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TRAINING AUXILIARY NURSING PERSONNEL IN HONDURAS:
AN ANALYSIS OF ITS DEVELOPMENT

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INTRODUCTION

Nursing has been a human activity ever since there have been sick people, and its importance in overall health care has always been recognized. Frequently, however, and especially at the present time, questions have arisen regarding the profession's contribution to the solution of health problems.

An analysis of the historical evolution of nursing practice and training may provide some insight into the contribution of the profession in the development of health-care efforts. At the same time it may highlight current problems, making it possible to develop health-care and training models designed to correct deficiencies.

At the same time, the practice of nursing cannot be analyzed without relating its evolution to health-care delivery. By and large, developments in nursing have been linked to the characteristics of service provided and by its actual role in health care. These, in turn, have tended to reflect general conditions in the country: economic structure, production methods, technological development, etc. This tendency whereby practice, training, and provision of services are closely linked is even more clearly reflected in the development of auxiliary nursing personnel.

For purposes of this analysis, the period from 1940 to the present will be studied in three stages which in our opinion mark important changes in Honduran health-care trends and reflect the determining factors of the overall social, political, and economic situation.

THE PERIOD 1940 - 1949

During this period, health efforts were based mainly on the notion that medical knowledge has been bestowed to cure existing ills: services were predominantly curative in orientation and they were dispensed mainly in hospitals. Nevertheless, some change was already beginning, and preventive medicine was starting its advance. It began with the training of health nurses, the first of whom arrived in Honduras fully trained in 1942 and undertook to give courses of three to six months' duration to other nurses.

Basic prevention efforts included the "Drop of Milk" program, in which children had their weight checked as well as receiving

milk; the monitoring of prostitutes, enforced by the sanitary police and involving regular medical attention; treatment for parasites in schools; and smallpox vaccination.

Not only were services basically curative and confined to hospitals and similar institutions, but the scope of health efforts was basically limited to the towns and especially the capital. Folk medicine therefore remained the source for most health care.

As for nursing, there were very few professionals in the modern sense; most of it was carried out by nuns with little or no formal training. Nurse's aids developed their skills as best they could, with "on-the-job-training" from nuns in hospitals. Most of such individuals were selected on the basis of their performance in housekeeping duties or spotted among cleaning or kitchen staffs as possessing the talents necessary for direct care of patients.

It has been noted that PAHO first directed serious attention to nursing in the 1940s, when the organization began to expand its scope and broaden its policies to make them consistent with actual practice and health policies of member countries. Cooperation by international organizations generally emphasizes education as the prime field of endeavor, including recommendations for the construction of facilities, curriculum planning, teacher training, and the development of clinical areas for practical action. By the end of the decade the role of nursing in the control of transmissible diseases was being stressed, along with the need to create training programs for public-health nursing personnel, particularly in areas such as transmissible-disease control, maternal and child care, and school hygiene.

THE PERIOD 1950 - 1972

In the first decade of this period, the health situation and socioeconomic trends in the region require new approaches to international health cooperation in the health field. International organizations reorient their policies as they seek to cover the areas of public health, medical attention, and social assistance.

Transmissible disease control continued to be regarded as central to the improvement of health services, with emphasis on the development of public health programs in health centers, the promotion of medical training, and the organization of hospital services. Emphasis on the development of nursing in

public health made itself felt through the promotion of nursing training, and in that decade a considerable number of international events were held to gain a better understanding of problems connected with nursing training and practice.

At the start of this period the international organizations fostered the implementation of nurses' aids programs. As this was a very controversial subject, they recommended that countries should make their own decisions regarding the training of auxiliary personnel in line with their own needs and preferences. However, interest on the part of the governments in such training was considerable and they were offered a great deal of support for it by WHO/PAHO, so that by the end of the decade programs were in place in almost all the countries.

Nurses tended to look askance at training for nurses' aids, presumably out of fear that the latter might come to replace qualified nurses, the fact being that a large number of nurses had little or no formal training.

At the national level, government policy was to extend coverage, which was pursued with the formation of mobile units and the construction of health stations, centers, and subcenters. Obviously, this "Extension of Coverage" was not what it became in later years when it was declared a fundamental strategy, but it did usher in a process of expanding services.

The training of nurses' aids in Honduras began with the creation of the School for Nurses' Aids and Health Inspectors in 1954. The school was chiefly intended as a pilot project for training the two categories of personnel indicated, but it also fulfilled a practical function. The training program, directed by a nurse, fell under the direct supervision of the Rural Services Unit, also directed by a nurse. From its inception, the program received wholehearted support from PAHO, which included technical and financial support. It also received support from UNICEF in the form of equipment.

Initially the program trained personnel only for the field of community health, through a course lasting six months. The student body was small and very carefully selected. Preference was given to candidates who came from areas where health stations and subcenters were located, so that they could return to work in their place of origin. Selection was based on a theoretical examination designed to gauge general knowledge and intelligence. In addition, candidates had to have at least a sixth-grade education, be 18 to 30 years old and single, and have no physical defects. Those that passed were accepted on probation, subject to dismissal after two months in the event of poor performance.

The initial results of this program were very good. Its graduates were considered well trained, with skill not only in

nursing but other areas as well, such as horsemanship, swimming, interpersonal relations, mathematics, and grammar. In addition, enough graduates were produced to staff all the health centers and stations. These, however, hardly began to fill the country's needs.

About 1958, demand for additional auxiliary nursing personnel in community facilities began to fall off, making it necessary to use fresh graduates in hospitals. There was also a policy change whereby prevention and assistance were merged, with the result that versatile workers were sought who could both dispense basic health care in a hospital setting and function in community prevention efforts. This gave rise to a new curriculum in the training program for nurses' aids, with a one-year course which included an assistance component. This program at Las Crucitas health center continued until 1971 without significant change in either content or the method of operation.

At the end of the 1950s and into the 1960s, changes in approach to health services shifted the focus to hospital care. These changes were presumably tied to alterations in the social structure that came about in Honduras, as in all countries of Latin America, largely because of the development model proposed by the OAS, which sought to step up industrialization and foster rapid expansion of health services, especially in the form of hospital complexes. As a result, the accent was now placed on the development of services and nursing care at the hospital level, which required more trained hospital nurses.

The training of nurses' aids for hospital care ceased in practical terms with the founding of the Centro de Capacitacion del Hospital General y Asilo de Invalidos [Training Center of the General Hospital and Home for the Disabled] in September 1960 under the direction of a Sister of Charity. The program lasted one year and was basically directed at personnel working in nursing care in that hospital. That is to say, its chief aim was the upgrading of empirical auxiliary personnel by combining conceptual knowledge with practice, thus improving the quality of nursing care.

In 1966 the program of San Felipe General Hospital was turned over to the National Thorax Institute, with the aim of training people for the national hospitals of the capital. Because personnel could be shifted from hospital to community work and vice versa, the decision was made to change the program by including community care in it.

In 1972 the two nurses' aids training schools were merged and the combined institution called National Center for the Training of Nursing Personnel. The program continues to function in the National Thorax Institute.

The auxiliary nursing personnel trained in this period is basically equivalent to that coming out of the official centers mentioned previously. However, nurses' aids were also trained in other private institutions and in State hospital centers, through programs run by foreign organizations. These programs were important in that they provided training, sometimes in areas not covered elsewhere. However, their contribution was rather modest when compared with all such training during those two decades.

The table in Annex No. 1 shows that the number of nurses' aids trained in this period was 345 at the Las Crucitas center as compared to 519 in hospital centers, for a total of 864. However, at the end of the period there were still only 6.06 nurses' aids per 10,000 inhabitants.

In summary, at the end of the 1960s hospital-based medical services enjoy a dominant position while public health stagnates. Approximately 80% of health personnel are concentrated in hospitals. This at a time when a series of problems in the industrial, economic, and agricultural spheres call for change and new strategies, which are to have their turn in the next period under analysis.

THE PERIOD 1972 - PRESENT

The 1970s see the adoption of the first policies designed to extend health-services coverage to rural populations; they start to emerge during the world food crisis (1972), and the process gathers force with the introduction of the economic policy to modernize agriculture and cattle-raising. The changes in health policy become official when the Hemisphere's health ministers establish as one of the goals of the Ten-Year Health Plan for the Americas (1972-81) the expansion of coverage with minimum comprehensive services to all inhabitants of communities with populations of less than 2,000, a step by which coverage extension gains universality. The Declaration of Alma Ata (1978) states that in efforts to achieve that goal primary care will receive priority.

These developments stimulated the Ministry of Health to lay the groundwork for improvements in the health of the Honduran people by pinpointing areas where the figures indicated the most pressing need for attention:

General mortality rate:	14.2 per 1,000 (16.5 in rural areas)
Infant mortality rate:	117.6 per 1,000 live births (128.1 in rural areas)
Doctors per 10,000 pop.:	3.3
Nurses per 10,000 pop.:	0.7
Nurses' aids per 10,000 pop.:	6.06
Fertility rate per 10,000 women of child-bearing age:	239.0
Percentage of deaths due to infectious diseases and intestinal parasites:	19.9

In 1973 the Government carried out an assessment of the health situation to serve as a basis for policy and practical action. It led to the establishment of the following priorities:

1. Extension of service coverage in rural areas;
2. Urgent development of health-promotion and disease-prevention programs;
3. Better nutrition;
4. Increased water supply;
5. Improved in-hospital medical care;
6. Manpower development;
7. Proper maintenance of facilities and equipment;
8. Comprehensive community development.

The changes launched in health care spread to the field of education, and a number of measures were taken to gear the training system to the requirements of the new health policy. This, plus the channeling of resources to education, led to projects in hands-on training, large-scale personnel training, self-teaching, etc. In nursing, the trend shifted from clinical and administrative to community-oriented, and specialized courses in maternal-and-child care, surgery, and psychiatry made their appearance.

In 1974 WHO published a report on nursing and community health recommending fundamental change in both practice and personnel training to address basic community problems.

Numerous publications on coverage extension, primary care, and community participation became, in effect, the basic documents for nursing programs.

With acceptance of the idea that primary care should be supplied by auxiliary personnel and community agents, diversified courses for Rural and Hospital Nurses' Aids are announced in 1976 with a 10-month curriculum of modular design with a uniform base for all students followed by diversification into hospital and community nursing.

These innovations lead to new approaches by the Division of Nursing acting in concert with the Division of Human Resources Development, created in 1975. First they reorganize the three centers already in existence, giving them more teaching staff, plant, equipment, and all facilities necessary to turn out more nurses. Then the name School for Nurses' Aids is changed to Human Resources Training Centers and centers are added for the north and south of the country, the resulting trio becoming known by their acronyms CENARH, CERARH SUR, and CERARH NORTE. The three centers are to train all auxiliary and mid-level technical personnel needed for the country. Rural nurses' aids are to be trained at CERARH SUR, while CERARH NORTE and CENARH are to produce nurses' aids for area, regional, and national hospitals.

The duration of the study programs was 10 months, with the following prerequisites for admission: completion of primary school, 18 to 40 years of age, pass an admission examination, submit personal documentation. It will be noted that these requirements have not been significantly altered since nurses' aid training began in 1954. Students were selected by the community where a rural health center was to be built, some of them being volunteers functioning as health warden, midwife, or health representative.

The curriculum for the rural nurses' aid course was restructured into the following units:

- Community Participation
- Simplified Medical Care
- Mother and Child Care Within the Family
- Epidemiology
- Elements of Administration.

The total curriculum included 1,260 hours of teaching, 40% of them devoted to theory and 60% to practical work. Teaching staff numbered the following:

CERARH SUR: 5 Honduran instructors
 2 supplied by CARE until 1978

CERARH NORTE: 7 Honduran instructors
1 Peace Corps volunteer until 1979

CENARH: 12 Honduran instructors
1 Peace Corps volunteer until 1979

The students in these programs received scholarships of 150.00 lempiras, financed by the Agency for International Development. Three hundred scholarships were provided per year, one hundred for each center. AID further provided the funds for the construction and equipment of the CERARH SUR residential facility. PAHO financed all necessary educational material and equipment through the NIDES project for manpower research and development.

Training of auxiliary personnel in a diversified program greatly increased the number of graduates available for the rural health centers, and these reinforcements made it possible to provide services at the primary and secondary care levels. The health-care situation in the more remote communities improved as a result of their presence.

In 1980 a new government comes to power, and health policy, while continuing to support the principle of coverage extension, does not give it the highest priority. Community efforts diminish and hospitals receive a little more emphasis. This affects services and touches off a major relocation of auxiliary nursing personnel from one work setting to another (rural area to hospital and vice versa). In many cases these changes could not be carried out because the personnel was not knowledgeable in all spheres of endeavor, and consequently nurses' aids had to stay put for an indefinite time or moved in order to learn new skills on the job in order to be able to function in new roles. All this created a host of problems in health-care delivery.

In view of this situation, the Divisions of Nursing and of Human Resource Development revised the curriculum again, returning to the all-purpose curriculum in which nurses' aids are trained to work indiscriminately in hospitals and in the community, with skills embracing both the care of hospital patients and work with groups and communities, applying secondary and tertiary prevention measures, teaching self-care, and providing follow-up care.

In this phase each training center is assigned different health regions and made responsible for training nurses' aids for each one of them. The same study plan is followed at all three centers. CENARH is assigned Region No. 1 and the Metropolitan area; CERARH NORTE, Regions 5, 3, and 6; and CERARH SUR, Regions 4, 2, and 7.

In 1981 the scholarship agreement with AID ends. In 1982 an agreement must be signed with EDUCREDITO to obtain student

loans which have to be repaid when the studies are completed and the graduate starts to work. As the Ministry of Public Health was unable to absorb all new graduates each year, EDUCREDIT suspended this plan, and at present each student has to finance his/her own studies. In 1983 PAHA's Honduras 6900 Program, which provided students with a small grant for their field work, was also terminated. The Ministry covered some of the centers' costs, but overall support for nurses' aids training activities at the centers has been severely cut.

Advanced training for teaching staff grew in conjunction with the changes instituted in nurses' aids training, in the fields of both educational technology and health programs. Such training enjoyed its best years from 1976 to 1980 but has since diminished considerably in all subjects.

In 1982 a meeting was organized by the training centers for teaching and nursing staff; at this event a follow-up system was established to evaluate graduates of the courses in order to identify shortcomings and thus to improve the curriculum. In that same year the student evaluation and selection systems were replaced with the following procedure:

1. Recruitment in the health-care regions.
2. Admission examination.
3. Three-week introductory course designed to familiarize the student with actual nursing tasks.
4. Admission to the program.

In 1984, the Divisions of Planning and Human Resource Development began a review, as part of the process of planning local activities, of the rules of the basic health programs (expanded immunization, acute respiratory infections, environmental hygiene, diarrhea control, mother and child care, family planning). Also reviewed were the occupational and educational profiles of nurses' aids, health promoters, vector control program evaluators, and community personnel (qualified traditional midwife, health warden and health representative). These reviews marked a fundamental change in the training of auxiliary nursing personnel, for the new requirements stipulate that such personnel be trained in the tasks and activities of each basic health-care program, in addition to the hospital component. Course duration is still 10 months and this system currently remains in effect. In this same year the family planning component begins to receive more emphasis within the mother and child care program, both in terms of institutional staff training and of community-oriented training. Moreover, it is incorporated as a key area within the advanced education program for doctors, nurses, and nurses' aids.

ANALYSIS OF THE TRAINING AND USE OF NURSES' AIDS

The evolution of the functions of the nurses' aid within the health-care system has been most powerfully determined by such factors as policies concerning the extension and coverage of health care, the multisectoral use and development of human resources, and the institutional reforms deriving from those policies and involving the service-providing system as well as the educational system.

A look back shows that although the number of nurses' aids has grown in recent years, there are still not enough of them to meet the health needs of the population: their number peaked at 7.6 per 10,000 inhabitants and is now down slightly to 7.4 per 10,000. Further, despite efforts to train them for rural areas, most of them remain concentrated in urban areas, with 44.4% serving in the Metropolitan Region (Annex 3). This underscores the urgency of planning the training and use of human resources in concert with the planning of health-care development: policy in this area must seek to expand the numbers of auxiliary personnel, whose potential for meeting the needs of the population has not been sufficiently considered in short- and long-term health-care planning.

One of the most severe constraints on the training of nurses' aids has been limited availability of educational resources. These resources consist of the plant, equipment, staff, and money necessary for educational activity and their availability defines the number of people that can be trained. This number bears no relation to the quantitative and qualitative expansion of this human resource needed to extend health-care coverage. Another problem is that policies are often devised without the budgetary means to implement them.

In conclusion, nurses' aids training programs are conditioned by social, political, and economic forces that predetermine many of their characteristics. It is to be hoped that changes in those conditions will lead in turn to changes in the conditions under which nurses' aids are trained and, consequently, to changes in their training. What is unlikely is that simply modifying course content will suffice to produce the desired transformations. Other conditions needed to encourage and augment the production of nurses' aids will be considered below:

1. The existence of health-program standards defined by levels of care, from which the various occupational types and profiles of auxiliary personnel in the health-care system are derived.

2. Short- and long-term planning to match the work force with the capacity of the health-care system to absorb it, including specification of the number of posts to be created for nurses' aids and their placement. This calls for a training program sensitive to changes in the system and flexible enough to permit corresponding changes in course content.

3. Suitable teaching personnel. Much of the success of training programs depends on the quality of the instructors, which is reflected in their mastery of subject matter, of the educational process, and of relevant technology. The first comes not only with basic training but with enrichment through the right kind of experience and ongoing clinical education. Similarly, work experience must encompass the performance of services under current conditions and be in line with current thinking where the system is concerned, and should be inspired by a renewed commitment to the needs of the community and generations to come.

4. Supervision is necessary at the various levels of care, but especially at the basic level, where, as previously noted, the nurses' aid is often the only member of the team who is present on a permanent basis. Because of their limited training, nurses' aids require frequent direct and indirect supervision to ensure that tasks are correctly performed and to keep them motivated with support, encouragement, and counsel, which, by furthering their development, help to foster effectiveness and efficiency on the job.

CONCLUSIONS

The foregoing considerations lead one to question the prevailing practice of acknowledging as real training programs only those that resemble, in terms of input, duration, and curriculum, the ones officially established in former decades, or that are inspired by them.

To reconsider this belief would be the first step to undertaking a review of the legal provisions pertaining to the training of nurses' aids or to reflect on their lack where they do not exist. One could then introduce provisions to change existing programs or create others that would permit timely training of nurses' aids for all levels of care, in an educational system where the various curricula, all oriented to the three levels of prevention, would offer students the necessary opportunities to acquire the

psychomotor and intellectual skills required for competent performance at the level of care at which they are to function, and to learn to work as members of a real health-care team.

In conclusion, determining types and numbers of nurses' aids is a task that requires constant research. Only thus will it be possible to ensure the training of personnel that can meet the changing needs of health care, society, and the individual.

ANNEX 1

NUMBER OF NURSES' AIDS PRODUCED BY
THE TRAINING CENTERS LOCATED AT TEGUCIGALPA

1957 - 1971

YEARS	TRAINING CENTERS		TOTAL
	LAS CRUCITAS	TEGUCIGALPA	
1957-1959	42	-	42
1960-1961	43	65	108
1962-1963	33	215	248
1964-1965	34	93	127
1966-1967	105	68	173
1968-1969	50	48	98
1970-1971	38	30	68
TOTAL	345	519	864

Source: Records of Las Crucitas and CENARH Training Centers.

ANNEX 2

PRODUCTION OF NURSES' AIDS AT THE THREE
HUMAN RESOURCES TRAINING CENTERS, 1974 - 1985

YEARS	TRAINING CENTERS			TOTAL
	CENARH	CERARH NORTE	CERARH SUR	
1974	57	45	24	126
1975	60	61	41	162
1976	68	52	60	180
1977	77	92	116	285
1978	190	80	82	352
1979	105	84	105	294
1980	83	95	94	272
1981	99	88	92	279
1982	109	57	42	208
1983	54	59	46	159
1984	67	51	36	154
1985	105	49	33	187
TOTAL	1074	813	771	2658

ANNEX 3

DISTRIBUTION OF AUXILIARY PERSONNEL
BY HEALTH-CARE REGION, 1982

REGION	NUMBER	%
Metropolitan	1,263	44.04
No. 1	144	5.02
2	212	7.39
3	400	13.93
4	189	6.59
5	260	9.07
6	256	8.92
7	141	4.91
Central Level	3	0.11
TOTAL	2,868	100.00