late 1950's up to the present, Latin America has undergone political as well as economic crises which have affected the
health care system. First, the increase of the national debt and the resulting inflationary economy have imposed a policy of increasing the efficiency of the health services delivered, and redefinition of individual and collective health care goals. (García, 1981). At the beginning of this period curative medicine completely dominated the health practice. It was at the center of the training of students in the health professions as well as the health sector in which the government was investing more resources. However, the rationalization movement began to criticize and challenge these practices.

As a result, new programs and strategies have been proposed which focus on community development and on health care as an element of great importance in the achievement of a better quality life in the region. This new emphasis reveals the increasing governmental concern with the social crisis that has evolved from the economic and political situation.

These new approaches have begun a new trend of thought in the health care area leading to international agreements and cooperation focusing on increasing the health coverage and the attainment of Health for All by the Year 2000. However, these new policies may be seen as a challenge for Latin American governments. On the one hand, knowledge of the influence of other sectors of the social structure, particularly the economic, on the health status of the population calls for profound changes, which should provide a more equitable distribution of wealth throughout the entire population. This can only be achieved through a more democratic political leadership in public affairs, as opposed to the situation that has prevailed during
this period of proliferating dictatorships throughout the Region. On the other hand, the health system itself has to be reorganized to be able to extend its services. This reorganization should include a new approach for the integration of the levels of care, through a hierarchical structure containing a coordination and referral system which should provide comprehensive and efficient care. To develop such a system, there must be a different perspective on human resources development.

Within this context, nursing's ties with social structure, especially the health field, are marked by the dual trend that has characterized this period. Further development and sophistication of medical attention has, on the one side, promoted the emergence of clinical specialization in nursing. As Verderese (1979) observes, specialized training in maternal and child health nursing, medical surgical nursing and psychiatric nursing are organized and nurses started to shift the focus of their practice from administration to a more direct intervention and control in health matters. On the other side, the emergence of the extension of health care coverage policies has promoted a series of new recommendations for changes in the nursing practice and education which promoted the expansion of its traditional role to include actions traditionally performed by physicians in the first level of health care. The result of these recommendations has not been evaluated yet, but the general expectation among nurses is that as nurses become involved in the coordination of first level of health care, the profession will be able to fully control its social position.
Assuming responsibility for developing primary health care could provide nursing with a more clearly defined independent role, thus allowing for the upgrading of the professional status it claims.

In summary, it is evident that, even though nursing education and its practice have predominantly focused on individual care and hospital activities, shifts of government expenditures in the development of primary care services are introducing trends toward very drastic changes in nursing practice and nursing education in Latin America.
Footnotes from Chapter 2

1 Not only the literature that deals with nursing professionalization extensively explores this issue in an attempt to justify and apply the criterion of existence of an abstract and specific body of knowledge, but also general literature on nursing history. In the area of professionalization see: E. Katz, "Nurses" in The semiprofessions and their organizations: Teachers, Nurses, Social Workers. Ed. by Amitai Etzioni, The Free Press, New York, 1969; and, in the general history of nursing see: A. M. Nutting and L. L. Dock, A history of Nursing, (G. P. Putnam's Sons, 1907-1912, New York).

2 Although Parsons' theory is previous to the development of modern system theory and the latter does utilize terminology which is not used by Parsons, the concepts are similar enough to accommodate R. Lilienfeld suggestion to group these theories together. For an analysis of the general system theory, see, for example Section I of Systems Behaviour Ed. by John Brishon and Geoff Peters, (The Open University Press. Harper and Row, New York, 1978). For further discussion of the criticism of Parsons' concept of equilibrium as a sociological bias for the maintenance of the status quo see: Barrington Moore, Jr. Ed. The New Scholasticism and Study of Politics in Political and Social Theory: Seven Studies, (Harper and Row, 1965); D. Foss, The World of Talcott Parsons, in M. Stein and V. Vidich, Sociology on Trial, (Prentice Hall, 1963); and C. Wright Mills, The Sociological Imagination, (Oxford University Press, New York, 1959).

3 The variation among lists of professionals' attributes are exemplified in D. Klegon paper on Sociology of Professions through a brief review of the pertinent literature, he observes: "One early and off-cited example is by Greenwood (1957) who defines a profession as having: (1) a basis in systematic theory; (2) authority recognized by the clientele; (3) broader community sanction and approval of that authority; (4) and ethical code regulating relations with clients and colleagues; and (5) a professional culture sustained by professional associations. Other authors who have taken up the challenge of defining the essence of a profession include Barber (1963) who suggests four attributes: generalized and systematic knowledge, primary orientation to community interest, self-control through codes of ethics, and a system of rewards that are ends in
themselves, not means to some end of individual selfinterest. Kornhauser (1962) adapts the definition to allow for professional to exist in organizational settings. He considers the claim to professional status to be based on specialized competence having a considerable intellectual content. Wilensky (1964) has a shorter list, consisting of two criteria: the job of the professional is technical, based on systematic knowledge acquired through long training; and the professional adheres to professional norms. Goode (1969) suggests one dominant factor, trust, since he argues that job of the professional is such that the client or society could be harmed by unethical or incompetent work by the practitioner. Finally, Moore (1970) although recognizing the possibility of a scale of professionalism, still continues the taxonomic tradition, offering yet another set of criteria; full-time occupation; commitment to a calling; identification with peers; often in a formalized organization; possession of esoteric but useful knowledge and skills; based on specialized training and education; service orientation; and proceeds by own judgment and authority; enjoying autonomy. There is, thus a great deal of inconsistency and differing terminology in these lists."

4 According with Klegon the knowledge basis criterion has been difficult to apply even by their proponents. For instance, Wilensky believes that knowledge based on long training is important. Nevertheless, the fact that knowledge should not be too technical or too common, makes it very difficult to apply this criterion. In still another angle of this question, Hall observes that professions stress mental power, whereas occupations stress manual dexterity, and professions are based on theoretical knowledge and occupations on technique. For Klegon "according to these criteria we might argue that surgery is a craft, for, are surgeons any different than mechanics who understand the theory of engines and must go through complex search procedures to diagnose difficulties and repair components (perhaps then, they are professionals too)?"

5 Maggs reference to 'ordinary' people has to be understood in the context of his work on Nurse Recruitment to Four Provincial Hospitals 1881-1921 in England. The concept of ordinary is used in the sense of studying nurse history through the analysis of data on nursing rather than looking into the great leadership names of the time.

6 The official publication of the Pan American Health Organization. The "Boletín de la Oficina Sanitaria Panamericana" published in the early 1929's and 1930's notes the organization of visiting nursing services in several countries in the Region. This issue will be treated in further detail in Chapter 4.
"The achievements of the past provide the only means at command for understanding the present.... The sound principle that the objectives of learning are in the future and its immediate materials are in present experience can be carried into effect only in the degree that present experience is stretched, as it were, backward. It can expand into the future only as it is also enlarged to take the past."

(John Dewey, 1948)

The aim of this chapter is to analyze the development of nursing in Latin America focusing on the influence of the internal and dynamic social processes in the Region. Three major elements will be considered in the analysis: firstly, secularization and modernization of medical care; secondly, public health movement; and thirdly, higher education programs. The three phases of nursing development described in Chapter II will also be taken into account.

At the end of the nineteenth century, Latin America had started to consolidate the oligarchical phase of its capitalist development, a period marked by diversity and heterogenity in the Continent as pointed out by Cueva (1978). These characteristics make themselves
evident in the development of nursing education. Even though a number of generalizations are possible, the analysis of the Latin American nursing education process also has to be framed within the characteristics of subregions and individual countries. Given the aforementioned considerations, the following approach has been taken for the development of this chapter: firstly, the analysis of the general framework of nursing education within the Region as a whole, secondly, the examination by country or group of countries. The criteria utilized for grouping countries were the dominant characteristics of their social formation which were described at length in Chapter II.

Precapitalist formation must be recognized as a major influencing factor in the complexity and heterogeneity of capitalist development in Latin America. Countries marked by weak precapitalistic formation such as Argentina, Chile, Uruguay and Southern Brazil developed earlier and stronger capitalistic economies. Those countries in which precapitalist structures were stronger and did not undergo a social revolution—as in the case of Mexico—developed capitalistic forms much later and without total consolidation. This is the case of Bolivia, Ecuador, Peru and Northeast Brazil. In addition, there are also some other situations which do not quite follow these two aforementioned said patterns:

1. Central America, (with exception of Panama which will be discussed separately), Colombia, Venezuela and Paraguay in which the role of enclave\(^1\) influenced the economic articulation of external and internal elements thus permitting a weak precapitalistic economy to persist;
2. The occurrence of military occupation by the United States in Cuba, Puerto Rico, Haiti and the Dominican Republic after breaking their European colonial ties; and,

3. United States direct administration in the Canal Zone territory.

Therefore, it is the endeavour of this Chapter to examine nursing educational development under each one of these situations.

GENERAL FRAMEWORK OF NURSING EDUCATION IN LATIN AMERICA

Secularization and Modernization of Medical Care

The beginning of institutionalized nursing education in Latin America occurred during the second phase of its development as it was defined in the previous chapter. However, toward the end of the first phase, the process of secularization of medical care, together with the development of the scientific conceptualization of medicine and the consequent need to organize patient care on a technical basis, set the foundation for the emergence of formal training (García, 1982).

The process of secularization of medical care in the nineteenth century emerged as a consequence of the separation between the State and the Catholic Church. This process occurred in countries in the Region where the Church was not able to maintain its alliance with the national bourgeois during the formation of national states. It is also important to bear in mind that the Catholic Church exercised more influence in countries in which precapitalist formation was strong. Mexico is the first and the most typical example of this situation.
Independence in Mexico was followed by a period of conservative government which was maintained until 1854 when the liberal revolution started. The liberal government in power started what became known in the Mexican history as the "Reforma". The "Reforma" made most of its impact on the Church. Not only Church property was taken over by law, but also the religious congregations were debarred from public affairs. Therefore, secularization of medical care and nursing followed immediately. (Donghi, 1972).

In those countries where the church was able to maintain a certain degree of influence, the secularization process occurred much later and may be directly linked to the efforts of the national bourgeois to modernize medical care in the liberal oligarchic phase. For instance, Brazil started this process in 1890. (Machado et. al., 1978). Nevertheless, the process of secularization of medical care in Latin America did not always affect nursing care immediately. In some instances, once secularization of the administration of health institutions (hospitals) was attained, religious congregations in charge of patient care were maintained under the jurisdiction of lay administration. This was the case of the majority of the countries in which the influence of the Church persisted, as for example Peru, Colombia, Ecuador and Bolivia. There are also examples, such as Venezuela which, after the overthrow of Guzmán Blanco whose government had promoted secularization, permitted in 1889 the reentry of religious congregations for patient care. (Bol Of Sanit Panam, 1943).

It is important to note that by the end of last century religious congregations dedicated to nursing care, conducted specific
nursing training during novitiate preparation. For example, the congregation of St. Vincent of Paul, which had a substantial network in Latin America, included a six to twelve month training period in hospitals. (Hamilton, A., 1901). Later, when nursing registration laws began to impose the need for formal education as a requirement for nursing practice, religious congregations started to send their members to lay schools. However, they subsequently developed nursing schools, and in 1933 an international congregation of Catholic nurses was created. In the first two international congresses held in 1935 and 1937, the basic themes treated were the need for professionalization of the nurse. The American Journal of Nursing (1936) reported that the 1935 Congress, addressed:

"...the necessity of state registration(s) first, as a moral obligation, second, an obligation for fitness, and third, a matter of vital interest to religious congregations".

During this meeting Pope XI also stressed the necessity of the religious being highly efficient in this work, and urged them to secure all diplomas and credentials necessary to attain this aim thus reinforcing the need to pursue studies in the field of nursing. (A. J. Nursing, 1936; Vianna, 1976). Therefore, nursing in religious congregations was incorporated into the lay process of nursing modernization as an strategy to regain its dominant influence in the field which had been lost.

Notwithstanding the influence of the Church, institutionalization of nursing education in Latin America is more directly associated with the process of modernization of medical care which occurred at
the end of the nineteenth century. Medical professionals educated in
Europe during this time, were able to acquire knowledge of the nursing
reforms in Great Britain, and to evaluate the advantages of having the
administration of hospitals in all respects under their control. For
instance, Dr. Cecilia Grierson, the founder of the first school of
nursing in Argentina, remarked on the advantages of the English system:

"Englishmen are practical, they are convinced that a
greater economy results from the employment of 'good'
nurses even if they are to be paid high salaries, and
money in generously spent in their well being, getting
in this way highly competent personnel with a good moral
who will put the means at their hands to good use, thus
resulting in greater benefits for the institution than
the one resulting in hiring incompetent personnel at a
negligible price" (Grierson, 1910).

She further remarks that Latin American doctors as leaders and
officials, making an analogy with the military services, have not
given the necessary attention to the preparation of nurses who are,
"the true soldier of the health battlefields". (Grierson, 1910).

During the third Latin American Congress held in Montevideo,
Uruguay in 1907, Dra. Grierson presented a resolution which was
approved. This resolution said:

"The physicians of all Latin American countries, should
work in each one of their own countries, for the devel­
opment of nursing schools, using as a general model the
English and North American patterns" of education.
(Grierson, 1910).

Nevertheless, this resolution was only put in effect at the
private hospital level and most often in foreign institutions within
the countries.

At the time of this Congress there were only five countries that
had nursing schools: Argentina, Brazil, Cuba, Chile and Colombia.
All of them, with the exception of Cuba, were developed by medical initiative. The school in Brazil was created at the time of the secularization of the state mental hospital. Nursing schools in Cuba were directly linked with the military occupation by the United States which had imposed modernization of the agency for public assistance.

In summary, the initial stages of nursing education in Latin America which occurred around the turn of the century was associated with efforts for the modernization of medical care. This process of modernization was associated with the liberalization of the state in the oligarchic phase which imposed regulations for the secularization of medical care and, in the case of Cuba, was associated with the military occupation by the United States.

**Public health movement**

The public health movement provided another important element for the development of nursing in Latin America. The public health movement started in the United States at the end of the nineteenth century. It stemmed from the need to regulate everyday life with respect to public and private hygiene. In Latin America the development of public sanitation during colonial times was under the authority of the municipalities. During the period of 1880-1930 the central government started to organize national health services, which eventually came to be in charge of national sanitation. After the First World War the Rockefeller Foundation started programs to create local health units, and for the first time, the concept of individual hygiene embodied in the public health movement was incorporated in public sanitation programs in Latin America. It is also necessary to
observe that the development of public health nursing was also associated with the need for private hygiene and health education of individuals and families.

At the end of the nineteenth century, the rapid growth of cities in the new Western industrialized nations made evident deepening cleavages between the upper and lower classes..." (Rosen 1975). This situation called for the establishment of national responsibilities for health and welfare. Since the prevailing ideology associated poverty with maladjustment to society, governmental actions were required to create conditions for better adjustment through setting standards for income, working conditions, housing of good quality and health care. (Rosen, 1975).

In the United States of America, the movement of conservation of natural resources which was developed toward the end of the nineteenth century, focused on the need for prevention of diseases and promotion of national health. Fisher's report on "National Vitality Its Wastes and Conservation presented to the Federal Commission on the Conservation" of National Resources appointed by President Theodore Roosevelt urged the government at all its levels to develop actions to protect the health of the people. Fisher (1909) pointed out the complex interdisciplinary nature of an industrial society and the need to consider social interest above individual interest in matters such as resource conservation, health promotion, disease prevention and sanitation. Fisher also called attention to the fact that social and health problems in the Untied States were not simply local matters but were an interest of national policy. Rosen (1975) remarked that:
"it is no accident that such a view achieved prominence in a period marked by a resurgence of mercantilist ideas and policies in the United States, by efforts to acquire colonies, to serve markets and sources of raw materials, and to have a large productive population. If an industrial power wanted a productive labor force, if it wanted enough healthy fit men to serve in its armed forces, conservation of its human resources was necessary."

By the end of the nineteenth century also, progress of the biological sciences had made feasible the idea of prevention of diseases. The effectiveness of smallpox vaccination and prevention of scurvy, were known, for instance, even though knowledge of their underlying biological mechanism were not fully understood. Nevertheless, at the beginning of this century the notion of contagious and infectious diseases was well established, setting the basis for programs of action centered on the prevention of diseases. (Rosen, 1975).

At the beginning of the twentieth century, therefore, in association with the development of biological sciences and knowledge about disease prevention, public health became a leading movement of the U.S. Government aimed at protecting the health of working men.

Before turning to the development of nursing within the framework of the public health movement, it is also important to point out how this movement led to the division between curative and preventive medicine. The division between prevention and cure in terms of governmental and voluntary health agencies on the one hand, and clinical practitioners on the other can be viewed under the influence of the emergence of control by and power of the medical profession over its practice in the United States. (Rosen, 1975).
Prevailing medical practice until the XVII century included only hospitalization for lower classes and home care for the dominant classes. At the beginning of the XVIII, however, under social pressure and in the midst of social outbreaks of diseases, establishments called dispensaries started to deliver medical care and medicine to the lower classes on an ambulatory and home care basis. These dispensaries evolved independent of hospitals until this century when hospitals started to organize out-patient services. (García, 1982, Davis and Warner, 1918).

In the United States, the first dispensary was established in Philadelphia in 1786. At the end of the nineteenth century they were found in all large cities of the country. First, the dispensaries were thought of exclusively as a relief for the poor, but later they also became a setting for teaching medical students (Davis and Warner, 1918). With the rapid growth of dispensaries as independent units, a coordination of services was proposed in order to unify efforts, and thus, emerged the first attempts to systematize the administration of public health voluntary services. Several experiences in district health services in large cities set the stage for the development of a governmental system of public health in the United States after the first World War (García, 1982).

At this time the medical profession was emerging as a dominant force. The American Medical Association began to fight against the indiscriminate utilization of public medical care by those sectors of the population which were supposed to afford medical services. Even though indiscriminate utilization was never fully proved, this
contention set the basis for the separation between preventive and curative services in the United States. (Davis and Warner, 1918). However controversial and much criticized, the medical system in the United States developed under this rather artificial division between cure and prevention. Later, this model was diffused to those countries which were under the dominant influence of the United States (García, 1982).

It was within this new trend of the public health movement that public health nursing in the United States grew rapidly in the first decade of this century. First, the visiting nursing services developed during the last quarter of the nineteenth century and became well established in the nursing care for the sick at the home, received substantial reinforcement when the Metropolitan Life Insurance Company started to employ nurses. The aim of the insurance company was alliv­ate death claims through lowering mortality rates. Public health nurses did appropriate health surveillance of policy holders and most important taught health protection measures (Canning and Lazonick, 1978; Waters, 1909).

After the First World War the public health movement gained a tremendous impetus. Official agencies started the promotion and employment of public health nurses as well as the International Health Board of the Rockefeller Foundation. As Roberts (1954) remarked: "Records of the rapid expansion of public health nursing following World War I, convey a sense of sustained drive and enthusiasm which had repercussions in the field of nursing education..." Three postwar pro­grams were of major importance for public health nursing development:
first, the national and international American Red Cross program which at the time became one of the largest agencies employing nurses in the world: second, the Children's Bureau Program between 1921-1929: third, the program of health demonstration sponsored by the Rockefeller Foundation and other agencies (Roberts, 1954).

It is under these circumstances that a number of bilateral agreements between the Rockefeller Foundation as well as the American Red Cross, through national chapters of Red Cross, and local Latin American governments were signed for the development of nursing schools. In 1916 with assistance of the American Red Cross, the Brazilian Red Cross started a nursing school. Later, on the same basis, schools were created in Argentina (1920-1928), Venezuela (1936), Colombia (1938). The first Rockefeller Foundation project for a nursing school was developed in Brazil in 1923. Subsequently, several countries received Rockefeller support: Colombia, Venezuela, Ecuador, Costa Rica.

At the onset of the Second World War, under the coordination of the Pan American Health Organization, the Institute of American Affairs and the Rockefeller Foundation started a project for the development of nursing schools and the reorganization of existing ones in several countries. This project marked the first direct assistance of PAHO to Latin America in nursing education and will be fully detailed in the next chapter. However, this project was part of a bigger public health project sponsored by these international agencies in Latin America, the purposes of which were the organization of a net-work of preventive health care services in strategic areas.
In conclusion, the second element in nursing education development in Latin America was associated with the public health movement. Internal conditions existing in the majority of Latin American countries in which the public health movement was expanding, allowed for the implementation of bilateral government agreements between government and international agencies, aimed at promote nursing education with a focus on the preparation of nurses for public health services.

University programs

The third major element in the development of nursing education in Latin America is marked by the expansion of university programs in the 1950's. Previously, these were a few nursing programs located at universities, either as isolated schools or attached to medical schools. In general, these programs initially did not meet university requirements or confer appropriate degrees. Although the expansion of nursing university programs occurred in the majority of countries in the Region, this was more evident in countries which expanded their university systems as a whole.

Although universities began to be established as far back as the sixteenth century in Spanish America, and in Brazil in 1920, expansion of the university systems only occurred in the majority of the countries after the 1950's, (Benjamin, 1965). Not only did the number of universities increase but also the number of students enrolled. Brazil, for example, during 1936-1956 (twenty years) increased by 216% the number of institutions of higher education (Texeira, 1957). This expansion was also marked by a general trend of
"modernization" based primarily on North American models. The process of expansion and modernization was in turn dependent on each country's internal social and economic development.

The late entry of nursing programs into universities has to be analyzed within nursing's own development as a professional category. Its long history of apprenticeship associated with medically dominant concepts of nursing and the role of professional women in society, may be viewed as elements which hindered development of university programs. Firstly, the so-called Nightingale reform of nursing had left a legacy of an educational system based on training on the job under very strictly disciplinary rules. As Davies (1980) remarks: "the Nightingale strategy of nurse education in effect meant the staffing of hospitals with a strictly disciplined labor force of probationers". This legacy delayed the appropriate development of a body of specific nursing knowledge which could justify a university program. Secondly, doctors have been concerned and suspicious of anything that could affect their own interest. Since the establishment of nursing schools, physicians have complained about increasing both time and content of training for nurses. For example, most physicians in control of nursing education in Latin America during the early century, emphasized practical training over theoretical. Grierson (1910) emphatically remarked that nurses should never receive "abstract" lectures. Thirdly, the professionalization of women in Latin America society is a recent event. On the one hand, education of middle class women in Latin America, until recently, did not attain the levels required for
university entrance. On the other hand, the moral reputation of lay women nurses was considered inadequate by middle classes families.

Following the battle for registration, each national nursing association began to promote the upgrading of professional status through the introduction of nursing programs at the university level. The first six Pan American Congresses held between 1942-1959 consistently recommended the need for establishment of national nursing organizations in countries where they were not yet founded, and the formulation of registration laws associated with the internal situation of each country. These goals were eventually met thus, permitting a step forward in the nursing movement. In 1969, when the first expert committee on nursing for PAHO met in Washington, there was a general consensus for the proposal of three levels of nursing in the Region: the first level should comprise nurses prepared at higher education level; the second, proposed the preparation of nurses at secondary education level; and the third, the preparation of auxiliary nursing personnel at primary school level.

University nursing programs have been a quite recent trend in nursing education in Latin America. Such programs emerged as a result of expansion and modernization of the university systems in the majority of the countries in the region and the degree of internal development of nursing within each one of the countries. The two most general trends observed however, were the incorporation of already existing nursing programs in universities, —most frequently, the major national nursing school created by the Ministry of Health have been incorporated in national universities; and, new universities
following the establishment of health teaching hospital complex promoted the organization of nursing schools. Because of the particularities observed in each country related to the degree of universalization of these programs, specific data will be analyzed in the countries section.

NURSING EDUCATIONAL DEVELOPMENT

Having established the general framework of nursing education in Latin America we can turn to the analysis of its development in each group of countries or individual country in accordance with the criteria proposed at the beginning of this Chapter. In order to facilitate the exposition, Brazil, which appears in two different groups because of marked distinction of its precapitalist formation in the southern region and northeastern, will be analyzed separately. Mexico, equally distinctive within its group, will also require a separate analysis. Consequently, the proposed groups are: 1) Argentina, Chile and Uruguay; 2) Brazil; 3) Bolivia, Ecuador and Peru; 4) Mexico; 5) Colombia, Central America, Paraguay, Venezuela; 6) Panama; and, 7) Cuba, Puerto Rico, Haiti and Dominican Republic.

Group 1: Argentina, Chile and Uruguay

Under the influence of an early formation of a liberal oligarchic state, nursing education began to be established in these countries during the last quarter of the nineteenth century. The legacy of rather weak precapitalist social formation has shaped the conditions that permitted this early development. On the one hand,
the Church had not exercised dominant leadership of the civil society. Thus, education welfare and cultural affairs were not concentrated in the hands of the Church. These circumstances favored secular policy practice at the time when the medical profession was consolidating its clinical practice at the hospital. On the other hand, the liberal state, to some extent, was able to establish a fairly large basic educational system. Therefore, at the turn of the century a wide segment of the population, including women, had in these countries a few years of elementary schooling.

These factors have thus facilitated the early introduction of nursing education in these countries. Subsequent development however, has not been homogeneous and has been influenced by internal developmental characteristics which only can be appreciated through individual analysis of each country.

Argentina

In Argentina, as has been noted elsewhere, the first nursing school of Latin America was founded in 1886. During the first five years this school was sponsored by the Ciclo Médico Argentino. In 1891, after the medical services of the Ciclo Médico were integrated in the recently created "Public Assistance", the school was incorporated into this municipal institution. Although adapted to local circumstances, this school had some features of the probationary training system utilized in England. Students were subjected to long hours of practical training at the hospitals under strict rules of discipline. During the first twenty-five years a total of 148 students received nursing diplomas, even though the annual number of applicants had
increased to 150 (Grierson, 1910). This fact demonstrates the proba-
tion characteristics of this school. In 1890 the British hospital
also began under the direction of an English matron, a probation
training program. In 1908 this program became a nursing school, the
program of which was modeled after London's St. Thomas Hospital. At
the same time the Adventist Sanatorium of the "Plata" started a school.
Both of these schools were created primarily to provide personnel for

Between 1908 and 1940 nine other schools were created. Table 1
shows the schools by year of founding and its supporting institution.
The school organized, at the Hospital Parmenio Piñero in 1921, is con-
sidered the first structured nursing program in the country with
training of three years duration and requirement of completion of six
years of elementary school. Shortly after its organization, it was
merged with the school maintained by the municipality since 1891, and
later it was given the name of "Cecilia Grierson".

The other schools, with exception of the one sponsored by the
Red Cross and the University of Litoral in Rosario, were also created
to provide nursing personnel to hospitals maintained by the sponsoring
institutions.

It is important to note that Argentina is one of the few
countries in the Region which, before 1940, had nursing educational
programs of considerable size. (Roffo, 1934; Bol Of Sanit Panam,
1945, and 1940).
There were also a number of programs that were discontinued. All of these programs, with exception of three which were founded previously, were created after 1940. According to Molina (1973), these discontinued programs were twenty one in number.

Table 1
Number of Nursing Schools in Argentina by Year of Foundation and Sponsoring Institution. 1866-1940

<table>
<thead>
<tr>
<th>Governmental Institutions</th>
<th>Religious Congregations</th>
<th>Medical Schools</th>
<th>University</th>
<th>Red Cross</th>
<th>Hospitals</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Municipal Nursing School</td>
<td>1896b</td>
<td>1906</td>
<td>1908</td>
<td>1914</td>
<td>1921c</td>
<td>1920</td>
</tr>
<tr>
<td>Nursing School of the Italian Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing School of the British Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing School Obras de la Coo de la Fe</td>
<td>1914</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing School Parishino Pibaro</td>
<td>1921c</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Red Cross Nursing School</td>
<td></td>
<td>1920</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing School of Instituto Medico Experimental</td>
<td></td>
<td></td>
<td>1924</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing School Hospital Clinics</td>
<td></td>
<td></td>
<td>1931</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing School Hospital Standard Oil</td>
<td></td>
<td></td>
<td>1937</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing School Instituto Materidades</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing School Universidad Litoral Rosario</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing School Hospital Adventista</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School of Visiting Nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

/ Governmental Institutions. Are classified according to several institutional levels such as Municipal, Provincial, Federal, etc.

/ During the first five years this school was sponsored by the 'Ciclo Medico Argentino,' and was transferred to the municipality in 1891.

/ This school was joined with the municipal school and after 1934 was named Cecilia Giresan.

After 1940 the number of nursing schools grow rapidly. Today there are 69 nursing programs officially recognized, all of them offering at least two and a half years training and requiring the completion of secondary education prior to admission. (Table 2 summarizes the present situation).
Table 2
Number of Nursing Schools in Argentina by Sponsoring Institution and Location. 1980

<table>
<thead>
<tr>
<th>Provinces</th>
<th>Supporting Institutions</th>
<th>Ministry of Health</th>
<th>Universities</th>
<th>Ministry of Education</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>70</td>
<td>20</td>
<td>13</td>
</tr>
<tr>
<td>Buenos Aires</td>
<td>23</td>
<td>8</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>Capital Federal</td>
<td>15</td>
<td>6</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Catamarca</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chubut</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cordoba</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Corrientes</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Entre Rios</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Jujuy</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mendoza</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Misiones</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Neuquen</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salta</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>San Juan</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Santa Cruz</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Santa Fe</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Santiago del Estero</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Tucuman</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: PAHO's Archives

Chile

The earlier nursing education programs in Chile were also promoted by physicians. The first school was created in 1902 at the Hospital San Borja and had the characteristics of probationer training of three years of duration. This school was incorporated in 1906 into the School of Medicine and Biological Sciences of the University of Chile. In 1903 the Superior Council of Hygiene had also sponsored the organization of an official course, directed by a physician for nursing training. (Romero; 1972, Guerra et al, 1942; Bol Of Sanit Pannam, 1943).

This school developed and gained prestige among the medical community. In 1910 it started to utilize nurses as instructors and
1921 it was restructured on basis of a full time internship.

Between 1919 and 1921 the Public Beneficency founded three schools: 1) Hospital Arriaran; 2) Hospital del Rio both in Santiago; and, 3) the Hospital San Agustin in Valparaiso. Years later the two schools located in Santiago were joined together. (Guerra et al, 1942; Bol Of Of Sanit Panam, 1946).

In the early 1920's the Chilean Government established its Ministry of Hygiene and Social Service. At that time the government contracted the services of Dr. John D. Long from the United States Public Health Services, who technically assisted in the organization of the public health programs. Along with provision for the creation of sanitary units the program included a project for the development of a nursing school focused on the training of public health nurses, and in 1927, a nursing school was founded by the recently created Ministry, with its first director being an American Nurse. Shortly after its inauguration the school was incorporated in the University of Chile. This school set the basic pattern for nursing education in Chile. (Guerra, et al 1942, Adams, 1927, Godoy et al 1951).

Table 3 summarizes the foundation of nursing schools in Chile until 1940. After the establishment of the school promoted by the public health program, only one school was founded in Valparaiso. The funds for its installation were donated by a private citizen and the school was to be managed by public beneficency. (Guerra, 1942 and Bol Of Sanit Panam, 1936).

Shortly after the integration of the Public Health Nursing School to the University it was joined to the earlier program of the
medical school. During the 1950's postgraduate programs were organized and Chile soon became the first training center for Latin American Nurses in the area of public health.

Table 3
Nursing Schools in Chile by Year of Foundation and Sponsoring Institutions. 1900-1940

<table>
<thead>
<tr>
<th>Governmental Institution</th>
<th>Medical School</th>
<th>University</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing School Hospital San Boya</td>
<td>1903</td>
<td></td>
</tr>
<tr>
<td>Nursing School Hospital San Vicente</td>
<td>1906</td>
<td></td>
</tr>
<tr>
<td>Nursing School Hospital del Rio</td>
<td>1921</td>
<td></td>
</tr>
<tr>
<td>Nursing School Hospital Arriaran</td>
<td>1919</td>
<td></td>
</tr>
<tr>
<td>Nursing School Hospital San Agustín</td>
<td>1921</td>
<td></td>
</tr>
<tr>
<td>Public Health Nursing Service</td>
<td>1927</td>
<td>1928</td>
</tr>
</tbody>
</table>

Source: Primer Congreso Panamericano de Enfermería (1942).

During the first two decades after the foundation of the public health school, nursing leadership fought for the complete control of their education. In 1948, during a national Congress held in Concepcion, a project was presented for reorganization of health services and nursing education. This project called for a new managerial concept of nursing services at hospital level; extended action of the public health nurse in order to promote earlier diagnosis, improved skills in prevention as well as increased participation in the rehabilitation process; and, complete control of nursing education by nurses. (Romero, 1972, Bol Of Sanit Panam, 1945). At the present time there are 14 nursing programs in the country, all of them supported by universities.
Uruguay

Nursing education in Uruguay started in 1912. The school, founded at the initiative of physicians, followed the model of St. Thomas Hospital School in London. Between 1927-1934 it was incorporated in the recent created Ministry of Public Health and was given the name of Carlos Nery after one of its founders. This is actually the only school presently in existence in the country. (Ministerio de Salud Pública, 1934).

In 1950 the University of Uruguay founded a school of nursing with the assistance of the Inter American Cooperative Services. This school rapidly gain the leadership of nursing organization in the country. In 1973 it was closed by the military dictatorship as part of the overall purge of liberal institutions in the country.

In addition to these two official schools, there are other indications that several training courses for nurses were developed throughout the period. For instance, the League Against Alcoholism during the 1940's sponsored three courses for visiting nurses and the school of public health and social service offered courses for visiting nurses during the 1930's. (Bol Of Sanit Panam, 1944).

Group 2. Brasil

Given the great heterogeneity characterizing brazilian social formation, nursing education was only consolidated, in the country as a whole, after the Second World War. Nevertheless, the first intent to establish nursing training dated from 1890 when policies for secularization of medical care were first formulated (Pontes, 1971).
Brazilian development of nursing education is a good illustration of the three major elements described at the beginning of this Chapter for Latin America. Firstly, secularization associated with modernization of medical care promoted the development of educational programs before the turn of the century. The first nursing school was created at the psychiatric hospital in 1890, --French nurses were specially commissioned to organize this school. Around 1889, English matrons had also been recruited to organize services in Sao Paulo, and soon they developed probationers training. For example, the Samaritans Hospital in Sao Paulo had in 1902 two probationer places, and after three years of service they awarded a certificate. (American Journal of Nursing, 1922; Johnson, 1902). There were also matrons in foreign hospitals in Rio.

Despite these firsts attempts complete secularization was not realized. For instance, Jackson (1901) in a letter to the American Journal of Nursing, stated that most of the hospitals in Rio at that time had the nursing work undertaken by Sisters of Mercy and the Order of St. Vincente of Paul. This supports the fact that the church had been able to make an alliance with the civil society in order to continue its doctrinarism and normative position in the process of social formation (Vianna, 1976).

Secondly, after the First World War when the public health movement was ascending, nursing education was given a new start. In 1916 the Red Cross started a school and in 1922 the then recently created national Department of Public Health, developed a program to organize nursing services in the country. The establishment of a
nursing school was part of this program. Seven American nurses were involved in this program, and one of them became the director of the school which was founded 1923. This school, today called Ana Nery, was funded by the Rockefeller Foundation. Its program was modeled on North American patterns, and it soon became a model school to be known widely all over the country.

In 1923, in one of the northeastern states called Pernambuco, the state government also organized a training school for visiting nurses in Recife, the Capital of the State. This school offered a one year program and focused its training on public health activities (Medeiros, 1923). It was not possible to obtain further records on the development of this school.

Until 1940 four other nursing schools were founded. Two of them were established in 1933, --one by the State Government of Minas Gerais and the other by a religious congregation in the State of Goiais. The remaining two were founded in 1939 by the School of Medicine of Sao Paulo and a religious congregation in Rio de Janeiro. (Paixao, 1952). During the 1940's, still under the influence of the public health movement, four other schools were founded by the States as well as the Federal Government.

In addition, as a consequence of the recuperation by the Church of the monopoly of the education in the country favored by the 1934 constitution, and the already mentioned Vatican reinforcement for technical preparation of nuns, four nursing school were founded by religious congregations. (Vianna, 1976).
Thirdly, starting in the 1940's and receiving an important reinforcement in the 50's and 60's, university programs emerged. During this period, some already existing programs created by the government were also integrated into the universities. For instance, the D. Ana Nery School was incorporated to the Federal University of Brasil in the 1940's as has been noted by Pinheiro, (1952) who observed.

"In the last 5 years nursing schools are growing like mushrooms. From 1945 twenty new schools have appeared: either old ones are asking for certification or new ones are founded, with or without resources, in conditions sometimes deplorable. If this phenomenon follows in the same geometric proportion in 1955 there will be more than 100 schools...."

Although the number of schools did increase this proportion did not materialize, primarily because Bill Number 775 of 1949 on nursing, requiring that nursing education should be centralized at universities centers, controlled this expansion.

The 775 nursing amendment also regulated the training of auxiliary personnel. Before 1949, existing training for this category of personnel was developed mostly at the service level with the immediate purpose of staffing the services. The same law provided for establishment of training programs integrated to the intermediate level of education. In 1966 training programs were also developed at the secondary school level, i.e. in the last years of high school. Consequently, nursing education in Brazil became officially divided into three levels: primary, secondary and higher education. Nevertheless, a great majority of nursing personnel with different nomenclatures, such as nursing attendants, community health workers, etc. are still trained at the services levels. (Bol Of San Panam, 1951).
<table>
<thead>
<tr>
<th>Nursing School</th>
<th>Year</th>
<th>Govermental Institution</th>
<th>Religious Congregation</th>
<th>Medical School</th>
<th>University Cross</th>
<th>Private Hospital</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printo Probationeers Training</td>
<td>1890</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing School National Red Cross</td>
<td>1892</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1902</td>
</tr>
<tr>
<td>D. Ana Nery</td>
<td>1923</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1916</td>
</tr>
<tr>
<td>Sao Paulo</td>
<td>1923</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1939</td>
</tr>
<tr>
<td>Visiting Nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Red Cross Sao Paulo</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1939</td>
</tr>
<tr>
<td>St. Francisco Assis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1945</td>
</tr>
<tr>
<td>Madre Ma. Teodora</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1949</td>
</tr>
<tr>
<td>Coras de Marfa</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1959</td>
</tr>
<tr>
<td>Porto Alegre</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1950</td>
</tr>
<tr>
<td>St. Vicente de Paul</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1943</td>
</tr>
<tr>
<td>Florence Nightingale</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1933</td>
</tr>
<tr>
<td>Carlos Chagas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1933</td>
</tr>
<tr>
<td>Hug. Weeneck</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1945</td>
</tr>
<tr>
<td>Fr Eugenia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1948</td>
</tr>
</tbody>
</table>
Table 4 (cont'd)

<table>
<thead>
<tr>
<th>Nursing School</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>L M</td>
<td>1939</td>
</tr>
<tr>
<td>Nursing School</td>
<td></td>
</tr>
<tr>
<td>Rachel R. Lobo</td>
<td>1944</td>
</tr>
<tr>
<td>Nursing School</td>
<td></td>
</tr>
<tr>
<td>Magalhães</td>
<td>1944</td>
</tr>
<tr>
<td>Bareton</td>
<td></td>
</tr>
<tr>
<td>Nursing School</td>
<td></td>
</tr>
<tr>
<td>St. Vicente Pauls</td>
<td>1943</td>
</tr>
<tr>
<td>Nursing School</td>
<td></td>
</tr>
<tr>
<td>of Recife</td>
<td></td>
</tr>
<tr>
<td>Nursing School</td>
<td></td>
</tr>
<tr>
<td>Nosse Su Graza</td>
<td>1945</td>
</tr>
<tr>
<td>Nursing School</td>
<td></td>
</tr>
<tr>
<td>of Bahia</td>
<td>1946</td>
</tr>
<tr>
<td>Nursing School</td>
<td></td>
</tr>
<tr>
<td>of Est Rio</td>
<td>1944</td>
</tr>
</tbody>
</table>

Table 4 summarizes the information on the development of nursing schools in Brasil between 1890-1950. At the present time there are 57 nursing programs, complete information on which is presented in the directory in Appendix A.

**Group 3. Bolivia, Ecuador, Perú**

In Bolivia, Ecuador and Perú, attempts to organize nursing education were initiated earlier in the century. Nevertheless the lack of social stability, which characterized the then particular social formation in which capitalist as well as feudal socio-economic interests coexisted, delayed continuous growth and development. The
Catholic Church maintained its feudal privileges, and as pointed out by Mariategui (1971), the state "never tried to secularize any more than it tried to defeudalize it." As a consequence, nursing practice was kept in hands of religious sisters despite the attempts at modernization of medical care led by physicians earlier in the century. Nursing training was kept at the service level, but however, it did not have the characteristics of the probationer system; rather it was more comparable with preparation of auxiliary personnel to work under the supervision of the nuns and to supply the immediate needs of the service, because this personnel did not receive a recognized title.

It was only in the 1940's, when the Inter-American Affairs started to organize public health services, that nursing education began to be fully developed.

**Bolivia**

In Bolivia, religious orders which arrived in 1882 from Italy and Spain were put in charge of hospitals in the most important cities of the country: La Paz, Oruro, Tupiza, Potosi and Tarija. These congregations dominated nursing practice until the 1930's when a group of lay students were sent to other countries in Latin America to study nursing. (Beck, 1942). Continuous training of auxiliary personnel was developed by the nuns to staff the services. During the Chaco war these training programs were expanded, and after the war the nurses were employed by hospitals.

In 1930, also the American hospital began a small training program which in 1937 was transformed into a nursing school. The basic program followed the patterns of the National League of Nursing
Education from the United States (Beck, 1942). Two other schools were also founded at that time, one by the medical school of Cochabamba and the other by the Adventist Mission at Chulumani.

In 1938, the government had attempted the organization of a nursing school, but without much success; after the first year of operation it was closed.

In 1942, in association with the public health program developed by the cooperative services of the Inter-American Affairs and with the advisory services of PAHO, a nursing school was organized at government level.

Table 5 summarizes the data on the number of schools in Bolivia by year of foundation and sponsoring institutions for the year 1930-1950. At the present time there are five nursing schools in the country, three of them are University type programs.

Ecuador

In Ecuador several attempts were made to establish a nursing school in the early 1900s. For instance in 1906, as a consequence of international conflict, a military school was founded, and in 1917 another school was established in Quito by physician initiative. Nevertheless, these early attempts did not survive for long or were not significant in terms of number of professionals prepared. In 1927, the medical school of the Central University established a nursing school, which in 1942 was reorganized as part of the Inter-American Affairs project and became the National School of Nurses. This project was the first nursing project in Latin America under the
coordination of PAHO. (Leon, 1977; Bol Of Sanit Panam, 1943).

Caccioppo (1942), reporting the reorganization of the central university school at the first Pan American Nursing Congress in Chile, refers to existing nursing education at the time. She mentioned the existence of six different courses at the service level. The duration of these courses varied from three months to one year and the content was specific according with the needs of the services. The existence of these courses reinforces our initial hypothesis of preparation of personnel at the service level in order to supply auxiliary personnel to work under the supervision and coordination of catholic sisters.

Table 5
Nursing Schools in Bolivia by year of Foundation and Sponsoring Institutions. 1930-1950

<table>
<thead>
<tr>
<th>Government Institution</th>
<th>Private Hospital</th>
<th>Religious Congregation</th>
<th>Medical School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Courses previous to schools</td>
<td>1882</td>
<td></td>
<td></td>
</tr>
<tr>
<td>American clinics</td>
<td>1937</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National School of nursing</td>
<td>1942</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School of Nursing Cochabamba</td>
<td>1942</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing School of Chulumani</td>
<td>1938</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: First Pan American Nursing Congress (1942).

of these courses reinforces our initial hypothesis of preparation of personnel at the service level in order to supply auxiliary personnel to work under the supervision and coordination of catholic sisters.

After the organization of the National School, the Congregation of San Vicente de Paul founded their school in 1943. Today there are
a total of seven nursing schools in the country. Complete information is presented in the directory of nursing schools of Latin America in Appendix A.

**Peru**

Although Peru became independent in 1821, it took a long time to establish its political formulation, and as is pointed out by Mariategui (1971) "...the continuation of feudal privileges was accompanied logically by the continuation of ecclesiastical privileges.... Peru had a liberal and patriotic clergy since the first days of its revolution", and the condition certainly did not allow for radical jacobinism or the establishment of radical secularization policies. Nevertheless, given that Peru was an important colonial center for Spain in South America, this may be regarded as having contributed to a greater development as compared to Bolivia and Ecuador. These facts may account for a relatively greater advance in nursing education in the early century.

The first attempt to establish nursing education are associated with the military conflict with Chile in 1880. At that time a number of nurses were prepared to work in the combat field. This was an isolated effort discontinued after the conflict. In 1904 probationers' training was started at the English-American Hospital. Years later, in 1915, a group of physicians founded a school and hired an American nurse, a Harvard graduate to organize the school in collaboration with another American and English nurse. The school was located at the hospital "Dos de Mayo" and was sponsored by the Public Welfare Association of Lima.
For Cernagué (1928) in the early 1920's, there was a movement against nursing education and the school was closed. Nevertheless, others sources of information (Larrabure, 1932; Primer Congreso Panamericano de Enfermería, 1942) reveal that in 1921 the group of foreign nurses left the school and, following a complete reorganization, the school was given to the Sisters of Charity of St. Vincent de Paul. This episode reveals the continuous contradiction and lack of stability of power in the civil society in its attempt at secularization. This school became the national school of nursing of Peru in 1928. At this time it began to organize its course in public health. (Primer Congreso Panamericano de Enfermería, 1942). Up to 1942 two other schools were founded: Social Welfare of Lima and Psychiatric Hospital School at Magdalena del Mar. Table 6 summarizes this information.

Nursing education growth was only consolidated after 1940 and under the influence of the public health movement. It is important to note that during the 1930's internal political affairs were very critical; revolution and economic instability, due to low prices of Peruvian products, cotton, sugar and metal in the international market affected all institutions in the country. Therefore, the Public Welfare Association of Lima underwent a crisis which made nursing progress difficult. (Larrabure, 1932). Between 1942 and 1959 ten new schools were created. Among them four regional schools of 'puericultura' (children's center) (north, center, south and west) are proposed to prepare personnel for maternal and child health care. These schools were supported by the Ministry of Public Health.
At present, Peru has 25 nursing schools located in the most important centers of the country. Fourteen of them are part of university programs and others are maintained by the Ministry of Public Health and private institutions. In the directory in Appendix A detailed information of present schools can be founded.

Table 6
Nursing Schools of Peru by Year of Foundation and Sponsoring Institutions. 1904-1942

<table>
<thead>
<tr>
<th>Institution</th>
<th>Government Institution</th>
<th>Private Hospital</th>
<th>Military</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing School English</td>
<td></td>
<td></td>
<td>1909</td>
</tr>
<tr>
<td>American Hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National School of Nursing</td>
<td>1915</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing School Psiquiatric Hospital &quot;Magadalena&quot;</td>
<td>1930's</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School of Visiting Nurse</td>
<td>1928</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Military Nursing School</td>
<td>1880</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sources: Larrabure (1932); Bol Of Sanit Panam:, 1945 (notas y Revistas), Cernaqué (1928).

a First organized at the Hospital "Dos de Mayo" later it functioned at the Hospital "Arzobispo Losayga of Lima; in 1928 in officially recognized as the National School of Nursing.

Group 4. México

After the struggle for independence in 1810, Mexico underwent a long period of political instability lasting almost one hundred years. Secularization policies were formulated during this period in the mid-nineteenth century. The constitution of 1857 banned monastic
orders from the Republic. As a result nursing care, traditionally in the hands of Catholic sisterhood, was secularized. Nevertheless, this early process of secularization did not promote immediately the development of nursing education. It was at the turn of the century, as a consequence of the development and modernization of medical care, that nursing education started to be promoted. (García, 1982).

Actually, complete departure of all religious orders in charge of nursing care in the country occurred in 1874. Therefore, the process of secularization of nursing care took almost forty years. During this period secular personnel without training gradually substituted catholic sisters until the final governmental decree of 1874 which banished all religious orders from the country. This period is known in Mexican history as the "reforma".

Toward the end of the century, modernization of medical care began. Physicians acquainted with nursing development in Europe started to promote the need for nursing training. When, in 1895, plans for a general hospital were made, the question of nursing training was explored. As a result, in 1907, the first school was organized. The literature on nursing history in México notes that there were previous attempts to organize nursing education. For instance, the military hospital established a school in 1894 and two other schools were organized in the early 1900's by physicians. However, as Peña (1980) pointed out, these attempts did not advance or have an impact on the development of nursing in the country. Therefore, the school founded at the General Hospital in 1907 fostered the growth and development of nursing in Mexico.
The school of the General Hospital was first organized with the cooperation of two German nurses who were later joined by American nurses. In 1910, most of the nurses in the services had a diploma. This fact is sufficient to show the impact of this school in the development of nursing in the country. (Pefias, 1980). It was also in this year that the University of Mexico was reopened and became responsible of all technical education in the country, including nursing which was incorporated into the medical school. In the 1950's the school was emancipated from the medical school becoming an independent school in the University of Mexico.

After the Mexican revolution, nursing education spread rapidly all over the republic. The majority of the schools were organized in hospitals. It was not possible to obtain a complete record of chronological development and location of all schools at this time. However, major nursing schools for which there is a record available were: National Red Cross, Green Cross, Military Hospital, Instituto Politécnico Nacional. At this time only the major schools required completion of primary school education as an entrance requirement. In the mid-1930's, the major schools upgraded their entrance requirement to completion of secondary school (9 years of previous schooling). On account of these entrance requirement, PAHO only included four mexican schools in their 1949 study of Latin American nursing education, and ten in 1959. In the 1959 study, PAHO noted the existence of 50 schools in Mexico which did not meet the criteria of at least six years of previous education in order to be considered in the survey. Table 7 summarizes the early development of nursing schools in Mexico.
At the present time, Mexico is one of the few countries in Latin America which has a large system of nursing education. There are 123 nursing schools distributed in 30 states. The schools are dependent on hospitals, universities and teaching institutions. Among the twenty one schools existing in Mexico City, fifteen are incorporated in the National University of Mexico. It is also important to observe that the number of students enrolled in Mexican nursing programs has increased steadily, reaching 1/4 of nursing student population in Latin America. Table 8 shows the distribution of nursing schools in Mexico by state and sponsoring institution.

Table 7

Nursing, Schools of Mexico by year of Foundation and Sponsoring Institution, 1895-1940

<table>
<thead>
<tr>
<th>Institution</th>
<th>Government (hospital)</th>
<th>Medical School</th>
<th>Red Cross</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing School of IPN</td>
<td>1895</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing School of Military Hospital</td>
<td>1937</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing School of Red Cross</td>
<td>1909</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing School of General Hospital</td>
<td>1907</td>
<td>1910</td>
<td></td>
</tr>
<tr>
<td>Nursing School of Chihuahua</td>
<td>1927</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sources: Peña (1980), Bol Of Sanit Panam (1943); Ocaranga (1934), Amezquita et al (1960).
Table 8  
Number of Nursing Schools in Mexico by Sponsoring Institution and Location. 1980

<table>
<thead>
<tr>
<th>Supporting Institutions</th>
<th>Secretary of Public Education</th>
<th>Not Incorporated</th>
</tr>
</thead>
<tbody>
<tr>
<td>States</td>
<td>Total</td>
<td>Universities</td>
</tr>
<tr>
<td>Aguas Calientes</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Baja California Norte</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Campeche</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Chihuahua</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Coahuila</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Colima</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Durango</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Distrito Federal</td>
<td>21</td>
<td>15</td>
</tr>
<tr>
<td>Guanajuato</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Guerrero</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Jalisco</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Mexico</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Michoacan</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Morelos</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Nayarit</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nuevo León</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Oaxaca</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Puebla</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Queretaro</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>San Luis Potosi</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Sinaloa</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Sonora</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Tabasco</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Tamaulipas</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Tlaxcala</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Veracruz</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Yucatan</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Zacatecas</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>


Note: Not incorporated includes: Private institutions and hospitals.
Group 5. Colombia, Venezuela, Paraguay and Central America

In spite of marked differences in the social formation of these countries, their rather weak precapitalist and capitalist formation constitutes a common ground which allows for grouping them together. Capitalist formation in these countries acquired the form of enclaves, which can be described as the development of isolated nuclei of economic development without any major impact on the entire societal structure. In Colombia enclave development occurred through the coffee economy produced on small plantations owned by individual farmers. Venezuela, through the exploitation of oil, had the center of its economic development in the production areas. Paraguay, despite the exploitation of "chaco" products (wood and tamano) by international corporations, had been isolated from international commerce since its independence until the last quarter of nineteenth century. In the Central American countries the United Fruit Company constituted isolated fragments of economic development. (Donghi, 1972; Cueva 1978).

The late and weak introduction of capitalism in these countries delayed nursing education development and with the exception of isolated attempts observed in Colombia and Venezuela in the early 1900's, nursing schools only began to be developed after the 1940's. Persistence of precapitalistic formation certainly did not promote changes in the health care practice, and consequently there was no demand to introduce changes in the preparation of health care personnel. In addition, the fact that nursing in this group of countries
only started after the 1940's, at a time when PAHO and other international organizations were specifically promoting nursing development, the influence of these organizations became the major factor in their nursing development.

Colombia

In Colombia there were isolated attempts to establish nursing schools at the beginning of the century. In Cartagena, for example, a school was founded in 1903. However, as documented by Pedraza (1954), this school and several other efforts of physicians to establish nursing education did not survive. Despite these attempts nursing care remained principally in the hands of catholic sisters. Camacho (1942), during the first Hospital Congress of Colombia, noted that in all hospitals of the Republic nuns comprised the majority of the nurses.

During the 1920's, the Congress of the Republic passed a Bill requiring the organization of a nursing school at the school of medicine. The school started in 1929 and was maintained until 1937, during which it graduated students between 1927-1929, in 1931 and 1933-1935. In 1927, at the Hospital San Juan de Dios a training course was organized for catholic sisters. This course was repeated in 1933 and in 1937 a nursing school was founded: Escuela de la Presentación. (Pedraza, 1954).

Nevertheless, continuous growth of nursing education is only observed after the foundation of the national school in 1930. This school was founded in association with the organization of national public health services. It was sponsored by the Rockefeller Foundation
which sent two American nurses to organize the institution. In 1933, a
group of nurses founded a private school in association with a center
for child welfare. This school only graduated 53 students during its
10 years of existence. In 1937, the University of Bogotá founded a
school, which in 1944, was incorporated into the newly organized
Superior National School for nurses at the Ministry of Work and
Hygiene. At the same time the National Red Cross founded its nursing
school. (Restrepo, 1944).

The National School of Nursing founded by the Ministry of Works
and Hygiene in 1943 had the assistance of the Inter-American Affairs
program, the Pan American Health Organization and the Rockefeller
Foundation. The organization of this school, based on patterns of
bachelor education in the United States, launched a national program
coordinated by the National Nursing Association for the unification of
criteria for nursing education in Colombia. In the first Pan American
Congress in Chile, Marti (1942) presented a paper describing this
project in detail. It included, basically, the major principles and
goals for nursing education, the organization and administration of
schools, curriculum development, legal basis, physical facilities,
association with hospitals and financial support. In general, further
development of nursing education in Colombia followed the high stan-
dards recommended at this time. Table 9 summarizes the development of
nursing education in Colombia between 1900-1940. (Sol Of Sanit Panam,
1943 and 1944).

In spite of these advances the growth of nursing education in
Colombia grew slowly. During the 1940's and 1950's only 5 new schools
Table 9
Number of Nursing Schools in Colombia by Year of Foundation and Sponsoring Institution, 1903-1940

<table>
<thead>
<tr>
<th>Institutions</th>
<th>Government Institutions</th>
<th>Religious Congregations</th>
<th>Medical Schools</th>
<th>Universities</th>
<th>Red Cross</th>
<th>Private Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing School of Cartagena</td>
<td>1905</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing School</td>
<td></td>
<td>1924</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing School Presentation</td>
<td></td>
<td>1937</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Nursing School</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing School of Children Welfare</td>
<td>1930</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing School</td>
<td></td>
<td>1937</td>
<td></td>
<td></td>
<td>1933</td>
<td></td>
</tr>
<tr>
<td>National Superior Nursing School</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing School</td>
<td></td>
<td>1937</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Vincent Paul</td>
<td></td>
<td>1939</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Red Cross</td>
<td></td>
<td>1919</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Pedraza (1954)

were founded. At the present time there are 22 schools, all of them offering a basic three-year program. Information on present schools is included in the Directory in Appendix A.

Venezuela

In Venezuela, after the Government of Guzmán Blanco in 1889, secularization policies were suspended. At that time religious congregations from France entered the country to be again in charge of nursing care. Until 1932, nursing education was only developed through short term in-service training. The school of Artes y Oficios (Arts Crafts) for women, founded in 1912, was officially in charge of the nursing training at the hospitals. Subsequently, the National Red
Cross organized special training for nurses. Later on, this school only offered a training program for auxiliary personnel. (Alegria, 1954).

In 1932 the first school of nursing was founded. The information available gives no details about the sponsors and initial conditions of this school (Naranjo, 1950; Fernandez, 1943). The National Normal School of Nursing founded by the Ministry of Education in 1937 may be considered the real starting point for nursing development in Venezuela. This school offered a three-year program and focused on public health nursing. Two other schools had been founded a year earlier: the Red Cross Nursing School and the Nursing School of the Municipal Children's Hospital.

In 1939, the Ministry of Public Health asked for the cooperative services of the Rockefeller Foundation in order to organize a system of nursing education in the country. The nurse consultant from the Foundation arrived in 1940. In the same year the National School of Nursing was founded as an autonomous institute under the direction of the Ministry of Public Health. This school absorbed the students from the National Normal School which was closed. During the 1940's this national school had also assistance from the Office of Inter-American Affairs through the Pan American Health Organization. In 1954 the Nursing School of the Municipal Children Hospital was integrated in this school. (Archila, 1956).

Subsequent development was, however, slow. Until 1959 only four new schools were founded in different regions of the country: Valencia, Barquisimeto, Cumaná and Maracaibo. During the 1960's university pro-
grams started to be developed, and at the present time there are 3 of those programs.

As a consequence of changes within the educational system of the country, nursing education in Venezuela was integrated into the secondary school system, under the Ministry of Education. The National School of Nursing was again reintegrated into this Ministry as a coordinating center for the 24 nursing programs at the secondary schools all over the country. (Manfredi, 1982).

**Paraguay**

In Paraguay formal nursing education started in 1940. The Ministry of Public Health organized at that time a vocational and technical school for visiting nurses. The school focused on the formation of professional visiting nurses with skills in sanitation and social welfare. In 1943, this school was incorporated into the Women's Institute for training auxiliary personnel for public health work and began to offer hospital nursing training. (Bol Of Sanit Panam 1945, 1944; Primer Congreso Latinoamericano de Enfermería, 1942). This school also received assistance from the Institute of Inter American Affairs and the Pan American Health Organization.

Between 1940 and the present time only 2 for new programs were created.

**Central América: Costa Rica, El Salvador, Guatemala, Honduras and Nicaragua**

Given the historical association and geographic proximity of the countries in Central America, together with the fact that the characteristics of nursing development are similar in time and organi-
zation of programs, data on nursing development will presented as a whole for this region.

During the first forty years of this century, almost all nursing care was in the hands of catholic sisters. As a consequence nursing education, as has been repeatedly point out, did not go beyond inservice training for auxiliary personnel. During the 1930's, the Government of Panama offered fellowships to students from Central America, thus, a small number of lay nurses returned to their countries and started to work mostly in public health services, which had been recently created. They also created courses for visiting nurses training. (Galliano, 1950; Galiano, 1975).

It was only in the 1940's, with the technical assistance of the U.S. Government through the Inter-American Cooperative Services, that Schools were organized in the Region. In PAHO's 1949 survey of nursing schools in Latin America, there were six schools which met the criteria of three-year programs in Central America: Guatemala (2), El Salvador (1), Costa Rica (1), Nicaragua (1), Honduras (1). Since that time 8 new schools have been created: Guatemala (1), El Salvador (2), Nicaragua (3), Honduras (2). After the 1960's the schools of Costa Rica (1), Nicaragua (3), Honduras (2) and El Salvador (2) were incorporated into the universities. Table 10 summarizes the data on Nursing Schools of Central America.

After the Nicaraguan revolution in 1979, the nursing education system was reorganized. The schools are now part of the technical education system which is being organized to operate in the entire country.
Table 10
Number of Nursing Schools in Central America by Country and Sponsoring Institution. 1980

<table>
<thead>
<tr>
<th>Sponsoring Institution</th>
<th>Country</th>
<th>Total</th>
<th>Universities</th>
<th>Ministerio de Salud</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>TOTAL</td>
<td>14</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Costa Rica</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>El Salvador</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Guatemala</td>
<td>3</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Honduras</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nicaragua</td>
<td>4</td>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>

Source: PAHO's Archives

Group 6. Panama

The early development of nursing education in Panama was directly influenced by the presence of United States administration in the Canal Zone during the construction of the Canal. In 1904, the Government of the United States took over the administration of the two existing hospitals, one in Panama City-Ancon, and the other in Colon on the pacific coast. Immediately, trained nurses were hired in the U.S. to staff these hospitals (Freeland, 1907; Mallory, 1926). According to an editorial comment of the American Journal of Nursing in 1903, the U.S. Commission in charge of the Canal Zone intended to establish a training school at the Ancon Hospital. This editorial based on the report of the sanitary situation of Panama by Dr. Walter Reed, strongly advised American nurses against such a plan. The
editorial presented an extensive quote of Dr. Reed's comments on the nursing department which were as follows:

"This report might be indefinitely amplified, but time will not permit. I feel it important, however, to allude to the fact that the policy which the commission, more specifically Mr. Grunsky, has adopted with reference to furnishing cheap medical service to those who risk their lives in the zone has been adopted for the purpose of furnishing nurses services in the sanitary department. This has been made under the subterfuge of establishing a training school to be conducted at Ancon, to get nurses to go to the zone at about the same rate that is paid for pupil nurses in the training schools of the United States. The same conditions, practically, are imposed on the nurses with reference to time service that is important on the interns, with the difference, however, that the period of enforced detention on the Isthmus under contract is placed at three years instead of one. This is not a place to take untrained nurses under any pretext, for nothing but fully developed talent in the various department of activity should be sent to the Isthmus" (Am. Jr. Nurs., 1905).

The editorial then concluded with the following remarks:

"There are no war conditions to be considered in the service at Panama, and nurses who enroll for this work should be carefully selected and well paid. Fifty dollars per month seems a faulty sum when one thinks of the terrible risk to life which is involved. If the government cannot, or will not, control the sanitary situation, at least let the men and women who risk their life in this work be liberally paid (Am. Jr. Nurs., 1905)."

On the one hand, this editorial points out the character of the training school at the time in the USA as source of cheap hospital labor. On the other hand, it reinforced the inadequacy of establishing a nursing school under the administration of the United States. After the Panama treaty, an agreement was made between the two governments to reorganize the Santo Tomas Hospital. A Board, appointed jointly by the Canal Commission and the government of Panama, was designated to administer the hospital. Therefore, in 1908, by a
special decree of the President of Panama, a nursing school was established. (Adams, 1926).

The school was organized by American nurses and had the characteristics of U.S. training schools. Naturally, the initial program suffered continuous evolution. Admission requirements were raised after the first two decades, and public health nursing was incorporated in 1937, and in the 1950's it was affiliated with the national university. This school was also a center for the preparation of nurses from Central American countries. Before the establishment of schools in these countries the government of Panama used to grant two fellowships for each country every year (Norelius et al, 1940). Up until the 1950's it was the only school in the country and by then had graduated 700 nurses. In the 1950's a school was also created at the Ministry of Health (Hughes, 1950). These are the two present schools in Panama.

Group 7: Cuba, Dominican Republic, Puerto Rico and Haiti

Nursing education development started early in the 1900's as a direct consequence of United States military occupation. The Spanish American War brought American nurses to the battlefront in Cuba and Puerto Rico in 1898. After the war those countries remained under military occupation by the United States for a few years, during which time public health services were organized as well as nursing schools. During the military occupation of Haiti and the Dominican Republic between 1915 and 1934 nursing schools were also founded in these countries.
The Spanish American war is an important historical mark in the development of United States nursing. As it is pointed by Roberts (1954) it "provided new opportunities for nurses which extended into the twentieth century". Expansion of nursing education in the United States is well associated with this episode. For a number of years an order of Spanish American war nurses developed activities in the United States. (American Journal of Nursing, 1900 and 1902).

Cuba

In 1899 the first school of nurses was officially established by the Department of Beneficencia, under the general supervision of the Department of State and Government of the United States. The superintendent of this school was a nurse from the Bellevue Hospital, New York City. (Hibbard, 1902). A year later six new schools were created: 1. Hospital Civil, Cienfuegos; 2. Hospital No. 1, Habana; 3. Hospital Santa Isabel, Matanzas; 4. Hospital General, Puerto Principe; 5. Hospital General, Remedios; 6. Hospital Civil, Santiago de Cuba.

In 1901 a draft of general regulations for nursing education was submitted for approval of the Board of the Beneficencia, and was subsequently approved by the military Governor. (Hilbard, 1902). These general regulations established guidelines for the organization of nursing schools in all public hospitals of the country with over 100 beds, as well as regulations for the admission of students, the administrative organization and program of instruction as well as evaluation of students. These regulations were, certainly, compatible with existing North American regulations at the time. In 1900, Hilbard
informed the *American Journal of Nursing* that these hospitals schools had been affiliated by law with the University of Habana.

From 1909, after the U.S. military occupation, until the 1940's it has not been possible to find data on further development of these or other schools. Notes from the "Boletin de la Oficina Sanitaria Panamericana" (1943) suggest that at least a few of these schools remained open and that others were created. However, PAHO's 1949 survey only acknowledged the existence of four schools in Cuba, and five, in the 1959 survey.

After the revolution in 1959, the whole system of national education was changed. Nursing education became part of the technical education system. Today there are 28, three-year programs for basic nursing preparation spread all over the country. In addition, there are three programs at the university level offering degrees compatible with baccalaureate programs.

**Dominican Republic**

The development of nursing education in the Dominican Republic started during the US military occupation. In 1919 a local school for nurses and midwives was started. At the same time, several hospitals hired American Nurses to instruct the existing nursing personnel, and organize nursing schools in the hospitals. For instance, the Military Hospital and Hospital of the "Cruz Roja de Seybo" had one American nurse in charge of the training its personnel in 1920, and plans were made to start a school in 1921. In addition, there was a school for nurse midwives directed by a nurse from Scotland in one of the maternity centers in the Republic. Aside from these training developments
in the 1920's, nursing practice was mostly organized and directed by the sisters of Charity in the majority of the Hospitals. (República Dominicana, 1921).

In 1926 the "Secretaría de Sanidad Pública" (comparable to a ministry or department of health), in complementing the new organization of the hospitals, planned the creation of a modern nursing school. A group of nurses from France was made responsible for the installation and direction of this school. They arrived in the country in 1927. This may have been the nursing school that years later became the National School of Nursing. (Ricart, 1928; and Bol Of Sanit, 1927).

At the present time there are two nursing schools in the country, the National School located at the Capital and a private school located in the City of Santiago de los Caballeros. Both schools are part of the local universities: The National University and the Catholic University.

Puerto Rico

Given the present situation of Puerto Rico, as part of the United States Commonwealth, only a brief description of nursing education development at the beginning of the century will be considered, since later evolution is compatible with the development of nursing in the United States of America.

Prior to U.S. military occupation during the Spanish American War, nursing care was in the hands of Catholic nuns. In 1889, shortly after the war, a group of American Nurses established two schools of nursing at the two largest municipal hospitals in San Juan, with the same characteristics of U.S. nursing education at the time,
Haiti

Nursing in Haiti before the U.S. military occupation was practiced by French Sisters of Charity. In 1890, a small group arrived on the Island, and they were in charge of all hospital nursing care until 1918. At that time they totalled 63 in the few hospitals in Port-au-Prince.

In 1919 the National Health Service was created and nursing services were organized. Four nurses from the American Red Cross and the French Sisters of Charity comprised the service. A year before, nursing education had started. A group of U.S. Navy nurses and the American Red Cross established the National Schools of Nursing of Port-au-Prince (Melhorn, 1930).

At the present time there are three schools in Haiti, all of which have three-year programs compatible with a diploma program.

CONCLUSION

In the outlines of the countries herein described, three major elements of nursing in Latin America discussed in the first part of this Chapter stand out. Firstly, to a certain extent secularization policies in association with a technocratic approach to, and modernization of medical care did promote emergence of nursing education. Nevertheless, it is important to observe that secularization policies, with the exception of Mexico and the countries militarily occupied by the United States, were never established completely in the majority
of the countries. During the liberal oligarchic period the Catholic Church was able to develop a new strategy to maintain its hegemony in the civil society (Vianna, 1976). In the case of nursing care, training of secular personnel to develop auxiliary functions was the initial strategy generally used by catholic congregations at the beginning of the century and later, after the policies of Pope Pio XI urging a technocratic approach to nursing care, Catholic sisters were also enrolled in formal nursing education programs. As a result nursing care in most countries in Latin America continued to be predominantly in the hands of catholic congregations. In addition, the nursing schools developed during this period, in general, were not only unstable institutions, but also did not have an impact in terms of numbers of graduate professionals necessary to meet all hospital staffing needs at the time. For example, several schools created by physicians, lasted but a few years. There were, however, exceptions: Chile, for instance, a country in which economic development had attained a considerable degree of autonomy, was able to secure continuous development of nursing education at that time. In Argentina also, nursing schools represented an important arena for a technical approach to nursing care, even though the number of students graduating at the time were small. It was not possible to obtain complete data on number of students enrolled in the programs or graduated during this period. Table 11, however, gives us an illustration of the size of some of these programs.

Another important aspect to observe is the apprenticeship characteristics of these initial programs. Apprenticeship patterns aligned with rigid disciplinary rules did not make room for early
Table 11  
Number of Nursing Students and Graduates from Programs in Selected Countries. 1886-1940

<table>
<thead>
<tr>
<th>Country</th>
<th>Students enrolled</th>
<th>Number of graduate nurses</th>
<th>% of graduate nurses per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina (1 school) (1892-1909) + 1360a</td>
<td>148</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Brazil (2 schools) (1918-1940)</td>
<td>-</td>
<td>461</td>
<td>21</td>
</tr>
<tr>
<td>Chile (1 school) (1924-1940)</td>
<td>-</td>
<td>261</td>
<td>16</td>
</tr>
<tr>
<td>Colombia (1 school) (1935-1940)</td>
<td>-</td>
<td>37</td>
<td>6</td>
</tr>
<tr>
<td>Cuba (6 schools) (1900-1928)</td>
<td>112b</td>
<td>84</td>
<td>3</td>
</tr>
<tr>
<td>Mexico (1 school) (1925-1928)</td>
<td>935</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Panama (1 school) (1908-1940)</td>
<td>-</td>
<td>382</td>
<td>12</td>
</tr>
<tr>
<td>Peru (1 school) (1915-1917)</td>
<td>14c</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Venezuela (1 school) (1934-1940)</td>
<td>-</td>
<td>192</td>
<td>32</td>
</tr>
</tbody>
</table>


a/ Approximation based on number of candidates for the year 1908.
b/ Candidates for the year 1928.
c/ Candidates for the year 1915.

development of national nursing leadership. Nursing education was dominated by physicians who emphasized the need for training in technical skills according to the English and American patterns of the Nightingale reform. Contrary to England, where the probation system was the method utilized during the Victorian era, in the development of professions emerging from the expanding middle classes (Baly, 1980) in Latin America, capitalist formation neither actively promoted the expansion of middle classes nor did it create an educational system which encouraged women to acquire basic education or their engagement in professional work. Therefore, recruitment of middle class women constituted a problem. This problem was generally treated in the early literature as the need to recruit women of sound "moral", and in references by Grierson, Pullen, Adams and several others, candidates
are said to be of "gampy" style and emphasis is made on the need to develop "moral" qualities for nursing work.

Mexico may be the only exception to the above situation, the strategy of a technical approach to nursing care after the revolution, encouraged professional development of lower middle class women. Even though, discipline and morals were incorporated in the nursing concepts, the emphasis was on the development of technical skills development. Indeed, nursing recruitment has been easier than in the countries of the Region; the number of students has steadily increased and, as has been stated earlier, 1/4 of all students today on the Continent are attending 123 Mexican nursing schools. Despite this enormous development of nursing education in Mexico, there still seems to be a tendency of the Latin American community to consider nursing in Mexico "less advanced". This may be because of the lower-middle class origin of the professionals.

In summary, nursing education development in Latin America during the early century, generally, did not promote changes in nursing practice as a whole. The number of schools as well as of students was limited and only a few stable programs have evolved to present time. (Table 12 present a summary of nursing education development during this period).

Secondly, the public health movement stands out as another major element in nursing education development in the Region. Not only were several schools created in the countries with no previous history of organized nursing education, but also new schools were established and programs are reorganized in the countries where
nursing education had already started. The Rockefeller Foundation played an important role at the beginning of this stage and during its whole duration. In the early 1920's, the Foundation started its cooperative services in Brazil and the Ana Nery school was founded; assistance was also given for the introduction of public health nursing in Chile, Panamá, Argentina at the time. In the late 1930's similar projects were developed in Colombia and Venezuela; and finally, during the war, the Foundation sponsored programs in cooperation with the Institute of Inter American Affairs and PAHO.

<table>
<thead>
<tr>
<th>Countries</th>
<th>More than six years of primary school and three years of nursing</th>
<th>Less than six years of primary school and/or less than three years of nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>110</td>
</tr>
<tr>
<td>TOTAL</td>
<td>294</td>
<td></td>
</tr>
<tr>
<td>Argentina</td>
<td>150</td>
<td>9</td>
</tr>
<tr>
<td>Bolivia</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Brazil</td>
<td>39</td>
<td>39</td>
</tr>
<tr>
<td>Chile</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Colombia</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Cuba</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Dominican Republic</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ecuador</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>El Salvador</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Guatemala</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Haiti</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Honduras</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Mexico</td>
<td>50</td>
<td>10</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Panama</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Paraguay</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Peru</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Uruguay</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Venezuela</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

Nevertheless, the role of PAHO and the Institute of Inter-American Affairs can be considered as even more significant. On the one hand, PAHO provided continuous technical assistance to individual schools for a long period. Details on PAHO's participation will be discussed at length in the next chapter. On the other hand, the Institute of Inter American Affairs created extensive cooperative public health programs in many countries, thereby developing conditions for public health nursing work in the field. Details on these service will also be treated in the next chapter.

During this period the number of schools and students in the Region almost tripled, as compared to the previous period. The results of PAHO's surveys in Table 13 will illustrate this sharp increase. However, nursing education in Latin America continued to be deficient and limited, having impact on nursing practice only in the big urban areas.

Thirdly, the affiliation of nursing schools to universities occurred massively after 1960's. According to the survey of university schools elaborated in 1976 by PAHO, 61.1% of new the schools began as university programs and the affiliation of 70% of programs which previously existed occurred after 1960. Nevertheless, problems have persisted. On the one hand, the increase of opportunity for the professional education of women has encouraged young women to enter into other professions, such as medicine, engineering, etc. which have higher social status, besides having systems with better rewards. In the countries where entrance to university did and does not require previous examination, nursing schools continued to be very small, and
in countries where such examinations are required because of placement limitations, nursing is generally opted for as a third choice.

<table>
<thead>
<tr>
<th>Country</th>
<th>Population in Thousands</th>
<th>Number of Schools</th>
<th>Number of Students</th>
<th>Ratio of Nursing Students per 100,000 Inhabitants</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>151,759</td>
<td>193,012</td>
<td>41</td>
<td>95</td>
</tr>
<tr>
<td>Argentina</td>
<td>16,738</td>
<td>20,614</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Bolivia</td>
<td>2,996</td>
<td>3,416</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Brazil</td>
<td>50,769</td>
<td>64,216</td>
<td>13</td>
<td>35</td>
</tr>
<tr>
<td>Chile</td>
<td>5,902</td>
<td>7,440</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Colombia</td>
<td>14,007</td>
<td>13,026</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>777</td>
<td>1,725</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Cuba</td>
<td>5,286</td>
<td>6,686</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Dominican Republic</td>
<td>2,080</td>
<td>2,896</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Ecuador</td>
<td>3,106</td>
<td>4,169</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>El Salvador</td>
<td>1,835</td>
<td>2,570</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Guatemala</td>
<td>2,726</td>
<td>3,652</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Haiti</td>
<td>3,076C</td>
<td>3,466</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Honduras</td>
<td>1,389</td>
<td>1,487</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Mexico</td>
<td>25,132</td>
<td>33,704</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>1,028</td>
<td>1,026</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Panama</td>
<td>777</td>
<td>1,026</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Paraguay</td>
<td>1,356</td>
<td>1,718</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Peru</td>
<td>8,334</td>
<td>10,524</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Uruguay</td>
<td>2,365</td>
<td>2,721C</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Venezuela</td>
<td>4,828</td>
<td>6,512</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

On the other hand, professional career prospects are limited. Nurses salaries are low, working conditions are deficient and most of all conditions for further technical and scientific development are unattainable for most nurses. Therefore, the number of candidates for a nursing career in Latin America continues to present a challenge for
the development of this profession. Table 14 shows the number of schools of nursing in Latin America today by sponsoring institution.

Table 14
Number of Nursing Schools in Latin America by Sponsoring Institution and Country. 1980

<table>
<thead>
<tr>
<th>Institutions</th>
<th>Total</th>
<th>University</th>
<th>Ministry of Education</th>
<th>Ministry of Health</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina</td>
<td>69</td>
<td>12</td>
<td>37</td>
<td>20</td>
<td>-</td>
</tr>
<tr>
<td>Bolivia</td>
<td>5</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Brazil</td>
<td>57</td>
<td>40</td>
<td>1</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Chile</td>
<td>16</td>
<td>14</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Colombia</td>
<td>22</td>
<td>13</td>
<td>9</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Cuba</td>
<td>29</td>
<td>1</td>
<td>-</td>
<td>28</td>
<td>-</td>
</tr>
<tr>
<td>Dominican Republic</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Ecuador</td>
<td>7</td>
<td>7</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>El Salvador</td>
<td>3</td>
<td>1</td>
<td>-</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Guatemala</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Haiti</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Honduras</td>
<td>3</td>
<td>2</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Mexico</td>
<td>123</td>
<td>99</td>
<td>15</td>
<td>-</td>
<td>9</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>4</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Panama</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Paraguay</td>
<td>3</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Peru</td>
<td>25</td>
<td>14</td>
<td>-</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Uruguay</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Venezuela</td>
<td>35</td>
<td>3</td>
<td>26</td>
<td>8</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: PAHO's Archives

In conclusion, the development of nursing education in Latin America reflects the rather irregular and heterogeneous social-economic development of the countries. Neither the on-job-training tried at the beginning of the century or the later, organized school system, created the necessary conditions for professional growth and the needed interventions to alter prevailing health conditions of Latin American population.
Footnotes for Chapter 3

1 Enclave is defined as a territory which belongs to a state located in other foreign one. In sociological terms, it is used to convey the idea of territories dominated by foreign capital inversions, making up for a special arrangement of the economy which does not contribute to the whole national economy. (Webster's English Dictionary and Agustin Cueva).

2 The Institute of Inter-America Affairs was organized in 1942 as an emergency corporation, chartered for five years under the law of the State of Delaware, United States of America. Its main purpose was to develop bilateral agreements between the United States and individual governments of Latin America in the field of public health in order to protect strategic areas of production in the Region.

3 Probationer is frequently used in nursing history literature in connection with the early nursing training programs at English Hospitals. It refers to the characteristics of inservice training in which a trainee could or could not receive a title.

4 The "Order of Spanish American War Nurses" was an association that gathered American nurses who served during the Spanish-American War. Data on the organization and meeting of this "Order" is found in Vol 1-5 of the American Journal of Nursing.

5 Normal School in Latin America is the denomination given to secondary schools specialized in the preparation of primary schools teachers.

6 Gamp. According with Davies (1980), "Mrs. Gamp in Martin Chuzzlewit is a character much referred to by nursing historians". It aludes to the nurse of the first half of eighteenth century "as a person who disgraced one of the noblest calling to which womankind can devote themselves." William, K. from Sarah Gamp to Florence Nightingale: A critical study of Hospital Nursing Systems from 1840 to 1897. In rewriting Nursing History Ed. by C. Davies. (Groom Helm London, 1980).
Chapter 4
NURSING IN PAHO

This chapter analyzes the organization and development of three consecutive phases of nursing services in the Pan American Health Organization from 1940 to 1980. In the first, although there is not a formal administrative organized service, a considerable amount of nursing consultation is given to the countries. This phase starts in 1940 and ends immediately after the World War II; and, it is marked by the initiation of an international cooperative service for the development of nursing in Latin America. However, before this phase, a considerable amount of information about nursing is found in PAHO literature, which will be taken as a background for the development of services in the first phase. In the second phase, advisory services are formally organized and reach its peak. In addition to the building of a network of advisory services several other activities, such as international conferences, seminars, surveys of nursing schools and publications are developed. This phase covers the period between 1947-1959. In the third phase, Nursing Advisory Services diversified and broadened its scope, and at the same time shifted its main orientation from education to service development. A trend of diminishing nursing services in the overall PAHO technical cooperation program is also observed. This phase covers the period from 1960-1980.
It was not until the expansion of the focus of PAHO's early activities, which dealt with the promotion of international agreements about sanitary measures to control quarantinable diseases in export areas, to broader aspects of public health activities in the early 1940's that nursing became an issue of concern to the Organization. The latter consideration as well as nursing's strong association with hospital development, may be factors reflecting the late introduction of nursing services. It is important to note, however, that the so-called "modern nursing movement" was taking place in Europe and North America since the mid-nineteenth century. (Verderese, 1979; Bustamante, 1950).

Before the first attempt to organize nursing services in 1941, several PAHO official documents mentioned this professional category either emphasizing its importance in public health or informing about its development in Latin America. Starting in the mid-twenties, these accounts reflect the growth of the Organization's scope and the influence played by the great development and prestige of public health nursing in the United States of America. For instance, in the first editorial on nursing published by the "Boletin de la Oficina Sanitaria Panamericana" there is a rather lengthy quotation of Dr. Winslow, publisher of the American Journal of Public Health, emphasizing this point and which is reproduced below:

"Since the first public health nurse was employed in New York City seventy-one years ago, the average span of life of a citizen of the United States has been increased by a quarter of a century. This triumph has been made possible by the advances made in the laboratory in discovering the underlying causes of disease. Our health departments, our hospital and trained personnel of
medical, nursing, dental, engineering and allied profes-
sions could not, however, have accomplished such results
without a final link in the chain—the public health
nurse. She renders the direct professional services of
nursing in the home; but she also is the messenger of
health, the point of contact with the individual family,
the ultimate channel through which the knowledge and
resources of the health science are actually brought to
the men and women and children whom they are to serve. At
the end of the chain are the Pasteurs and the Listers,
the Theobald Smith and Walter Reeds. At the other end
are the 21,000 public health nurses who toil through the
grimy tenement streets, or ride over the Appalachian
Mountain passes, or bring succor to the residents of
Rockbound Island off Maine coast. The public health
nurse is the spearhead of our attack on preventable
disease, the preacher in the home of the gospel". (Bol
Of Sanit Panam, 1948).

Thus, it is under the influence of the role of public health
nursing that PAHO formally begins its advisory services in the 1940's.

A BEGINNING OF NURSING IN PAHO (1940-1946)

This rather short period of six years during the Second World
War marks the emergence of nursing advisory services in PAHO. The
Second World War may well be seen as the triggering circumstance which
promoted these initial services. During an extraordinary meeting of
Foreign Ministers of the Americas held in Rio de Janeiro, shortly
after the Pearl Harbor attack, the organization of the Institute of
Inter-American Affairs was proposed. This Institute was to provide
international cooperation in the area of health, utilizing the method
of "service pattern" which emphasized direct bilateral agreements
between the United States of America and individual countries in the
Region. PAHO was immediately thought as an agency competent to
undertake the coordination of these projects (Gottas, 1946). Raising of sanitary and public health standards in strategic areas was one of the main purposes for the cooperation services, thus, public health nursing became a major concern. In the majority of the countries, as we have seen in Chapter III, nursing was not adequately prepared to assume this new public health role, thus the need to promote nursing education and more specifically public health nursing. Therefore, international nursing advisory services started to be coordinated by PAHO.

It is important to point out that World War II gave only material means for a rapid development of nursing advisory services at PAHO. Internal prevailing conditions in the Organization at the time indicate that nursing services would soon be organized.

First, after the decades of the 20's and 30's, shifts in PAHO policies are observed. These shifts reflect the new interests of the member countries in public health policies, which were in turn related to the expansion of national economies. In addition to port sanitation and quarantinable disease policies, health protection of workers engaged in production of export products gradually became a goal of health care in the Region. It was in relation to this new reality that PAHO started to reorganized its services in the 1920's. Second, the efforts of the Rockefeller Foundation in implementing nursing in the Region in the 1920's started to demand PAHO's participation as an agency for intercommunication and information about nursing.

This section will examine the major areas of influence of the beginning of nursing in PAHO as well as provide a description and ana-
ysis of the activities developed. Even though, the period proposed, 1940-1946, is considered the point of insertion of advisory services in PAHO, earlier information and observations on nursing will be included, since it constitutes background data which supports our assumption of internal conditions within PAHO which made possible the emergence of advisory services during the Second World War.

It can be generally stated that nursing advisory services at PAHO are rooted in two major areas of influence. 1) in the public health nursing visiting services developed in the United States, and 2) the efforts of the Rockefeller Foundation and other international organizations towards the implementation of education and nursing services in Latin America.

In 1919 a Nursing Division was organized in 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 invested in demonstration projects utilizing public health nurses. (Davies, 1980). Davies observes that "trained nurses did not in the USA, as they did in Britain, find employment in the hospitals." They were largely employed, until the depression, in home nursing services and public health work. This dominant trend of public health in the United States during the first quarter of this century can be tied to the modernization efforts in nursing sponsored by the Rockefeller Foundation in the early 1920's, which was more fully discussed in the previous chapter on nursing in Latin America.

As soon as visiting nursing services and educational programs started to be organized in the Region, PAHO began to promote nursing
and to gradually build up its involvement until its own advisory services were organized. For instance, in the Annual Report of the Director for 1924, nursing development is cited as demonstrative of the interest of the health authorities in the Region for improving public health services and levels of prevention of communicable diseases. The report says:

"Argentina has great interest in the establishment and development of visiting nursing services in Buenos Aires, Bolivia is reorganizing its national health services in a somewhat similar fashion with United States Services and for such a purpose inaugurated last December 22, 1923 its first national school of nursing and visiting nursing. Brasil has also developed a visiting nurse service in cooperation with the Rockefeller Foundation. Chile is trying to reorganize its public health service and establish a visiting nurse service." (PASB, 1924).

These may have been the first statements on nursing published in an official PAHO document. In the subsequent years the "Boletín de la Oficina Sanitaria Panamericana," its official monthly publication, began to include articles and general information on nursing. Between 1925-1948 a total of 371 nursing related items were published in the "Boletín" of which 5.5% were articles, 76% notes and reviews, 10% information on specialized bibliography, and the remaining 8.5% were reports, PAHO news and consultations. The general trend observed is one of steady increase in the amount of nursing related matters such as notes and reviews. In early 1940's this increase acquires an almost geometric growth, versus a moderate to stationary growth in the rate of publication of original articles in the "Boletín". (See Fig. 1.)
The first article appeared in the Number 5, 1925 edition of the "Boletín". Its title is "The Science of Nursing and its Relation to Public Health by a North American nurse." Not only the title of this paper, but also the nationality of the author lends support to our initial assumption about the roots of nursing in PAHO. By 1943, when a heading for "nursing" was introduced in the notes section, 11 original articles had been published up to that time. The majority (73%) were written by North American nurses, and an equal number (68%) were on public health nursing. During the same period, notes and comments on the development of visiting nursing services and nursing schools made up
the bulk of nursing information in the "Boletín." These notes are an important record on nursing history during this period in Latin America. The introduction of nursing as a heading in the "Boletin," which occurred in the early 1940's, is unquestionably linked to the nursing activities started by PAHO around this time. In addition, during this period two articles on nursing are reprinted as a special PAHO publications numbers 83 and 183, one "Public Health Nursing and its Importance to Social Life" published in 1932, and the other "Public Health Nursing" published in 1939. Before proceeding with a further examination of the "Boletín" it is important to address the broader context of nursing within the Organization as background for further discussions of the publications.

By the end of the 1930's, under the influence of changes in the social and economic structure of Latin America and the new international order resulting from the great economic depression, PAHO's activities were gradually expanded and broadened. (Bustamente, 1950). Increased financial contributions, authorized by the X Pan American Sanitary Conference and the VII International Conference of American States is an indication of the reinforcement and support that made possible this expansion. The X Pan American Sanitary Conference also recommended the creation and reinforcement of visiting nursing services in the Region.

It is in relation to the reorganization and expansion of field services, through the establishment of sanitary zones, that nursing is again mentioned in the Annual Report of the Director. The scope of public health work was first broadened through the incorporation of
sanitary engineers in field services after the two first decades of PAHO activities. Thus, when plans for the development of field offices in geographic sanitary zones were developed in 1940, assignment of a physician and a sanitary engineer as travelling representatives were considered the basic staff; the inclusion of a nurse is first suggested in the proposal of the sanitary zone in the Caribbean. Despite the burden imposed by the Second World War, the growth of the PAHO activities, including nursing, is intensified and accelerated during this period. Immediately after the designation of a Caribbean zone, the Atlantic and Pacific zones were created and staffed with nurses.

In the Annual Report of the Director for the fiscal year of 1942-1943 an extensive report on nursing activities started with an acknowledgement by the Organization of its involvement in this area. The Report says:

"In view of the importance of the role played by nurses in the field of public health, the Bureau has tried to lend assistance in this movement. Its intervention has consisted in bringing a limited number of nurses to the United States for postgraduate training in public health, procuring well-qualified Spanish-speaking nurses to go to the various countries to help organize nursing schools and furnishing advice and literature on request. Assistance and encouragement are now being, also, given to establish nursing services and societies in defense activities." (PASB, 1944).

The remaining most important aspect of this report is the description of a nursing project for the reorganization and development of a school of nursing and services in Ecuador. The project is considered typical of the nursing programs planned for other countries to be presented to other North American agencies concerned with nursing and seeking to establish cooperative work. These agencies were the
Rockefeller Foundation, the Institute of Inter-American Affairs, and the Children's Bureau. The Ecuador project had two public health nurses commissioned by PAHO.

This project marked the emergence of the coordination of nursing field activities by PAHO with the international cooperative services promoted by the Institute of Inter-American Affairs. This institute was created in 1942 as an emergency task force to protect military zones in Latin American during the Second World War (Gottas, 1946). Thus, with international cooperation, the Ecuador project was expanded to include in 1942, assistance to Colombia, Guatemala, Haiti, Mexico, Panama, Paraguay and Venezuela. In all these countries, with the exception of Mexico, the project expansion focused on the organization of assistance to the development of educational nursing programs. Its overall goal was "a coordination and integration of all nursing activities in the various republics into an overall program with a definite objective in relation to both medical and public health services" (PASB, 1944). In Mexico, the project was established at the United States/Mexico border to assist in the venereal disease control programs. It also included granting of fellowships to a group of Mexican nurses for advanced studies in public health nursing in the United States. In addition, the projects were coordinated by a nurse consultant stationed in the Organization's Headquarters in Washington and another one stationed at the Headquarters of the Caribbean Sanitary Zone in Panama.

During the five years of cooperation between PAHO and the Institute of Inter-American Affairs a network of nursing consulting services was coordinated by PAHO; at least 15 nurses scattered
throughout nine different countries were at a time involved in this project.²

These developments were reflected in 1943 when the "Boletín" began to publish a section on Nursing within the general section on Notes and Comments. The introductory statements for the new section praised the developments of inter-American nursing relations and the traditional human concern of nursing in caring for the sick and poor. It considers nursing "a great vocation and a major profession," singles out the role of nursing in national defense, illustrating this point with figures of the number of nurses in the armed services in the United States, the participation of Nightingale in the Crimea War and of Ana Nery², a Brazilian nurse in the Paraguayan War,³ and finally, reinforces the need for better communication among nurses —noting that such was the purpose of the newly instituted section in the publication. (Bol. Of Sanit Panam, 1943).

Besides this introductory note, the editorial which followed it gives an account of PAHO's attention and cooperation in nursing development. It conceptualizes nursing in the most traditional fashion, stressing the stereotyped role of women in motherhood and sick care. It praises the participation of the Systers of Charity in the nursing movement and emphasized the "modern concept of nursing" emerged from Nightingale's participation in the Crimean War.

In considering nursing an important profession it stresses the need for scientific preparation. However, it makes quite clear the subordination of nurses to physicians: "nurse, the right arm of the physician and surgeon...." and their role as 'advanced guards' in the
prevention of diseases. In arguing about the importance of the profession and the need to increase the number of nurses, this editorial discloses one of the first controversial policies of the Organization with respect to nursing—promotion of auxiliary personnel. The editorial says: "...and also the creation of auxiliaries or ward supplement, nurse's aides that could take the place at least in certain tasks that do not require technical knowledge." This issue shall be discussed in further detail in the next section of this chapter.

Three major aspects are underlined in this editorial. The first is the ambiguous conceptualization of nursing. This may be a reflection of physicians' views for whom this professional category is a must in the division of medical labor. Thus, it became necessary to recognize a professional status for nurses. However, this is done with a limited knowledge of the technical and scientific background of nursing itself. As a result they praised the qualities and virtues of nursing within the traditional healing aspects of womanhood. Second, it further assured the Catholic leadership of the Region that PAHO was aware of their contribution and that it praised and recognized the work of nuns in the health sector. And, third, the condition of war which called for a large participation of all civil sectors in actions of defense.

This section was maintained in the "Boletín" until 1949 when nursing was given article space in the publication. During this period eight original articles were published; among the 142 notes, there were at least 15 articles reproduced from other publication either in their entirety or in summary form. Over 60% of the notes
published in the "Boletin" between 1925-1949 appeared during the 1940's. While the majority of the notes informed mostly about visiting services and development of nursing schools, the articles began to address general issues of nursing as well as specific aspects of public health nursing on the care of communicable diseases such as polio, tuberculosis, and veneral diseases. (See Figure 2).

The organization of this section on nursing in the "Boletin" also expressed the aspiration of Latin American nurses. During the First International Nursing Conference held in Chile, on the commemoration of the centennial anniversary of the University of Chile, nurses
from 10 countries suggested the organization of this new section of the "Boletín", and also recommended the publication of an inter-American periodical. The fact that PAHO itself acknowledged that "there is more than a casual coincidence in the fact that the Organization has started an almost continental nursing service at the same time that this inter-American meeting was held," indicates the close relationship which existed between the organization of nursing in PAHO and its development in Latin America. (Bol Of Sanit Panam, 1943).

The first International Nursing Conference is also closely tied to PAHO's nursing activities. On the one hand, the international cooperation which promoted Latin American nursing development since the early twenties also fostered intercommunications. The presence of North American nurses from the same or different institutions stimulated the need for intercountry communications as a means of strengthening the professional status. Griffin and Griffin (1973), for instance, note that the main purpose of the organization of the International Council of Nursing was to unite nurses with a view to achieving "complete professional freedom." Thus, in a similar manner, Inter-American relationships would influence the raising of nursing standards in the Region and promote self-governing national organization of nurses to attain this goal.

On the other hand, all countries represented at this first meeting had an international cooperative project for nursing development. Evidently, this participation supports our contention about the influence of international cooperative services in the development of interrelationships among countries. In addition, the University of
Chile recognized publicly the cooperation they had received from the International Council of Nursing, the Rockefeller Foundation, the American Nurses' Association and the International Red Cross in the organization and development of this conference.

**Program, Budget and Personnel**

The major field activity developed during the period under review was education. Assistance to the organization of nursing schools included recommendations for building physical facilities, curriculum design, preparation of teachers, and development of clinical areas for practical activities. (PASB, 1942).

There is no available information on the type of physical facilities recommended. In general, however, they included the construction of classrooms, laboratories, library as well as housing quarters including recreation rooms, dining rooms and dormitories, adjacent to a hospital. Nursing schools were the first academic institutions to have living facilities for students in Latin America.

Curriculum, in general, stressed public health nursing. All projects included a short preclinical period, in which introduction to biological and physical sciences as well as nursing principles were taken as independent subjects. The clinical activities included hospital and public health practice focusing on the control of communicable diseases, maternal and child health and school hygiene. The available data do not provide details on content or schedules for each programmed activity. The emphasis in public health is mostly
observed in the discourse of the projects. In connection with curricular design a great need for literature in Spanish is evident. From the fragmented information available on the nature of the curriculum recommendations proposed by PAHO at this time, it can be concluded that some of Nightingale's proposals were taken into account, such as an independent nursing program and nursing control of its implementation (Matheney, 1973). In addition, it shows the general characteristics proposed in the curriculum guide series of 1937 (Curriculum Guide for Schools of Nursing, 1937) which stressed, according to Matheney "the apprenticeship system in nursing education and gave greater emphasis to doing than learning."

The preparation of teachers, in addition to a fellowship program in the United States, included teaching and supervisory techniques. Teaching techniques mainly addressed the organization and delivery of lectures; while instruction on supervision included demonstration techniques of nursing procedures, as well as distribution and control of students. Organization of libraries and audiovisual materials were also included. These were, evidently, the patterns of teaching preparation at the time, and can be considered as a support and assistance for initiation in teaching. As noted by Eisner (1979), the concern about teaching only became a major scholarly interest during the 1950's when teaching was reconceptualized to include aspects of the learning process and criteria for attaining specific goals.

The development of the clinical area included studies in the administration and organization of hospitals and public health facilities. None of these studies are presently available; nevertheless, it
is assumed that it consisted of an inventory of resources that could guide the design of teaching facilities in these institutions. In public health, the studies recommended the organization of health centers because this kind of institution was mostly nonexistent at this time in the Region (García, 1981).

Budget

It is not possible to verify the amount of monies expended by PAHO during this period. The Annual Report of the Director 1941-1942 mentions that the Bureau was expending USA$48,593 for the improvement of nursing education in Latin America. These funds were from the Institute of Inter-American Affairs, the U.S. Public Health Service and the Commonwealth Fund.

Personnel

There were at least 15 nurses involved in PAHO's nursing activities during this period, all from the U.S. Public Health Service. Each country project was staffed with two consultant nurses, besides staff nurses at the zone headquarters and one nurse at the Washington headquarters.

Summary

The conditions which made nursing services development possible in PAHO were created by the broadening of its scope of activities in the Region. First, there was an increasing acknowledgement of the important role of nursing rooted in the American public health movement as well as an account of nursing development in the Region. Second,
PAHO created zone headquarters including nurses in its staff. Third, the onset of World War II brought to United States concern over strategic zones in Latin America. As a consequence the Institute of Inter-American Affairs was created in 1942 with the purpose of raising public health and sanitary standards in strategic areas. Nursing education development is introduced as part of the cooperative services of the Institute of Inter-American Affairs as a means to provide required public health nurse staff. It is thus, in association with this project, that PAHO for the first time organized nursing assistantship to nursing schools in Latin America.

During this period there was no formal nursing services at PAHO. Nevertheless, eight projects were coordinated in different countries where nursing schools were either founded or reorganized. In general, it can be recognized that these activities set the basis for the formal organization of nursing at PAHO.

THE FIRST 13 YEARS OF THE NURSING SECTION (1947-1959)

This period is marked by the reorientation and reorganization of PAHO's activities. Firstly, the agreement which followed the adoption of the Constitution of the World Health Organization which provided for administrative decentralization by regions and for the integration of the Pan American Sanitary Bureau as its operating agency for the Americas, demanded definitions, both technical and political of its responsibilities. During the XII Pan American Sanitary Conference (Caracas, 1947) this agreement was formalized and
guidelines for policy development were established. The health needs of the Hemisphere should be met through a full range of technical services. PAHO should coordinate scientific and technical efforts to promote the aspirations of health of the peoples of the Americas. Therefore, the mandate of the Organization would cover the field of public health, medical care and social welfare. (PASB, 1950).

Secondly, the Organization faced the competition of other international agencies which started to operate in the field of health throughout the Continent in an isolated manner. The Institute of Inter-American Affairs, the Inter-American Institute for Protection of Infancy and the United Nations International Children's Emergency Funds, after the World War II, started to develop independent programs in the Region. Fear of duplication of activities was the main concern at the time, and the Director of the Bureau requested the member countries, during the XIII Pan American Sanitary Conference, to evaluate the specific proposals of these agencies and coordinate their actions. In addition, the Organization started to develop policies for its relationship with all international Organizations operating in the Region.

Thirdly, the health panorama and the socioeconomic conditions prevailing in the Region demanded new approaches of international health services. The socioeconomic conditions of Latin America and the new demands on the health sector have been already analyzed in Chapter II. Although control of communicable diseases continued to be viewed as the fundamental activity of the Organization, improvement of national health services with emphasis on the public health program
focused on the development of health centers. The promotion of medical education and hospital organization began to be given attention and priority. Therefore, the shift of focus and expansion of activities were a direct consequence of the new socioeconomic reality in Latin America.

Immediately after World War II nursing programs at PAHO were largely discontinued. This resulted from the restructuring of the Inter-American Cooperative Services which funded most of these activities during the war, and the reorganization of PAHO which followed its integration into the World Health Organization.

After the war the Institute of Inter-American Affairs was combined with the Inter-American Educational Institute and rechartered under its former name as a U.S. Federal Cooperation program responsible to the Department of State. It continued cooperation efforts through bilateral agreements between the U.S. Government and individual Latin American governments. However, it began to design and to administer its own nursing projects without any direct cooperation with PAHO, (PASB, 1950; Gottas, 1946).

The reorganization of the institution was more than an indirect factor in the discontinuation of nursing services. For a short period of time the Organization had to concentrate all its efforts on the "the development of professional and administrative mechanisms" necessary to unify the activities of the Bureau and the World Health Organization (PASB, 1950).

During the XII Pan American Sanitary Conference (Caracas 1947). The Director of the Organization lamented the lack of funds
that had restricted nursing activities and reaffirmed the great interest of the Organization in this field. The maintenance of nursing staff at two zone offices and plans for the organization of a nursing section among others, were examples of this continued interest. (PASB, 1950).

In September of 1947 through a grant from the Rockefeller Foundation nursing services began to be reorganized. Even though, the records acknowledged it as a beginning of activities and an expansion of nursing services. (PASB, 1950). As it was stated by the Director, "the Bureau expanded its nursing program aimed at the stimulation of improved nursing education and public health practice in the Americas, through consultation, direct service, correspondence, publications, conferences and fellowships." These statements reaffirmed two of our initial assumptions: the trend on nursing policies oriented towards education and the emphasis on public health nursing. A nursing consultant was appointed as the head of the nursing services and was stationed at the headquarters in Washington.

**Initial activities**

Returning to the issue of an Inter-American Federation of Nurses' Association, an aspiration expressed during the First Inter-American Congress (Chile 1942), the Nursing Section initiated activities to promote the development of national associations. At that time only 9 out of the 21 countries had a national nurses' association. It was then deemed necessary to create national
organizations before such a Federation could be organized. For this purpose the head nurse visited national leaders of different countries in the Region. In 1950 the Brazilian Nursing Association hosted a first conference to study the organization of the Federation.

The Conference was unable to promulgate the Federation because few countries attended the event. Only eight were present: Argentina, Brazil, Chile, Mexico, Paraguay, Peru, the United States of America, and Uruguay. The International Council of Nursing, PAHO and the Institute of Inter-American Affairs were also represented at the Conference. The meeting decided to postpone all activities directed at the development of the Federation until a majority of the countries in the Region had organized national nursing associations. General guidelines for future meetings, and strategies for the development of national associations were also considered. PAHO was appointed as the coordinating institution to facilitate communications and render assistance to delegates.

Parallel to these activities, the nursing section started to plan its services. A preliminary visit to all the countries in the Region aimed at establishing contact with all schools officially recognized of nursing and national nursing leaders was made. As a result an overall plan of activity was developed, including headquarters general activities and field program. The headquarters program dealt with coordination of field work, development of nursing information, publication and literature, fellowships and promotion of international conferences. The field program established general guidelines for advisory services in nursing education and public health nursing. In
addition, there were orientation for: 1) assistance in the planning for recruitment of student nurses; 2) compilation of information on social, health and professional legislation, 3) assistance in the organization of professional associations, 4) promotion of standards for the nursing profession, and, 5) selection of candidates for fellowships.

In general, the records of this initial program that appeared in the Annual Report of the Director (1947) were very broad. Lack of detailed information about the nature of the activities and specification of strategies does not permit a thorough analysis. However, it is possible to state that the initial plan of the nursing services followed the same trends which marked the previous Inter-American cooperative services. First, the promotion of professionalization through the organization of national nursing associations. Second, general discourse emphasizing public health nursing. Both education and services guidelines point out the need for an adequate program in public health nursing. And, the third, main focus was on the development of nursing education.

Following this initial program and also as a result of the initial contact with the nursing schools in the region, the nursing section conducted a survey on nursing schools in 1949. This was the first of a series that were conducted in a 10-year intervals, up to the 1960's. Because the results of the first survey became the main source for the development of recommendations and policies, its discussion will be included under this section rather than under the specific section on nursing education.
The results of the first survey of nursing schools in Latin America appeared in the Publication PAHO No. 264. Two articles which appeared in the "Boletín" in February 1950 and January 1952 also analyzed the data.

The survey project was prepared with the assistance of the U.S. National League of Nursing Education. The National League of Nursing Education had conducted an important four-year study to prepare the 1937 curriculum guide. According to McManus (1967):

"It would be very hard to estimate the breadth of influence of the curriculum guide. We did count up the numbers of names of individuals that had served on committee meetings across the country and it was in the thousands. And for nurse educators at the time, that was a tremendous proportion of them. So whatever else it was, it was mass education in nursing education. And it taught many people not only what curriculum was, but how to share in the development of a curriculum".

This was a major study on American Nursing Education. As noted by Christy et al (1974), the 1970 National Commission for the Study of Nursing and Nursing Education, published "An Abstract for Action" recommended apparently without realizing that an almost identical project for nursing had been conducted earlier in the United States.

Certainly, PAHO made clear that American norms were not utilized in the Latin American study. Chagas (1950) stated that only the elements or main subjects used in the American studies and the relative importance of each one were considered. The schools qualification plan was based on the standards of Latin American schools and the recommendations of the International Council of Nursing. Nevertheless, the point addressed here is the marked North American influence in the
development of this study. Irrespective of Chagas' affirmation, the main subjects and their importance constituted a major conceptual framework and the utilization of evaluation standards—local or international—do not realistically fit the social structure of the Region.

Neither the Publication 264 or the cited articles presented a formal body of recommendations. The three general conclusions of this study, as stated by Chagas were:

"1. Each school can be improved.
2. It is necessary to utilize the greatest effort to obtain for each school a well prepared body of professors and the direction of the school under nursing control, because they would bring improvement to other elements of the school.
3. It is necessary to develop a well organized study for the reorganization of nursing practice in the majority of the schools, mostly in relation to the field of communicable diseases and psychiatry."

These conclusions are of a general nature, implying that further specification was needed before recommendations could be formulated. As a matter of fact, Chagas (1952) pointed out that a study of the situation of each country would be necessary before formulation of recommendations could be reached. In general, these conclusions reveal a lack of attainment of preset standards. There is also a concealed demand in it for nursing to take over full control of its education.

In summary, the initial activities of the Nursing Section provided a preliminary evaluation of the regional situation, which in turn provided the elements for the development of its program.
Regional Congresses

Regional congresses were intended to substitute the lack of an Inter-American Federation of National Associations until its organization. During this period (1947-1959) PAHO organized a series of five regional congresses. The first two congresses, held in 1949, were almost a duplication; however, this duplication was intended to facilitate assistance by splitting the Hemisphere in two parts: northern and southern. The meeting for the northern part was held in Costa Rica where delegates from 11 countries from North and Central America congregated; the second one was held in Peru with the participation of 10 countries and official delegates from eight South American Republics (PASB, 1952).

The recommendations of these two congresses were summarized and published in the "Boletín" (1950), they are:

"In Nursing Education: That directors of schools of nursing be qualified nurses; that schools of nursing be independent educational institutions controlling their own budgets; that efforts be made to increase the number of girls in schools of nursing with full secondary education; that the minimum educational program recommended by the International Council of Nurses be adopted by all schools of nursing; that principles and practice of teaching and supervision be included in the basic course of nursing; that a national council of nursing education be established in each country to supervise the teaching of nursing in official and in private schools.

Concerning Nursing Publications in Spanish: The Pan American Sanitary Bureau was designated to serve as a clearing house for information on texts already translated and in the process of translation; and it was
recommended that the Pan American Sanitary Bureau take steps to interest reliable publishers in translating texts for the Latin American schools.

On General Nursing Problems: That improved salary scales, pensions, etc., be set up for the graduate nurse; that physical facilities in schools of nursing be improved, such as residences, classrooms, laboratories, libraries, etc.; that nurses in rural areas be provided with housing facilities, better salaries, opportunities for professional contacts and longer vacation periods, than the city nurse.

Regarding a Glossary of Nursing Terms in Spanish: That the Pan American Sanitary Bureau in cooperation with the Publications Committee of each country make up and publish a glossary of the various Spanish nursing terms used in the Latin American countries.

Concerning an Inter-American Federation of Professional Nurses' Associations: That nurses in each country through their national associations communicate with the sub-committee of the International Council of Nurses to discuss the formation of an Inter-American Organization."

In general, these recommendations can be related to two previous events: the 1942 Inter-American Congress (Chile) and the 1949 PAHO survey of nursing schools.

Basically the recommendations on nursing professional problems and education are almost the same as the ones formulated in Chile, prompting the same kind of analysis presented elsewhere.

Since one of the basic documents discussed was the survey of nursing schools, the recommendations on education stems from the conclusion of the study previously mentioned. Thus, it allowed for a more detailed account of educational needs if compared with the 1942 Chile Congress.

Despite the eagerness of Latin American leadership to acquire control of nursing education, promotion of indigenous literature is
not reinforced and translation is the alternative pursued. Since the
first cooperative projects for nursing school development in the
1920's, the lack of specialized literature in Spanish, and the lack of
knowledge of the English language are considered a major handicap in
nursing education in Latin America. Therefore, recommendations to
PAHO were aimed at reinforcing its role of information mediator,
resulting in maintaining a long range trend on international concepts
in nursing education in the Region which still continues to the
present.

In summary, the two first regional nursing congresses following
the trend of the Chile Congress in 1942 expressed the general interna­
tional aspirations of nursing as a profession. However, realistic
considerations about concrete possibilities of the governments to
implement them were not taken into account. A complete acquiescence
on the part of national authorities for the demands of nursing power
and control is therefore assumed. It is also assumed that good
standard of nursing care had universal qualities which would not
require any transformation to fit internal societal conditions.

The Third, Fourth and Fifth Regional Congresses had a conti­
nental character. In 1953, the Third Congress was held in Rio de
Janeiro immediately after the Tenth Meeting of the International
Council of Nursing. The Fourth Regional Congress was held in Mexico
in 1956, and the Fifth in Argentina in 1959.

Table No. 15 shows a summary of the number of countries
represented, number of participants and a summary of the main
recommendations.
Table 15. Regional Congresses: Participation and Summary of Recommendations
From the Third, Fourth and Fifth Regional Congresses on Nursing

<table>
<thead>
<tr>
<th>Congresses</th>
<th>Third</th>
<th>Fourth</th>
<th>Fifth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating countries</td>
<td>17</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>Official delegates</td>
<td>26</td>
<td>77</td>
<td>56</td>
</tr>
<tr>
<td>Observers</td>
<td>179</td>
<td>213</td>
<td></td>
</tr>
<tr>
<td>Students</td>
<td>124</td>
<td>93</td>
<td>38</td>
</tr>
<tr>
<td>International staff</td>
<td>23</td>
<td>26</td>
<td>31</td>
</tr>
</tbody>
</table>

SUMMARY OF RECOMMENDATIONS

Legislation
1. Where national associations are nonexistent, promote studies for its organization.
2. To promote national studies on nursing prior specific legislation formulation.
3. Legislation on nursing should include definition of nurses and auxiliary nurses and their respective roles; creation of an agency for professional control and channels for public information is also advisable.

Education
1. To provide high standards of education in nursing care at the postbasic level.

Undergraduate
2. Development of projects of graduate education should be based in the analysis of available facilities and needs in each country.
3. Basic education should be evaluated in the light of minimal requirements.
4. Development of postbasic education should follow high international standards.

1. Reinforce the Third Congress recommendations on this matter.
2. National associations should estsimulate the governments to appropriate funds for institutional and continuing education.
3. Establishment of schools should be made only where there are adequate resources.
4. Schools should be directed by nurses specialized in education, and the faculty integrated by full-time nurses and nonnurses in accordance with specialized fields.
5. Schools should integrate Public Health in their curriculum.
6. Continuing education programs needs to be estimated.
7. Post basic and graduate programs on public health should be promoted.

Auxiliary Personnel
1. Establish admission requirements for training according to needs of the country.
2. Limit the number of auxiliary personnel to specific needs of the country.

1. Each country should develop a study of nursing resources.
2. A single law on nursing should be formulated.
3. A single professional association should be organised.
Table 15 (cont'd)

<table>
<thead>
<tr>
<th>Services</th>
<th>General</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Creation of national departments to assume policy-making and technical advisory functions.</td>
<td>1. National associations should be strengthened recruiting a large number of members, and work to fulfill the requirements for admission in the International Congress of Nursing.</td>
</tr>
<tr>
<td>2. Development of a survey of nursing resources and needs.</td>
<td>2. Publication of a Pan American nursing journal.</td>
</tr>
<tr>
<td>3. Planning for activities based on countries' needs and resources.</td>
<td></td>
</tr>
<tr>
<td>4. Participation on health care planning as a team.</td>
<td></td>
</tr>
<tr>
<td>5. Development of a salary scale for nursing personnel.</td>
<td></td>
</tr>
<tr>
<td>7. All health services should be staffed with professional nurses.</td>
<td></td>
</tr>
</tbody>
</table>

| 1. Control of professional practice under the responsibility of nurses agencies should enforce pertinent registration. |
| 2. Determination of three levels of nursing: Nurse auxiliary, basic nurse, high-level nurse. |

Sources: Reports of the Third, Fourth and Fifth Regional Congresses.

Basically, the issues discussed in the three regional congresses are education, service and legislation. In education, the recommendations approved during the Third Congress considered the priority need for post-basic education. It is difficult to understand how post-basic nursing education could have been considered a must at this stage of nursing development in the region. Firstly, the already mentioned 1949 PAHO survey on nursing schools had demonstrated a marked deficiency in the basic nursing preparation. In reporting the survey, Chagas emphasized the great heterogeneity of nursing preparation in the Region saying that nurses from some countries could only be compared to nurse auxiliaries of another, in terms of admission requirements and specific training. It is implied that in the majority of the countries there was not a consolidated nursing educational system which could expand into post-basic preparation.
Secondly, the small number of graduate nurses could not support a system of graduated education. Finally, with the exception of a few countries, graduate education was nonexistent in the Region.

In order to understand these apparent contradictions the following hypothesis is proposed: international nursing standards based on the development of nursing in North American and European nations continued to be the model for nursing standards in Latin America.

The Third and Fourth Regional Congresses reinforced this position. In addition to the above mentioned standards, attention is called to the role and need of knowledge of administration in education as well as the need for integration of public health in the curriculum.

Development of services is the main emphasis of the Fourth Regional Congress. All recommendations reinforce the need for structuring national control of nursing activities and participation in national health planning. They reflected the growth of health services, mostly in hospitals, which occurred during this period. Emphasis, for the first time, was given to the need to study national conditions and to equate nursing according to country needs and resources (PASB, 1957).

The Fifth Congress reconsidered the question of legislation originally opened at the Third Congress. Legislation on nursing is systematically discussed as well as its implication for education and services. In general, the strategies recommended to develop nursing legislation followed the same steps attempted by North American nurses. McIver (1953) notes:
"In nursing, as in medicine, the passage of licensing laws in the United States was directly related to the organization of national and state nurses' association. Forty five of the 48 states enacted nurse practice law between 1900 and 1920, and the majority of the state nurses' associations were organized during the period before 1910. Currently, all the states and territories of the United States have some type of legislation for control of nursing practice. Licensing of occupational groups is one of the functions which the Constitutions of the United States reserves for the States. Therefore all such laws are state laws in the United States, whereas in many countries occupational groups are licensed by the national government".

It can be concluded that it is not a coincidence that national associations are constantly recommended as a prior step to the preparation of nursing legislation.

Studies of nursing resources was another practice of the North American strategy recommended for Latin America. Studies of nursing resources and conditions of work had been utilized in the United States not only to justify accreditation bills but also to plan nursing care. The point here is not to judge this strategy as adequate or inadequate, but rather to show the persistence of North American influence in the Region through PAHO. In addition, the essential feature of nursing practice legislation, as defined by McIver, Chief of the Division of Public Health Nursing of the U.S. Department of Health, Education and Welfare were recommended. These features are:

1. Definition of nursing, both professional and practical nursing, if the act covers both.
2. Specific provision for selection and appointment of the board or persons who are to administer the act.
3. Authority for the board to make regulations concerning the qualifications of those applying for license and the standards required of educational institutions which prepare the practitioners.
4. Authority to prosecute those violate provisions of the law (Mc Iver, 1953).

In conclusion, the Fifth Regional Congress fostered nursing legislation modeled on the North American experience, living out from the discussions the need to acquire knowledge about the whole social context in which legislation occurs in each country. In other words, failing to acquire the knowledge about the factors that influenced nursing practice in Latin America.

In conclusion, it is possible to state that during this period the PAHO nursing section promoted a continuous forum for nursing communication in Latin America based on North American model.

**Policies and Recommendations**

The policies and recommendations of the Nursing Section at PAHO during this period focused on four main areas: basic nursing preparation; graduate education; interchange of nursing ideology, and development of national nurses associations. The basic conceptual framework utilized for the overall planning was, according to Chagas (1953), the standards of the profession as set by the International Council of Nurses. Baly (1980) states that the International Council of Nurses (ICN), after the 1949 Stockholm Congress, "became a nongovernmental body acting in an advisory capacity to the World Health Organization". In discussing the development of this organization in the post-war period, Baly notes that the increase in membership had introduced
"very different aspirations" as compared to the ones held since its foundation in 1899. She further notes:

"The health needs being met by nursing services in the Western World are different from those of the developing countries, and the problem of the International Council of Nurses is the problem of the United Nations writ small, ideology and such political issues as apartheid cannot be ignored because they do affect the provision of services and ethical codes. The question has to be asked whether an organization can lay down guidelines for countries with problems so dissimilar or, as the money and the oil run out in the west, and the developing countries are touched by the new, and costly, technology, will our problems converge, and we meet together to learn from past history? All over the world nurses have this much in common that being nearest to the patient, they can be his advocate and speak up for what the patient needs against what governments and sometimes medical politicians think they want" (Baly, 1980).

Indeed, if the common link between nurses in the world is to be an advocate of patient needs, what kind of common guidelines could be shared for their preparation, other than the universal principles of human rights? Nevertheless, the standards of nursing education set by the ICN in the Basic Education for Professional Nurses were deeply rooted in the modern development of nursing in Western Europe, mostly in England and in the United States of America. These guidelines however, stressed the need to relate nursing education and services to socioeconomic development of each country.

In general, the policies and recommendations adopted by PAHO at this time can be summarized as follows:

- Improve skills and abilities of nurse instructors in administration and supervision in public health services.

- Translation of nursing literature.

- Promote the organization of national nurses' association in the countries where they had not as yet been organized, and
the establishment of an Inter-American Federation of Nursing Associations.

- Promote the ICN minimum standards for nursing basic education.
- Cooperate with individual programs for the improvement of health services, mostly hospitals and public health establishment, that would be used in practical training of nursing students.
- Promote the organization of a system for training nursing auxiliaries in each country.

Program and Budget

Basically, the programs and budget of the PAHO Nursing Section reflects the policies and recommendations of the period. Data reveal a considerable amount of regional as well as local activities covering all the countries in Latin America. In this section, we will analyze basic data on programs and activities, personnel, fellowships, publications and budget.

Education

Basic Nursing Education. It has been mentioned that during this period the Nursing Section concentrated on the promotion of basic nursing education. Basically, the programs of nursing education included individual projects for each school receiving assistance. However, projects were markedly similar in that they included:

a. revision of curriculum;
b. training of nurses instructors and nurse director;
c. organization of practical training of students in clinical facilities both at hospitals and public health services;
d. fellowships.
Within the period under review, the majority of the countries in the region had one or more such project in schools of nursing. In support of these projects specific activities were developed on a more regional basis; they included seminars and short-term courses designed to meet the "most urgent needs" of the schools. (PASB, 1958). These needs were defined as:

a) Preparation of nurses for teaching, supervisory and administrative functions. At the time, nursing curriculum emphasized bedside care, while graduate nurses were being employed to perform the above mentioned functions. Almeida et al (1981) noted that this contradiction in nursing education can be traced to the very roots of the Nightingalean reform. Nevertheless, the Quadrienal Report of the Director (PASB, 1958) acknowledged that nursing leadership "...have realized that practically all schools of nursing in Latin America are patterned after the North America system of nursing education which prepares graduates primarily for bedside nursing care, whereas in reality graduate nurses in Latin America are being employed in teaching, supervisory and administrative functions for which they were unprepared." It is pointed out that need for this training activity as a continuing education program would disappear as soon as all basic nursing curriculum included the above mentioned areas;

b. Modernization of the nursing curriculum to include social as well as biological aspects of health and integrate aspects of teaching, supervisions and administration. It is also recommended the inclusion of mental hygiene, psychiatric nursing and a greater emphasis
on obstetrics. Between 1950 and 1955 PAHO organized an international workshop on principles of teaching and supervision in six countries.

**Advanced Nursing Education.** As a mean to overcome the language barrier which had impeded a broader participation of Latin American nurses in U.S. graduate programs, PAHO promoted the organization of centers for advanced nursing education in Latin American (PASB, 1958). The first of these centers was organized in Chile in 1955.

**Auxiliary Nurses.** It was mentioned on the first section of this chapter that the training of nursing auxiliary personnel was a controversial issue. During the First Regional Congress (Costa Rica, 1949) the Nursing Section included in its agenda the discussion on this issue; however, lack of general agreement and consensus among the group prevented the formulation of recommendations on the matter. The report reads: "The Congress is not in a position to make recommendations on this matter until some time has passed". This situation was repeated in the Second Regional Congress (Peru, 1949) in which it was resolved that: "each country should consider the preparation of nursing auxiliary personnel according with its own needs and the opportunity that might be convenient to each government". For Chagas (1964) the main reason behind the rejection of the idea by Latin American nurses was the fear that this category of personnel could one day substitute graduate nurses; this fear was greater, according to Chagas, in the countries where general admission requirement for nursing schools was six years of elementary school. She further elaborates explaining that in the countries where the requirements for admission were three to six years of education above elementary school,
the fear was almost nonexistent, and nurses became instructors of these personnel. The fear, explained Chagas, was based on the existence of a great number of individuals without any formal preparation in nursing employed as "nurses," thus it would be even more difficult to make a clear distinction between a category of personnel with very little nursing education and nurses prepared in a three years program.

Evidently, these observations only considered the issue from the internal point of view of nursing leadership, which was marked by a contradictory historical perspective. On the one side, in the development of nursing in the United States of America and Europe, the preparation of nursing auxiliary personnel had a different historical precedent. In England as well as in the United States of America the development of "modern nursing" dated from the onset of the emergence of medical clinic and hospital organization. By the end of the nineteenth century most women in practice had had the nursing training and there were standards regulating the hiring and admission of prospective nurses, as well as widespread training programs for nurses, the majority associated with hospitals. It was not until the great shortage of nurses after World War II that the nurses in the United States gave some thought to the training of practical nurses. Russel (1970) observed:

"Practical nurses, many without any formal training, have been used as long as one can remember. These women have given nursing care in the home; but before the advent of the course for nursing assistants, nursing in hospitals was provided entirely by registered and student nurses."

On the other side, the historical situation was quite different in Latin America. As stated previously, when the movement of "modern
nursing education" started in Latin America, a vast number of untrained "nurses" staffed the health services. The label might not have had the same connotation, however, it was the same: nurse. As Latin American nursing schools started to recruit young women from the upper and middle classes, they broadened the gap between untrained practical nurses from the lower classes and trained ones. These historical course of events are more directly responsible for the attitude described by Chagas than by what her analysis suggests.

Nevertheless, the Nursing Section persisted in developing its nursing auxiliary policies until it was fully accepted by the nurse leadership in Latin America. It is important to note that there was great interest on the part of the governments in training this enormous number of lay personnel working in nursing. The number of PAHO/WHO assisted programs in the region at this time is evidence of this interest. There were programs in nine different countries.

In 1956 the Nursing Section reviewed the programs in those countries. Programs focused on training of auxiliaries in public health nursing. In summarizing the results of this review it is stated that the data "has (sic) revealed a wide variation in the training objectives (functions and activities of graduates), length of training and course content. There are some similarities in procedures for the selection of students". (PASB, 1956).

Based on this review the following recommendations were made:

"1. Determination of functions and activities of such auxiliary personnel must constitute the first step."
2. Such functions and activities should be genuinely auxiliary in nature; others requiring more preparation and broader technical knowledge and skills should be assigned to professional personnel.

3. Functions and activities should be planned within the possibilities of work facilities and transportation.

4. The content and duration of the course should be based upon functions and activities envisioned. "Little nursing" or "little medical" courses should be avoided and emphasis placed on practical training for work in the field.

5. Prospective students should come from areas in which they will ultimately work, if at all possible.

6. Educational requirements should be the highest possible for candidates qualifying under (5) but should, in general, be lower than, and certainly not in excess of, requirements for entrance into recognized schools of nursing within the country.

7. If the length of the course necessary to prepare personnel for functions anticipated exceeds 15-18 months, consideration should be given to encouraging Governments to develop concentrated educational programs in basic nursing, such as those which have been found practical in other countries". (PASB, 1956).

These recommendations basically oriented all the activities developed by the nursing section during this period. Several studies were conducted to define functions and activities of auxiliary personnel; training programs were designed and implemented; training of nursing instructors for auxiliary educational programs were developed. By the end of the foregoing period, the nursing section was actively involved in auxiliary nursing educational programs in the majority of the countries in the Region.
Services

The majority of programs and projects were conducted at the zone offices and were related to the administration and organization of public health nursing services. Nursing projects were, in general, integrated with health projects at the national planning level. This policy, however, started around the mid-1950s, since most of the previous service projects were related to educational projects. The health services projects included evaluation of services and recommendations for the organization of a national nursing system. Several countries for the first time approved the organization of a nursing section at the ministerial level. Definition of nursing functions and review of activities development by nursing personnel were the main emphases of PAHO's cooperation projects for the national nursing sections. All the projects aimed at the development of policies for nursing practice at the national level.

At the local services level a few projects were aimed at developing demonstration areas. Emphasis was given to maternal and child health care. PAHO nurses involved in these projects assisted in activities directed at the organization of clinics as well as in home visits. It also involved orientation and instruction of traditional birth attendants.

Beginning with this phase the Nursing Section gradually became more involved in training programs for traditional birth attendants. The amount of instructional materials produced at the country level with assistance of PAHO is impressive; training manuals, audio visual materials, equipment for birth attendance developed and financed by
PAHO and UNICEF spread in almost all rural areas in the majority of countries, and it is even possible to find different versions of this kind of materials.

Communicable disease control was also another area of concern at this time. Several projects dealt with immunization campaign against smallpox and tuberculosis.

Nevertheless, training activities were the basic features of all services projects. Continuous in-service education aimed to covering aspects of public health not covered by academic programs for nurses. In addition, formal training programs were developed for auxiliary personnel.

**Budget**

PAHO activities are financed by the individual contributions of the member governments and voluntary contributions of international agencies such as UNICEF, United Nations Technical Assistance and the Organization of American States Technical Assistance. In addition, private foundations such as Rockefeller, Kellogg, Milbank, etc. have financed programs which PAHO has administered.

During the period, 3% is the average proportion of funds allocated to the Nursing Section in relation to the total budget of the Organization. For the three first years of the Nursing Section there is no available information on the amount of funds expended in nursing. At this time, the Organization budget was not organized according to specific programs or administrative organization. Beginning in 1950 the information available showed total amount of funds expended on nursing activities. For the first five years
(1950-1954) nursing funds are reflected in total amounts; funds expended on salaries were only available for two years, 1950 and 1951. In 1955 the funds were earmarked for nursing education, and during the four subsequent years it represented the total amount assigned to the Nursing Section. In 1959 the budget showed funds for public health activities for the first time. Table 16 presents a summary of this information.

Table 16
Total PAHO Budget and Allocated Budget for the Nursing Section, (1947-1949)

<table>
<thead>
<tr>
<th>Years</th>
<th>Discrimination</th>
</tr>
</thead>
<tbody>
<tr>
<td>1948</td>
<td>1. Total PAHO 317,352</td>
</tr>
<tr>
<td></td>
<td>2. Percentage Nurse 4</td>
</tr>
<tr>
<td></td>
<td>3. Total Nursing 48,900</td>
</tr>
<tr>
<td>1949</td>
<td>4. Total Nursing 69,220</td>
</tr>
<tr>
<td>1950</td>
<td>5. Total Nursing 67,249</td>
</tr>
<tr>
<td>1951</td>
<td>6. Total Nursing 180,982</td>
</tr>
<tr>
<td>1952</td>
<td>7. Total Nursing 180,982</td>
</tr>
<tr>
<td>1953</td>
<td>8. Total Nursing 180,982</td>
</tr>
<tr>
<td>1954</td>
<td>9. Total Nursing 180,982</td>
</tr>
<tr>
<td>1955</td>
<td>10. Total Nursing 180,982</td>
</tr>
<tr>
<td>1956</td>
<td>11. Total Nursing 180,982</td>
</tr>
<tr>
<td>1957</td>
<td>12. Total Nursing 180,982</td>
</tr>
<tr>
<td>1958</td>
<td>13. Total Nursing 180,982</td>
</tr>
<tr>
<td>1959</td>
<td>14. Total Nursing 180,982</td>
</tr>
</tbody>
</table>

| Source: Annual Report of the Director and Proposed Program and Budget of the Organization. |
| Note: There is no information of the nursing section budget for the years of 1947-1949. |

While the total budget for nursing steadily increased during this period, its proportion in relation with the total PAHO budget remained, with exception of 1954 (8%), around 3%. If the geometric increase in the PAHO budget is considered, it can be concluded that within a very limited range the nursing budget has remained the same.
Despite the fact that the Organization continued affirming its interest in nursing activities, the budgetary situation cannot be taken as evidence in support of this affirmation. Although it can be claimed that other PAHO programs indirectly promoted nursing, figures indicate a limited participation of this service in the Organization.

The allocation of funds to education reflects the dominant trend of the nursing section during this period. Even though, some of the activities previously described, covered public health services --because they were primarily aimed at the development of clinical settings for nursing schools,-- the funds were all appropriated for education activities.

**Personnel**

During this period the Nursing Section worked on a hemispheric wide recruitment campaign for nurses to staff its advisory services. Recruitment notices were distributed among North American, Canadian as well as Latin American institutions. In 1951, for instance, 1,300 of these notices, in Spanish and Portuguese, were distributed to Latin American countries (PASB, 1952).

The number of staff nurses increased rapidly. In 1947 there were two nurses at the Washington Headquarters and two stationed at the zone office in Lima and Guatemala. As early as 1951, twenty nurses were working in the several field activities, and by the end of the foregoing period the number of nurses in PAHO had reached its highest number: 43 nurses. Unfortunately the available data do not permit a
complete analysis of either the distribution of these nurses in the several countries of the Region and the programs under their responsibility. Such data are only available beginning in 1958. From these data, which will be discussed at length in the next section of this chapter, the following can be summarized:

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total nurse staff at PAHO</td>
<td>42</td>
</tr>
<tr>
<td>Total nurses from Latin America</td>
<td>21</td>
</tr>
<tr>
<td>Total nurses from United States</td>
<td>19</td>
</tr>
<tr>
<td>Total nurses from other countries (Canada and Europe)</td>
<td>2</td>
</tr>
</tbody>
</table>

Three nurses were stationed at Washington Headquarters, and the others in 17 different countries in Latin America: Argentina (7), Bolivia (3), Brazil (1), Chile (2), Costa Rica (3), Cuba (2), Dominican Republic (1), El Salvador (3), Ecuador (3), Honduras (2), Mexico (3), Nicaragua (2), Panama (2), Paraguay (1), Peru (3) and Uruguay (1).

In general, nurses staffed the zone headquarters or were stationed in a country assigned to a specific program. For instance, in Argentina there were two nurses at the zone headquarters in Buenos Aires, the remaining were working in different areas within the country developing specific programs at nursing schools. The general policy at the time was to maintain in the zone one consultant for nursing education and another for service development.
The "Boletín de la Oficina Sanitaria Panamericana" continued to be the main vehicle of nursing information. As it has been mentioned elsewhere, in 1949 the "Boletín" started a nursing section in the article space, fifteen pages of every issue and one issue per year were dedicated to nursing. For a few years one nurse from the headquarters staff was assigned to organize the section.

The number of articles published increased rapidly, outdistancing the number of notes as compared to the previous period. The majority of these articles were written by nurses. At the onset of the period the majority of the authors were North American nurses and most of the articles had previously appeared in one of the following publications: American Journal of Nursing, Nursing Outlook, Canadian Nurses and The American Journal of Public Health. Toward the end of the 1950's, however, the number of articles written by Latin American nurses started to surpass those of the North Americans. The PAHO nursing staff also published regularly as contribution of physicians and other professionals decreased steadily.

The number of notes about development of nursing schools in Latin America decreased, almost disappearing by the end of the period. The same is true for notes accounted for as "others", which included information on meetings, conferences and nursing events in Latin America in general. The information on nursing bibliography, even though increased, fluctuated throughout the period. Table 17 summarizes this information.
The scope of subjects treated in the articles was also broadened. General subjects on nursing, such as ethics, professional trends, legislation, etc. decreased; however, education and public health averaged well above 50%. The increase on general nursing subjects and education reveal a new trend as compared to the previous period when most of the articles dealt with public health. In addition, new areas of nursing such as administration, auxiliary personnel, maternal and child health also revealed some basic concerns of the Nursing Section at the time. Table 18 and Figure 3 summarize this information.

Since Latin American nurses started for the first time to contribute in this section of the "Boletín", it is important to see
Table 18
Boletin OFSANPAN: Number of Articles on Nursing by Subject. 1949-1960

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Editorial</td>
<td>3</td>
<td>5</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>General nursing</td>
<td>15</td>
<td>23</td>
<td>17</td>
<td>28</td>
</tr>
<tr>
<td>Nursing in DT</td>
<td>10</td>
<td>15</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Administrative nursing</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Education nursing</td>
<td>14</td>
<td>21</td>
<td>12</td>
<td>20</td>
</tr>
<tr>
<td>MED/nursing</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>MCH nursing</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Public health nursing</td>
<td>13</td>
<td>20</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Auxiliary personnel</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Country situation</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Nutrition</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Nursing in other articles</td>
<td>3</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>22</strong></td>
<td><strong>100</strong></td>
<td><strong>60</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

*NOTE: NUMBERS IN PARENTHESIS ARE ABSOLUTE NUMBERS.*
their contribution country by country. In Table 19 and Figure 4 the information is summarized. Nurses from Brazil, Chile and Mexico presented a greater number of contributions followed by Costa Rica, Panama, and Peru, and, a minor contribution from the other countries listed. These data supports the currently acknowledged status of nursing development in the Region already discussed in the previous chapter.

In addition to the reports of the major activities such as the regional congresses, the first seminars on education, and the 1949 nursing survey, the eleven editorials and articles written by PAHO's nurses exemplify well this point.

The conceptualization of nursing began to experience some changes in discourse. It moved from a purely humanistic ideal, as stated in the first editorial published in 1948, to a more technical and professional discourse. The first one was further reinforced by Bustamante (1949) who in a long editorial linked to modern nursing the history of a Spanish smallpox vaccination mission to the New World during the eighteenth century which had included nurses.

Nevertheless, the definition of nursing remained circumscribed by its public health role. All the editorials and articles of this period emphasized public health as the "essential" contribution of nursing to the improvement of health status. For instance, in one of these editorials (Bol. Of Sanit Panam, 1951), the WHO Expert Committee reinforces this point. The Committee noted "that medical and health authorities acknowledge that the lack of public health nurses in reality hinders the progress of all health programs."
### Table 19
Boletin OFSANPAN: Number of Articles Published by Latin American Nurses by Countries, 1949-1960

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolivia</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brazil</td>
<td>2</td>
<td>8</td>
<td>4</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Chile</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Colombia</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Costa Rica</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>El Salvador</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Ecuador</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Guatemala</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Mexico</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Panama</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Peru</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Paraguay</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Venezuela</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>17</td>
<td>17</td>
<td>22</td>
<td>14</td>
<td>76</td>
</tr>
</tbody>
</table>

**Figure 4:** Boletin OFSANPAN: Articles Published by Latin American Nurses According to Sub-Region of Origin (1949-1960)

Legend:
- **Bolivia (2)**
- **Brazil (20)**
- **Colombia (2)**
- **Ecuador (2)**
- **Peru (6)**
- **Venezuela (2)**
- **Central America**
- **Mexico (8)**
- **Southern Cone (1)**
- **Uruguay (6)**
- **Argentina (6)**
- **Paraguay (2)**

Note: Numbers in parenthesis are absolute quantity.
Certainly the change in the general nursing concept reflected the presence of nurses in the organization. This presence stressed the technical role of nursing, within the markedly public health orientation of the Organization.

The editorials expressed the urgent need to increase the number of nurses in the Region, calling for public support of educational programs, not only to increase the quantity but also the quality of the programs. In setting up the basic aims for nursing education the role of social sciences is emphasized as essential to the training of nurses for the new public health programs. An editorial on the new goals of nursing (Bol Of Sanit Panam 1952) states:

"In the nursing plan of studies it is essential that the subject matters related to mental hygiene, community organization, psychology, sociology and health education receive major attention because these subjects should provide the basic knowledge which is indispensable for a better work coordination and the establishment of fruitful public relations".

Promotion of public health nursing is clearly, as stated elsewhere, linked to the public health movement discussed in the previous chapter. Other aspects of nursing education were also considered. The need to reorganize the curriculum according to health needs of each country and the development of post-basic educational programs were frequently mentioned.

The editorials also repeatedly stressed the need and importance of nursing auxiliary training. In the Editorial "The nurse - A guide to health" the Director of the Organization stated in 1954: "Since so much is now demanded of nurses, some of her former activities are being entrusted to an auxiliary group, trained and supervised by her. Large
numbers of these auxiliaries must be trained in the Americas if we are to use wisely professionally trained nurse." (Bol. Of Sanit Panam, 1954). This statement reinforced PAHO’s position on this matter, despite the current attitude of the nursing leadership in Latin America at the time. Subsequently, the need to define functions for this category of personnel and to organize a system of training is also discussed.

Altogether, the "Boletín", during this phase of implementation of nursing services at PAHO, provided an accurate account of the major policies and activities developed by the recently created Nursing Section. In addition, it constituted the major source of literature in Spanish on nursing for Latin America.

Besides "Boletín" other official publications of the Organization treated nursing subjects. First, a glossary of nursing terminology utilized in different countries of the Region was published. This glossary facilitated standard translation from English into Spanish and Portuguese as well as the exchange of information and communication in the Region. Two scientific publications (No. 15 and No. 42) reprinted the report of the Third WHO Expert Committee on Nursing and the Didactic International Seminar on Nursing Survey. The first was published by WHO in English and the latter had appeared in the "Boletín".

Second, the Nursing Section started a long-range textbook translation program. The first three textbooks translated were selected during the first two regional congresses. They were:
Fellowships

During this period PAHO awarded 402 fellowships to Latin American nurses. Over 58 per cent were long term, defined by one or more complete academic years. Among those, the majority (229 - 57%) had a duration of one academic year (237). Short-term fellowships, defined as six months or less in duration, represented 41% of the total, being the majority (165 - 34%) less than six months in duration. These short term fellowships, in general, included attendance to PAHO's seminars and in-service visits. (See Figure 5)

The relative dispersion of fellowships by students'country of origin shows that the distribution was within a range of zero to 35 fellowships per country and an averaged of 20 fellowships per country. Countries in the Andean and Central America regions showed the widest range (8% - 2%, 9% - 3%), and the Southern Cone the narrowest (9% - 6%). The Caribbean (Spanish/Haiti) received the lowest proportion of awards, while the other subregions received almost an equal proportion (See Figure 6).
FIGURE 8. Nursing Fellowships According to Duration of Program for Each Sub-Region (1950-1959)

FIGURE 8. Distribution of Nursing Fellowships by Country within Each Sub-Region (1950 - 1959)

LEGEND

ARG: Argentina
BOL: Bolivia
BRA: Brazil
ECU: Ecuador
CHI: Chile
COL: Colombia
CUB: Cuba
DOM: Dominican Republic
HAI: Haiti
HND: Honduras
NIC: Nicaragua
PAH: Panama
PAR: Paraguay
PER: Peru
URU: Uruguay
VEN: Venezuela
MEX: Mexico
Fellowships were granted in the following fields of study: public health nursing (33%), nursing services (29%), nursing education and teaching (28%); all other areas represented a proportion of only 9.85% (pediatrics, nursing education and administration, psychiatry, basic nursing, obstetrics, midwifery, surgery, health education and medical records). (See Figure 7)

Some fellows attended programs in more than one area, in most cases, the seminars on nursing education and development of services promoted by the Nursing Section in the early 1950s. In a few cases there were combinations of public health programs with nursing education or midwifery. Two of the public health programs also included maternal and child health training.
Latin America was the most common place of study. Long term programs in Latin America included studies in Universities in Chile, Costa Rica, Guatemala and Peru, all of them in public health. However, the majority of the awards for studies in the Region were short-term fellowships. The United States of America received 20% of the fellows, most of which received one year award. Puerto Rico, Canada, the English Caribbean and a few countries of Europe (United Kingdom, Norway, Portugal, Sweden and Finland) received 12% of Latin American fellows (See Figure 8).
During the period under consideration formal nursing services were organized at PAHO. In 1947 nursing activities began to be coordinated from Washington headquarters. The general structure of the programs and activities continued to follow the previous trends of services which began during the World War II. That is, emphasis on development of public health nursing through the promotion of basic nursing education.

Several international conferences and seminars were organized by the PAHO Nursing Section. The conferences aimed at the promotion of international communication among Latin American nurses to study their problems of education and practice, as well as to develop recommendations to guide not only national nursing development, but also the actions of the Section. The seminars focused on the training of nurses in the areas of supervision and education.

A survey of Latin America nursing schools was also conducted. This survey, for the first time in the history of nursing in the Region, gathered data on the existing number of schools, their programs, as well as technical and physical facilities, number of students, etc. This knowledge facilitated programming and development of activities.

In spite of a relatively small budget, an average of 3% of PAHO's total budget, the Nursing Section during this period rapidly increased the number of staff nurses in international service and the number of programs and activities developed at the country level.
There was also an increase of nursing publications as well as accompanied by an outstanding participation of Latin American nurses. For the first time specialized literature on nursing was also translated into Spanish. Finally, the fellowship program provided opportunities for graduate training among nurses from Latin America.

In conclusion, the Nursing Section created in response to internal demands of the Organization to expand its role, as an international agency in the health field in the Americas, developed during this period a vast network of nursing advisory services for the Region. It formulated policies and undertook activities, in general, associated with PAHO's general policies at the time. However, the influence of the international nursing professional development and movement shaped fundamental nursing ideology within the organization.

NURSING SECTION: 1960-1980

Before attempting to characterize this period, it is important to note that the economic crisis of the late 1960's resulted from the failure of the socioeconomic development model introduced in the late 1950's by the Organization of the American States and other agencies such as the Inter-American Development Bank (BID) and the International Agency for Development (AID). Thus, it will be necessary to divide this 20-year period into two decades. The first decade, 1960-1970, corresponds to the implementation of the development model. This period is marked by a relative expansion of Latin American economy through consolidation or insertion of industrialization in most
countries. The second decade, 1970-1980, corresponds to the failure of the development model and is marked by the general economic crises of the system.

In the early 1960's, PAHO's nursing policy shifted its main focus from educational development to nursing services development. Service development at PAHO also acquired a new dimension: medical care. Consequently, nursing activities began to emphasize nursing care at the hospital level in contrast to the development of public health service which had characterized the previous period.

In general, the shift of PAHO's general policies to incorporate medical care activities was a result of PAHO's endorsement of the new development model as proposed by the Organization of American States. The Act of Bogota\(^6\) (1960) and the Charter of Punta del Este (1961)\(^7\) pointed out the need to recognize medical care as part of public health and called PAHO's attention to integrating medical care into its programs.

Therefore, the shift in focus observed in nursing policies is not an isolated event. It is linked to the general trend of the Organization which, in turn, can be associated with Latin American social structures.

PAHO's Director (PASB, 1961) considered the following principal steps for the implementation of medical care policies: (1) inclusion of medical care as a basic service integrated into the general health plans for assistance to the governments; (2) appointment of regional advisors specialists in medical care; and, (3) development of studies to define the relationship between medical care and health services in
the Americas. These steps fostered the expansion of the Organization's traditional activities in the public health sector.

In addition, 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 necessary steps to make health a component of development," and he considered that a plan for development, in which human and material resources were integrated, was an immediate task. He further acknowledge that: "health as a concept and a methodology must be given its rightful place in plans and programs, in keeping the magnitude of problems, their social and economic importance, and the concrete possibilities to solve them." (PASB, 1962).

It was under the influence of this broad conceptual view of development and integration of health aspects that the nursing section had to reorient the scope of its activities in the period under review. The purpose of this section is to study specific nursing policies recommendations programs, activities and budget of the Organization during this period.

Policies and Recommendation

The shift in nursing policies which occurred in the first decade of this period has to be analyzed in the light of the changes in the Latin American socioeconomic structure and the dominant influence of the United States of America. It has been pointed out that during this period most of the countries in the Region were consolidating the industrialization process which promoted the rapid
expansion of health services, particularly hospital complexes. At the same time reassessment and modernization of agricultural production had also created a demand of health services in the rural areas. In order to assure continued production, governments had to protect the health of rural workers as it had done in the cities, although the official discourse at the time emphasized the humanitarian purpose of social welfare which should accompany the socioeconomic development. For instance, the Director commented (PASB, 1962): "the dominant policy both nationally and internationally, is to accelerate development and abolish the enormous disparities in the distribution of income, in order to raise standards of living". Yet, such acceleration in Latin America proved the contrary in the majority of countries -instead of abolishing inequalities in income distribution it accentuated them. The end result has been the development of a mass of very poor population increasingly dependent on government social benefits and services, such as health care and, ultimately, causing the prolonged fiscal crisis and political instability which has persisted throughout the Region.

It is also important to note that at the onset of this period the Hemisphere was under the impact of the Cuban revolution. Indeed most of the humanitarian discourse may be linked to this event. To enumerate all national and international initiatives promoting the need to accomplish a better distribution of national wealth, would certainly take us on a long detour in this exposition; however, it is sufficient to recall that the OAS created a special committee -the so called "Committee of Twenty One"- to formulate special policies on
economic cooperation that should include aspects of social welfare as well, and the disclosure by the United States of its famous program, Alliance for Progress.

Apart from the process of socioeconomic development in Latin America, the dominant economic and ideological influence of North America has also to be considered. On the one hand, North American capital has been largely invested in Latin America increasing dependency and national debt, as well as adding to the internal fiscal crisis as profits returned to central market. On the other hand, dominant concepts and ideologies were continuously disseminated through the dominant groups of influence. Andrade (1979), in reviewing the international influence on medical education in Latin America during the last 25 years, suggested that medical education had been under continuous and sometimes conflictive international influence which led to the thoughtless adoption of foreign models. It may be appropriate to note that Andrade's suggestion does not coincide with our basic hypothesis of internal determination of nursing educational development in Latin America. Nevertheless, it is necessary to acknowledge the role of international influence on the dominant classes in their projects of innovation and modernization.

PAHO, as an international organization, was not marginal to these processes. On the contrary, it takes the "vanguard" position of reasserting its role in the coordination of international efforts and dissemination of the dominant ideologies in health. The Organization, in 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 living standards of the broad masses", embarked in the process of transferring technology as a strategy to harmonize economic development and welfare (PASB, 1962).

The OAS "Committee of Twenty-one" recommended that the governments seek technical advice from PAHO for the formulation of public health programs which should be incorporated to the economic cooperation programs. And, the Act of Bogotá and the Charter of Punta del Este, two documents originated by the above Committee, reaffirmed the interdependency of economic development and social problems.

Based on the guidelines of the Ten-Year Public Health Plan of the Charter of Punta del Este, PAHO started to formulate its policies, programs and projects for the 1962-1971 period. In 1972 the III Special Meeting of Ministers of Health of the Americas approved the Ten-Year Health Plan for the remaining period. This was the major source for the determination of nursing policies during this period.

Aside from this dominant influence, the international nursing movement also contributed to the retention of a few professional issues. For instance, upgrading of professional status through the strengthening of national associations. The creation of a Pan American Nursing Federation continued to be a concern of the PAHO's Nursing Service in the early 1960's. In addition, the rhetoric of official documents continued to utilize the prevailing concepts of the role of nursing with respect to the health status of the population. For instance, the First Special Committee on Nursing, 1950 states:
"Experience has shown that in countries where medicine is highly developed and nursing is not, the health status of the people does not reflect the advanced stage of medicine" (PAHO, 1951). This kind of rhetoric is incongruent with the one the Organization consistently emphasized about the social determination of health status. Thus its usage may only be conceived as promotion of the professional status of nurses.

The Ten-Year Health Plan derived from the Charter of Punta del Este emphasized health planning and programming consistent with the health needs of each country and availability of funds. Nursing policies therefore promoted the development of national nursing planning. All the countries were encouraged to study existing nursing resources as the basis for a sound plan. Assistance was made available for the development of national nursing systems. Recommendations addressed the need for educational systems to develop three levels or categories of nursing personnel and for the revision of curricula to allow for the incorporation of new concepts as well as their adequacy to the needs of each country.

During the second decade (1970-80), the results of the initiatives undertaken during the first half of the period under study, can be more properly assessed in socioeconomic terms. Unemployment, underemployment, internal migration, stagnant economies, adverse monetary fluctuations, inflation, and the proliferation of military governments are among the most dramatic examples of the economic crises and fiscal indebtedness of the Region which have in turn resulted in situations of extreme poverty for the great majority of the population.
This situation reflects what some economists have qualified as the cyclical crisis of international capitalism, which has not only affected the underdeveloped nations of the world, but also the most developed ones. (Petras, 1981; dos Santos, 1979).

As a response to the crisis, the world community adopted—with reservations by a minority of countries— the New International Economic Order. In health, the Second Ten-Year Plan for the Americas was adopted, and much later, in 1978, the Declaration of Alma Ata became the central focus of attention. In the first one the emphasis was on the extension of health coverage and in the second one, the primary health care approach is adopted as the central strategy to attain the goal of Health for All by the Year 2000. In both the cost factor of health care has played a dominant role.

The second Ten-Year Health Plan was more specific in qualifying and quantifying specific goals for health in the Americas. It also emphasized the need for the extension of coverage of health services. For the first time the governments of the Region approved a resolution on nursing. Based on this resolution and the four subsequent ones which were approved during the decade (1970-1980), PAHO's Nursing Section built its program of action. Table 20 presents a summary of the five resolutions on nursing approved by Member Governments during the last decade.

In addition to the second Ten-Year Health Plan, although consonant with them, the recommendations of the first meeting of the Technical Advisory Committee in nursing held in 1969 were also an important source for policy making within the Nursing Section. In
general, the recommendations of this Committee, summarized on Table 21, reinforced recent efforts of the Organization in planning and forecasted some of the resolutions approved in the 1970's.

**Table 20**

**Summary of Nursing Resolutions Approved by Members Governments of PAHO Between 1970-1980**

<table>
<thead>
<tr>
<th>Year</th>
<th>1972</th>
<th>1974</th>
<th>1975</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ten-Year Health Plan</strong> for the Americas.</td>
<td>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.</td>
<td>Examine the nursing situation in the countries, provide positions for nurses at all service levels and promote training on direct care of individuals.</td>
<td>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.</td>
</tr>
</tbody>
</table>

1977

1980

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

Finally, toward the end of this period, in 1978 the 33rd World Health Assembly of Alma Ata launched the theme of Health for All by the Year 2000 as a goal for future activities of the Organization. This new goal has as its fundamental strategy the primary health care approach.

In the following paragraphs the major policies of the Nursing Section are identified according to the specific areas of action.

Integrated Health Services

Integration of health services meant the interrelationship between the preventive and curative aspects of health work. Curative aspects necessarily involve hospital care. As a consequence, nursing expanded its policies in this area as part of its previous concern with the establishment of a clinical setting for the nursing student to plan and organize hospital facilities in general. To reflect this change the Regional Adviser in Public Health Nursing was retitled Regional Advisor in Nursing Services.

Policies in this area included: 1) Determination of the adequacy of existing nursing services and ratio of nursing personnel to population. 2) Organization and strengthening of nursing units, sections or departments at the national level. 3) Training of nursing leadership in the Region for supervisory and administrative posts. 4) Determination of duties of the nursing personnel at the hospital level. 5) Development of nursing systems.
Table 21
Summary of Recommendations Present to the Nursing Services of PAHO
by the Technical Advisory Committee on Nursing.
Washington, D.C. 10-22 November 1968
(First Meeting)

<table>
<thead>
<tr>
<th>System of Nursing Personnel</th>
<th>Planning, Research and Investigation</th>
<th>Utilization of Nursing Personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encourage the countries to develop three levels/categories of nursing personnel: High</td>
<td>Improve abilities of nurses to participate in planning.</td>
<td>Support principles of nursing participation in planning at all levels.</td>
</tr>
<tr>
<td>Intermediate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High level university programs</td>
<td>Promote leadership and support investigation.</td>
<td>Prepare standards for transfer of medical technical activities to nurses.</td>
</tr>
<tr>
<td>Basic Level auxiliary nursing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Publications and Textbooks</td>
<td>Additional Recommendations</td>
<td>Nursing Advisory Services (PAHO)</td>
</tr>
<tr>
<td>Encourage schools and universities to establish a system to facilitate acquisition of textbooks.</td>
<td>Discuss curriculum of midwives and nurses midwives.</td>
<td>Provide for staff development of nurse advisors.</td>
</tr>
<tr>
<td>Encourage preparation of nursing papers for publication.</td>
<td>Promote assistance for students through fellowships and loans.</td>
<td>Explore means for better utilization of advisory resources and ways to implement the committee recommendations.</td>
</tr>
<tr>
<td>Establish a textbook program.</td>
<td>Promote integration of nursing education in the area of health professions.</td>
<td></td>
</tr>
<tr>
<td>Promote publication by Latin American nurses.</td>
<td>Promote collection of data on nursing for Latin America.</td>
<td></td>
</tr>
<tr>
<td>Increase nursing publications at PAHO.</td>
<td>Promote continuing education for nurses.</td>
<td></td>
</tr>
</tbody>
</table>

Source: Scientific Publication PAHO No. 180.
Education

Education policies were changed. Instead of providing advice on particular subjects of the curriculum by a team of consultants in one school, a nurse educator assisted or collaborated in the preparation of faculty for a given subregion. Budgetary considerations, along with the recognition that in some cases schools could not take advantage of concentrated attention, were factors influencing this change. The new major policies in education were: 1) to consolidate the three levels of nursing education; 2) to reinforce the inclusion of social and health aspects of nursing in the curriculum; 3) to reinforce the postbasic programs; 4) to integrate nursing training with the work of educational institutions; and, 5) to develop minimum standards for nursing education.

Extension of Coverage

In the mid-1970s PAHO and the Latin American governments began to promote extension of services coverage to the total population, emphasizing primary care and community participation. This renewal emphasis on public health under a new concept of health care which included simplified measures for health surveillance. In response to this demand, nursing at PAHO started to recommend strategies for planning and organizing health services at the community level, and to redefine nurses' functions at the primary health care level.
Early in this period projects for nursing services began to collaborate in hospital development and in-service training of personnel. Hospital development included organization, administration and specialized care, such as intensive care units. In-service training focused on the preparation of auxiliary personnel. Recommendations on ratios of nurses to population and ratios of nurses to auxiliary personnel for services were also developed. These ratios were intended to help the national authorities in devising nursing personnel policies. Several studies on the functions of the nursing personnel were also conducted at the hospital level and the general conclusions demonstrated that much of the time of the nursing personnel was spent outside patient care. Based on these results several recommendations were formulated on the need to restructure nursing functions in order to promote more direct involvement in patient care. By 1965 the majority of nurse advisers were involved, to some degree, in hospital activities.

Promotion of national nursing services also continued. In the mid-1960's twenty countries out of twenty-two had a nursing section within the ministry of health. The formulation of general policies and standards in nursing was promoted with a view towards guidance and practice, emphasizing the improvement in the administration of services. Promotion and collaboration in several national surveys on nursing resources were also part of the activities of the Organization.
In most of the countries national surveys were conducted by the national nursing association with the support of international institutions, such as Rockefeller Foundation.

Public health activities focused on extension of services to rural areas. Studies were undertaken to organize service integration and establish policies for a referral system. Maternal and child health and communicable diseases were given emphasis in this type of service development. By the end of the 1960's the concept of community development and extension of coverage emerged culminating with the second Ten-year Health Plan for the Americas approved by the Ministers of Health in Chile in 1972. Thus, PAHO's Nursing Section began to define strategies in order to assist the Region to reach the specific goals set for the nursing field. Redefinition of the nursing role to better fit the requirements of the extension of coverage program, training auxiliary personnel and the definition of standards for hospitals and community services became major concerns.

A number of interregional activities were developed during this period in connection with service oriented projects. In 1965 the first Latin American Seminar on Administration of Nursing Services was held in Paracas, Peru; 10 countries participated. Previously, in 1961, a series of five seminars on the participation of nurses in planning of health services was conducted. And, by the mid-1970s seminars on community health and primary health care were held in Colombia, Costa Rica and Ecuador.
Education

Basic programs. During this period collaboration with countries in basic educational programs for nurses was reoriented. Cooperation was mostly provided in the training of instructors and supervisors rather than in direct involvement in basic educational programs. In 1960 a workshop sponsored by PAHO brought together nurses from 12 Latin American countries and several educational advisers to prepare the first guide for Schools of Nursing in Latin America. This guide contains the major principles for basic nursing education. It considers essential that nurses be in charge of nursing schools and that these should be incorporated with the educational system according with its respective level. Fundamental concepts in education are derived from Ralph Tyler's Basic Principles of Curriculum and Instruction and, basic nursing concepts from ICN recommendations. The major features of Tyler's principles are quite well known. ICN nursing concepts are based on humanistic philosophy and technical abilities. Both set of concepts are positively oriented. This is evident in the five broad concepts recommended for curriculum formulation. They are (PAHO, 1961):

1. Education is a continuous process.

2. The scientific knowledge on which nursing is based is so broad and will be increasing so rapidly that it is quite impossible to have a complete domain of it. However, nursing needs to know some concepts and principles of science.

3. Nursing has a body of knowledge, principles and techniques of its own.
4. Essential elements of science and of nursing need to be organized in interrelated areas to facilitate integration.

5. Nursing education has grown beyond the point of simple acquisition and accumulation of knowledge and facts; nursing students have to be stimulated to learn in terms of aptitudes toward nursing problems and utilize the scientific method to solve them."

The guide also contains instructional principles orienting selection and organization of content as well as learning experiences. The suggested framework includes a nucleus of nursing content integrating physical and social sciences, general education, and communication. In addition, the guide suggests strategies for the control of nursing education at the national and school levels, organization and administration of nursing schools, and financing.

Throughout the foregoing period emphasis was placed on the inclusion of social as well as health aspects of nursing curricula and the preparation of students in the areas of education and supervision.

In 1964 the Organization started a pilot project for interchange of faculty members, in order to meet the specific needs of some schools requiring direct assistance in the implementation of their programs. This initiative was intended to replace the direct assistance given in the past by PAHO advisers. The pilot project was conducted in Costa Rica and consisted of the exchange of faculty members between universities and nursing schools of the United States of America. The American faculty would spend the Summer in Latin America as an STC and the Latin American faculty would spend a year of graduate studies in the North American university or school. The records describe the
institutions on the program; however, it does not provide information on further developments of the program or about its results.

Nevertheless, basic preparation of nurses remained a constant feature of PAHO. The need to increase the numbers and quality of professional nurses was systematically stressed in the majority of the Annual Reports of the Director. There was a growing awareness of the lack of congruence between nursing preparation and specific health needs at the country level. For instance, in the quadrennial report of 1966-1969 it is stated that: "The principal problem faced by the countries of the hemisphere in the nursing field is the lack of a suitable educational system, that is, one adapted to the present needs of health programs, responsive to scientific and social change, and capable of forecasting future personnel needs." (PASB, 1970).

Studies were conducted in the Region regarding the current system of nursing education, definition of levels and review and improvement of curricula. The functions of nurses became the basis for recommendations on curriculum. During the 1970's when the policies on extension of coverage were expressed by the Organization, the Nursing Section gave special emphasis to the preparation of nurses in primary health at the basic educational level for health care activities.

In addition, during this period the Organization sponsored nursing advisory committees for the selection of nursing textbooks. Even though the textbooks were specially aimed at the basic level of educational programs, the recommendations and the scope of the meetings
were of a broader nature. Considering this later aspect, the analyses of these meetings will be addressed in a section under this heading.

Post-basic education. In the area of post-basic education PAHO continued to support the development of national centers for graduate programs. Clinical specialities, in addition to public health, teaching, supervision and administration, were promoted. During the early 1960's the majority of Latin American countries had one or more post-basic programs. Early in the period the emphasis was in teaching and supervision, while in the 1970's this emphasis began to shift to clinical specialization in areas such as maternal and child health, pediatrics, obstetrics, psychiatry, and primary care as well as the expanded role of nursing.

Training of Auxiliary personnel. Although the general policy of this period did not aim directly at the participation in the development of training programs, this educational area may be considered one in which PAHO placed the greatest priority. Most of the activities in this area consisted of the preparation of nurses to become instructors of auxiliary personnel, the production of instructional materials and the definition of the functions of this category of personnel for the formulation of curriculum guides.

Programmed instruction was thought of as a basic strategy for the rapid preparation of auxiliary personnel. In 1964 the Organization started a regional project to develop the program. Educational advisors in this methodology worked in a five-year project in Chile and Peru. This strategy sought to cover the lack of well prepared nurse instructors. PAHO advisors and nurses from 10 different
countries attended a workshop on programmed instruction at Teachers College, Columbia University, and the project started immediately after. Data on results and continuation of this project were not available for evaluation.

According to Meyer (1980), there are over 310,000 practical nurses in Latin America today, and this group of personnel is in charge of approximately 80% of direct patient care in hospitals and at community level programs. In addition, Meyer comments that around 50% of these personnel have received very little training. Although the number of auxiliary personnel has increased throughout the period under review, its rate per 10,000 inhabitants has remained constant. In Table 22 the data presented by Meyer is reproduced to illustrate this point.

<table>
<thead>
<tr>
<th>Region</th>
<th>1964</th>
<th>1968</th>
<th>1972</th>
<th>1976</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Ratio</td>
<td>Number</td>
<td>Ratio</td>
</tr>
<tr>
<td>North America</td>
<td>701,517</td>
<td>34.4</td>
<td>1,132,833</td>
<td>51.5</td>
</tr>
<tr>
<td>Central America</td>
<td>63,749</td>
<td>8.2</td>
<td>72,926</td>
<td>8.6</td>
</tr>
<tr>
<td>South America</td>
<td>113,988</td>
<td>7.2</td>
<td>151,530</td>
<td>9.0</td>
</tr>
</tbody>
</table>


As a consequence of this reality, one of the greatest problems that challenges government authorities and nursing services at PAHO with respect to auxiliary personnel continues to be the provision of adequate training. Adequate training relies basically on the existence
of well prepared instructors and supervisors, which in turn, as pointed out by the literature in the field is the major difficulty in the development of training projects. Macedo et al (1980) in describing the Brazilian experience in the training of auxiliary personnel for primary care, refers to availability and quantity of instructors and supervisors as a major challenge confronted by directors of these programs at the local level.

Therefore, training auxiliary nursing personnel remains a complex problem in Latin America. On the one hand, great differences in the level of basic schooling among the candidates have hindered the development of educational programs and the adequate preparation of instructional materials. On the other hand, the lack of well defined functions, regulated by law, also impede and limit training development.

The Nursing Services of PAHO made continuous efforts to give its technical assistance to the countries aiming at overcoming these problems. During this period over 50 seminars and short-term courses directed at preparing instructors and developing guidelines for training programs were held. (See Table 23 for data and local). In 1964 a guide for Nursing Auxiliary Training was prepared. PAHO also gave assistance to national centers in Argentina, Bolivia, Chile, Guatemala, Panama, Paraguay and Venezuela for preparation of instructors for auxiliary personnel. (During the 1970's, seminars on definition of roles and functions were also organized.) Regardless of all these efforts, Latin America has entered the 1980 decade without having completely resolved this problem: on the contrary, they have
Table 23

Seminars and Short Term Courses Held in Latin America for Preparation of Auxiliary Nursing Personnel 1960-1980

<table>
<thead>
<tr>
<th>Activity</th>
<th>Year</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ninth Seminar on the Training of Auxiliaries for Latin America</td>
<td>1963</td>
<td>México</td>
</tr>
<tr>
<td>Training for Nurse Instructors</td>
<td>1972</td>
<td>Brazil, Ecuador (1), Colombia, Guatemala</td>
</tr>
<tr>
<td>Teachers of Auxiliaries Courses</td>
<td>1973</td>
<td>Brazil (2), El Salvador, Peru, Uruguay</td>
</tr>
<tr>
<td>Program for Auxiliary Training</td>
<td>1974</td>
<td>Dominican Republic, Ecuador, México, Nicaragua</td>
</tr>
<tr>
<td>Training Teachers for Auxiliary Programs</td>
<td>1975</td>
<td>Belize, Bolivia, The Dominican Republic</td>
</tr>
<tr>
<td>Training Rural Auxiliary</td>
<td>1975</td>
<td>Brazil, Colombia, Costa Rica, The Dominican Republic, Paraguay, Peru, Venezuela</td>
</tr>
<tr>
<td>Rural Health Auxiliaries</td>
<td>1976</td>
<td>Peru</td>
</tr>
<tr>
<td>Training of Auxiliaries, Implication for Nursing Education</td>
<td>1976</td>
<td>Brazil, Costa Rica, El Salvador, Guyana</td>
</tr>
<tr>
<td>Teachers of Auxiliaries</td>
<td>1976</td>
<td>Brazil, Costa Rica, El Salvador, Guyana, Honduras, Jamaica, Nicaragua, Paraguay, Venezuela</td>
</tr>
</tbody>
</table>

been aggravated. Not only the proportion of this category of personnel vis-a-vis the population has not improved, but also the attainment of the goal of Health For All By The Year 2000 requires new skills and abilities from them, thus creating an additional demand.

Advisory committee on textbooks. Five advisory committees were held in the period under review as part of the textbook programs.
They covered the following nursing areas: medicine and surgery (1971), maternal and child health (1972), introduction to nursing (1973), teaching of community health nursing (1975) and teaching of nursing in mental health and psychiatry (1976).

With little variation the first three advisory committees followed the same procedure. First, a basic review of the objectives of nursing education and its functions; second, a statement of the conceptual frameworks through which the specific area should be approached. Third, the definition of specific nursing functions and instructional objectives. Fourth, the identification of specific content and general strategies for teaching and evaluation. Finally, recommendations for textbooks and sources of bibliography along with a few general proposals on education in the specific area. With the exception of two books written by Latin American authors cited in the bibliography, all the recommended texts and bibliography of the three first seminars are in English and written by North American authors.

The Committee on Teaching of Community Health Nursing used a different approach. The specific situation of community health nursing in Latin America is analyzed as well as the trends in the delivery of health care in the region and the implications for community health nursing. Within this framework concepts of community nursing and strategy for teaching are derived. The committee specified some criteria for selection of textbooks and recommended an American text.

The last committee on mental health and psychiatric nursing also considered the general characteristics and trends of practice in this area in Latin America and recommended an American text.
In summary, all five committees on textbooks selection emphasized the need to relate education to practice in the context of Latin America. However, paradoxically and rather surprisingly, instead of making a recommendation for the production of textbooks by a Latin American team of authors under the sponsorship of PAHO, translations of American texts were chosen.

**Educational technology.** Based on the recommendations of the 1972 Ten-Year Health Plan for the Americas for establishment of centers to foster the development of educational technology and research in nursing, the Nursing Section in 1974 established an interregional project at CLATES-RIO to create centers of educational technology in selected schools of nursing in Latin America. This program is still operative and has developed centers in nursing schools in different countries. Rodriguez et al. (1979) in reviewing the development of this program distinguished three marked phases:

First, the production of instructional materials centralized at CLATES-RIO. This initial phase, in reality, never became consolidated. Shortly after the development of the first activity which had gathered in Rio, five nurses from different countries in the Region began to produce an auto-instructional unit to be used by all nursing schools in Latin America, showing clearly the limitations of this strategy to help solve the multiple and different problems of nursing education in the various countries. Even though the quality of the instructional material would not have been questioned, this strategy, using already made instructional packages, would have impeded the understanding of the scientific process and methodology to incorporate new knowledge
among nursing professors. The contention was that the nursing professors would not benefit or acquire knowledge about the methodology for the production of auto-instructional materials. Therefore, the possibilities to become independent in terms of preparation of instructional materials to serve their own individual and specific needs could never be achieved.

Second, training of nursing professors at national centers through standardized production of instructional materials. During this phase, five centers were created (Brazil, Chile, Ecuador, Costa Rica and Venezuela). Through a series of workshops in basic instructional methodology, each center started to prepare its own materials. Based on this experience the centers involved were able, at the end of two years, to question the real capacity of the school to produce quality instructional material, and the possible role of the instructional technology in maintaining traditional concepts. Based on this consideration the program was revised.

Third, technical cooperation was made available based on previous diagnoses of educational needs of each individual center and establishment of a program according to these needs. In this phase the program lost its characteristics of a vertical program to be molded to local needs and available resources. Under this new concept five more centers were created (Mexico, Brazil (2), Cali and Bogota). Each original center has also developed a network of subcenters incorporating nursing schools in their area of influence. All the subcenters, with the exception of Costa Rica that has incorporated schools from
other countries of Central America, are within the same country or state of the national or state center.

Until 1969, this program prepared 1250 nurses in several aspects of educational technology and a total of 275 instructional materials were produced.

Research

Development of nursing research in Latin America through PAHO's projects did not start until the late 1960s. Projects at first were limited to country level, and advisory services were developed by short-term consultants. At the present time there is no specialist in nursing research on the PAHO staff.

In 1972 the Nursing Section also started for the first time an interregional program in nursing research. The program is being conducted in selected schools in the Region, and provide specific training on the fundamentals of scientific methodology as well as giving a small grant to each school. As a result, a small nucleus of nurses have started to produce a reasonable amount of research, of which the most interesting ones are those investigating the development of nursing in Latin America.

Besides individual projects the research project aimed at the development of nucleus for research development whose focus should be as it is noted by Manfredi (1982):

1. Organization of Research units, that is, the establishment of these units within institutions at the national or regional level.
2. Training of researchers: plans were developed for programs of continuing education at the national and local levels to train nurses as well as the development of a small group of researchers in post graduate programs.

3. Comparative research for the development of nursing: the possibility of conducting comparative research in the field of nursing by the different research nucleous was also considered.

Manfredi (1982) in addressing one of the nuclei of nursing research in Honduras pointed out the need for development of nursing research in the area of nursing practice and its interrelationships with educational process. Research in nursing practice and its implications for the improvement of health conditions of population should be viewed as a very important area for PAHO's action in the future. The results of this kind of research could provide an in depth understanding of the future role of nursing in Latin America health care.

Summary

The description of major programs and nursing activities in PAHO during the period under review are evidence of operationalization of the conceptual framework ingrained in the general policies. Each one of the projects can be linked to PAHO internal discourse and Latin American development.

The Nursing Program engaged in new experiences in education as well as in service. The most important aspect of these experiences has been the acknowledgement of Latin America social reality and the process of accumulation of knowledge about nursing within this reality.
Budget

During the period under discussion a decrease in the nursing budget can be observed. This decrease is not only in relative but also in absolute terms. Throughout the first nine years (1960-1968) nursing maintained an average relative proportion of 3.3% of the total budget which was the same as in the previously reviewed period. Subsequently this proportion decreased to 2% until 1978 when it dropped to 1%. In the three last years of the period the absolute amount also decreased.

The discrimination of expenditure for nursing reflected a shift in policies. While the relative amount expended in education steadily decreased, service experienced a general increase. The expenditure for services including zone or area offices operation and midwifery surpasses education for the first time in 1967, and by the end of the period amounted to 76% of the total nursing budget. This delayed shift in budgeting relationship may have two alternative explanations. First, changes in policies, in general, do not appear markedly in budget in an organization of complex administrative procedure, such as PAHO, until specific reorganization of administrative policies are in effect. Administrative policies, in turn, are subsequent and sometimes delayed in relation to substantive policies. Second, previous dominant policies may continue to influence expenditure at the expense of the organized structure to promote activities and allotment of funds at a long range. The case here might have been a combination of both.

Table 24 shows the budget lines and amount allocated to the Nursing Section. It should be noted that four areas are clearly
identified: education, services, zones services and midwifery.

Table 24

Total PAHO Budget and Allocated Budget for the Nursing Section, 1960-1979

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PAHO Total</td>
<td>10,025,807</td>
<td>11,164,949</td>
<td>13,719,596</td>
<td>15,788,991</td>
<td>16,422,096</td>
</tr>
<tr>
<td>Nursing Total</td>
<td>300,243</td>
<td>322,480</td>
<td>637,086</td>
<td>446,862</td>
<td>508,102</td>
</tr>
<tr>
<td>Percentage</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Education</td>
<td>283,178</td>
<td>299,605</td>
<td>445,963</td>
<td>253,684</td>
<td>289,060</td>
</tr>
<tr>
<td>Service</td>
<td>17,565</td>
<td>14,013</td>
<td>29,377</td>
<td>29,377</td>
<td>89,398</td>
</tr>
<tr>
<td>Zones/Service</td>
<td>12,497</td>
<td>120,697</td>
<td>104,904</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwifery</td>
<td>34,302</td>
<td>17,296</td>
<td>24,350</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PAHO Total</td>
<td>19,886,278</td>
<td>20,010,506</td>
<td>21,908,971</td>
<td>23,493,747</td>
<td>24,785,930</td>
</tr>
<tr>
<td>Nursing Total</td>
<td>325,273</td>
<td>758,478</td>
<td>574,062</td>
<td>602,350</td>
<td>559,997</td>
</tr>
<tr>
<td>Percentage</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Education</td>
<td>396,033</td>
<td>650,757</td>
<td>262,992</td>
<td>257,317</td>
<td>247,057</td>
</tr>
<tr>
<td>Service</td>
<td>55,820</td>
<td>147,111</td>
<td>139,866</td>
<td>179,780</td>
<td>96,344</td>
</tr>
<tr>
<td>Zones/Service</td>
<td>156,084</td>
<td>124,206</td>
<td>127,788</td>
<td>111,245</td>
<td>127,424</td>
</tr>
<tr>
<td>Midwifery</td>
<td>34,202</td>
<td>23,424</td>
<td>24,066</td>
<td>24,066</td>
<td>24,066</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PAHO Total</td>
<td>27,963,634</td>
<td>32,499,344</td>
<td>37,467,239</td>
<td>40,272,426</td>
<td>47,416,458</td>
</tr>
<tr>
<td>Nursing Total</td>
<td>351,135</td>
<td>499,889</td>
<td>816,267</td>
<td>964,913</td>
<td>829,506</td>
</tr>
<tr>
<td>Percentage</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Education</td>
<td>209,070</td>
<td>211,597</td>
<td>333,098</td>
<td>348,456</td>
<td>350,606</td>
</tr>
<tr>
<td>Service</td>
<td>124,688</td>
<td>67,350</td>
<td>297,674</td>
<td>320,222</td>
<td>323,178</td>
</tr>
<tr>
<td>Zones/Service</td>
<td>159,057</td>
<td>160,242</td>
<td>201,063</td>
<td>179,373</td>
<td>177,722</td>
</tr>
<tr>
<td>Midwifery</td>
<td>67,400</td>
<td>60,790</td>
<td>74,812</td>
<td>98,902</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PAHO Total</td>
<td>55,600,379</td>
<td>61,809,046</td>
<td>65,976,471</td>
<td>71,902,393</td>
<td>77,098,879</td>
</tr>
<tr>
<td>Nursing Total</td>
<td>1,233,002</td>
<td>1,163,062</td>
<td>1,201,269</td>
<td>1,217,676</td>
<td>1,258,124</td>
</tr>
<tr>
<td>Percentage</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Education</td>
<td>269,623</td>
<td>269,243</td>
<td>357,785</td>
<td>309,196</td>
<td>346,029</td>
</tr>
<tr>
<td>Service</td>
<td>652,731</td>
<td>651,163</td>
<td>653,490</td>
<td>399,196</td>
<td>164,029</td>
</tr>
<tr>
<td>Zones/Service</td>
<td>242,405</td>
<td>208,656</td>
<td>273,124</td>
<td>288,380</td>
<td>256,377</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PAHO Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zones/Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwifery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: PAHO's Annual Budget Proposal.

The most significant aspect observed in the nursing budget is the already mentioned relative and absolute trend of decrease in nursing allocations. The absolute decrease of the three last years represented a total decrease of 57% in relation to the previous year 1977, this without accounting for the inflationary rate at this time which would have make this figure much decreased. This decrease in budget denotes an overall decline in nursing activities in the Organization.
Personnel

In 1958 PAHO started to compile a monthly list of authorized posts. Retrieving the information for one month of each year (December), it was possible to have an overview of the personnel situation during this period. This overview should be considered an approximation of reality since vacancies and appointment of personnel may have varied within a year. At the end of the preceding period, the Nursing Section had already achieved its highest number of posts. In Figure 9 it is possible to observe that during the foregoing period this number steadily decreased returning in 1980 to figures of the early 1950s.

The data allow for three types of analysis. The composition of the staff by country of origin, the distribution by country in the Region and the allocation of posts to programs.

Forty-six percent was the average number of nurses from Latin America throughout the period, the range being 53% (1979) - 34% (1967). This group included nurses from almost all the countries from Latin America; however, the number of nursing staff from Brazil, Chile and Colombia was greater. The United States of America had an average of 44% with a range from 53% (1967) to 35% (1980). The remaining 10% was represented by nurses from Canada and other European countries, mostly United Kingdom. Although the ratio between Latin American and North American nurses shows a relative balance, if individual countries are considered, North American nurses represented an overwhelming majority. It is also important to note that most of the staff had
some kind of post-basic nursing training, and the majority of Latin Americans had had some formal training in the United States of America.

In regard to regional distribution all the countries in the Region had at one time a nurse advisor. However, the number of nurses in each country varied throughout the period. In general, in countries which were headquarters for Areas or Zones, there was a greater number of nurses. The number of nurses in a country ranged from 8 (Argentina 1960 and 1961) to 1. In some countries the number of nurses did not vary substantially, while others show an increasing or decreasing trend, and yet others discontinued it. Argentina, Brazil, Guatemala, Mexico and Peru served as headquarters to Zone or Area offices where at least one nursing post was maintained throughout the period. Chile,
Colombia, Cuba, El Salvador, Panama, and Paraguay discontinued permanent posts by the end of the 1960's. This may be associated with the internal conditions of each country in relation to nursing development as well as to the whole social structure, for instance, Cuba. In addition, the headquarters in Washington, D.C., maintained an average of three nurses. (Table 25 presents this information).

Data for the distribution of nurses in the specific projects were not available for each year of the period. There is information for the years 1960, 1966-1970 and 1971-1975. The available data shown in Fig. 10 reveal a marked dominance of health services projects over all the others. In 1960 education and service were split in almost half. By the mid 1960's, while services maintained over half of the staff, the other half was divided first between education and general nursing, (posts occupied by nurses at area or country level) and second, at the beginning of the 1970 among education, general nursing, systems and planning.

It is also important to mention that the decrease in number of long term post was accompanied by an increase in number of short term consultants (STC). Unfortunately, we were not able to compile all the existing information on short-term appointment. Until 1960 the Nursing Service did not use this kind of appointments, it began around 1964. The data compiled for the year 1966-1975 shown on Table 26 reveal a steady increase in the utilization of STC in all areas.

Classification of nursing personnel is another aspect to be examined. Freeman (1965) observed that the classification of nurses at WHO was inconsistent with the description of works and the
Table 25
Distribution of Nurse advisors by Latin American Countries
1950 - 1980

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Washington Headquarters</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>2. Argentina</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>3. Bolivia</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4. Brazil</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>5. Caribbean</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>6. Chile</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>7. Colombia</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

* No information was available for the 1959.

1. Washington Headquarters
2. Argentina
3. Bolivia
4. Brazil
5. Caribbean
6. Chile
7. Colombia
8. Costa Rica
9. Cuba
11. El Salvador
12. Ecuador
13. Guatemala
14. Haiti
15. Honduras
16. Mexico
17. Nicaragua
18. Panama
19. Paraguay
20. Peru
21. Uruguay
22. Venezuela
23. Frontera Mexico USA

Qualifications required in the job description, even though she pointed out that in general, personnel policies were reasonable.
By and large the nursing personnel throughout the Region, including the United States and Canada, is considerably underpaid if compared with other occupations requiring equal or even less years of academic and practical training. It is well known that teachers and librarians, in general those occupations traditionally performed by women, are paid less than those generally perceived as "male" occupations.

This inequity in remuneration is not the result of the "free market theory" or the "laws of supply and demand" -- the increasing demand for nurses bears no relationship to the low salaries being
Table 26

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Systems Nursing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>2</td>
<td>5</td>
<td>18</td>
<td>2</td>
<td>1</td>
<td>9</td>
<td>9</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Hospital</td>
<td>16</td>
<td>21</td>
<td>1</td>
<td>8</td>
<td>13</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Rural Areas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Maternal Child</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>8</td>
<td>10</td>
<td>9</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All levels</td>
<td>10</td>
<td>10</td>
<td>14</td>
<td>15</td>
<td>4</td>
<td>4</td>
<td>19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td>13</td>
<td>5</td>
<td>29</td>
<td>41</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Auxiliary</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Technology</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research</td>
<td>1</td>
<td>8</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>33</td>
<td>52</td>
<td>35</td>
<td>35</td>
<td>46</td>
<td>42</td>
<td>64</td>
<td>89</td>
<td>48</td>
</tr>
</tbody>
</table>

offered in private, semi-private and public institutions. The Organization is no exception in this regard.

PAHO, like most civil service employers, uses a post or job classification and grading system. The scale for the professional category goes from P.1 to P.6. To illustrate the inequity previously pointed out, it will suffice to compare the education and experience requirements for a P.3 nurse post and a P.3 sanitary engineer post as they appear in the PAHO/WHO Administrative Manual. Given the dependant characteristics of the nursing profession to the medical profession, medical officers posts were purposely not selected for comparison.
P.3 Nurse Post

"Education and experience

In addition to the basic requirement of a master's degree or its equivalent, at least five years of appropriate administrative and/or educational experience is desirable. Nurse education must meet the academic requirements of the institution to which they are assigned." (WHO/PASB, 15 February 1971).

P.3 Sanitary Engineer Post

"Education and experience

P-3 sanitary engineer posts require a degree in a field of engineering, in a university of recognized standing and, in addition, a training in sanitary engineering at the postgraduate level. At least two years of progressive experience in operational or research work is required. This experience must have been in a sanitary engineering field that is related to the WHO assignment." (WHO/PASB, 20 December 1971).

Further, it is important to note the total number of nursing posts in the Organization today, their grade distribution and income levels as compared to the sanitary engineering posts. Table 27 shows that of 25 occupied nursing posts 68% are P.4 and of 46 engineering posts 57% are in the same grade level; 28% of the occupied nursing posts are P.3, and 0% are in the same grade level for engineering; 4% occupied nursing post are classified at the P.5 level, and 42% engineering posts are in the same grade level.
Table 27

Comparative Distribution of Grade and Salary for Nurses and Engineers. 1981

<table>
<thead>
<tr>
<th>Grade and Salary Range</th>
<th>Nurses</th>
<th>Percentage</th>
<th>Engineer</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>25</td>
<td>100</td>
<td>46</td>
<td>100</td>
</tr>
<tr>
<td>P.3 21,600/28,271</td>
<td>7</td>
<td>28</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>P.4 25,672/32,349</td>
<td>17</td>
<td>68</td>
<td>26</td>
<td>57</td>
</tr>
<tr>
<td>P.5 30,776/36,252</td>
<td>1</td>
<td>4</td>
<td>19</td>
<td>42</td>
</tr>
<tr>
<td>P.6 33,998/38,522</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>D.1 33,998/38,522</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

* Salaries in US dollars, based on net without dependants.
Source: PASB/WHO Staff Rules and Personnel Statistics.

Evidently, this information leads to the conclusion that there has been no change in the situation since Freeman's observations of 1965.

Publications

During this period nursing publications, which was up to this time mostly concentrated in the "Boletin", started to appear in other sources. Most articles and information were divided between the "Boletín" and Medical Education and Health which started to be published in 1966. The scientific publications dedicated 26 issues on nursing matters and a series of nursing reports started to be published
in 1961, with a total of 21 of these reports. This diversification resulted in a considerable decrease of nursing subjects in the "Boletín". While in general there was a decrease in absolute terms, it is difficult to establish a definite trend from such a decrease. This difficulty arises from the fact that the types of publications are not comparable, as was the case in the previous period reviewed.

Perhaps this decline reflects an increase in specialized nursing literature published in the countries even though this does not justify the decrease of PAHO's interest as compared with previous periods, to promote Inter-American communications. Most probably this decline may be tied to internal factors of the Organization, such as selection criteria for publications and/or the lack of effective interoffice communications between nursing and publication sections.

The "Boletín" published 165 subjects on nursing, which are summarized in Figure 11. Forty five percent of them were notes, 27% articles, 23% PAHO news on nursing and 5% bibliography. The majority of the notes, in contrast to the previous period which reported about nursing development in Latin America, only informed about future events, such as seminars, ICN conferences and events. Quite frequently these notes were repeated over a period of time. The number of articles declined sharply as compared to the previous period, from a record of 112 articles to only 44. Figure 12 shows the proportion of specialized subjects: nursing education represented the highest area with 23% of the total, followed by general issues on nursing with 20% and public health with 18%. The remaining was spread among maternal and
child health (4%), psychiatry (7%), auxiliary personnel (5%), country situation (9%), and nursing administration (7%).

Considering the origin of the authors of articles by professional groups, there were 16 written by Latin American nurses, 11 by North Americans, 14 by PAHO staff, one from a Canadian nurse, and two by physicians. These data are summarized in Figure 13. Latin American countries that contributed were Colombia (2), Perú (1), Brazil (4), Costa Rica (1), Nicaragua (3), Mexico (3) and Chile (2).

The Medical Education and Health published 56 subjects on nursing between 1967-1980. Sixty four percent were articles, 30 percent were PAHO notes and news and 6 percent were comments. The majority of the articles dealt with the role of nursing in national planning, curriculum development and community health.
FIGURE 12. BOLETIN OPSANPAI ARTICLES PUBLISHED ON NURSING CLASSIFIED BY SUBJECTS (1980-1989)

LEGEND

- Nursing General
- Public Health
- Nursing Education
- MEH
- Psychiatry
- Auxiliary Personnel
- Country Situation
- Nursing Administration

FIGURE 13. BOLETIN OPSANPAI ARTICLES PUBLISHED BY LATIN AMERICAN NURSES BY SUB-REGION OF ORIGIN (1980-1989)

LEGEND

- Anglo
- Brazil
- Central America
- Mexico
- Southern Cone
The scientific publication and nursing reports may be more representative of the dominant trends of this period than the others' publications. The majority of the scientific publications dealt with education, giving emphasis to curriculum structure in response to the new demands of services and to the integration of community health. (Appendix B list of Scientific Publications on Nursing and Nursing Reports).

**Fellowships**

During this period a total of 1771 fellowships were awarded to nurses from the Region. Sixty percent of all fellowships awarded were short-term in duration (less than 6 months). Figure 14 shows the distribution according to duration for each Region. In all the Regions short-term fellowships have the highest proportion, followed by academic fellowships of one year, six months and twenty-four months. The range of fellowships awarded is 136 (Chile), 39 (Cuba and Paraguay), and the mean is 89. In Figure 15 the percentual distribution of fellowships awarded to each country is shown. In general, it can be stated that countries, with small variations, have had the same opportunity to receive nursing fellowships.

In order to establish a comparison with the preceding period the distribution of fellowships according to field of study presented in Figure 16 follows the same categorization. It is possible to see that the percentile distribution for the three first categories,
(nursing services, nursing education and teaching, public health nursing) have decreased, while the fourth category (other) increased substantially as compared with the preceding period. (Observe Figure 7 on page 171). The first three categories not only decreased but in proportion public health nursing, which was the second in the preceding period, became third. In the category of "others", new fields of study such as public health planning, family health and rural health appears together with the fields of maternal and child health, psychiatry, surgery, etc which had appeared in the preceding period. Certainly this shift in field of study mostly observed in the 1970s reflects the overall tendency of this period.

Latin America was the major place of study. Seventy-eight percent of all fellows undertook their study in Latin America countries. This was true for all types of fellowships; whether of short or long term duration as well as for all the areas of study. Studies in the United States were only of considerable proportions for Brazilians, and in Puerto Rico for Central American countries. Canada and other countries had a very small proportion of fellowships. This information is presented on Figure 17.

In general, the number of fellowships increased and the opportunities have been used equally by most of the countries in the Region. The trend during this period has been one of short term programs in Latin American countries as compared with academic programs.
FIGURE 16. NURSING FELLOWSHIPS ACCORDING TO FIELD OF STUDY (1960-1980)

FIGURE 17. NURSING FELLOWSHIPS ACCORDING TO PLACE OF STUDY (1960-1980)
Summary

During the period under review (1960-1980), the Organization underwent a series of changes in its conceptual framework which oriented the formulation of policies, recommendations and activities. The changes observed were linked to specific conditions of Latin American socioeconomic development in the decades of the period. The first phase was characterized by an economic growth which in turn, promoted health sector policies for integration of medical care and development of services for extension of health care coverage. The second phase was, characterized by a general socioeconomic crisis which in the health sector resulted in a public demand for health care and scarcity of public funds to satisfy it. This situation promoted the endorsement of new strategies of simplified and less costly health care.

Nursing activities appear to have adopted to and followed the aforementioned changes. A general trend of decrease in the amount of nursing services at PAHO was also observed. This decrease poses an important question which is difficult to answer due to the multiplicity of factors influencing this phenomenon. The question is: Why is it that during the second decade of this period a rapid decrease in nursing resources is observed, at a time when the primary health care approach is being promoted as a central strategy to achieve the goal of Health for All in the Year 2000?

This observation is somewhat puzzling and paradoxical given the fact that nursing has claimed a major role in this area. One can
recognize and accept that budgetary constraints—due to inflationary conditions—limited, and in some cases stopped the growth of some general programs. However, it is difficult to accept that budgetary constraints are exclusively responsible for the decrease in nursing resources. They were always a rather small percentage of the total budget. Thus, in searching for an answer, one must go deeper into issues of a more substantive nature. In this respect, it is submitted that the profession is considered slow in accepting changes and not sufficiently flexible to develop the multidisciplinary and open approaches required to meet new demands in the production of health personnel; and that the major role in primary health care claimed made by the nursing profession is a belief not shared by the Member Governments, individually or collectively.
Footnotes from Chapter 4

1 The "Boletín de la Oficina Sanitaria Panamericana" is a monthly official publication of PAHO established in 1923. Its main purpose has been the publication of current events in the field of sanitary and public health in the world and more specifically in Latin America. Its circulation is very wide 13,200 copies are distributed among libraries and health services member countries, besides other countries of Europe, Asia and Africa.

2 Ana Nery was a dedicated Brazilian women that went to the Triple Alliance War against Paraguay and served as a "nurse".

3 The countries represented at the first Pan American Congress of Nursing in Chile (1942) were: Argentina, Bolivia, Brazil, Colombia, Chile, United States, Peru, Paraguay, Panama, Puerto Rico, Venezuela, Uruguay.

4 An Abstract for Action is the report of the national Commission on Nursing and Nursing Education. It is based on a 2 1/2-year study of the nursing situation in North America between 1968-1970. The investigation was supported by the W. K. Kellogg Foundation, The Avalon Foundation and a private individual. For additional information see: Geronne P. Lysaught, An Abstract for Action. National Commission for the Study of Nursing and Nursing Education. MacGrow-Hill Book Company, New York, 1970.

5 International Council of Nurses is a non profit organization founded in 1899 which congregates national associations of the majority of the countries in an international federation. Its purposes are:

- To provide a means of communication between nurses of all nations, and to afford facilities for interchange of international hospitality.

- To provide opportunities for nurses from all parts of the world, to meet together and confer about questions relating to the welfare of their patients and their profession.

6 Act of Bogotá is a document which summarized the deliberations of the Third Meeting of the Special Committee to study the formulation of new measures for economic cooperation, known as the Committee of 21, of the Organization of the American States.

7 The Charter of Punta del Este established the objectives of the Alliance for Progress. It is a document from the Special Meeting of the Inter-American Economic and Social Council at the ministerial level held in Punta del Este, Uruguay in 1961. It also includes objectives for health programs. For details see OAS Official Records, OEA/SER H1/: II.1, 1961.

8 The Declaration of Alma-Ata was promulgated during the International Conference on Primary Health Care held in Alma-Ata, USSR (6-12 September 1978). The Conference was sponsored by the WHO and UNICEF. The Declaration reads:

"The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need of urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people particularly between developed and developing countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III.

Economic and social development, based on a New International Economic Order, if of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and
protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

Primary health care:

1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

2. addresses the main health problems in the community, providing promotive, preventive, curative
and rehabilitative services accordingly;

3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; and adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; promotion of mental health; and provision of essential drugs;

4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

6. should be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be
necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

* * *

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, nongovernmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration." (WHO Alma-Ata 1978. "International Conference on Primary Health Care. Geneva: ICPHC/ALA/78.11).
Chapter 5

IMPACT OF PAHO ON CURRICULUM'S INNOVATIONS OF LATIN SELECTED
LATIN AMERICAN NURSING SCHOOLS

The development of nursing education in Latin America and PAHO's
nursing service were analyzed in Chapter Three and Four respectively.
The internal aspects of Latin American social formation were shown to
be the major determinant of nursing educational development in the
majority of the countries of Latin America. Not only the initial
organization of nursing education but also the observed changes and
development were tied to different periods of Latin American socio-
economic history.

The internal policies of PAHO reflecting the dominant interna-
tional interest were also shown to be a major determinant of PAHO's
nursing policies. Nursing services were established under the
influence of the North American public health movement of the early
twentieth century. The expansion and the broadening of scope of
activities followed the changes in PAHO's policies, which in turn
reflected changes in Latin America social formation as well as the
dominant political and economic international interests. In both,
nursing development in Latin America and PAHO's nursing service, the analysis suggests the continuing presence of international professional nursing development which has to a certain extent shaped the professional characteristics of nursing education and practice in the Region and at PAHO.

This chapter is an attempt to relate nursing educational policies of PAHO's Nursing Service to the nursing educational process in Latin America.

An exploratory study was chosen because of the lack of previous studies in the area, indicating concrete mechanisms through which PAHO exercised its influence and also because of the lack of well developed methodological instruments in this field. Furthermore, the constraints of time of the researcher could not allow for the utilization of a longer and representative number of observations. Consequently, the results of this study are expected to raise questions which could apply to the universe of nursing schools in the region, pointing out directions for further research in the area. In addition, the methodological strategy of analysis can be tested allowing for the refinement of the measures and indices utilized thus facilitating further analysis in this area.

The basic thesis of the present dissertation is that the adoption of PAHO's policies by the schools, is dependent on the degree of congruence between PAHO and each country's health policies. Furthermore, it is assumed that adoption of policies results in actions that bring forth observed changes. In the present case, these changes are
to be observed within the context of the nursing curriculum of Latin American schools.

QUESTIONS AND DEFINITIONS

To answer the question of PAHO's impact in Latin American Nursing Education, the present study assumed that PAHO's influence should be related to contacts or exposure of the schools to direct PAHO's assistance. Even though we are aware of probability of indirect influence, theoretical as well as methodological, limitations would cause great constraints and problems for the development of this exploratory study. Therefore, the guiding question or hypothesis of this exploratory study was formulated as: schools which have had direct linkage with PAHO have introduced PAHO's recommended curricular innovations.

The following considerations were made in selecting PAHO's recommendations on curriculum, to define the dependent variables for this study:

In the analysis reported for the development of PAHO's nursing service in Chapter Four, four major recommendations for nursing education in Latin America are notable for each one of the periods examined. (1) the recommendation for introduction of public health content into nursing curriculum, formulated in the 1950's. (2) the recommendations for upgrading the level of nursing education through the introduction of nursing specialization in the curriculum, and the upgrading of the level of nursing professors though graduate education promoted in the
1960's; (3) the recommendations for the development of skills and abilities to expand the role of nurses to accomplish the goals of extension of coverage and primary health care which started to be promoted by the end of the 1960's and the beginning of the 1970's; and, (4) the recommendations for introduction of educational technology in the teaching methodology of the schools promoted in the 1970's.

Introduction of public health nursing in the nursing curriculum had been a major recommendation since the creation of PAHO's nursing service. Although, the North American Public Health movement had triggered the development of nursing education in Latin America as discussed in Chapter Three, the teaching and practice of public health was almost nonexistent in curriculum of nursing schools at the time PAHO started its nursing service. Chagas (1952) has perceived a discrepancy between this inspiring movement for creation of schools and inclusion of this field in the curriculum. In the report of the first survey of nursing schools in Latin America she noted:

"...nursing education in these countries focus their training in hospital care, especially for staffing operating rooms... Of the 52 schools surveyed, 28 or half of the total, located in 12 countries, fit within this category. In addition, in several schools, hospital administrators were not permitting public health courses, arguing that students would be out of the hospital and they would consequently not be able to provide the necessary help." (Chagas, 1952)

This situation is even better illustrated by the School of Brazil, founded in 1923, which was created for the purpose of providing public health training, although dedicated most of its instructional time to hospital care activities (Dourado, 1942).
The guide for the schools of nursing in Latin America published by PAHO in 1961 stresses the role of educational objectives as a guideline tool in helping students develop concepts, abilities and attitudes compatible with the professional, individual and citizen roles. It recommended the development of two groups of objectives; the first aimed at giving guidance to the development of professional concepts, abilities and attitudes, and the second addressed the development of students as individuals and citizens at the same levels mentioned above.

Three main areas are included in the objectives related to professional development: service, including direct nursing care of patients; families and communities; administration of nursing care, education, including aspects of health education for the public and training of nursing personnel; and research.

For the second group of objectives four major areas are included: ethics, philosophy, psychology and sociology.

The guidelines for development of objectives for nursing education constitute an area of inquiry of PAHO's influence. As a first approach, the present study intends to analyze objectives of the schools in the area of professional development. It is assumed that PAHO recommendations have influenced not only the statement of nursing objectives but also their rank order.

Nursing specialization as stated above was also an early field of PAHO's nursing service concern. Since the Third Regional Congress; recommendations for specialization and graduate education, this area became a priority for assistance of PAHO to the schools. Throughout
In the years several centers for graduate education were created and assisted by PAHO. First, the emphasis was on specialization in education, nursing administration and public health nursing. Second, emphasis was placed on specialization of clinical areas such as maternal and child health, surgery, medicine, psychiatric nursing and mental health. Third, community health and development of competencies in primary care were the focus of attention. The promotion of specialization and graduate programs was also related to the recommendations for upgrading the educational level of nursing professors.

This evidence brings forth another area of investigation of PAHO's influence. On the one hand, our knowledge of nursing development in the region indicates that the educational system was not sufficiently developed at the time these recommendations were formulated, to establish specialized and graduate programs. On the other hand, PAHO's direct assistance to schools may be viewed as a key variable for the adoption these recommendations, given the conditions mentioned.

The recommendations for the development of skills and abilities for expansion of nursing role have been stressed by PAHO in several ways since the early 1960's. First it was associated with the need for extension of coverage and later with the programs for primary health care. For instance, the first Technical Advisory Committee (1969) included guidelines to be used by the countries in the development of standards for the transfer of medical-technical activities to nurses; the Expert Committee in Teaching of Maternal and Child Health (1973) includes specific functions for the promotion and protection of mothers and children which rely on the ability to perform physical
examination, evaluation and control of pregnant women and children; in addition, the textbook program has translated a manual on *Physical Appraisal Methods in Nursing Practice* (1975). Those are only a few examples of the efforts of PAHO to promote the expansion of nursing role through specific activities within the schools.

In 1973 PAHO's nursing section launched a regional project aimed to disseminating the new developments in the area of educational technology. For Rodriguez (1979) the initial premise of this project was the increase of number of nursing students without the correspondent increase in number of nursing professors. Even though, the initial premise of the project, as discussed in Chapter Four, has been changed, its activities have been directed towards the introduction of individualized instruction, modular instruction, and use of simulations in education.

Therefore, to answer the question of PAHO's influence on Latin America nursing education the identification of its major recommendations discussed above, were considered in the definition of the dependent variable to establish the relationship between PAHO and nursing education in Latin America. Consequently, the present study is concentrated on the relationship between PAHO's four major policies on nursing education and changes in the curriculum of selected nursing schools.
METHODOLOGICAL CONSIDERATIONS

The aim of this section is to further detail the methodology used for the development of the exploratory study on the impact of PAHO's policies in nursing education in Latin America as outlined in the introduction of this dissertation.

Variable and Measures

Measures of PAHO's Impact in Nursing Education in Latin America

Consistent with the promises of PAHO's impact discussed above, its measure consisted in the dichotomization of the sample into two groups on the basis of linkage or lack of linkage with PAHO.

Measures of Curricular Innovation or Substantive Changes in the Content, Methodology and Administration of the Curriculum

Based on the knowledge of the major policies and recommendations of PAHO's nursing section since its initial organization, six indicators were selected:

1. Time of introduction of public health content and practice in the curriculum.
2. Period of introduction and kind of nursing specialization introduced in 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 needed to accomplish the goals of extension of coverage and primary health care; and,

6. Number of schools utilizing educational technology.

**Instrument**

A combination of multiple choice and open ended questions were used in the questionnaire. The questionnaire is divided into seven major sections with a total of 39 questions. The seven sections divided the questionnaire into the following areas: a) curriculum, including eleven questions on the structure and content of the present curriculum and the innovations introduced throughout the years; b) goals of the school, including three questions related to the objectives of nursing education as conceived and prioritized by the school; c) professors, including six questions on the number, academic qualifications and contract of teachers; d) students, including three questions on the number of students graduated by the school, requirement for admission and the present number of students enrolled in the program; e) administration, including five questions on the structure and administrative organization of the school; f) PAHO's assistance, including three questions on the nature, years and main objectives of assistance received from PAHO by the school; and, g) textbooks, including eight questions on the utilization, administration and evaluation
of PAHO's Textbook Program. The questionnaire was designed to be auto-administrated and the instructions are inserted in its main body; an additional sheet of instruction which contains additional guidelines as well as definitions of concepts and terms is also included. The questionnaires were published in Spanish and Portuguese. (Appendix D. Questionnaire)

Prior to application, the questionnaire was revised by a group of professionals of the Division of Human Resources, including all nurses at PAHO headquarters; and also the adviser of this dissertation. However, a pretest was not conducted.

The questionnaires were mailed to 362 (85.6%) of the nursing schools existent in Latin America. In the countries where there is PAHO's nurse staff, their assistance was made available to the schools, in case there were any problem in handling it.

There was no devised mechanism to establish the reliability of the information. The establishment of such a mechanism would be very difficult in the present circumstances because it would have to rely on field visits and they were untenable given the time and budgetary constraints of this study. To overcome this problem, the information was whenever possible checked with existing data in PAHO and no expressive differences were found.

Statistical Treatment of the Data

The statistical analysis of the data for this exploratory study was limited to the use of less efficient statistics: means, deviation
and proportions. The utilization of more efficient statistical analysis was not feasible because of the small number of schools included in the study.

RESULTS

General Characteristics of the Schools Included in the Study

The study included the first 45 questionnaires which arrived at the Division of Human Resources by the first week of September, 1982. The schools represented are from 13 countries of Latin America: Argentina (8), Bolivia (3), Brasil (5), chile (6), Colombia (8), Costa Rica (1), Dominican Republic (1), Ecuador (1), Guatemala (2), Honduras (1), Mexico (5), Paraguay (1), and Peru (2).

Twenty-nine (64.40%) of the schools offer a four-year program, while the remaining 16 (35.60%) offers a three-year program. The majority of the schools 77.80% have a formal linkage with universities and 98% requires secondary education as an entrance requirement in addition to entrance examinations. Among the 35 programs linked to Universities, 15 (42.90%) are under the administration of Medical Schools or Faculty of Medicine, 13 (37.10%) are independent units within the university, and, 6 (17.00%) are departments of schools of Health Science or Biological Sciences.

The number of nursing professors in the 45 schools is 682, 420 (61.60%) are working on a full time contract (40 hours); 144 (21.10%) on a part-time (20 hours); 27 (4.00%) on a contract with less than 20
hour/week; and 91 (13.30%) are working on hours/week contract.

The number of students enrolled in the 45 schools is shown on table 28. According to the most recent data available at PAHO there are a total of 95,751 students enrolled in nursing programs in Latin America. The proportion of students is equivalent to the proportion of schools. That is, the study includes 10.60% of the schools of Latin America and 9% of the students. This data shows the degree of confiability of the information.

Table 28
Number of Students Enrolled in the Schools Included in the Study by Academic Year and Sex.

<table>
<thead>
<tr>
<th>Academic year</th>
<th>Number of students</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>Total</td>
<td>8600</td>
</tr>
<tr>
<td>1st year</td>
<td>3075</td>
</tr>
<tr>
<td>2nd year</td>
<td>2266</td>
</tr>
<tr>
<td>3rd year</td>
<td>2045</td>
</tr>
<tr>
<td>4th year</td>
<td>1214</td>
</tr>
</tbody>
</table>

F= Female  M= Male

Linkage with PAHO

The distribution of the 45 schools with respect to linkage with PAHO reveals that 22 (48.90%) of them have had one or more formal agreements and/or individual consultation. Table 29 shows this distribution.

The schools which have had vinculum with PAHO differs in terms of number and kind of assistance received. Seven (31.80%) have had formal agreements and individual consultations, six (27.30%) have had only formal agreements and nine (40.90%) have had only individual
consultations. Table 31 shows the distribution for number and kind of linkage with PAHO.

Table 29

Distribution of Schools According with linkage to PAHO, by Countries. 1982.

<table>
<thead>
<tr>
<th>Countries</th>
<th>Total</th>
<th>Linkage w/PAHO</th>
<th>No Linkage w/PAHO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>45</td>
<td>22</td>
<td>23</td>
</tr>
<tr>
<td>Argentina</td>
<td>8</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Bolivia</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Brasil</td>
<td>5</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Chile</td>
<td>6</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Colombia</td>
<td>9</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Dominican Rep.</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Ecuador</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Guatemala</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Honduras</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Mexico</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Paraguay</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Peru</td>
<td>2</td>
<td>2</td>
<td>-</td>
</tr>
</tbody>
</table>
Table 30
Number of schools according with kind and number of assistance received from PAHO.

<table>
<thead>
<tr>
<th>Number Contacts w/PAHO</th>
<th>Total</th>
<th>Formal agreement and individual consultation</th>
<th>Formal agreement</th>
<th>Individual consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>22</td>
<td>7</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>1</td>
<td>8</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>1</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>+5</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
The total number of consultations received from PAHO among the 45 schools is 90, the mean is 4.10 and the range is from 1 to 19.

The analysis of the objectives for the 90 consultations received reveals 9 major categories. These categories are: training of teachers in different areas of nursing speciality: 22 (29.00%); programs related with curricular development, including design, implementation and evaluation: 28 (31.10%); development of courses, workshops and seminars in specific areas of nursing: 13 (13.40%); projects for reorganization of schools 4 (4.40%); projects for introduction of educational technology 6 (6.70%); training programs for auxiliary personnel at different levels: 6 (6.70%); development and evaluation of clinical setting: 3 (3.30%); development of research projects: 1 (1.10%); and, other including general health programs and library assistance: 3 (3.30%).

These categories of objectives of assistance and its distribution are compatible with the overall programs and goals of the nursing section discussed in Chapter Four, mostly before the 1970's. It is important to note that the majority of the assistance received by the schools included in the study, 69 (76.70%) occurred before 1970.

**Distribution of the six indicators for the dependent variable Public Health**

According with the time of introduction of public health content 27 (60%) of the schools did it at the time of its inauguration and 18
(60%) five years or more after its inauguration. In general, the schools created between 1900 and 1940 took a greater lapse of time to introduce public health, ten or more years, the schools created later introduced it within the first four years from inauguration. With respect to amount of time spent in public health training in theory and practice, the average time for each year is shown in table 31.

Table 31

<table>
<thead>
<tr>
<th>Average Time (in hours) of Public Health Training in the 45 Schools Included in the Study by Academic Year.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average number of hours</strong></td>
</tr>
<tr>
<td><strong>Academic year</strong></td>
</tr>
<tr>
<td>1st</td>
</tr>
<tr>
<td>2nd</td>
</tr>
<tr>
<td>3rd</td>
</tr>
<tr>
<td>4th</td>
</tr>
</tbody>
</table>

Introduction of specialities

Nursing specialization programs is offered by 21 (46.70%) of the 45 schools included in the program. Table 32 shows the number of schools which offers specialization according with decades of its introduction in the school program.

The majority of the schools offer more than one speciality. The frequency order is public health, obstetrics, psychiatry, maternal and child health, pediatrics and administration. Medical-surgical is the most frequent, 13 (61.90%) of the 21 schools offer programs in this field.
Table 32
Number of Specialized Nursing Programs Offered in 21 of the Schools Included in the Study, According to Decade of Introduction.

<table>
<thead>
<tr>
<th>Decade of introduction of specialty</th>
<th>Number of Schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>1950</td>
<td>3</td>
</tr>
<tr>
<td>1960</td>
<td>3</td>
</tr>
<tr>
<td>1970</td>
<td>12</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>21</strong></td>
</tr>
</tbody>
</table>

Teacher graduate education

There are a total of 682 nursing professors contracted by the schools and 355 nurses at clinical setting, which do not have a formal contract by half in the supervision which makes a total of 1,037 nursing professors in the 45 schools included in the study. Table 33 shows the distribution of teachers and instructors according with level of academic preparation.

Table 33
Number and Percentage of Teachers from the 45 Schools Included in the Study According with Level of Academic Preparation.

<table>
<thead>
<tr>
<th>Academic preparation of teachers</th>
<th>Teachers Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>1,037</td>
<td>100</td>
</tr>
<tr>
<td>Basic</td>
<td>229</td>
<td>22.10</td>
</tr>
<tr>
<td>BS</td>
<td>276</td>
<td>26.60</td>
</tr>
<tr>
<td>Specialization</td>
<td>254</td>
<td>24.60</td>
</tr>
<tr>
<td>Master</td>
<td>256</td>
<td>24.60</td>
</tr>
<tr>
<td>Doctor</td>
<td>24</td>
<td>2.20</td>
</tr>
</tbody>
</table>
The majority of nursing professors (80%) have completed their specialization and graduate studies in their own countries. Latin America is the second place of choice for advanced training where (12.50%) completed their studies. And, United States of North America as well as other European countries are third.

The distribution by area of specialization of nursing teachers is shown in Table 36. Education, followed by public health and maternal and child care are the fields of advanced programs more frequently taken among the nursing professors.

Table 34

<table>
<thead>
<tr>
<th>Field of Studies</th>
<th>Nursing Professor Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>895</td>
<td>100</td>
</tr>
<tr>
<td>Administration</td>
<td>68</td>
<td>7.60</td>
</tr>
<tr>
<td>Education</td>
<td>226</td>
<td>25.30</td>
</tr>
<tr>
<td>Maternal and Child Health</td>
<td>154</td>
<td>17.20</td>
</tr>
<tr>
<td>Medical-Surgical</td>
<td>101</td>
<td>12.30</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>72</td>
<td>8.00</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>51</td>
<td>5.70</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>69</td>
<td>7.70</td>
</tr>
<tr>
<td>Public Health</td>
<td>154</td>
<td>17.20</td>
</tr>
</tbody>
</table>

Skills and Abilities of Nursing Expanded Role

The criteria used to assess information on the development of skills and abilities for the nursing expanded role, was the inclusion of independent nursing activities in the surveillance and promotion of health of adults, pregnant women and children in the program.
Independent activities can include three levels of complexity. First, abilities and skills to take the clinical history of patients previous to physician physical examination and evaluation of the patient. Second, abilities and skills to perform physical examination prior to physician's consultation. Third, abilities and skills to conduct the complete process for evaluation of patient conditions and make the final decision whether to send the patient for a physician's examination or to take needed therapeutic actions.

Schools that developed the second and third level of abilities were classified as having included in their curriculum activities for development of skills and abilities in the development of the expanded role of nursing. The first level of abilities and skills were not considered because they have been promoted for a long time in the curriculum of nursing schools quite independently of the activities related to the expanded role, even though they are without doubt the first step for the development of the subsequent ones.

The development of activities which include experiences aimed at developing skills and abilities related to the expanded role of nursing is included in 23 (51.10%) of the programs of the 45 schools.

**Objectives of nursing education**

All the schools included in the study have written objectives. In general, the statements of objectives reflect the general guidelines included in the PAHO's guide for school of nurses in Latin America. They express the basic concepts of professional, individual and citizenship development, in general, for the majority of the schools. A small minority, however, have operationalized the same
basic concepts into competency objectives.

With regard to what is viewed as the three main objectives of the school in the area of professional development the ranking order most frequently expressed was: first, preparation for direct nursing care; second, preparation for community health education and third, preparation in introduction of scientific methodology and research.

**Educational technology**

Forty (88.90%) of the 45 schools has incorporated one or more technological educational innovation in their methodology of teaching.

**Homogeneity of groups**

The two groups based on linkage or lack of linkage with PAHO were examined for their homogeneity. The homogeneity was determined in relation to the general characteristics of the schools discussed above.

Assuming that the ability to receive assistance from PAHO would decrease for schools recently created, the distribution of schools for the two groups was examined in relation to year of foundation. Table 35 shows this distribution, although there is a definite trend for a greater proportion of new schools in the group with lack of linkage with PAHO, there is a degree of compatibility which would not cause too many biases for the results of this study.

With relation to country of location of the 45 schools the distribution does not vary greatly. Seven (53.80%) of the 13 countries in the sample are represented in both groups. Table 36 shows this
distribution. The distribution of formal linkage of schools with universities and requirements for entrance shown on table 37 also indicates that there is not great variation among the two groups.

Table 35
Distribution of the 45 Schools Included in the Study by linkage with PAHO and Decade of Foundation of the School.

<table>
<thead>
<tr>
<th>Decade of Foundation</th>
<th>Linkage with PAHO</th>
<th>Lack of Linkage with PAHO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total 45</td>
<td>Number 22 Percentage 100.00</td>
</tr>
<tr>
<td>1900-1920</td>
<td>3</td>
<td>2 Percentage 9.0</td>
</tr>
<tr>
<td>1921-1940</td>
<td>3</td>
<td>2 Percentage 9.0</td>
</tr>
<tr>
<td>1941-1960</td>
<td>16</td>
<td>11 Percentage 50.00</td>
</tr>
<tr>
<td>1961-1981</td>
<td>23</td>
<td>7 Percentage 31.00</td>
</tr>
</tbody>
</table>

Table 36
Distribution of the 45 Schools Included in the Study by Linkage with PAHO and Country of Location of the School

<table>
<thead>
<tr>
<th>Country</th>
<th>Total 45</th>
<th>Linkage with PAHO</th>
<th>No Linkage with PAHO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>45</td>
<td>22</td>
<td>23</td>
</tr>
<tr>
<td>Argentina</td>
<td>8</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Bolivia</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Brasil</td>
<td>5</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Chile</td>
<td>6</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Colombia</td>
<td>8</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Dominican Rep.</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Ecuador</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Guatemala</td>
<td>2</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Honduras</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Mexico</td>
<td>5</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Paraguay</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Peru</td>
<td>2</td>
<td>2</td>
<td>-</td>
</tr>
</tbody>
</table>
Table 37

Distribution of the 45 Schools Included in the Study by Linkage with PAHO, Duration of Program, Linkage with University and Academic Admission Requirements.

<table>
<thead>
<tr>
<th>Linkage w/PAHO</th>
<th>Duration of Program</th>
<th>Institution</th>
<th>Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4 yrs</td>
<td>3 yrs</td>
<td>Univ.</td>
</tr>
<tr>
<td>Yes</td>
<td>16</td>
<td>6</td>
<td>18</td>
</tr>
<tr>
<td>No</td>
<td>12</td>
<td>11</td>
<td>16</td>
</tr>
</tbody>
</table>

yrs = years; Univ. = University; Comp. = complete; Incomp. = Incomplete 2nd. Secondary

The number of students enrolled in the 45 schools are also compatible among the two groups. In the group with linkage with PAHO there are 4,850 (56.00%) students enrolled, and in the group with lack of linkage with PAHO there are 3,722 (43.40%) students enrolled.

The two groups, although present some variations in respect to their general characteristics, have a degree of homogeneity which allow for the proposed analysis of the relationships between linkage and introduction of curricular innovations.

Relationships Between PAHO's Linkage and Curricular Innovation

To understand the relationships between PAHO's policies and the changes or introduction of innovations in the curriculum of Latin American nursing schools, two issues are examined. First, we are interested in demonstrating the relationship of PAHO policies and the introduction of innovation in the curriculum that could be assumed irrespectively of the congruence of PAHO's and countries policies.
Second, we are concerned with the interrelationships among measures of impact and academic level of the school. It is assumed that, because these factors represent different concepts and are based on different information, that they should be fairly independent.

**Introduction of Public Health Nursing in the Curriculum**

Independent of assistance from PAHO the general trend observed was that the schools created after the 1960's had this field of study incorporated in their curriculum at the time of the inauguration. Meanwhile, for schools created before the 1960's the general trend is the incorporation of public health after five years of school's inauguration. In addition, the fact of maintaining a relationship with PAHO did not show a marked difference in the adoption of public health at the time of inauguration. Table 38 summarizes this information.

These finds seems to support the general assumption of this study with respect to internal determinants of nursing development. Public health nursing is introduced more greatly in the nursing curriculum as a consequence of national demands which resulted from the expansion of the public health services observed in the majority of the countries in the 1960's. Thus allowing for the congruence of PAHO's and national countries policies.

The content and duration in length of public health training also does not vary greatly among the two groups. Table 39 shows that there is a greater concentration in duration for the 4th academic year and a light trend in favor of the group with lack of linkage with PAHO to offer more hours of training at this level.
Table 38
Introduction of Public Health Nursing in the Curriculum of the 45 Schools included in the Study by Linkage with PAHO and Period of Inauguration of School.

<table>
<thead>
<tr>
<th>Schools</th>
<th>Linkage with PAHO</th>
<th>Lack Linkage with PAHO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 2</td>
<td>1 2</td>
</tr>
<tr>
<td>At Inauguration</td>
<td>4 33.30</td>
<td>7 70</td>
</tr>
<tr>
<td>After Inauguration</td>
<td>8 66.70</td>
<td>3 30</td>
</tr>
</tbody>
</table>

1 = Schools created between 1900 - 1960
2 = Schools created after 1960

Table 39
Average Hours of Public Health Training in the Schools Included in the Study According with linkage with PAHO and Academic Year.

<table>
<thead>
<tr>
<th>Academic Year</th>
<th>Theory</th>
<th>Practice</th>
<th>Theory</th>
<th>Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>75</td>
<td>78</td>
<td>75</td>
<td>75</td>
</tr>
<tr>
<td>2nd</td>
<td>63</td>
<td>134</td>
<td>98</td>
<td>131</td>
</tr>
<tr>
<td>3rd</td>
<td>73</td>
<td>176</td>
<td>90</td>
<td>185</td>
</tr>
<tr>
<td>4th</td>
<td>92</td>
<td>414</td>
<td>158</td>
<td>501</td>
</tr>
</tbody>
</table>

Nursing specialization

Introduction of nursing specialization in the programs of the 45 schools indicates a trend of positive relationships in favor of the schools with linkage with PAHO. Table 42 shows this data. Not only the proportion of schools that offer specialization is greater for the
schools that received assistance from PAHO, but also when the information is examined for the year of its introduction it reveals that this group have introduced it earlier in their programs.

While 13 (59.10%) of the schools (22) that have received assistance from PAHO offer nursing specialization programs, only 8 (34.78%) in the group with lack of linkage with PAHO offers it (See Table 40).

Table 40
Number of Schools Included in the Study that Offers Specialization in Nursing by linkage with PAHO and Decade of its Introduction in the Program.

<table>
<thead>
<tr>
<th>Decade of Introduction of Specialization</th>
<th>Linkage with PAHO</th>
<th>Lack Linkage with PAHO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>1950</td>
<td>3</td>
<td>23.00</td>
</tr>
<tr>
<td>1960</td>
<td>5</td>
<td>38.50</td>
</tr>
<tr>
<td>1970</td>
<td>5</td>
<td>38.50</td>
</tr>
</tbody>
</table>

The number of teachers with graduate education and specialization also shows a trend for greater number of teachers with advanced education in the group of schools with linkage with PAHO. This group have 340 (54.70%) of their teachers with an academic level beyond the equivalent to a B.S. degree, while the group with lack of linkage with PAHO, have 194 (46.70%) at the same level of academic preparation. And the difference between the two groups is increased if only graduate education is considered. Table 41 gives detailed information.
Skills and abilities in the nursing expanded role

An examination of the information on the introduction of activities to develop skills and the abilities of the expanded role of nursing suggests that there is no meaningful difference between the two groups of schools. Table 42 shows that the development of independent nursing activities are almost equally distributed for both groups. The information was also examined with respect to the relationship between introduction of these innovations and the year of foundation of the schools. The results shows that the majority of the schools created after the 1970's which are dominant in the group with lack of linkage with PAHO have introduced this innovation. In addition, these schools are located in countries that have adopted a policy of expansion of nursing role before the 1970's, such as Colombia and Chile.

Table 41
Number and Percentage of Teachers from the two Group of Schools Included in the Study by Level of Academic Preparation.

<table>
<thead>
<tr>
<th>Academic Preparation of teacher</th>
<th>School with Linkage with PAHO</th>
<th>School with out Linkage with PAHO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Total</td>
<td>622</td>
<td>100.00</td>
</tr>
<tr>
<td>Basic</td>
<td>134</td>
<td>21.50</td>
</tr>
<tr>
<td>BS</td>
<td>148</td>
<td>23.80</td>
</tr>
<tr>
<td>Specialization</td>
<td>126</td>
<td>20.30</td>
</tr>
<tr>
<td>Master</td>
<td>194</td>
<td>31.20</td>
</tr>
<tr>
<td>Doctorate</td>
<td>20</td>
<td>3.20</td>
</tr>
</tbody>
</table>
Table 42

Activities of Expanded Role of Nursing in the two Group of Schools Included in the Study.

<table>
<thead>
<tr>
<th>Kind of Expanded Role Activity</th>
<th>Linkage with PAHO</th>
<th>Linkage with PAHO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>No activities</td>
<td>5</td>
<td>22.80</td>
</tr>
<tr>
<td>Completed activities</td>
<td>14</td>
<td>63.60</td>
</tr>
<tr>
<td>Only with child</td>
<td>1</td>
<td>4.50</td>
</tr>
<tr>
<td>Only with pregnant woman</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Adult and child</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Adult and pregnant woman</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Child and pregnant woman</td>
<td>2</td>
<td>9.10</td>
</tr>
</tbody>
</table>

The number of nursing professor trained to guide the experiences in this field differ slightly among the two groups. There are 18 (2.60%) of the professors in the group with linkage with PAHO, and 3(0.60%) of the professors in the group with lack of linkage with PAHO.

Objectives of nursing education

The fact that all the schools included in the study reported having written objectives in accordance with the general guidelines recommended by PAHO in 1961, may indicate that at the level of the formal discourse, it is possible to argue for a general PAHO's influence on both groups. This generalization can be supported by a theory relying on the degree of diffusion of PAHO's published materials, independent of direct linkage.

However, the schools included in the study differ with regard to their view of the three main objectives of nursing education related to professional development. While the schools that received assistance from PAHO order these objectives as:
1. direct care,
2. research,
3. community education,

The school with lack of linkage with PAHO consider:
1. direct care
2. community education
3. administration of health care.

For the later group more emphasis is given to direct care and community education as compared with the first group and research is viewed as a fourth goal of nursing education by these schools.

These differences in ranking education objectives for professional development in the two groups rises a few questions related to PAHO's influence. Firstly, PAHO's relationship with the schools seems to favor the inclusion of research abilities among the three first goals of nursing education. Secondly, this relationship seems to be conflictive with PAHO's own experience in the area of nursing research. As discussed in Chapter Four, PAHO's experience in nursing research has been limited and its promotion, except in the formal discourse which appears in related nursing publication, has been minor as contrasted to the promotion of activities in community health education. Thirdly, the lack of linkage with PAHO seems to favor a ranking of objectives more congruent with the actual conditions of nursing practice in the Region, and to a great extent more related to the explicit policies of PAHO.

Despite these differences, it was not possible to identify substantive differences in the curriculum of these schools. The content
in terms of kind of courses offered and the duration of programs, -theoretical and practical experiences- essentially do not differ between the two groups. Table 43 shows the data for duration of program.

This issue needs to be further investigated. It is necessary to analyze the content of courses to be able to relate more conclusively the relationship between priorities of nursing educational goals and the structure of the curriculum. In accordance with the present analysis which did not explore in detailed course content this relationship was not observed, both group of schools independent of differently ranking educational objectives do not show differences in the structure of their curriculum.

Table 43
Mean and Annual Hours of Theory and Practice in the Two Groups Schools Included in the Study.

<table>
<thead>
<tr>
<th>Activities</th>
<th>Linkage with PAHO</th>
<th>No Linkage with PAHO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>Percentage</td>
</tr>
<tr>
<td>Theory</td>
<td>466</td>
<td>42</td>
</tr>
<tr>
<td>Practice</td>
<td>629</td>
<td>58</td>
</tr>
</tbody>
</table>

Introduction of educational technology. There seems to be no difference between the two groups with respect to introduction of educational technology. In the group with linkage with PAHO 20 (90.90%) of the schools have incorporated one or more kind or technological innovations in their teaching methodology, while 20 (87.00%) in the group with lack of linkage with PAHO have also done it. The
slight difference between the two groups, examined in its details indicates that for the group with linkage with PAHO the difference between the utilization of modular instruction (a basic proposition of PAHO's educational technology project) is greater. While 13 (59.10%) of the schools with linkage with PAHO has adopted this methodology, only 8 (34.80%) of the schools with lack of linkage have adopted it. Table 44 summarize this information.

Table 44

<table>
<thead>
<tr>
<th>Modular Instruction</th>
<th>Linkage w/PAHO</th>
<th>No Linkage w/PAHO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.  Percentage</td>
<td>No.  Percentage</td>
</tr>
<tr>
<td>Yes</td>
<td>12  54.50</td>
<td>10  43.50</td>
</tr>
<tr>
<td>No</td>
<td>10  45.50</td>
<td>13  56.50</td>
</tr>
</tbody>
</table>

It is also important to note that PAHO's Project on Educational Technology for nursing schools has been designed with the aim of creating national centers of educational technology for nursing, which should in turn create a network of sub-centers within the area of influence of the school. This fact may raise the question in favor of an influence of PAHO with respect to the introduction of educational technology in the nursing schools of Latin America. Nevertheless, this issue should be taken with caution. Before a final statement could be made, further questions and investigation have to be considered. It is necessary to answer the question of the state of technological innovations in the area of education within each country. What are the
explicit national policies and what are the needed basic soft and hardware infrastructure for these technological innovations in each country. The answer to these questions may further more reliable conclusions with respect to PAHO's role in the dissemination of educational technology in the nursing schools of Latin America.

CONCLUSIONS

The major finding of this exploratory study is that linkage with PAHO does not foster any significant differences in the measures of introduction of selected curricular innovations. While the measures for introduction of public health, abilities and skills for the development of nursing's expanded role and the introduction of educational technology yield relatively similar distributions, the measures for nursing specialization, teachers' graduate education and ranking of educational objectives seems to indicate a slight trend, although not significant, in favor of PAHO's assistance for the impact of these curricular innovations. This study demonstrates that there is a need to examine more closely these associations. Furthermore, the findings indicate that curricular innovations are more related to the congruence of PAHO's recommendations with national policies in the field, as has been demonstrated by the analysis of time of introduction of these innovations.

This study represents only a preliminary approach to the questions proposed, since better measures of the variables included and a greater number of observations will be more feasible to develop
in the future. Future research in this area should improve the methodological strategies and the design used. Not only refinements of the variables measured, but also the use of more efficient statistics is advised. In addition, it is recommended that a close analysis of the curricular content of the schools through a comparative and more conceptual research be done. This kind of research could provided a better assessment of reality to guide curriculum development. The limitations and number of options that educators are confronted with in the selection of curriculum content are well known. (Eisner, 1979; Giroux, 1981; Huckabar, 1982). If nursing education in Latin America is expected to move from "nursing's traditional conceptualization" to the development a cadre of professional nurses prepared to assume new roles in the health care system, then it is a pivotal field for further research.

A second finding of this exploratory study is that the trend of PAHO's influence in the measures for nursing specialization, teacher's graduate education and the ranking of educational objectives raises a series of questions related to the characteristics of schools which have received assistance from PAHO. While these relationships are not significant, the differences merit attention because of the importance of possible new findings in future research. The actual question is a hunch: Do schools with vinculum with PAHO have a higher academic standard? Two possibilities should be closely examined in the future, to answer this question. First, does PAHO have a defined strategy for working with schools characterized by higher academic standards? The study of PAHO's nursing development conducted in Chapter Four
indicated that the initial projects, in general, aimed at national schools officially recognized were either linked to Universities or Ministries of Health. Certainly, judging from the status of nursing development at the time in the Region, it can be assumed that those could have been schools of higher academic standards. However, the question of primacy of association remains. That is, did PAHO continue to purposely target its attention on schools characterized by higher academic standards? Second, whether schools with such characteristics define and search more diligently for outside assistance. Perhaps these schools have more access to information and better knowledge of formal procedures needed to obtain assistance.

The answer to these questions would give better clues for understanding the relationships of PAHO in this area, furthering conclusions which at this point is very uncertain. That is, curricular innovations which foster improvement of academic level of the schools tend to be more readily adopted by schools that have received assistance from PAHO. Definitively the present study cannot resolve either one of the above questions, but it certainly points out the need for future research. It is important to examine these relationships against the whole social context of the schools and their capabilities as far as the infrastructure and resources available to adopt these recommendations. Above all there is a need to develop a framework which could clarify the association between PAHO's recommendations and adoption of curricular innovations and other structural features of the educational content.
Another question that remains from this study is how PAHO's influence operates. Although, the design of studies based on questionnaires and statistical data analysis would improve knowledge of some proposed associations, to gain a more complete knowledge of the process which is established between the advisors and the schools, alternative research strategies should also be used. Therefore, case studies of selected schools through a retrospective analysis or a longitudinal study should be pursued as an alternative to uncover the concrete mechanism through which PAHO's influence operates. An evaluative follow-up of advisors work is also suggested as another alternative route which could supplement the knowledge acquired in case studies.

In conclusion, the questions raised by this exploratory study opens a concrete path of inquire which could lead to a better understanding of the work of an international organization. It also proposes methodological procedures that once refined could provide useful instrument for further development in this field.
Footnotes for Chapter 5

1. The source of data for the number of students presently enrolled at Latin American schools is the Division of Human Resources and Research of PAHO.

2. Discussion and informal papers of the Division of Human Resources and Research and the Division of Comprehensive Health Care of PAHO have presented the results of survey conducted in Latin America on the prevailing conditions of nursing related to primary health care, in which only 54% of the countries is training nurses on the functions related the expanded role of nursing.
CONCLUSIONS

This dissertation has disputed, from a specific view of change, that in order to understand the development of professional nursing practice in an international organization and the impact of its policies in Latin American nursing education it is necessary to do so from the overall perspective of social change. To understand the professional nursing practice at PAHO, two major issues were addressed—the relationship between PAHO's health concepts, policies and recommendations, and the relationship between PAHO's policies and dominant international interests. Furthermore, change in professional practice has traditionally focused on the general framework of externally determined causes. However, not to conform to the positivist view of change—describing it instead of explaining its causation (Taylor, 1979)—requires a thorough search of causes within the social structure in which change is or has taken place.

Beginning with nursing educational development of Latin America we argued that nursing development did not merely reflect the scientific and technical advances experienced by the health science; it rather reflected the internal conditions of the social structure of each country in terms of dominant practice in health care education. The secularization of medical care, the public health movement and the introduction of nursing education in the university system, the major
elements considered in the development of nursing education, were all associated with distinctive phases of Latin American social formation in the twentieth century. The realistic dialectical approach proposed in the conceptual framework allowed for a full examination of the articulation of dominant aspects of the social formation of Latin America which influenced the dominant health care practice and consequently the development of nursing education in the Region.

The study of the development of PAHO's nursing service that followed, also showed clearly the relationships of PAHO's internal as well as international context. PAHO's nursing services development reflected all the levels of complexity of an international organization which has a major role in the diffusion of dominant health concepts and innovations. The exploratory study on the influence of PAHO in Latin American Nursing education provided preliminary evidence which indicates that further analysis of PAHO's nursing recommendations and strategies should be undertaken. We believe, that because of the importance of international cooperation, and PAHO's leadership role in the formulation of guidelines and in the development of alternative proposals for improvements in a specific field, should be grounded on better strategies of impact.

The purpose of these last remarks is to discuss briefly the importance of the findings of this dissertation for the future of nursing education in Latin America and to make recommendations, which could be of relevance for PAHO's nursing services.

The perspective for the future of nursing practice and education in Latin America has to be viewed in the light of the goal of Health
for All by the Year 2000 and the strategies developed to achieve it. The Division of Health Manpower Development of the World Health Organization (WHO) organized in November of 1981 a Conference on "Nursing in Support of the Goal Health for All by the Year 2000." The meeting's report points out the need for careful consideration by nursing of the approaches to health care as indicated in the WHO document Global Strategies for HFA/2000. It considers specially important for relevant nursing practice in primary health care, the following:

"(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" (WHO, 1982).

Based on these general premises the meeting arrived at the following conclusions:
Nursing has the ability and the 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.

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.

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.

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.

Acceleration of the nursing impact on community health requires dramatic change in practice and in the preparation 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 programmes, especially as they pertain to the practice of students. Consequently, change in one is an integral part of change in the other and they must be planned in concert". (WHO, 1982).

Although there is no doubt that nursing will be required to assume a role in the implementation of the strategies required to attain the goal HFA/2000, we may question nursing capabilities to assume a major role in effecting the changes needed in the health care system to attain this goal in Latin America. The long history of
limited professional power, which Torres (1982) qualifies as oppression in the sense utilized by Freire in his work *Pedagogy of the Oppressed*, points toward a more secondary role, in which nursing will have to struggle to determine its space for practice in primary health care. The lack of a well organized nursing sector in the majority of the countries and the ever growing conflicts and contradictions existing among the several levels of nursing personnel is hindering an objective position taking by the sector as a whole.

If radical changes in nursing practice and education are expected, the first advisable step would be a critical examination by nurses and nursing personnel of its professional development, which could lead them to a better understanding of the relationships between its religious and military roots and the prevailing dominant health care practice, determined ultimately by the political and economic structure of society. The understanding of these relationships should, in turn, foster a realistic approach to the formulation of new goals for nursing practice and education. In addition, it should lead to a way for the formulation of new strategies for integration and coordination of the nursing sector.

In Latin America auxiliary personnel, with very little training and sometimes with no training at all, today constitutes the majority of the nursing labor force. The limited capacity of the nursing educational sector to train all the needed personnel indicated that to attain the goal HFA/2000 a greater number of untrained nursing personnel will continue to engage in nursing work in the future. This situation will certainly continue to present a challenge for the
nursing leadership, and which requires 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 have to be taken into consideration if service to people, individually and collectively is the true concern of nursing.

Apart from these internal considerations about the nursing sector, it is important to bear in mind that the success of the strategies to attain the goal HFA/2000 are conditioned to the fiscal crisis in which Latin America is immersed today. For dos Santos (1979) the present economic crisis, characterized by increase inflationary economic and high ratio of unemployment tend to persist for a long time. What are then the real possibilities of the countries to expand their health services? Undoubtedly, governments will adopt less costly alternatives, which necessarily include the utilization of a greater numbering of less qualified personnel. Therefore, limitations will not only be imposed on the nursing sector itself.

From the above discussion one conclusion is apparent: that future nursing practice in Latin America, under the new perspectives of the goal HFA/2000, will continue to rely on the hands of less trained nursing personnel. Nevertheless, the role of the nursing leadership in providing a re-conceptualization of nursing should not be forgotten. Re-conceptualization based on more critical models of interpretation of national realities would guide the educational sector in formulating more integrated and coordinated programs for all nursing levels, as well as a more efficient allocation and utilization of
educational funds. Future nursing practice will have an important impact in the attainment of the goal RFA/2000, if instead of striving for professional isolation, and following the footsteps of the medical profession for acquiring professional status, professional nurses, should join with all levels of auxiliary personnel in the pursuit of better services for individuals and communities.

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

"It will be necessary to achieve more than a simple modification of teaching methods—it will be necessary to attain a clear definition of the theoretical methodology of pedagogy as a science.

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

A plan of studies centered in the community and in the health services shall be established which will develop a coherent relationship between the process of health and illness and 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 which shall focus on the healthy family in its social and community life, then on concern with illness, invalidity and social disability, and finally lead to treatment and rehabilitation."

Under these new perspective, reconceptualization of PAHO's nursing services is demanded. PAHO's recommendations in the field of nursing education, in general have been based on the experience of nursing development in advanced countries and also inspired in an
"ideal" model for the nursing profession internationally promoted, without a close critical view of Latin America social reality. The strategies, although revised in the course of time, have not been sufficiently powerful to produce changes. Given the results of the exploratory study, it is important that attention be given to alternative ways to understand the social process which has an influence in the adoption of international recommendations. If the Organization desires to make full use of its influencing power it needs to explore more framework in Latin America. The knowledge of nursing practice and education based on a critical analysis of its relationship with society as a whole, should improve the adequacy of recommendations and strategies for their implementation.

The strategy by which PAHO could establish a continuous analysis of the health sector and nursing throughout the Region and in each individual member country, should be developed on the basis of sound social research, taking into account the theoretical as well as the empirical work already produced by researchers at national level.

Consistent with this perspective, recommendations for innovations in nursing education should be grounded on the indigenous experience of nursing in Latin America, which represented not only an effort for its reconceptualization, but that also proved successful in diminishing the existing contradictions within this sector.

In addition, we believe that more indepth research on the development of nursing auxiliary personnel should be pursued. We are aware that the contribution of this dissertation for the knowledge of nursing educational development in Latin America is limited to the so
called professional level of nursing. And, even at this level far more knowledge can be acquired. Therefore, the panorama of the nursing sector cannot be considered as complete.

This dissertation has sought to further the understanding of the work of nursing in an international organization and its influence on the development of nursing education in Latin America. We have attempted to further this understanding by providing a critical view of nursing development within the dynamics of socio-economic development of Latin American society and in this respect specifically, a critical perspective of the cooperation and support provided by PAHO Nursing Services. It is also hoped that the view in this dissertation will stimulate further research on the concrete mechanism of PAHO's impact on nursing education.

In a broader sense, the thesis suggests that Nursing in Latin America today, will need to engage in continuous, constructive and vigorous debate, the fundamental purpose of which should be to bring new dimensions to the politics of health care so that the professionals involved may more fully realize their professional commitment to a better quality of life for the peoples of Latin America.
LIST OF REFERENCES


American Journal of Nursing. 1902. (Foreign Department.) "The Regulations for the Schools of Nursing in the State Hospitals of Cuba." Am. J. Nursing. 2:466-469; March.


Boletín de la Oficina Sanitaria Panamericana. 1944. (Notas y Revistas: Enfermería.) "Historia en Colombia." Boletín de la Oficina Sanitaria Panamericana. 23:945-946; December.


Boletín de la Oficina Sanitaria Panamericana. 1950. (Enfermería)
"Summary of the First and Second Regional Nurses Congresses." Boletín de la Oficina Sanitaria Panamericana. 29:104-105; January.


Boletín de la Oficina Sanitaria Panamericana. 1951. (Enfermería)
"Legislación sobre Enfermería en el Brasil." Boletín de la Oficina Sanitaria Panamericana. 30:767-777; July.

Boletín de la Oficina Sanitaria Panamericana. 1951. (Editorial)
"America Necesita Enfermeras." Boletín de la Oficina Sanitaria Panamericana. 32:703-706; June.

Boletín de la Oficina Sanitaria Panamericana. 1952. (Editorial)
"Nueva Meta para la Enfermería." Boletín de la Oficina Sanitaria Panamericana. 35:257-258; September.

Boletín de la Oficina Sanitaria Panamericana. 1954. (Editorial)
"La Enfermera: Guía de la Salud" (Declaraciones de Dr. Fred L. Soper, Director de PAHO). Boletín de la Oficina Sanitaria Panamericana. 38:474-475; April.


Bustamante, M.E. 1949. (Editorial) "La Primera Enfermera de Salubridad en Misión Internacional." Boletín de la Oficina Sanitaria Panamericana. 28:188-191; February.


García, J.C. 1982. "La Medicina en América Latina 1880-1930." (To be Published).


Manfredi, N. 1982. "Resolutions about Nursing During the Last Decade." (Mimeo.)


ARGENTINA

Directora
Dirección de Instrucción
Naval de la Armada Argentina
Edif. Libertad
Comodoro P.Y. y Corbeta Uruguay
1104, Buenos Aires, Argentina

Directora
Area Económica Financiera
Facultad de Enfermería
Universidad Nacional de Córdoba
Ciudad Universitaria
Pabellón Perú, Estafeta 32
5000, Córdoba, Argentina

Directora
Escuela de Enfermería
Instituto de Patología Regional
Mariano R. Castex 30
4400 Salta, República de Argentina

Directora
Escuela de Enfermería
de la Cruz Roja Palermo
Capital Federal, Argentina

Directora
Escuela de Enfermería
de la Cruz Roja Argentina
Filial Villa Ballester
Prov. de Buenos Aires, Argentina

Directora
Escuela de Enfermería de la Cruz Roja Argentina
Filial Casilda
Prov. de Santa Fe, Argentina

Directora
Escuela de Enfermería Argentino Bermejo del Colegio
Nuestra Señora del Huerto de Nocoya
Prov. de Córdoba, Argentina

Directora
Escuela de Enfermería Cruz Roja Argentina
Laprida 1553, Rosario
Prov. de Santa Fe Argentina

Directora
Escuela de Enfermería Cruz Roja Argentina
Rondeau 153
Mendoza, Pcia. de Mendoza Argentina

Directora
Escuela de Enfermería del Colegio Adventista del Plata
3103 Villa Libertador San Martín
Villa Libertador San Martín Entre Ríos Argentina
Directora
Escuela de Enfermería
Cruz Roja Argentina
Filial Gualeguay
Provincia de Entre Ríos
Argentina

Directora
Escuela de Enfermería
Cruz Roja Argentina
Filial Santiago del Estero
Absalón Rojas, Esq. Jujuy
Santiago del Estero, Jujuy
Argentina

Directora
Escuela de Enfermería
Calle 47 No. 697
La Plata, Pcia. de Buenos Aires
Argentina

Directora
Escuela de Enfermería
Hosp. Nacional Prof. Alejandro Posadas
Martínez de Hoz, Villa Sarmiento
Haedo, Prov. de Buenos Aires
Argentina

Directora
Escuela de Enfermería
Universidad Nacional de Córdoba
Ciudad Universitaria
E斯塔feta 32
Córdoba, Prov. de Córdoba
Argentina

Directora
Escuela Municipal de Enfermería
"Dra. Cecilia Grierson"
Juan B. Ambrosetti 601
Capital Federal
C.P. 1405
Argentina

Directora
Escuela Superior de Santa Fe
Saavedra 2149
Santa Fe, Argentina

Directora
Escuela de Enfermería
Inst. Nac. Serv. Soc. para Ferroviarios
Dependiente del Ministerio de Salud Pública
Ramón S. Castillo y Calle 2, Puerto Nuevo
C.P. 1404 Argentina

Directora
Escuela de Enfermería
"Hospital Bernardino Rivacavía"
Ave. Las Heras y Sanchez de Bustamante
Capital Federal, Argentina

Directora
Escuela de Enfermería de la Municipalidad de San Isidro
9 de Julio 506 - San Isidro
Provincia de Buenos Aires
Buenos Aires, Argentina

Directora
Escuela de Enfermería Profesional
Hospital Interzonal General Mar del Plata
Prov. de Buenos Aires
Buenos Aires, Argentina

Directora
Universidad Nacional de Tucumán
Gral. Paz 882
San Miguel de Tucumán
Argentina

Directora
Universidad Nac. de Santiago del Estero
Avda. Belgrano 1912 Sur
Santiago del Estero
Argentina

Directora
Universidad Nacional de Mar del Plata
Funes 3250
Mar del Plata, Argentina
Directora
Escuela de Enfermería
del Hospital Italiano
Capital Federal, Argentina

Directora
Escuela de Enfermería
de la Cruz Roja Argentina
Filial Isidro
Prov. de Buenos Aires
Argentina

Directora
Escuela de Enfermería
de la Cruz Roja Argentina
Filial Santos Lugares
Prov. de Buenos Aires
Argentina

Directora
Escuela de Enfermería
de la Cruz Roja Argentina
Filial Bahía Blanca
Prov. de Buenos Aires
Argentina

Directora
Escuela de Enfermería
de la Cruz Roja Argentina
Filial Comodoro Rivadavia
Prov. de Chubut, Argentina

Directora
Escuela Provincial de Entre Ríos
Corrientes 218
Paraná, Prov. de Entre Ríos
Argentina

Directora
Escuela de Enfermería
de la Cruz Roja Argentina
Filial San Cristóbal
Prov. Santa Fe, Argentina

Directora
Escuela de Enfermería
de la Cruz Roja Argentina
Filial San Andrés
Prov. de Buenos Aires
Argentina

Directora
Escuela de Enfermería
Cruz Roja Argentina
Godoy Cruz 270
San Rafael, Pcia. de Mendoza
Argentina

Directora
Escuela de Enfermería
Cruz Roja Argentina
Hospital Militar
Curuzu Cuatía
Pcia. de Corrientes
Argentina

Directora
Escuela Provincial de Enfermería
Cruz Roja Argentina
Irigoyen y Pampa
Cutral-Co, Neuquen
Argentina

Directora
Escuela de Auxiliares de Medicina "Dr. Guillermo Paterson"
Patricias Argentinas y Salta
San Salvador de Jujuy
Argentina

Directora
Escuela de Enfermería
Universidad Nacional de Buenos Aires
Córdoba 2351
Buenos Aires, Argentina

Directora
Escuela de Enfermería
Universidad Nacional de Rosario
Santa Fe 2000, Rosario,
Prov. de Santa Fe, Argentina
Directora
Esc. Municipal "Dra. Cecilia Grierson"
Hospital Municipal
"Carlos Durand"
Ambrosetti 601
Capital Federal
Argentina

Directora
Escuela Superior de Rosario
Hospital Provincial de Rosario
Alem 1450
Rosario
Argentina

Directora
Escuela de Enfermería "Hospital Central de la Provincia de Mendoza"
Hospital Central – Alem y Salta
Mendoza
Argentina

Directora
Escuela de Enfermería
Instituto de Servicios Sociales Bancarios
Canning 2886
Capital Federal
Argentina

Directora
Escuela de Enfermería del Ministerio de Educación y Cultura de la Provincia de Santa Cruz
Centro de Estudios Superiores "General San Martín"
Don Bosco 105
Río Gallegos
Argentina

Directora
Escuela de Enfermería Profesional
Hospital Subzonal "San José"
Junio – Provincia de Buenos Aires
Buenos Aires
Argentina

Directora
Universidad Nacional de Misiones
Avda. Lopez Torres 1150
Posadas
Misiones, Argentina

Directora
Universidad Nacional de Salta
Gral. Guemes 533
Salta, Argentina

Directora
Escuela de Enfermería
Sanatorio Guemes
Capital Federal
Argentina

Directora
Escuela de Enfermería de la Cruz Roja Sede Central
Capital Federal
Argentina

Directora
Escuela de Enfermería de la Cruz Roja Argentina Filial Fernando
Prov. de Buenos Aires
Argentina

Directora
Escuela de Enfermería de la Cruz Roja Argentina Filial Lomas de Zamora
Prov. de Buenos Aires
Argentina

Directora
Escuela de Enfermería del Hospital Británico
Perdriel 74
Buenos Aires
Argentina

Directora
Escuela de Enfermería de la Cruz Roja Argentina Filial Córdoba
Prov. de Córdoba
Argentina
Directora
Escuela de Enfermería de la Cruz Roja Argentina
Filial Santa Fe
Provincia de Santa Fe, Argentina

Directora
Escuela de Enfermería de la Cruz Roja Argentina
Filial Vicente López
Provincia de Buenos Aires, Argentina

Directora
Escuela de Enfermería de la Cruz Roja Argentina
Filial Tandil
Provincia de Buenos Aires, Argentina

Directora
Escuela de Enfermería Cruz Roja Argentina
Departamento de Misiones
Oberá, Chaco, Argentina

Directora
Escuela de Enfermería Cruz Roja Argentina
Departamento de Corrientes
Bolívar 1219
Provincia de Corrientes, Argentina

Directora
Escuela de Enfermería de la Cruz Roja Argentina
Calle 51 esq. 4, La Plata
Provincia de Buenos Aires, Argentina

Directora
Escuela de Enfermería de la Cruz Roja Argentina
Departamento de Sanidad
Calle 51 esq. 4, La Plata
Provincia de Buenos Aires, Argentina

Directora
Escuela de Enfermería del Ejército Argentino
Av. Pueyrredón 1640
Capital Federal, Argentina

Directora
Escuela de Enfermería del Ejército Argentino
Av. Pueyrredón 1640
Capital Federal, Argentina

Directora
Universidad Nacional de Catamarca
República 350
Catamarca, Argentina

Directora
Universidad Nacional de Río Negro
Enlace Ruta 8 y 36 - Km. 603
Río Negro - Provincia de Córdoba
Argentina

Directora
Universidad Nacional del Nordeste
Republica 350
Catamarca, Argentina

Directora
Universidad Nacional de Río Negro
Enlace Ruta 8 y 36 - Km. 603
Río Negro - Provincia de Córdoba
Argentina

Directora
Universidad Nacional del Nordeste
Republica 350
Catamarca, Argentina

Directora
Universidad Nacional de Río Negro
Enlace Ruta 8 y 36 - Km. 603
Río Negro - Provincia de Córdoba
Argentina

Directora
Universidad Nacional del Nordeste
Republica 350
Catamarca, Argentina
Directoras
Escuela de Enfermería
Bahía Blanca
Vieytes 150 1er. Piso
Bahía Blanca
Prov. de Buenos Aires
Buenos Aires, Argentina

BOLIVIA

Directoras
Escuela de Enfermería
Elizabeth Setón
Casilla 926
Cochabamba, Bolivia

Directoras
Escuela de Enfermería
Facultad de Ciencias de la Salud
Universidad Mayor, Real y Pontificia de San Francisco Xavier de Chuquisaca
Casilla 233
Sucre, Bolivia

Directoras
Escuela de Enfermería
Facultad de Ciencias de la Salud
Universidad Boliviana "Juan Misael Saracho"
Casilla No. 51
Tarija, Bolivia

BRASIL

Universidade de Caxias do Sul
Rua Francisco Getúlio Vargas
s/n, Caixa Postal, 1352
Campus Universitário
95100 Caixas do Sul-RS-Brasil

Curso de Enfermagem
Fundação Universidade do Maranhão
Rua Rio Branco, 308
65.000 - São Luiz
MA - Brasil

Departamento de Enfermagem da Universidade Federal do Paraná
Rua Padre Camargo 280
Biblioteca 2 Andar
80000-Curitiba-PR-Brasil

Departamento de Enfermagem
Escola Paulista de Medicina
Rua Napoleão de Barros, 754
Vila Clementino
04.024 - São Paulo
SP - Brasil
Curso de Enfermagem da Escola de Ciências da Saúde e Promoção Social da Fesso-ccce
Ave. José Acacio Moreira
787 Dehon
88700-Tubarão-SC-Brasil

Curso de Enfermagem da Universidade Gama filho
Rua Mandel Vitorino
625-Piedade
20740-Rio de Janeiro-RJ-Brasil

Curso de Enfermagem Universidade de Passo Fundo
Caixa Postal 567
99100-Passo Fundo-RS-Brasil

Fac. Católica de Medicina de Porto Alegre
Caixa Postal 464
Porto Alegre
Rio Grande do Sul-Brasil

Centro Interescolar de Saúde de Brasília
Fundação Hospitalar do Distrito Federal
Ed. Pioneiras Sociais
Sala 3 (Protocolo Gral.)
Brasília, Brasil

Faculdade de Enfermagem da Universidade Federal do Mato Grosso
Ave. Fernando Correia da Costa, s/n
78000-Cuiabá-MT-Brasil

Centro de Formação Profissional Becerra de Araujo
Rua Barao de Mesquita, 701
Andarai
20540-Rio de Janeiro-Brasil

Fac. de Ciências da Saúde U.B.S.B. - Campus Universitario Bloco FE5
70910-Brasília-DF-Brasil

Faculdade Enfermagem São José Sociedade Instrução Popular e Beneficência
Rua Martínico Prado, 85
01.224 - Sao Paulo - SP - Brasil

Curso de Enfermagem Universidade Federal do Espirito Santo
Rua Pietrangelo de Biase, s/n CENTRO
29000-Victória-ES-Brasil

Curso de Enfermagem e Obstetricia
Fundação Educacional do Alto Uruguaí, Catarinense
Rua Lauro Muller 21
89700-Concordia-SC-Brasil

Curso de Enfermagem da Universidade de Taubate
Rua Conceleiro Moreira de Barros 177
12100-Taubate-SP-Brasil

Curso Superior de Enfermagem da BRA-8351
Universidade Estadual de Campinas
C.P. 1170
13100-Campinas-SP-Brasil

Centro de Ciências Biológicas e Médicas, PUC/SP
Praca Dr. José Erminio de Moraes, No. 290
18.100 - Sorocaba - SP - Brasil

Faculdade Adventista de Enfermagem
Estrada de Itapecirica da Serra, Km. 23
01.100-São Paulo-SP-Brasil

Departamento de Enfermagem Centro Ciências Saúde - UFRN
Av. Nilo Pecanha, 619 - Petrópolis
59.00 - Natal - RN - Brasil
Curso de Enfermagem e Obstetricia da Universidade Federal de Pelotas
Rua Duque de Caxias, 250
Bairro Fragata
Caixa Postal, 464
96100-Pelotas-RS-Brasil

Curso de Enfermagem
Alfredo Pinto FEFIERJ
Rua Dr. Xavie Siogoud, s/n
Botafogo
20.000 - Rio de Janeiro - RJ
Brasil

Curso de Enfermagem
Pontificia Universidade Católica de Campinas
Sociedade Campineira de Educacao
Rodovia Dr. Pedro I, Km. 112
13.100 - Campinas - SP - Brasil

Escola de Enfermagem
Universidade Sao Paulo
Av. Dr. Enéas de Carvalho Aguiar, 419
Caixa Postal 5751
05.403-Sao Paulo - SP - Brasil

Curso de Enfermagem
Universidade Católica do Paraná
Av. Imaculada Conceicao, 1155
80.000 - Curitiba - PR - Brasil

Departamento de Enfermagem
Fundacao Universidade Estadual de Londrina
Rua Pernambuco, 520
86.100 - Londrina - PR - Brasil

Faculdade Enfermagem Nossa Senhora Medianeira
Av. Presidente Vargas, 2377
97.100-Santa Marfa-RS-Brasil

Curso de Enfermagem
Centro de Ciencias Biomédicas
Universidade Valle dos Sinos
Praca Tiradentes, 35
93.000-Sao Leopoldo-RS-Brasil

Curso de Enfermagem
Fundacao Universidade Caxias do Sul
Rua Francisco Getulio Vargas
95.100-Caxias do Sul-RS-Brasil

Curso de Graduacao em Enfermagem
Bloco Modulado 3C
Campus Universitario Trinidad
Florianopolis - 88.000 - SC
Brasil

Curso de Enfermagem
Universidade Federal Rio Grande do Sul
Av. Protasio Alves, 297
90.000 - Porto Alegre - RS
Brasil

Curso de Enfermagem
Centro de Ciencias da Saude da UFCE
Av. Washington Soares, s/n
60.000 - Fortaleza - CE - Brasil

Curso de Enfermagem
Universidade Federal da Paraíba
Hospital das Clinicas
Cidade Universitaria
58.000 - Joao Pessoa - PB - Brasil

Curso de Enfermagem
Fundacao Regional do Nordeste
Campus Universitario-Bodocongo
58.100 - Campina Grande - PB
Brasil

Curso de Enfermagem
Universidade Federal Fluminense
Rua Miguel de Frias, 09-Icarai
24.000 - Niterói - RJ - Brasil

Curso de Enfermagem
Universidade Federal de Minas Gerais
Av. Alfredo Balena, s/n CP 1556
30.000 - Belo Horizonte - MG
Brasil
Departamento de Enfermagem
Sociedade Goiana de Cultura
1a. Avenida, 240
Setor Leste Universitário
74.000 - Goiânia - Go - Brasil

Escola de Enfermagem de Manaus
Rua Terezinha, 495-Adrianoopolis
69.000 - Manaus - AM - Brasil

Curso Superior de Enfermagem
Universidade Federal do Rio Grande do Norte
Rua Dionísio Filgueira, 386
59.600 - Mossorô - RN - Brasil

Curso de Enfermagem
Universidade Católica de Minas Gerais
Av. Dom José Gaspar, 500
Campus Prédio 25 3 andar
30.000-Belo Horizonte-MG-Brasil

Escola de Enfermagem Ana Neri - UFRJ
Cidade Universitaria
Centro Ciencias Saude
Bloco K - Sala 040
20.000-Rio de Janeiro-RJ-Brasil

Escola de Enfermagem São Vicente de Paulo
Av. do Imperador, 1367
60.000-Fortaleza-CE-Brasil

Escola de Enfermagem Hermantina Beraldo
Av. Dos Andradas, 170
36.100 - Juiz de Fora - MG
Brasil

Escola de Enfermagem Wenceslau Braz
Av. Cesário Alvim, 472
37.500 - Itajubá - MG - Brasil

Escola de Enfermagem Magalhães Barata, FEEP
Av. José Bonifácio, 1289 - Guamá
66.000 - Belem - PA - Brasil

Curso de Enfermagem
Universidade Federal de Pernambuco
Av. Prof. Moraes do Rego, s/n
Cidade Universitaria
50.000 - Recife - PE - Brasil

Curso de Enfermagem
Nossa Senhora Das Graças
Rua Henrique Dias, 208
- CP 1742
50.000 - Recife - PE - Brasil

Curso de Enfermagem
Fundação Universidade Federal do Acre
Av. Getulio Vargas, 666-Centro
69.900 - Rio Branco - ACRE
Brasil

Curso de Enfermagem
Fundação Universidade Federal do Piauí
Campus Universitário
Bairro Inincá
64.000-Terezinha - PI - Brasil

Curso de Enfermagem do Centro
Universidade Federal do Maranhão
Praca Gonzalves Duas, 21
Remédios
65.000-São Luís-MA-Brasil

Curso de Enfermagem
Universidade Católica de Minas Gerais
Av. Dom José Gaspar, 500
Campus Prédio 25 3o. andar
30.000 - Belo Horizonte - MG
Brasil

Curso de Enfermagem da Escola de Enfermagem Ana Neri - UFRJ
Cidade Universitaria
Centro Ciências a Saúde
Bloco K - Sala 040
20.000 - Rio de Janeiro - RJ
Brasil
Escola de Enfermagem
Sao Vicente de Paulo
Av. do Imperador, 1367
60.000 - Fortaleza - CE - Brasil

Escola de Enfermagem
Hermantina Beraldo
Av. dos Andradas, 170
36.100 - Juiz de Fora - MG
Brasil

Escola de Enfermagem de Ribeirao Preto
Campus Universitario de Ribeirao Preto
14.100 - Ribeirao Preto - SP
Brasil

Curso de Enfermagem da Escola de Enfermagem Magalhaes Barata
FEEP
Av. Jose Bonifacio, 1289
66.000 - Belem - PA - Brasil

Curso de Enfermagem da Univ. Federal de Fernambuco
Av. Prof Moraes do Rego, s/n
Cidade Universitaria
50.000 - Recife - PE - Brasil

Escola de Enfermagem Santa Emilia de Rodat
Praca Caldas Brandao s/n
58.000 - Joao Pessoa - PB - Brasil

Curso de Enfermagem Nossa Senhora das Gracas
Rua Henrique Diaz, 208
- CP 1742
50.000 - Recife - PE - Brasil

Curso de Enfermagem Fundacao Universidade Federal do Acre
Av. Getulio Vargas 666 - Centro
69.900 - Rio Branco - ACRE
Brasil

Curso de Enfermagem Universidade Federal do Ceará
Avenida da Universidade, 2853
Belfica
60.000-Fortaleza-CE-Brasil

Curso de Graduacao em Enfermagem
Universidade Federal de Sergipe
Rua Largato, 952 - Centro
49.000 - Aracajú - SE - Brasil

Curso de Enfermagem Universidade Federal do Espirito Santo
Rua Pietrangelo de Viase s/n
Centro 29.000-Vitoria-ES-Brasil

Curso de Enfermagem Departamento de Medicina Complementar
Campus Universitario - Asa Norte
70.000 - Brasilia - DF - Brasil

Curso de Enfermagem do Colegiado Enfermagem e Nutricao.
Quinta Avenida
Praca Universitaria s/n
74.000 - Goiania - GO - Brasil

Curso de Enfermagem Universidade Federal de Santa Maria
Campus Universitario - Km. 9
1184 - Camobi
97.100-Santa Maria-RS - Brasil

Curso de Enfermagem Faculdade de Filosofia e Enfermagem Sagrado Coracao
Rua Irma Arminda, 10-50
- J. Planalto
17.100 - Bauru - SP - Brasil

Curso de Enfermagem Universidade de Sao Carlos
Via Washington Luiz, Km. 235
13.560 - Sao Carlos - SP - Brasil
<table>
<thead>
<tr>
<th>Faculdade de Enfermagem</th>
<th>Universidade Estadual de Feira de Santana</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universidade Católica</td>
<td>Curso de Enfermagem</td>
</tr>
<tr>
<td>de Salvador</td>
<td>Universidade Federal do Paraná</td>
</tr>
<tr>
<td>Av. Joana Angélica</td>
<td>Rua Cavaleiro Lorea, 261</td>
</tr>
<tr>
<td>da Lapa-Nazare</td>
<td>96.200 - Rio Grande - RS -</td>
</tr>
<tr>
<td>40.000-Salvador-Bahía</td>
<td>Brasil</td>
</tr>
<tr>
<td>Brasil</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Curso de Enfermagem</td>
<td>Curso de Enfermagem</td>
</tr>
<tr>
<td>Universidade Federal do</td>
<td>Universidade Federal de Paraíba</td>
</tr>
<tr>
<td>Paraná</td>
<td>Praca Visconde de Sinimbu</td>
</tr>
<tr>
<td>Rua Cavaleiro Lorea, 261</td>
<td>Avenida Pedro II 231</td>
</tr>
<tr>
<td>1229 Centro</td>
<td>Joao Pessoa - Paraíba</td>
</tr>
<tr>
<td>80.000 - Curitiba - PR</td>
<td>Brasil</td>
</tr>
<tr>
<td>Brasil</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Curso de Enfermagem</td>
<td>Curso de Enfermagem</td>
</tr>
<tr>
<td>da PUC/RJ</td>
<td>Universidade Federal de Goiás</td>
</tr>
<tr>
<td>Rua Marques de Sao Vicente</td>
<td>Caxia Postal 9</td>
</tr>
<tr>
<td>20.000 - Rio de Janeiro-RJ-</td>
<td>74.000 - Goiania - GO -</td>
</tr>
<tr>
<td>Brasil</td>
<td>Brasil</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Curso de Enfermagem</td>
<td>Curso de Enfermagem</td>
</tr>
<tr>
<td>e Obstetricia de Sobral</td>
<td>Universidade Superior de Mogi das Cruzes</td>
</tr>
<tr>
<td>Av. da Universidade s/n</td>
<td>Rua Senador Dantas, 326 - Bl.</td>
</tr>
<tr>
<td>Betania</td>
<td>CCB Centro</td>
</tr>
<tr>
<td>62.100 - Sobral - CE</td>
<td>08.700 - Mogi das Cruzes - SP</td>
</tr>
<tr>
<td>Brasil</td>
<td>Brasil</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Director
Carrera de Enfermería
Universidad Tecnológica de los Llanos Orientales
Apartado Aereo 2621
Villa Vicencio, Meta
Colombia

Director
Facultad de Enfermería
Instituto de Ciencias de la Salud C.E.S.
Apartado Aereo 034591
Medellín, Colombia

Director
Escuela de Enfermería Cruz Roja Colombiana
Av. 68 Calle 66-31
Bogotá, D.E., Colombia

Director
Facultad de Enfermería
Universidad de Cartagena Sector Zaragocilla
Hospital Universitario de Cartagena
Cartagena, Colombia

Director
Programa de Enfermería Universidad Metropolitana
Carrera 42D No. 75B-169
Barranquilla, Colombia

Director
Programa de Enfermería Universidad Surcolombiana
Av. Pastrana Borrero Carrera 1a.
Apartado Aéreo 385
Neiva, Colombia

Director
Programa de Enfermería Universidad del Norte
Kilómetro 5 Vía Puerto Colombia
Apartado Aéreo No. 1569
Barranquilla, Colombia

Director
Programa de Enfermería Universidad de Sucre Sincelejo, Sucre, Colombia

Director
Programa de Enfermería Facultad de Ciencias de la Salud Universidad Popular del César César, Valledupar, Colombia

Director
Facultad de Enfermería Universidad de Antioquia Apartado Aéreo No. 1226
Medellín, Antioquia, Colombia

Director
Facultad de Ciencias de la Salud Escuela de Enfermería Universitaria
Av. Pastrana Borrero Carrera 1a.
Apartado Aéreo 385
Neiva, Colombia

Director
Facultad de Ciencias de la Salud Universidad de Sucre
Carrera de Enfermería Universidad de Antioquia
Apartado Aéreo No. 1226
Medellín, Antioquia, Colombia

Director
Facultad de Ciencias de la Salud Universidad de Antioquia
Apartado Aéreo No. 1226
Medellín, Antioquia, Colombia

Director
Programa de Enfermería Universidad de Córdoba Carretera a Cerréte
Montería, Colombia

Director
Departamento de Enfermería Instituto Universitario de Cundinamarca
Calle 16, Cra. 16
Girardot, Colombia

Director
Facultad de Ciencias de la Salud Escuela de Enfermería Universidad Pedagógica y Tecnológica de Colombia Carretera Central del Norte Tunja, Colombia

Director
Carrera de Enfermería Facultad de Ciencias de la Salud Hospital San José Calle 10a. No. 18-75
Bogotá, Colombia
Directora
Escuela de Enfermería
Cruz Roja Colombiana
Av. 68 Calle 66-31
Bogotá, D.E., Colombia

Directora
Facultad de Ciencias de la Salud
Departamento de Enfermería
Instituto Mariano Pasto
Calle 18 No. 34-104
Pasto, Narino, Colombia

Directora
Escuela de Enfermería Universidad del Cauca
Calle 5a. No. 4-70
Popayán, Colombia

Directora
Departamento de Enfermería Departamento de Ciencias Paramédicas
Universidad Industrial de Santander
Apartado Aéreo No. 678
Bucaramanga, Colombia

Directora
Escuela de Enfermeras Univ. Francisco Paula Santander
Av. Gran Colombia No. 12E-96
Apartado Aéreo 1055
Cucuta, Colombia

Directora
Departamento de Enfermería Universidad del Valle
Apartado Aéreo 2188
Cali, Colombia

Directora
Facultad de Enfermería Universidad Nacional de Colombia
Ciudad Universitaria
Bogotá, D.E., Colombia

Directora
Facultad de Enfermería Universidad Pontificia Javeriana
Carrera 7a. 40-82
Bogotá, D.E., Colombia

COSTA RICA

Escuela de Enfermería Universidad de Costa Rica
Apartado 2675
San José
Costa Rica

CUBA

Directora
Direc. Nac. Docencia Médica Media
Inst. Politécnico de la Salud "Clodomira Acosta"
Enfermería General
Ciudad Bayamo
Provincia Granma, Cuba

Directora
Direc. Nac. Docencia Médica Media
Inst. Politécnico de Enfermería "Rosa Castellanos"
Enfermería General
Municipio 10 de octubre
Prov. Ciudad Habana, Cuba
Directora
Programa de Licenciatura en Enfermería
Universidad de La Habana
Habana, Cuba

Directora
Direc. Nac. Docencia Médica Media
Inst. Politécnico de Enfermería "Pelegrina Sarda"
Enfermería General
Municipio Plaza de la Revolución
Prov. Ciudad Habana, Cuba

Directora
Direc. Nac. Docencia Médica Media
Inst. Politécnico de la Salud "Simón Bolívar"
Enfermería General
Pinar del Río
Provincia Pinar del Río, Cuba

Directora
Direc. Nac. Docencia Médica Media
Inst. Politécnico de Enfermería "Joaquín Albarrán"
Enfermería General
Municipio Cerro
Prov. Ciudad Habana, Cuba

Directora
Direc. Nac. Docencia Médica Media
Inst. Politécnico de la Salud "Miss Mary O'Donell"
Enfermería General
Municipio Plaza de la Revolución
Ciudad Habana, Cuba

Directora
Direc. Nac. Docencia Médica Media
Inst. Politécnico de Enfermería "Lidia Doce"
Municipio 10 de octubre
Prov. Ciudad Habana, Cuba

Directora
Direc. Nac. Docencia Médica Media
Esc. Politécnica de la Salud Manzanillo
Enfermería General
Municipio Manzanillo
Provincia Granma, Cuba

Directora
Direc. Nac. Docencia Médica Media
Inst. Politécnico de la Salud "Lidia Jovenau"
Enfermería General
Ciudad Matanzas
Provincia Matanzas, Cuba

Directora
Direc. Nac. Docencia Médica Media
Inst. Politécnico de la Salud de Villa Clara
Enfermería General
Ciudad Santa Clara
Provincia de Villa Clara, Cuba

Directora
Direc. Nac. Docencia Médica Media
Inst. Politécnico de la Salud "María Cabrera"
Municipio Boyeros
Prov. Ciudad Habana, Cuba

Directora
Direc. Nac. Docencia Médica Media
Inst. Politécnico de la Salud "Mercedes Tellez"
Municipio Cerro
Prov. Ciudad Habana, Cuba

Directora
Direc. Nac. Docencia Médica Media
Inst. Politécnico de Salud "cmdte. Arides Estevez"
Enfermería General
Ciudad Holguín
Provincia de Holguín, Cuba
Directora
Direc. Nac. Docencia Médica Media
Inst. Politécnico de la Salud de Cienfuegos
Prov. Cienfuegos, Cuba

Directora
Direc. Nac. Docencia Médica Media
Inst. Politécnico de la Salud de Matanzas
Enfermería General
Ciudad Matanzas
Prov. Matanzas, Cuba

Directora
Direc. Nac. Docencia Médica Media
Inst. Politécnico de Enfermería de Colón
Enfermería General
Municipio Colón
Prov. Matanzas, Cuba

Directora
Direc. Nac. Docencia Médica Media
Inst. Politécnico de Enfermería "Mariana Grajales"
Enfermería General
Municipio Habana del Este
Prov. Ciudad Habana, Cuba

Directora
Direc. Nac. Docencia Médica Media
Inst. Politécnico de la Salud "Dr. Mario Muñoz"
Enfermería General
Ciudad Las Tunas
Prov. Las Tunas, Cuba

Directora
Direc. Nac. Docencia Médica Media
Escuela Politécnica de la Salud de Morón
Enfermería General
Municipio Morón
Prov. Ciego de Avila, Cuba

Directora
Direc. Nac. Docencia Médica Media
Instituto Politécnico de la Salud "Octavio de la Concepción"
Enfermería General
Camaguey
Prov. de Camaguey, Cuba

Directora
Direc. Nac. Docencia Médica Media
Inst. Politécnico de la Salud de Santiago de Cuba
Enfermería General
Santiago de Cuba
Prov. de Santiago de Cuba, Cuba

Directora
Direc. Nac. Docencia Médica Media
Inst. Politécnico de la Salud de Guantánamo
Ciudad de Guantánamo
Prov. Guantánamo, Cuba

Directora
Direc. Nac. Docencia Médica Media
Inst. Politécnico de Enfermería "Sagua la Grande"
Enfermería General
Municipio Sagua la Grande
Prov. Villa Clara, Cuba

Directora
Direc. Nac. Docencia Médica Media
Inst. Politécnico de la Salud "Ignacio Agramonte"
Enfermería General
Ciudad Camaguey
Prov. Camaguey, Cuba

Directora
Inst. Politécnico de la Salud Sancti Spiritus
Enfermería General
Ciudad Sancti Spiritus
Prov. Sancti Spiritus, Cuba
Directora
Direc. Nac. Docencia
Médica Media
Inst. Politécnico de la Salud
"Fe del Valle"
Enfermería General
Ciudad Ciego de Avila
Prov. Ciego de Avila, Cuba

Directora
Escuela de Enfermería
Universidad de Chile
Sede La Serena
Colina El Pino
Casilla 59 D
La Serena, Chile

Directora
Escuela de Enfermería
Universidad de Concepción
Casilla 603
Concepción, Chile

Directora
Departamento de Enfermería
Facultad de Medicina
División Norte
Universidad de Chile

Directora
Carrera de Enfermería
Universidad de Osorno
Osorno, Chile

Directora
Escuela de Enfermería
Universidad de Temuco
Casilla 54 D
Temuco, Chile

Directora
Escuela de Enfermería
Pontificia Universidad Católica de Chile
Av. Vicuna Mackenna No. 4686
1er Piso
Santiago, Chile

Directora
Inst. Politécnico de la Salud
Isla de la Juventud
Enfermería General
Ciudad Nueva Gerona
Municipio Especial
Isla de la Juventud
Cuba

Directora
Carrera de Enfermería
Universidad de Chile
División Oriente
Condell No. 343
Santiago
Chile

Departamento de Ciencias Biológicas y de la Salud
Carrera de Enfermería
Instituto Profesional de Punta Arenas
Casilla 113 D
Punta Arenas
Chile

Directora
Departamento de Enfermería
Facultad de Medicina
División Norte
Universidad de Chile

Directora
Carrera de Enfermería
Universidad de Valparaíso
Casilla 92-V
Valparaíso, Chile

Directora
Carrera de Enfermería
Universidad de Valparaíso
Casilla 92 V
Valparaíso, Chile
Directora  
Departamento de Enfermería  
Facultad de Medicina  
División Sur  
Universidad de Chile  
Barros Luco No. 3301  
Santiago, Chile  

Directora  
Carrera de Enfermería  
Universidad de Chillán  
Casilla 848  
Plaza de Armas  
Chillán, Chile  

Directora  
Carrera de Enfermería  
Universidad de Talca  
Casilla 747  
Talca, Chile  

Directora  
Escuela de Enfermería  
Universidad de Chillán  
Isla Teja Valdivia  
Casilla No. 567  
Valdivia, Chile  

ECUADOR  

Directora  
Escuela de Enfermería  
Universidad Estatal de Guayaquil  
Ciudadela Universitaria  
Apartado 4997  
Guayaquil, Ecuador  

Directora  
Escuela de Enfermería  
"San Vicente de Paul"  
Universidad Católica de Santiago de Guayaquil  
Apartado 4671  
Guayaquil, Ecuador  

Directora  
Escuela de Enfermería de Portoviejo  
Universidad Técnica de Manabí  
Portoviejo, Manabí  
Ecuador  

Directora  
Facultad de Enfermería  
Pontificia Universidad Católica  
Avenida 12 de Octubre Carrión  
Apartado 2184  
Quito, Ecuador  

Directora  
Escuela Nacional de Enfermería  
Universidad Central del Ecuador  
Av. Colombia s/n  
Quito, Ecuador  

EL SALVADOR  

Directora  
Escuela Nacional de Enfermería de San Salvador  
San Salvador  
El Salvador  

Directora  
Departamento de Enfermería  
Escuela Nacional de Enfermería  
Alameda Roosevelt  
Contiguo al Hospital Militar  
San Salvador, El Salvador
Directora
Escuela Nacional de Enfermería
Hospital de San Juan de Dios
Santa Ana, El Salvador

Director
Escuela de Enfermería
Dirección Regional de Salud
de San Miguel
San Miguel, El Salvador

GUATEMALA

Directora
Esc. Nac. de Enfermería
de Occidente
Apartado No. 14
Quetzaltenango, Guatemala

Directora
Esc. Nac. de Enfermería
de Cobán
Cobán Alta Verapaz, Guatemala

HAITI

Ecole Nationale D'Infirmières
des Cayes
Hôpital General des Cayes
Les Cayes, Haiti

Ecole National D'Infirmieres
"Notre Dame de la Sagesse"
Hôpital Justinien
Cap. Haitien, Haiti

Ecole National D'Infirmieres de
Port-au-Prince
Hôpital General
Rue Monseigneur Guilloux
Port-au-Prince, Haiti

HONDURAS

Directora
Escuela de Enfermería
Univ. Nac. Autónoma de Honduras
Facultad de Ciencias Médicas
Edificio Escuela de Enfermeras
2do. Piso
Tegucigalpa, Honduras

Directora
Escuela de Enfermeras
"Dr. Maurice Campagna"
Apartado Postal No. 33
La Ceiba, Atlantida, Honduras

Directora
Escuela de Enfermería
Universidad Autónoma de Honduras
Centro Universitario Regional
del Norte
Apartado 269
San Pedro de Sula, Honduras
MÉXICO

Directora
Carrera de Enfermería
Universidad Autónoma de
Aguascalientes
Galeana Num. 465
Aguascalientes, México

Directora
Escuela de Enfermería
María Esther Zuno de Echeverría
Cuauhtemoc Num. 446 Sur
Coahuila, México

Directora
Escuela de Enfermería
Instituto Autónomo de Ciencias
y Tecnología del Estado
Aguascalientes, Ags., México

Directora
Escuela Superior de Enfermería
Miguel Servet
Santelmo y Abelardo Rodríguez
Ensenada Baja California
México

Directora
Escuela de Enfermería del IMSS
Blvd. Salinas y Francisco
Cárdenas s/n
Tijuana, Baja California
México

Directora
Escuela de Enfermería
Universidad Autónoma de
Baja California
Guillermo Prieto y continuación
Obregón s/n
Mexicali, Baja California
México

Directora
Escuela de Enfermería de La Paz
(Escuela de Técnicos)
Carretera al Sur
- Bravo No. 1010
La Paz, Baja California, México

Directora
Escuela de Enfermería
Universidad del Carmen
Av. Aeropuerto y Benito Juárez
Ciudad del Carmen
Campeche, México

Directora
Escuela de Enfermería
Iberoamericana de
Guerrero y Padre de las Casas
Piedras Negras
Coahuila, México

Directora
Escuela de Enfermería
Centro Médico Quirúrgico
Av. Monterrey s/n
Zaragoza, Nueva Rosita
Coahuila, México

Directora
Escuela de Enfermería
"Dr. Santiago Valdés Galindo"
Fco. I Madero 1237
Saltillo, Coahuila, México
Directora
Escuela de Enfermería Num. 1
Universidad de Colima s/n
Colima, México

Directora
Esc. de Enfermería de Manzanillo
Manzanillo, Colima, México

Directora
Esc. de Enfermería del Instituto Ciencias y Artes de Chiapas
Carretera Panamericana Km. 1080
Chiapas, México

Directora
Esc. de Enfermería y Obstetricia
Hospital General Libertad
Paseo Triunfo de la República Num. 2401
Ciudad Juárez
Chihuahua, México

Directora
Escuela de Enfermería del Centro Médico de Especialidades
Av. de las Américas Num. 201
Ciudad Juárez
Chihuahua, México

Directora
Escuela de Enfermería del Hospital de Jesús
Eugenio Cintrón Num. 30
Parral, Chihuahua, México

Directora
Escuela de Enfermería Apartado Postal 245
Ciudad Delicias
Chihuahua, México

Directora
Esc. Enfermería y Obstetricia Anexa al Sanatorio "Palmore"
Incorporada a la Universidad de Chihuahua
Chihuahua
Chihuahua, México

Esc. Enfermería y Obstetricia.
Universidad Autónoma Chihuahua Rosales y Colón 3300
Chihuahua, Chihuahua, México

Directora
Esc. Enfermería y Obstetricia Universidad del Estado de Durango
Ave. Cuauhtémoc No. 223
Nte. Z.P. 34,000
Durango, Gto., México

Directora
Escuela de Enfermería de León Aquiles Serdán Num. 924
León, Guanajuato
México

Directora
Escuela de Enfermería de la Univ. de Guanajuato Mutualismo s/n Z.P. 4
Celaya, Gto., México

Directora
Escuela de Enfermería de Irapuato Calle Grecia 2981
Fracc. Cd. Deportiva C.P. 36500
Irapuato, Gto., México

Directora
Esc. Enfermería y Obstetricia de León Universidad de Guanajuato Aquiles Serdán, 924 C.P. 47000
León, Guanajuato, México

Escuela de Enfermería Universidad de Guanajuato Noria Alta s/n
Guanajuato, México
<table>
<thead>
<tr>
<th>Escuela de Enfermería</th>
<th>Universidad Autónoma de Guadalajara</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universidad de Guanajuato</td>
<td>Esquina Avenida Yanquis y Palermo</td>
</tr>
<tr>
<td>Morelos No. 232</td>
<td>Fracc. Acueducto Providencia</td>
</tr>
<tr>
<td>Irapuato, Guanajuato, México</td>
<td>Apartado Postal 1-440</td>
</tr>
<tr>
<td>Directora</td>
<td>Guadalajara, Jalisco, México</td>
</tr>
<tr>
<td>Escuela Enfermería</td>
<td>Directora</td>
</tr>
<tr>
<td>Universidad Autónoma de Guerrero</td>
<td>Esc. de Enfermería del IMSS</td>
</tr>
<tr>
<td>Av. Ruiz Cortines s/n</td>
<td>Vista Alegre</td>
</tr>
<tr>
<td>Vista Alegre</td>
<td>Acapulco, Guerrero, México</td>
</tr>
<tr>
<td>Directora</td>
<td>Directora</td>
</tr>
<tr>
<td>Esc. Enfermería y Obstetricia</td>
<td>Esc. Regional de Enfermería de Ciudad Guzmán</td>
</tr>
<tr>
<td>Universidad Autónoma de Guerrero</td>
<td>Enrique Díaz de León</td>
</tr>
<tr>
<td>Av. Juárez No. 38</td>
<td>Gonzalez Ortega s/n</td>
</tr>
<tr>
<td>Chilpancingo, Guerrero, México</td>
<td>La Barca, Jalisco, México</td>
</tr>
<tr>
<td>Directora</td>
<td>Directora</td>
</tr>
<tr>
<td>Esc. Enfermería y Obstetricia</td>
<td>Escuela de Enfermería de la Asociación Mexicana de la Cruz Roja</td>
</tr>
<tr>
<td>Universidad Autónoma de Hidalgo</td>
<td>Av. Ejército Nacional Num. 1032</td>
</tr>
<tr>
<td>Esquina Pasteur y Manuel Gea Gonzalez s/n</td>
<td>México 10, D.F., México</td>
</tr>
<tr>
<td>Pachuca, Hidalgo, México</td>
<td>Directora</td>
</tr>
<tr>
<td>Directora</td>
<td>Escuela de Enfermería</td>
</tr>
<tr>
<td>Universidad de Guadalajara</td>
<td>del Hospital Anglo-Americano</td>
</tr>
<tr>
<td>Sierra Nevada y Caucaso</td>
<td>Sur 136 y Av. Observatorio</td>
</tr>
<tr>
<td>Colonia Independencia</td>
<td>México 18, D.F., México</td>
</tr>
<tr>
<td>Guadalajara, Jalisco, México</td>
<td>Directora</td>
</tr>
<tr>
<td>Directora</td>
<td>Escuela de Enfermería</td>
</tr>
<tr>
<td>Escuela de Enfermería</td>
<td>del Hospital Español</td>
</tr>
<tr>
<td>Fray Antonio Alcalde</td>
<td>Av. Ejército Nacional Num. 613</td>
</tr>
<tr>
<td>Miguel Blanco Num. 1225</td>
<td>México 5, D.F., México</td>
</tr>
<tr>
<td>Guadalajara, Jalisco, México</td>
<td>Directora</td>
</tr>
<tr>
<td>Directora</td>
<td>Escuela de Enfermería</td>
</tr>
<tr>
<td>Escuela de Enfermería de Ocotlán</td>
<td>Escandón</td>
</tr>
<tr>
<td>Hidalgo, Num. 175-A</td>
<td>Gaviota Num. 33</td>
</tr>
<tr>
<td>Ocotlán, Jalisco, México</td>
<td>Col. Tacubaya</td>
</tr>
<tr>
<td>Directora</td>
<td>México 18, D.F., México</td>
</tr>
<tr>
<td>Directora</td>
<td>Escuela de Enfermería</td>
</tr>
<tr>
<td>Universidad Autónoma de Guadalajara</td>
<td>de Ocotlán</td>
</tr>
<tr>
<td>Lomas del Valle 1a. Sección</td>
<td>Guadalajara, Jalisco, México</td>
</tr>
</tbody>
</table>
Directora
Escuela de Enfermería del Hospital Guadalupe
Pza. de San Lorenzo Num. 13
Col. Guadalupe Tepeyac
México 14, D.F., México

Directora
Escuela de Enfermería del Instituto Marillac
Frontera Num. 60
San Angel de Tizapan
México 20, D.F., México

Directora
Escuela de Enfermería del Instituto Nacional de Cardiología Periférico Sur Num. 3459 (Esq. Viaducto Tlalpan)
México 22, D.F., México

Directora
Escuela de Enfermería del ISSSTE
Roberto Gayol Num. 1421
Col. del Valle
México 12, D.F., México

Directora
Escuela de Enfermería del Instituto Nacional de la Defensa Nacional
Dir. General de Educación Militar
Jardines Ponientes del Hosp. Central Militar
Lomas de Sotelo
México 10, D.F., México

Directora
Esc. Militar de Enfermeras de la Sta. de la Defensa Nacional

Directora
Escuela de Enfermería y Obstetricia del Inst. Politécnico Nacional
Prolongación de Carpio y Plan de Ayala
Santo Tomás México 17, D.F., México

Directora
Enep - Ixtacala
Carrera de Enfermeras
Los Reyes Ixtacala
Tlalnepantla
Edo. de México, México

Directora
Escuela de Enfermería y Obstetricia
Univ. Autónoma del Estado de México
Paseo Toluca, esq. Jesús Carranza
Toluca, Edo. de México, México

Directora
Colegio de la Comunidad de Ciudad Nezahualcóyotl
Prep. y Esc. de Enfermería
Condesa y Av. Aviación Civil
Vicente Villada
Eduardo Ruiz Num. 152
Morelia, Michoacán, México

Directora
Universidad Michoacana de "San Nicolás de Hidalgo"
Gertrudis Bocanegra Num. 330
Morelia, Michoacán, México

Directora
Esc. Enfermería del Hospital de "Nuestra Señora de la Salud"
Eduardo Ruiz Num. 152
Morelia, Michoacán, México

Directora
Esc. Enfermería del Hospital San José
Hidalgo, 62 - Sur
Zamora, Michoacán, México
Escuela de Enfermería
Primo Tapia
Naranjo de Tapiua - Zacapu
Michoacán, México

Directora
Escuela de Enfermería
Dr. Jesús Silva
Calz. Feay Juan de San Miguel
Num. 6, Uruapan
Michoacán, México

Directora
Escuela de Enfermería de Apatzingan
(Anexo Hospital General)
Emiliano Zapata
y Av. Constitución
Num. 601 - Apatzingan
Michoacán, México

Directora
Escuela de Enfermería "María Nava"
Esq. Aldama y Mina
Maravatío
Michoacán, México

Directora
Escuela de Enfermería
Florencia N.
Miguel Carrillo Landa y Pina
Zitacuaro
Michoacán, México

Escuela de Enfermería
Dr. Ignacio Medrano Tolón
Emiliano Zapata Num. 35
Ap. Postal 26, Centro
Yautepec, Morelos, México

Directora
Esc. de Enfermería y Obstetricia
Univ. Autónoma del Estado de Morelos
Av. Morelos 136, Centro
Cuernavaca
Morelos, México

Directora
Esc. de Enfermería Cuautla
Constituyentes Num. 211
Centro - Cuautla
Morelos, México

Escuela de Enfermería
"Dr. José Joaquín Herrera"
Ciudad de la cultura
Amado Nervo Tepic
Nayarit, México

Escuela de Enfermería
Universidad Autónoma de Nuevo León
Calzada Madero Pte.
y Av. Gonzalitos
Monterrey, Nuevo León, México

Directora
Esc. de Enfermería de la Universidad de Montemorelos
Carr. México Km. 906
Montemorelos
Nuevo León, México

Directora
Esc. Enfermería y Obstetricia de la Clínica de Maternidad Conchita
A.C. - Matamoros Num. 1603
Monterrey
Nuevo León, México

Directora
Esc. Enfermería de los Servicios Coordinados de Educ. Pública
Edo. de Nuevo León
Vallarta Sur, 4-35 - Monterrey
Nuevo León, México

Directora
Esc. de Enfermería de San Vicente
Hospital San Vicente
Serafin Pena Num. 106
Pte. Monterrey
Nuevo León, México
Directora
Escuela de Enfermería de la Cruz Roja
José y Martínez
Universidad y Canelo
Delegación Monterrey
Nuevo León
México

Escuela de Enfermería y Obstetricia
Universidad Autónoma "Benito Juárez"
Calzada San Felipé del Agua s/n
Oaxaca, Oaxaca
México

Escuela de Enfermería y Obstetricia
Universidad Autónoma de San Luis Potosí
Ave. de los Poetas No. 1
San Luis Potosí, S.L.P., México

Escuela de Enfermería
Trabajo Social
Universidad de Sonora
Hermosillo, Sonora, México

Amelia Sanchez Bulnes
Escuela de Enfermería
Universidad Juárez Autónoma de Tabasco
Hospital "Juan Graham Casaus"
Villahermosa, Tabasco, México

Escuela de Enfermería y Obstetricia
Universidad Autónoma de Tamaulipas
Calle Marte y Saturno-Cop. Alianza
Apartado Postal No. 6
H. Matamoros
Tamaulipas, México

Escuela de Enfermería y Obstetricia
Universidad Autónoma de Tamaulipas
Nuevo Laredo, Tamaulipas
México

Escuela de Enfermería Universitaria
Universidad de Veracruzana
Zamora No. 25
Xalapa-Enríquez, México

Escuela de Enfermería Universidad Veracruzana
Poza Rica, Veracruz, México
Escuela de Enfermería
Universidad de Yucatán
Interior del Hospital O'Horan
Apartado Postal 871
Mérida, Yucatán, México

Esc. Sup. Enfermería
y Obstetricia
Instituto Tecnológico de Sonora
R. Elías Calles y Chihuahua
Ciudad Obregón, Sonora, México

Esc. Enfermería y Obstetricia
Universidad de Zacatecas
Zacatecas, Zacatecas, México

Escuela de Enfermería
Instituto Nacional de Nutrición
"María Elena Maza Brito"
Avenida San Fernando y Viaducto Tlalpan
México 7, D.F., México

Escuela de Enfermería de la
Escuela Libre de Homeopatía
Santa Lucía No. 6
México 2, D.F., México

Escuela de Enfermería de la
Secretaría de Salubridad y Asistencia
Hospital General
Dr. Balmis No. 148
México 7, D.F., México

Escuela de Enfermería del
Hospital Colonia de los Ferrocarriles Nac. de México
Manuel Villalongín, 117
México, D.F., México

Escuela de Enfermería de Mazatlán
Universidad Autónoma de Sinaloa
Sixto Osuna No. 13 Puente
Mazatlán, Sinaloa, México

Departamento de Enfermería
Educación Profesional en Salud Pública de la S.S.A.
Avenida Dr. Francisco de P. Miranda 177, 3
México, D.F., México

Esc. Enfermería y Obstetricia
Universidad Veracruzana de Orizaba
Ave. Colón Oriente, 1300 Esq. Sur-25
Orizaba, Veracruz, México

Escuela de Enfermería
Universidad Autónoma de Sinaloa
Culiacán, Sinaloa, México

Esc. Enfermería y Obstetricia
Universidad Nacional Autónoma de México
Brasil 35
México, D.F., México

NICARAGUA

Directora
Escuela Nacional de Enfermería
Apartado Postal No. 2267
Managua, D.N., Nicaragua

Directora
Escuela de Enfermeras
Hospital Adventista
La Trinidad, Esteli, Nicaragua
Directora
Escuela Bautista de Enfermería
Instituto Politécnico Nicaragua
Apartado 3595
Managua, Nicaragua

Directora
Escuela de Enfermería de Puerto Cabezas
Politécnico de Salud
Managua, Nicaragua

Directora
Escuela de Enfermería de la Univ.
Politécnica de Managua
Managua, Nicaragua

PANAMA

Directora
Escuela de Enfermería Comunitaria
Hospital Regional de Azuero
Provincia de los Santos
Panamá, República de Panamá

Directora
Escuela de Enfermería
Universidad Nacional de Panamá
Apartado 3368
Panamá 4, Panamá

PARAGUAY

Directora
Escuela de Enfermería
Instituto Dr. Andres Barbero
Universidad Nacional Asunción
Cruz Roja Paraguaya 2do. piso
Asunción, Paraguay

Directora
Universidad Católica
Escuela de Enfermería
Nuestra Señora de la Asunción
Lirio y Emeterio Miranda
Asunción, Paraguay

PERU

Directora
Programa Académico de Enfermería
Univ. Católica "Santa Marfa"
Casilla No. 1350
Arequipa, Perú

Directora
Escuela de Enfermería
Universidad Nacional de San Agustín
Casilla 23
Arequipa, Perú

Directora
Programa Académico de Enfermería
Universidad Nacional de Cajamarca
Guillermo Urrelo 1042
Cajamarca, Perú

Directora
Escuela de Enfermería
Hospital San Juan de Dios
Av. Guardia Chalaca 860
Callao, Perú
Directora
Escuela de Sanidad de la Marina
"Cirujano Felipe M. Rotalde"
Centro Médico Naval
Av. Venezuela s/n
Callao, Lima, Perú

Directora
Prog. Académico de Enfermería
y Obstetricia
Universidad Nacional
San Cristobal de Huamanga
Portal Independencia No. 50
Ayacucho, Perú

Directora
Escuela de Enfermería
Jirón Lima 549
Apartado No. 16
Cajamarca, Perú

Directora
Programa Académico
de Enfermería
Universidad "Daniel A. Carrión"
Apartado 77 - San Juan
Cerro de Pasco, Perú

Directora
Programa Académico
de Enfermería
Universidad Nacional de
San Antonio Abad
Apartado 367
Cuzco, Perú

Directora
Programa Académico
de Enfermería
Universidad Nacional "Faustino
Sanchez Carrión"
Huacho, Perú

Directora
Prog. Académico Enf.
y Obstetricia
Universidad Nacional
"Hermilio Valdizan"
Centro Universitario Cayhuayán
2 de Mayo No. 680
Huánuco, Perú

Directora
Prog. Académico de Enfermería
y Servicio Social
Univ. Nacional del Centro
del Perú
Calle Real 160, Apto. 77
Huancayo, Perú

Directora
Programa Académico
de Enfermería
Univ. Nac. de la Amazonia
Peruana
Apartado 496
Iquitos, Perú

Directora
Esc.de Enfermeras del Inst.
Peruano de la Seguridad
Social
Av. Cangallo 180
Lima, Perú

Directora
Progr. Docente de Ciencias
para la Salud del Ejército
(PRODOCISA)
Av. Brasil s/n
Jesús María
Lima, Peru

Directora
Escuela de Enfermería
Caja Nacional del Seguro Social
Hospital Obrero, Ave. Grau 700
Lima, Perú

Directora
Escuela de Enfermeras
Clínica Anglo-Americana
Apartado 2713
Lima, Perú
Directora
Escuela Nacional de Enfermería
Sociedad de Beneficencia
Pública de Lima (Ex-Hospital "Arzobispo Loyaza")
Baqueros s/n
Lima, Perú

Directora
Centro de Formación Profesional
Paramédica de Sanidad de las Fuerzas Policiales
Ministerio del Interior
Avenida Brasil Cuadra 26
Jesús María
Lima, Perú

Directora
Escuela Nacional de Enfermería
"Hospital del Niño"
Avenida Brasil 642
Lima, Perú

Directora
Programa Académico Enfermería
Univ. Nacional de San Martín
Tarapoto, San Martín, Perú

Directora
Programa Académico de Enfermería
Univ. Nacional de Pucallpa
Pucallpa, Ucayali, Perú

Directora
Programa Académico
de Enfermería
Universidad Nacional de San Martin
Tarapoto, San Martin, Perú

Directora
Programa Académico de Enfermería
Universidad Nacional del Altiplano
Ciudad Universitaria
Apartado 291
Puno, Perú

Directora
Programa Académico de Enfermería
Universidad Nacional Técnica de Salud
Avenida Pacheco No. 362
Tarma, Junín, Perú

Directora
Escuela de Enfermería Regional del Centro Ministerio de Salud
Calle Federico Barreto s/n
Tacna, Perú

Directora
Programa Académico de Enfermería
Universidad Nacional de Trujillo
Apartado No. 315
Trujillo, Perú

REPUBLICA DOMINICANA

Directora
Escuela de Enfermería
Universidad Católica Madre y Maestra
Calle 1 No. 10
Santiago de los Caballeros
República Dominicana

Directora
Departamento de Enfermería
Facultad de Ciencias Médicas
Universidad Autónoma de Santo Domingo
Santo Domingo
República Dominicana

URUGUAY

Directora
Escuela de Enfermería
Universidad de la República
General Flores 2125
Montevideo, Uruguay

Directora
Escuela de Enfermería
"Dr. Carlos Nery"
Sarandi 122
Montevideo, Uruguay
VENEZUELA

Directora
Escuela Nacional de Enfermería
Ciudad Universitaria
Prolongación Avenida Fernando Peñalver 59
San Bernardo
Caracas, Venezuela

Directora
Escuela Nacional de Enfermería
"Marfa Almenar"
Caracas, Venezuela

Directora
Escuela Nacional de Enfermería
"Dr. Francisco A. Risquez"
Avenida Andrés Bello
Cruz Roja
Caracas, Venezuela

Directora
Escuela Municipal de Enfermería
Caracas, D.F., Venezuela

Directora
Escuela de Enfermería
"Florencia Nightigale"
Avenida Principal Las Palmas
Quinta Fina
Urbanización Las Palmas
Caracas, D.F., Venezuela

Directora
Escuela Nacional de Enfermería
"Nerza Gonzalez"
San Cristobal, Estado Táchira
Venezuela

Directora
Escuela Nacional de Enfermería
"Dr. Francisco A. Risquez"
Urbanización "La Margarita"
Valencia, Estado de Carabobo
Venezuela

Directora
Escuela Nacional de Enfermería
"Dr. Francisco Suarez"
Maracaibo, Estado Zulia,
Venezuela

Directora
Escuela Nacional de Enfermería
"Dr. Domingo Badaracco Bermudez"
Urbanización Caiguire
Calle Bolívar
Cumaná, Estado Sucre
Venezuela

Directora
Escuela de Enfermería
Universidad del Zulia
Maracaibo, Estado Zulia
Venezuela

Directora
Esc. de Enfermería
Universitaria de Mérida
Universidad de los Andes
Antigua Maternidad
Avenida Urdaneta
Mérida, Estado Mérida,
Venezuela

Directora
Esc. de Enfermería
Universitaria
Universidad de Carabobo
Valencia, Estado Carabobo
Venezuela

Directora
Esc. Nac. de Enfermería
"Dr. Juan A. Olivares"
Barquisimeto, Estado de Lara
Venezuela
Coordinadora Programa de Enfermería
Ciclo Básico Antonio José de Sucre
Final Calle El Lago
Los Magallanes, Catia
Caracas, Distrito Federal
Venezuela

Coordinadora Programa de Enfermería
Ciclo Básico Mariano Picón Salas
Urbanización Lebrum
Avenida Francisco de Miranda
Caracas, Distrito Federal
Venezuela

Coordinadora Programa de Enfermería
Ciclo Básico Andrés Bello
Calle El Canal
Cooperativa las Delicias
Maracay, Estado Aragua
Venezuela

Coordinadora Programa de Enfermería
Ciclo Diversificado Fernando Peñalver
Avenida Cardozo
Ciudad Bolívar Estado Bolívar
Venezuela

Coordinadora Programa de Enfermería
Ciclo Diversificado Alberto Carnevali
Octava Carrera s/n
El Tigre Estado Anzoátegui
Venezuela

Coordinadora Programa de Enfermería
Escuela Normal
Alejandro Fuenmayor
Urbanización Monteclaro
Al lado del grupo escolar
23 Enero
Maracaibo Estado Zulia
Venezuela

Coordinadora Programa de Enfermería
Ciclo Diversificado Jesús Enrique Losada
Los Haticos
Maracaibo Estado Zulia
Venezuela

Coordinadora Programa de Enfermería
Ciclo Diversificado" Chávez"
Avenida 14, Urbanización Las 40
Maracaibo, Estado Zulia
Venezuela

Coordinadora Programa de Enfermería
Ciclo Diversificado "Dr. Emilio Muñoz"
Avenida San Fernando de León
Guanare, Estado Portuguesa
Venezuela

Coordinadora Programa de Enfermería
Ciclo Diversificado "José Antonio Páez"
Calle 3, Frente al Parque Andrés Eloy Blanco
Acarigua, Estado Portuguesa
Venezuela

Coordinadora Programa de Enfermería
Ciclo Diversificada Alberto Arístides Rojas
Avenida La Patria
San Felipe, Estado Yaracuy
Venezuela

Coordinadora Programa de Enfermería
Ciclo Diversificado Pedro María Morantes
La Concordia
Prolongación Carrera 12
San Cristóbal, Estado Táchira
Venezuela
<table>
<thead>
<tr>
<th>Coordinadora Programa de Enfermería</th>
<th>Coordinadora Programa de Enfermería</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ciclo Diversificado &quot;Francisco Isnardi&quot;</td>
<td>Ciclo Diversificado Miguel José Sanz</td>
</tr>
<tr>
<td>Avenida Bicentenario</td>
<td>Avenida Libertador</td>
</tr>
<tr>
<td>Maturín, Estado Monagas</td>
<td>Frente al Seminario</td>
</tr>
<tr>
<td>Venezuela</td>
<td>Barquisimeto, Estado Lara</td>
</tr>
<tr>
<td></td>
<td>Venezuela</td>
</tr>
<tr>
<td>Coordinadora Programa de Enfermería</td>
<td>Coordinadora Programa de Enfermería</td>
</tr>
<tr>
<td>Ciclo Diversificado &quot;Creación&quot;</td>
<td>Ciclo Diversificado Gervasio Rubio</td>
</tr>
<tr>
<td>Calle Vargas 23 de Enero</td>
<td>Prolongación Las Américas</td>
</tr>
<tr>
<td>San Carlos, Estado Cojedes</td>
<td>Rubio, Estado Táchira</td>
</tr>
<tr>
<td>Venezuela</td>
<td>Venezuela</td>
</tr>
<tr>
<td>Coordinadora Programa de Enfermería</td>
<td>Coordinadora Programa de Enfermería</td>
</tr>
<tr>
<td>Ciclo Diversificado Cristobal Méndez</td>
<td>Escuela Técnica &quot;Dr. Francisco A. Risquez&quot;</td>
</tr>
<tr>
<td>Avenida Cuatricentenaria</td>
<td>Urbanización La Margarita</td>
</tr>
<tr>
<td>Trujillo, Estado Trujillo</td>
<td>Valencia, Estado Carabobo</td>
</tr>
<tr>
<td>Venezuela</td>
<td>Venezuela</td>
</tr>
<tr>
<td>Coordinadora Programa de Enfermería</td>
<td>Directora</td>
</tr>
<tr>
<td>Ciclo Diversificado Cecilio Acosta</td>
<td>Escuela de Enfermería</td>
</tr>
<tr>
<td>Calle Juan de Ampúes</td>
<td>Calle 24 (Rangel) No. 7-80</td>
</tr>
<tr>
<td>Coro, Estado Falcón</td>
<td>Mérida, Estado Mérida</td>
</tr>
<tr>
<td>Venezuela</td>
<td>Venezuela</td>
</tr>
</tbody>
</table>
APPENDIX B

LIST OF SCIENTIFIC PUBLICATIONS ON NURSING AND NURSING REPORTS

Scientific Publications:

NUMBER


42. Seminario Didáctico Internacional sobre Levantamientos de Enfermagem (Salvador, Bahía, Brasil, 6-15 de julio de 1958). 1959


57. CIE-Principios básicos de los cuidados de enfermería 1961.


78. Enfermería-Recopilación de trabajos. (No. 1) 1963.


Scientific Publications (Cont'd)

NUMBER

259. Seminario sobre Enseñanza de Enfermería a Nivel Universitario - Informe Final (Lima, Perú, 22 de noviembre - 3 de Diciembre de 1971). 1973;


333. Epidemiology and Nursing. 1976.

348. The Role of the Nurse in Primary Health Care. 1977.


383. The Role of the University of West Indies in Promoting Regional Health Service. 1979.


Nursing Reports:

NUMBER

Nursing reports (Cont'd)

NUMBER

2. Seminario de Enseñanza Avanzada de Enfermería. 4-10/11/62 Jamaica.


4. Seminario sobre Adiestramiento de Auxiliares de Enfermería. Melzar, Colombia. 6-16/12/64.

5. Seminar Nursing Services Planning for continuity of Nursing Care. 9-17/11/64 Trinidad, Tobago.


11. Relatorio do Seminario Regional sobre Assistencia Maternoinfantil no Nordeste do Brasil.

12. Guía de orientación y supervisión de Parteras Empíricas - (Para Enfermeras y Obstétricas Responsables del Programa)


Informe sobre Enfermería (Cont’d)

NUMBER


17. Proyecto para la evaluación de programas de educación de enfermería (Por Mayra Allen).


19. Papel de la Enfermera Obstétrica en la atención materno-infantil. (Informe de un grupo de trabajo).

20. Normas de atención de Enfermería Obstétrica en el Parto Normal y participación en el parto prematuro. 8-24/7/75 Uruguay (en CLAP).

APPENDIX C

QUESTIONNAIRE USED IN EXPLORATORY STUDY

ORGANIZACIÓN PANAMERICANA DE LA SALUD
Oficina Sanitaria Panamericana, Oficina Regional de la

ORGANIZACIÓN MUNDIAL DE LA SALUD

DIVISIÓN DE RECURSOS HUMANOS E INVESTIGACIÓN

INQUERITO SOBRE ENSINO DE ENFERMAGEM NA AMÉRICA LATINA
E AVALIAÇÃO DO PROGRAMA DE LIVROS DE TEXTO DE ENFERMAGEM

IDENTIFICAÇÃO

1. Nome da Faculdade ou Escola

2. Natureza da Instituição ou vínculo oficial
   (pública, privada, departamento do Ministério de Educação, Universidade, etc.)

3. Cidade, País

4. Endereço Postal

5. Nome do Diretor

6. Ano de Fundação

INSTRUÇÕES GERAIS

Este questionário diz respeito ao ensino de enfermagem na América Latina e avaliação do Programa Ampliado de Livros de Texto e outros Materiais Educacionais (PALTEX). Por favor indique as suas respostas circulando a alternativa adequada ou fornecendo a informação requerida. Em caso de dúvida, consulte as folhas de instrução suplementar.
1. **CURRÍCULO**

1. Quantas reformas curriculares ocorreram na escola desde a sua fundação?

2. Por favor envie-nos uma cópia de cada um dos currículos postos em execução desde a fundação da escola. Informe o número de cópias enviadas.

3. Indique a continuação como se originaram as iniciativas de reformas curriculares:

   (Selecione uma ou mais alternativas segundo cada reforma ocorrida e em caso de não ter a informação ou não saber deixe em branco)

<table>
<thead>
<tr>
<th>REFORMAS CURRICULARES</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMERO</td>
</tr>
<tr>
<td>ANO 19</td>
</tr>
</tbody>
</table>

   a) Como consequência de uma reforma curricular no país?
      - sim
      - não

   b) Como uma proposta originada pelo corpo docente?
      - sim
      - não

   c) Como uma proposta originada pelos estudantes?
      - sim
      - não

   d) Como uma proposta originada por consultores nacionais?
      - sim
      - não

   e) Como uma proposta originada por consultores internacionais?
      - sim
      - não

   f) Como uma proposta originada por estudo de avaliação do currículo?
      - sim
      - não

**Observação:** Se ocorreram mais de sete reformas curriculares, por favor adjunte informação utilizando a mesma lista de alternativas.
4. No currículo atual quantas horas anuais se dedica a:

<table>
<thead>
<tr>
<th>Ano Acadêmico</th>
<th>Primeiro</th>
<th>Segundo</th>
<th>Terceiro</th>
<th>Quarto</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Atividades teóricas?</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
</tr>
<tr>
<td>b) Atividades práticas?</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □ □</td>
</tr>
</tbody>
</table>

5. Para cada um dos currículos adotados por esta escola como resultado de reforma curricular, indique o total de tempo dedicado a atividades práticas e teóricas. (Se considera adequado uma aproximação).

<table>
<thead>
<tr>
<th>Procentagem (teoria)</th>
<th>Procentagem (prática)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Reforma Curricular</td>
<td>□ □ □ □ □ □ □ □ □</td>
</tr>
<tr>
<td>Primera</td>
<td>□ □ □ □ □ □ □ □ □</td>
</tr>
<tr>
<td>Segunda</td>
<td>□ □ □ □ □ □ □ □ □</td>
</tr>
<tr>
<td>Terceira</td>
<td>□ □ □ □ □ □ □ □ □</td>
</tr>
<tr>
<td>Quarta</td>
<td>□ □ □ □ □ □ □ □ □</td>
</tr>
<tr>
<td>Quinta</td>
<td>□ □ □ □ □ □ □ □ □</td>
</tr>
<tr>
<td>Sexta</td>
<td>□ □ □ □ □ □ □ □ □</td>
</tr>
<tr>
<td>Sétima</td>
<td>□ □ □ □ □ □ □ □ □</td>
</tr>
</tbody>
</table>

b) Esta resposta foi dada em base a uma aproximação? sim □ não □

Observação. Se ocorreram mais de sete reformas curriculares, por favor anexe informação de acordo com a classificação acima.
6. Em que estabelecimentos se realizam as atividades práticas, em que ano foram introduzidas e a que nível?

<table>
<thead>
<tr>
<th>N Í V E L</th>
<th>Internação</th>
<th>Consulta externa ou ambulatório</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Hospital universitário</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>b) Hospital estatal</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>c) Hospital da Previdência Social (INAMPS)</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>d) Hospital particular</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>e) Centro de Saúde</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>f) Posto de Saúde</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>g) Outros da comunidade (indique qual ou quais)</td>
<td>19</td>
<td></td>
</tr>
</tbody>
</table>

7. Em que ano a escola iniciou práticas em saúde pública? Ano 19____

Descriva resumidamente as atividades iniciais:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
10. A metodologia utilizada para o ensino teórico inclui:

a) Palestra ou exposição teórica?
   - sim □ não □

b) Instrução programada?
   - sim □ não □

c) Instrução individualizada?
   - sim □ não □

d) Seminários?
   - sim □ não □

e) Trabalhos de grupos?
   - sim □ não □

f) Outros (Indique quais)

11. Em que anos se introduziram as seguintes técnicas de ensino?

a) Instrução programada? Ano 19

b) Instrução modularizada? Ano 19

c) Técnicas ativas de ensino em grupo? Ano 19

d) Simulações? Ano 19

II: OBJETIVOS DA ESCOLA

1. Os objetivos da escola estão escritos?
   - sim □ não □

Observação: Por favor envie uma cópia dos objetivos.
8. Quantas horas anuais em saúde pública estão incluídas no currículo atual?

<table>
<thead>
<tr>
<th>Horas</th>
<th>Teoria</th>
<th>Prática</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Primer ano</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Segundo ano</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Terceiro ano</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Quarto ano</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

e) Descreva resumidamente as atividades práticas atuais:

9. Quais das seguintes atividades estão incluídas no currículo atual:

a) Anamnese do adulto? não □ sim □ ano de início 19__

b) Anamnese da criança? não □ sim □ ano de início 19__

c) Anamnese da gestante? não □ sim □ ano de início 19__

d) Exame físico do adulto? não □ sim □ ano de início 19__

e) Exame físico da criança? não □ sim □ ano de início 19__

f) Exame físico da gestante? não □ sim □ ano de início 19__

g) Consulta independente de enfermagem para adultos? não □ sim □ ano de início 19__

h) Consulta independente de enfermagem para crianças? não □ sim □ ano de início 19__

i) Consulta independente de enfermagem para gestantes? não □ sim □ ano de início 19__
2. Os três objetivos que a escola considera em orden de importância são:
   (Indique com o número 1 a mais importante, 2 a seguinte e 3 a terceira em importância)

<table>
<thead>
<tr>
<th>Orden de Importância</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Preparação para prestação de serviços:</td>
</tr>
<tr>
<td>- Atenção direta?</td>
</tr>
<tr>
<td>- Administração?</td>
</tr>
<tr>
<td>b) Preparação para investigação:</td>
</tr>
<tr>
<td>- Metodologia científica p/ investigação?</td>
</tr>
<tr>
<td>- Realização de investigação?</td>
</tr>
<tr>
<td>c) Preparação para docência:</td>
</tr>
<tr>
<td>- Educação para a comunidade?</td>
</tr>
<tr>
<td>- Educação para formação de pessoal?</td>
</tr>
<tr>
<td>d) Preparação de enfermeiras especializadas em áreas clínicas?</td>
</tr>
<tr>
<td>e) Preparação de enfermeiras especializadas em saúde pública?</td>
</tr>
<tr>
<td>f) Preparação de enfermeiras especializadas em administração?</td>
</tr>
</tbody>
</table>
3. Que áreas de especialização em enfermagem são oferecidas, e em que ano foram iniciadas?

a) Enfermagem médico/cirúrgica? não □ sim □ Ano de início 19___
b) Enfermagem pediátrica? não □ sim □ Ano de início 19___
c) Enfermagem obstétrica? não □ sim □ Ano de início 19___
d) Enfermagem materno/infantil? não □ sim □ Ano de início 19___
e) Enfermagem psiquiátrica? não □ sim □ Ano de início 19___
f) Enfermagem em saúde pública? não □ sim □ Ano de início 19___
g) Administração em enfermagem? não □ sim □ Ano de início 19___
h) Educação em enfermagem? não □ sim □ Ano de início 19___

III. PROFESSORES

1. Indique o número de professores segundo o tempo de trabalho:

<table>
<thead>
<tr>
<th>Número</th>
<th>Enfermeiras</th>
<th>Outros Professores</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Tempo integral</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>b) tempo parcial (40 horas)</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>c) Menos que tempo parcial (20 horas)</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>d) Por horas</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
2. Indique o número de professores enfermeiros segundo o nível de maior preparação acadêmica obtida.

<table>
<thead>
<tr>
<th>Número</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Enfermeiras</td>
</tr>
<tr>
<td>b) Licenciatura em Enfermagem</td>
</tr>
<tr>
<td>c) Especialização em Enfermagem</td>
</tr>
<tr>
<td>d) Mestrado</td>
</tr>
<tr>
<td>e) Doutorado</td>
</tr>
</tbody>
</table>

3. Quantos professores enfermeiros realizaram cursos de pós-graduação no:

<table>
<thead>
<tr>
<th>Número</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Próprio país?</td>
</tr>
<tr>
<td>b) América Latina?</td>
</tr>
<tr>
<td>c) Estados Unidos?</td>
</tr>
<tr>
<td>d) Outro (indique o lugar)</td>
</tr>
</tbody>
</table>
4. Indique o número de professores com especialização ou estudos acadêmicos de pós-graduação em:

<table>
<thead>
<tr>
<th>Número</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Enfermagem médico-cirúrgica</td>
<td></td>
</tr>
<tr>
<td>b) Enfermagem obstétrica</td>
<td></td>
</tr>
<tr>
<td>c) Enfermagem pediátrica</td>
<td></td>
</tr>
<tr>
<td>d) Educação em enfermagem</td>
<td></td>
</tr>
<tr>
<td>e) Enfermagem materno-infantil</td>
<td></td>
</tr>
<tr>
<td>f) Enfermagem em saúde pública</td>
<td></td>
</tr>
<tr>
<td>g) Administração em enfermagem</td>
<td></td>
</tr>
<tr>
<td>h) Especialista em prática independente</td>
<td></td>
</tr>
</tbody>
</table>

5. Os professores participam rotineiramente em atividades práticas como:

<table>
<thead>
<tr>
<th></th>
<th>sim</th>
<th>não</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Supervisores de estudantes?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Instrutores de estudantes?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Investigadores clínicos?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Membros da equipe nos estabelecimentos onde a escola utiliza como campo para estágio prático?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Quanto tempo, em média, os professores dedicam à atividade prática por semana para:

<table>
<thead>
<tr>
<th>Horas</th>
<th>Horas</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Supervisão de estudantes</td>
<td></td>
</tr>
<tr>
<td>b) Instrução de estudantes</td>
<td></td>
</tr>
<tr>
<td>c) Investigação clínica</td>
<td></td>
</tr>
<tr>
<td>d) Serviço em estabelecimentos que a escola utiliza como área de estágio prático.</td>
<td></td>
</tr>
</tbody>
</table>
IV. ESTUDANTES

1. Indique o número de estudantes graduados por décadas:

<table>
<thead>
<tr>
<th>Década</th>
<th>Feminino</th>
<th>Masculino</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) 1900-1920</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) 1921-1930</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) 1931-1940</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) 1941-1950</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) 1951-1960</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) 1961-1970</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) 1971-1980</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Quais têm sido os requisitos para admissão de estudantes na escola desde a sua fundação?

<table>
<thead>
<tr>
<th>Anos de escolaridade</th>
<th>Feminino</th>
<th>Masculino</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) 12 anos</td>
<td></td>
<td>desde 19__ até 19__</td>
</tr>
<tr>
<td>b) 11 anos</td>
<td></td>
<td>desde 19__ até 19__</td>
</tr>
<tr>
<td>c) 10 anos</td>
<td></td>
<td>desde 19__ até 19__</td>
</tr>
<tr>
<td>d) 9 anos</td>
<td></td>
<td>desde 19__ até 19__</td>
</tr>
<tr>
<td>e) 8 anos</td>
<td></td>
<td>desde 19__ até 19__</td>
</tr>
<tr>
<td>f) 7 anos</td>
<td></td>
<td>desde 19__ até 19__</td>
</tr>
<tr>
<td>g) 6 anos</td>
<td></td>
<td>desde 19__ até 19__</td>
</tr>
<tr>
<td>h) menos de 6 anos</td>
<td></td>
<td>desde 19__ até 19__</td>
</tr>
</tbody>
</table>
3. Indique o número de estudantes atualmente inscritos na escola:

<table>
<thead>
<tr>
<th>Número</th>
<th>Feminino</th>
<th>Masculino</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Primeiro ano</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>b) Segundo ano</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>c) Terceiro Ano</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>d) Quarto Ano</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

V. ADMINISTRAÇÃO

1. A escola é parte integrante de uma universidade? sim □  não □

2. Qual é a dependência administrativa da escola na Universidade?
   a) Unidade acadêmica isolada? sim □  não □
   b) Departamento dependente da escola de medicina? sim □  não □
   c) Departamento dependente da escola de ciências da saúde? sim □  não □
   d) Outra (indique qual) sim □  não □
3. A diretora da escola ou departamento é:
   a) Enfermeiro □
   b) Médico/médica □
   c) Outro profissional (indique qual) □

Em que ano uma enfermeira assumiu a direção da escola em forma permanente?
Ano 19____

4. As matérias de área básica de ciências pré-profissional são oferecidas por outras unidades acadêmicas da universidade?
   sim □   não □

5. Enumere os departamentos ou sessões acadêmicas da escola e as matérias sob a responsabilidade de cada um deles:
   (Descreva o organograma da escola e se possível envie uma cópia)
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
VI. ASSESSORIA OPS

1. A escola tem mantido convênios como a OPS?

<table>
<thead>
<tr>
<th>NÃO</th>
<th>SIM</th>
<th>ANOS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) 19</td>
<td>e) 19</td>
<td>i) 19</td>
</tr>
<tr>
<td>b) 19</td>
<td>f) 19</td>
<td>j) 19</td>
</tr>
<tr>
<td>c) 19</td>
<td>g) 19</td>
<td>k) 19</td>
</tr>
<tr>
<td>d) 10</td>
<td>h) 19</td>
<td>l) 19</td>
</tr>
</tbody>
</table>

2. Indique cada um dos convênios, a data de vigência e o consultor responsável.

<table>
<thead>
<tr>
<th>Objetivo da assessoria</th>
<th>Data</th>
<th>Assessor responsável</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Observação: Se houver mais convênios por favor adicione a informação utilizando...
3. A escola tem recebido assessoria da OPS sem convênios específicos?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Ano 19</td>
<td>Objetivo</td>
</tr>
<tr>
<td>b)</td>
<td>Ano 19</td>
<td>Objetivo</td>
</tr>
<tr>
<td>c)</td>
<td>Ano 19</td>
<td>Objetivo</td>
</tr>
<tr>
<td>d)</td>
<td>Ano 19</td>
<td>Objetivo</td>
</tr>
<tr>
<td>e)</td>
<td>Ano 19</td>
<td>Objetivo</td>
</tr>
<tr>
<td>f)</td>
<td>Ano 19</td>
<td>Objetivo</td>
</tr>
<tr>
<td>g)</td>
<td>Ano 19</td>
<td>Objetivo</td>
</tr>
<tr>
<td>h)</td>
<td>Ano 19</td>
<td>Objetivo</td>
</tr>
<tr>
<td>i)</td>
<td>Ano 19</td>
<td>Objetivo</td>
</tr>
<tr>
<td>j)</td>
<td>Ano 19</td>
<td>Objetivo</td>
</tr>
</tbody>
</table>

Observação: Se houve mais assessorias por favor anexe a informação utilizando o mesmo modelo acima.
VI. LIVROS DE TEXTO

1. A escola vem utilizando o programa de livros de texto da OPS?
   
   não □  sim □  Incluí em 19__

2. Aproximadamente quantos estudantes compram os livros do Programa de Livros de Texto da OPS?
   
   a) A maioria (80% - +)  sim □  não □
   b) A média (70% - +)  sim □  não □
   c) A menoria (30% - +)  sim □  não □

3. No caso que a resposta acima seja b ou c, quais acredita que são as razões mais importantes pelas quais os estudantes não utilizam o Programa de livros de texto da OPS?
   
   a) Os textos não correspondem aos recomendados pelos professores?
      □
   b) Existe pouca divulgação do programa?
      □
   c) Os estudantes em geral não utilizam textos?
      □
   d) Razões socioeconômicas dos estudantes?
      □
   e) Por problemas administrativos, tais como: os livros não chegam a tempo ou em número suficiente, etc.?  □
   f) Outras (Indique qual o quais)  □

______________________________________________

______________________________________________

______________________________________________
4. Qual dos seguintes livros do Programa Ampliado de Livros de Texto da OPS são recomendado aos alunos pelos professores da escola?

<table>
<thead>
<tr>
<th></th>
<th>Livro</th>
<th>Sim</th>
<th>Não</th>
<th>Razão (ou es)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>Enfermagem materno-infantil, Reeder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b</td>
<td>La práctica de enfermía de salud mental, Morgan Moreno.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>Enfermagem Médico-Cirúrgica, Smith</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>Enfermagem Pediátrica Weechter.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e</td>
<td>Enfermagem Prática Dugaz-Koziar</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f</td>
<td>Enfermagem de saúde comunitária, Archer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g</td>
<td>Intervención de enfermería psiquiátrica, Travelbee.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h</td>
<td>Métodos para el examen físico en la práctica de la enfermería, Sana-Judge.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i</td>
<td>Enfermagem médico-quirúrgico, Brunner</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. Dos livros de texto do Programa da OPS quais são mais utilizados pelos estudantes?

<table>
<thead>
<tr>
<th></th>
<th>sim</th>
<th>não</th>
<th>razão (oés)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Enfermagem materno-infantil, Reeder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) La práctica de enfermería de salud mental, Morgan Moreno</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Enfermagem Médico-Cirúrgica</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Enfermagem Pediatrêcia Weechter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) Enfermagem Práctica Dugaz-Kozi</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) Enfermeria de salud comunitaria, Archer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) Intervención en enfermería psiquiátrica, Travelbee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h) Métodos para el examen físico en la práctica de la enfermería, Sana-Judge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Enfermeria médica-quirúrgica, Brunner</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6. Que livros de texto no campo de enfermagem úteis para os estudantes a escola considera adequados para os propósitos do seu programa e que não estão incluídos no Programa da OPS.

<table>
<thead>
<tr>
<th>Título</th>
<th>Autor</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td></td>
</tr>
<tr>
<td>b)</td>
<td></td>
</tr>
<tr>
<td>c)</td>
<td></td>
</tr>
<tr>
<td>d)</td>
<td></td>
</tr>
<tr>
<td>e)</td>
<td></td>
</tr>
<tr>
<td>f)</td>
<td></td>
</tr>
<tr>
<td>g)</td>
<td></td>
</tr>
<tr>
<td>h)</td>
<td></td>
</tr>
<tr>
<td>i)</td>
<td></td>
</tr>
<tr>
<td>j)</td>
<td></td>
</tr>
</tbody>
</table>

7. Que medidas de divulgação existem para dar a conhecer o programa de livros de texto da OPS?

a) Para estudantes de enfermagem:

b) Para enfermeros graduados:

8. Qual é a participação da escola na administração do Programa de Libros de Texto?
INSTRUÇÕES SUPLEMENTARES DETALHADAS

Os números dos parágrafos abaixo, correspondem ao número de cada pergunta em cada seção do questionário. Não estão incluídas as pergunetas que não necessitam aclararções.

1: Currículo

1 e 2. Para fins desta pesquisa se define como currículo o conjunto de matérias, que compreendem as atividades teóricas e práticas que a escola programa com o propósito de cobrir o campo de conhecimentos correspondente a enfermagem.

Para a pergunta dois são importantes todas as listas de matérias e programas implementados em épocas diferentes desde a fundação da escola. Caso a história da escola tenha sido escrita, por favor envie-nos a bibliografia ou se possível, uma cópia do artigo.

3. Para esta pergunta se considera como reforma curricular as mudanças substantivas no conteúdo, metodologia e administração do currículo. Por exemplo, inclusão ou supressão de uma matéria; aumento ou diminuição relativa de tempo em uma área prática ou teórica; introdução de novas metodologias de ensino.

4 e 5. Esta pergunta pode ser respondida dando uma aproximação global do tempo total de atividades teóricas e práticas.

6. Considera-se nesta pergunta todos os estabelecimentos utilizados atualmente pela escola para as experiências práticas. Enumere as instituições não mencionadas nas alternativas.

7 3 8. Para estas duas perguntas, se considera como prática de saúde pública todas as atividades realizadas no primeiro nível de atenção em saúde, que incluem atividades de promoção e proteção da saúde de populações. Aceita-se uma aproximação global do tempo.

9. Esta pergunta inclui aspectos da função ampliada da enfermagem e suas alternativas se definem como:
   - anamnese: utilização de um questionário ou roteiro organizado de perguntas antes da consulta médica;
   - exame físico: quando é realizado pela enfermeira, previamente à consulta médica;
338

- 2 -

- consulta Independente de enfermagem: se refere às atividades realizadas por enfermagem em atenção primária, em que o paciente somente é referido para consulta médica se a enfermeira o recomenda.

11. Considera-se basicamente, dois grupos de metodologias no ensino teórico. As que não requerem uma participação ativa do estudante, (assistência a aulas, palestras, filmes, vídeo, diapositivos, etc.); e as que requerem uma participação ativa do estudante, (seminários, trabalhos de grupos, instrução programada ou modular, etc.).

12. Instrução programada é a metodologia que utiliza textos programados, em que o material está dividido em pequenos passos e o estudante trabalha de maneira dinâmica resolvendo problemas, respondendo perguntas, etc. (este material pode ser utilizado para substituir a palestra do professor ou reforçá-la.)

Ensino modular se refere a um pacote completo de ensino em que o estudante administra a sua própria aprendizagem de acordo com o seu ritmo próprio a fim de alcançar determinados objetivos e submeter-se a uma avaliação formativa, para progredir no programa.

Técnicas ativas de ensino em grupo são todas aquelas que incluem a participação de grupos de estudantes que trabalham em forma dinâmica para desenvolver um tema ou área de conhecimento, ex: trabalho em grupo, seminários, dinâmica de grupo, etc.

Por simulações se entende a utilização de situações semelhantes à realidade para a instrução. A simulação pode ser escrita, oral, por computador ou vídeo.

11. Objetivos da escola

1. Define-se como objetivos da escola as proposições gerais que indicam qual é a finalidade da escola e quais são as suas propostas, gerais e específicas com relação à formação de enfermeiros.

2. Nesta pergunta é importante que se indique qual tem sido o enfoque principal da escola na preparação de enfermeiros. As alternativas deste pergunta se definem como:

- Preparação para prestação de serviços em:
- Atenção direta: ênfase no cuidado direto de pacientes em unidades hospitalares e a atenção dirigida a grupos prioritários da população.
- Administração: ênfase em planificação, supervisão e controle da atenção de pacientes ou populações.

- Preparação para investigação em:
  - Metodologia científica/investigação: ênfase em iniciação à metodologia científica e técnicas de pesquisa.
  - Realização de investigação: inclui prática real no desenvolvimento de investigação em enfermagem.

- Preparação para o magistério em:
  - Educação da comunidade: que inclui fundamentos de ensino-aprendizagem, metodologias e técnicas básicas utilizadas em educação.
  - Educação para a formação de pessoal: que inclui fundamentos da teoria educacional e da educação em enfermagem, ademais da preparação nos pontos acima mencionados.

III. Programa

5. Entende-se por supervisão de estudantes ou controle das atividades práticas realizadas pelo estudante em que o professor visita a intervalos regulares os locais onde se encontram os estudantes.

Por instrução prática de estudantes se deve entender a permanência do professor nas salas e outros lugares durante todo o tempo em que estejam presentes os estudantes. O professor, nesta circunstância, demonstra e continuamente assessoria o trabalho do estudante.

6. Considera-se adequado uma aproximação do tempo médio que os professores atualmente se dedicam às atividades clínicas.

IV. Estudantes

1. Caso não seja possível responder completamente esta pergunta, comece pela década em que informação esteja disponível. Se não for possível a subdivisão por sexo, indique os totais fazendo a devida identificação.

2. Número de anos de estudos anteriores à admisão na escola.

3. Solicita-se uma lista das matérias oferecidas por outras unidades da universidade para estudantes de enfermagem.
VI. Consultorias da OPS

1 e 2. O principal objetivo desta pergunta é obter a enumeração mais completa possível das assessorias recebidas da OPS por esta escola.

VII. Livros de Texto

1. O Programa Ampliado de Livros de Texto e outros Materiais Educacionais (PALTEX) da OPS foi criado em 1966 e o seu objetivo principal é contribuir para o melhoramento da formação e capacitação do pessoal profissional, técnico e auxiliar para os serviços de saúde da América Latina.

3. Por livros recomendados por professores se entende os textos básicos indicados em um programa.

Por pouca divulgação do programa se entende a não existência de informação para os professores e estudantes sobre o programa.

Se estudantes utilizam apostilas da escola.

Se os estudantes tiveram problemas de recursos econômicos para a compra de livros.

4 e 5. Nesta pergunta estão incluídos todos os livros disponíveis na área de enfermagem através do Programa de Livros de Texto da OPS. Se a escola indica outros livros incluídos nesse programa, ou se os estudantes os utilizam, solicitar-se incluir uma lista desses textos.
APPENDIX D

LIST OF NURSING SCHOOLS INCLUDED IN EXPLORATORY STUDY

Escuela de Enfermería San Miguel de Tucuman, Argentina.
Escuela de Enfermería Universidad Nacional de Rosario, Argentina.
Escuela de Enfermería Instituto Personal Ferroviario, Buenos Aires, Argentina.
Escuela de Enfermería Universidad Nacional de Rio Cuatro, Cordoba, Argentina.
Escuela de Enfermería Sor Camila de San Jose Roldon, San Isidro, Argentina.
Escuela de Enfermería Colegio Adventista de la Plata, Argentina.
Escuela de Enfermería Escuela de Enfermería Guillermo C. Paterson, San Salvador, Argentina.
Carrera de Enfermería Universidad de Corrientes, Argentina.
Escuela de Enfermería de La Paz, Bolivia.
Escuela de Enfermería Universidad Miguel Sancho, Bolivia.
Escuela de Enfermería Universidad Católica Boliviana, Bolivia.
Escuela de Enfermagem da Universidade de Sao Paulo, Brasil.
Escuela de Enfermagem de Riberão Preto, Brasil.
Escola de Enfermagem Magalhaes Barata, Brasil.
Departmento da Enfermagem da Escola Paulista de Medicina, Brasil.
Escuela de Enfermería de Valdivia, Chile.

341
Appendix D (Cont'd)

Carrera de Enfermería Universidad Chile, Sede Norte, Chile.
Departamento de Enfermería Universidad Concepción, Chile.
Escuela de Enfermería Pontificia Universidad Católica, Chile.
Escuela de Enfermería de Magallanes, Punta Arenas, Chile.
Facultad de Enfermería Nacional de Colombia, Colombia.
Facultad de Enfermería Instituto de Ciencias de la Salud, Medellín, Colombia.
Facultad de Enfermería Universidad Metropolitana Barranquilla, Colombia.
Programa de Enfermería Universidad de Barranquilla, Colombia.
Facultad de Enfermería Villavicencio, Colombia.
Facultad de Enfermería UTPS, Colombia.
Escuela de Enfermería Surcolombiana, Neiva, Colombia.
Facultad de Enfermería, San José, Costa Rica.
Departamento de Enfermería de la Universidad de Santiago de los Caballeros, República Dominicana.
Escuela de Enfermería, Pontificia Universidad Católica de Ecuador, Ecuador.
Escuela Nacional de Enfermería de Guatemala, Guatemala.
Escuela Nacional de Enfermería de Occidente, Quetzaltenango, Guatemala.
Escuela de Enfermería CURN, Honduras.
Escuela de Enfermería y Obstetrica, Universidad Juárez, México.
Escuela de Enfermería Universidad de Leon, México.
Escuela de Enfermería Irapuato, Guanajuato, México.
Appendix D (Cont'd)

Escuela de Enfermería Stela Maris Zacapá, Michoacán, México.

Escuela de Enfermería Ntra. Sra. de la Assunción, Paraguay.

Escuela de Enfermería del Hospital Bautista, Paraguay.

Programa de Enfermería Universidad Nacional Huamucó Hermilio Valdés, Perú.

Programa Enfermería Universidad Arequipa, Perú.