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A RURAL COMMUNITY HEALTH
NURSING CURRICULUM MODEL FOR
IMPLEMENTATION IN INTEGRATED RURAL
DEVELOPMENT PROJECTS IN ECUADOR

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EXECUTIVE SUMMARY

The majority of deaths in Ecuador are due to communicable diseases, diarrheal disorders, and malnutrition, which are a direct result of inadequate diet and lack of potable water and sanitation facilities. While this is true throughout the country, enormous differences exist in the standard of living between urban and rural areas, and those differences directly affect the health status of the rural population. These disparities are compounded by limited access to health care facilities. In addition, absent in rural health care in Ecuador are such important functions as case finding, facilitation of entry into the health care system, monitoring of patient compliance, followup, data gathering and epidemiological control, health education and facilitation of community participation, program planning and administration, and effective utilization of auxiliary personnel in order to extend coverage.

The consultant recently conducted a field study regarding the planning and implementation of maternal-child preventive health programs in rural Ecuador. It revealed a lack of educational orientation toward primary health care in institutions of higher learning in that country, with a resultant lack of skills in the area of community health. These education deficiencies have had serious consequences for health care delivery in the rural areas.

While the development of skills in these areas by physicians and other members of the health team would be ideal, these functions are typically performed by community health nurses with aid of auxiliary personnel. Although nursing education in Ecuador takes place in the university setting, baccalaureate programs presently emphasize hospital-based nursing, which is strongly oriented toward the surgical specialties and critical care. As the Ministry of Health began to place increased emphasis on primary health care, the faculty of the School of Nursing of the Pontificia Universidad Católica realized that a curriculum change with a new orientation toward community health was necessary if nursing personnel were to participate more fully in the development of a national health care system.

The consultant was asked to provide the following input into the curriculum development process:

- Analyze proposed curriculum design for community nursing developed by the university.
- Provide information on curriculum design based on the University of New Mexico School of Nursing and/or other similar community nursing programs.

- Visit areas where training experiences for students can be provided.
- Meet with nursing faculty members as well as Ministry of Health officials on training needs related to community nursing.
- Recommend modifications to proposed nursing curriculum, develop an implementation and evaluation plan for the curriculum design proposed, and suggest community nursing models for incorporation in Integrated Rural Development projects.

After a review of the literature, a paradigm developed by Ifaf Meleis, which was successfully implemented in Kuwait, was selected. The paradigm is a developmental model which focuses on:

- I. The most significant social properties of the country.
- II. Dimensions of health care.
- III. Properties of nursing.
- IV. Potential paradoxes due to the interaction between and among parts I, II and III.
- V. The stated consequences of the consultations.

The objectives of this pilot project were to develop a model for community health nursing as well as an appropriate curriculum design and to implement the design in close coordination with rural health care providers, such as the Ministry of Health and USAID.

The project resulted in a nursing curriculum with an interdisciplinary preprofessional level and four semi-integrated professional levels (see Appendix III). The curriculum focuses on community health and follows a levels-of-prevention model, progressing from primary to tertiary care and program planning. The content areas as well as the integrating strands (research, administration, nursing process, health education, and trans-cultural nursing) are taught in units that correspond to the organization of primary care according to the life cycle, which was completed by the Ministry of Health in 1982. Terminal performance objectives established for each level of the program will facilitate the evaluation of the curriculum.

The graduates of this program are to be placed in three Integrated Rural Development Projects, which were jointly under-



taken by the Government of Ecuador and USAID, as well as other sites which the Ministry of Health deems appropriate.

It is the hypothesis of the consultant that improved case finding, followup, and referral for treatment to appropriate levels of service, as well as improved preventive program coordination by CHNs will increase the internal efficiency of the health care component of the Integrated Rural Development Projects. Furthermore, these will increase utilization rates and improve the health status of the rural population over the long term. These factors will be measured by means of indicators of internal efficiency, morbidity and mortality statistics, as well as an interview schedule to be used to evaluate the level of program coordination on site.

ABBREVIATIONS

APHA	American Public Health Association
CH	Community Health
CHN	Community Health Nurse
CONADE	Consejo Nacional de Desarrollo/National Development Council
DRI	Desarrollo Rural Integral/Integrated Rural Development
GCDA	Grupo de Coordinación de Desarrollo Administrativo/ Group for Coordination of Administrative Development
MSP	Ministerio de Salud Pública/Ministry of Health
PUCE	Pontificia Universidad Católica del Ecuador/ Catholic University of Ecuador
SEDRI	Secretaría de Desarrollo Rural Integral/Integrated Rural Development Secretariat
USAID	U.S. Agency for International Development
WHO	World Health Organization

INTRODUCTION AND BACKGROUND

Purpose of the Assignment

This project is the result of a request by the Pontificia Universidad Católica del Ecuador School of Nursing to the U.S. Agency for International Development for technical assistance in the development of a curriculum for Rural Community Health Nursing at the baccalaureate level. Nursing education in Ecuador, as in the United States, is presently undergoing a transition from skill-oriented diploma programs to a university baccalaureate program. While 4-year programs are currently available in the country, the emphasis of such programs (which were originally based on U.S. nursing programs) is on hospital-based nursing, which is strongly oriented toward medical-surgical specialties and critical care. The faculty of the School of Nursing realized that this type of educational program was not producing the nursing personnel that the country needs. After several minor changes, which proved to be unsatisfactory, it was decided that the school should pursue a complete revision of its curriculum, with the help of the Kellogg Foundation.

In contrast with the other schools throughout the country, the focus of the new curriculum would be on family-centered community health nursing that would prepare graduates to participate more fully in the development of a national system of primary health care. The consultant was asked to provide the following input into the curriculum development process:

- Analyze proposed curriculum design for community nursing developed by the university.
- Provide information on curriculum design based on the University of New Mexico School of Nursing and/or other similar community nursing programs.
- Visit areas where training experiences for students can be provided.
- Meet with nursing faculty members as well as Ministry of Health officials on training needs related to community nursing.
- Based on the above analysis, observations, and discussions recommend modifications to proposed nursing curriculum; develop an implementation and evaluation plan for the curriculum design proposed; and suggest community nursing models for incorporation in Integrated Rural Development Projects.

Itinerary

The major portion of project activities were to be carried out in Quito at the PUCE and USAID Mission. The possible sites for training experiences that were visited by the consultant and the

members of the Curriculum Committee included the DRI projects in Salcedo, Cotopaxi, and Quimiag-Penipe, Chimborazo, as well as health subcenters and posts in the areas of Zumbagua, Cotopaxi, and Columbe, Chimborazo. The DRI project in Jipijapa, Manabi, was inaccessible due to flooding of the coastal provinces.

Country Profile Data

Demographic Statistics

The majority of deaths in Ecuador are due to communicable diseases, for which there presently exist methods of prevention and cure, and to diarrheal disorders and malnutrition, which are a direct result of inadequate diet and lack of potable water and sanitation facilities.

Enormous differences exist in the standard of living between urban and rural areas, and these differences directly affect the health status of the rural population.

In 1980, 48.3 percent of the country's economically active population (2.7 million persons) was engaged in some form of agricultural production [7]*. In 1981, 4.8 million of the country's total population of 8.6 million resided in the rural areas, yet only 11.8 percent of this rural population had access to potable water, compared with 83.7 percent of urban dwellers. Only 10.8 percent of rural inhabitants have access to sanitation services, compared with 79.3 percent of the urban population [8]. The population of Ecuador is relatively young, with 44 percent under 15 years of age. The female population of childbearing age (15-44 years) reaches 19 percent of the total population [6]. Maternal and infant care and care of school-age children are important policy issues in a country where 63 percent of the population falls into these categories.

Nevertheless, until recently the importance of providing primary health care to this population has been ignored. At the time the National Plan was written in 1980, based on 1977 statistics, the maternal mortality rate was 1.6 per 1,000 live births and the infant mortality rate was 58 per 1,000 live births, although in some provinces in the rural areas this rate reached 70 per 1,000. Furthermore, these statistics are based on the number of deaths recorded, and these rates are probably somewhat higher in actuality. Only 29 percent of pregnant women receive prenatal care, 17 percent of deliveries are attended by a physician, and only 4.5 percent receive postpartum care. Well-child visits for children up to 5 years totaled 122,190 of a total patient population of at least 1.4 million. It was estimated that 40 percent of school age children suffer from some degree of protein-calorie malnutrition. In the tropical zones of the country, 45 percent of the population is anemic. According to the Government, this is because the incomes of most of the rural and marginal urban population do not cover the cost of a balanced diet. Differences between urban and rural areas in nutritional status, quality of life, and in accessibility

*Numbers in brackets ([]) refer to the Bibliography at the end of this report.

of medical services result in great disparities in risk factors for the pregnant woman, as evidenced by the fact that 70 percent of maternal deaths occur in rural areas [8].

These alarming statistics and the resulting concern on the part of the Government have been translated into health care policy decisions that have significantly changed the overall picture in the health care sector.

Overview of the Health Care Sector

In April 1982, the Ministry of Health of the Government of Ecuador underwent an administrative reorganization in an attempt to integrate several health programs that were designated as priority programs. Until that time, goals and objectives for individual programs, such as maternal-child health, nutrition, etc., were elaborated independently. Each program was directed by a physician on the national level, who carried out all planning and administration and who was responsible for disseminating information to the provincial health directors regarding program planning and standards for delivery of clinical services. The provincial director and his staff were then responsible for planning and supervision of these programs at the provincial level. In the field clinics, the physician and a registered nurse or nurse's aide organized the programs on the basis of national and provincial guidelines and provided clinical services to the local patient population.

Large amounts of funding were obtained from international funding sources, such as the U.S. Agency for International Development, the Interamerican Development Bank, and the World Bank for construction of rural health care facilities. In addition, the country adopted a policy that requires 1 year of rural service in the Ministry's facilities from every graduate of a school of medicine or nursing. In spite of these moves, the coverage of the country's total population still ranges between 35-40 percent. For example, in the Province of Napo in the Amazon Region, the coverage of the population reached 37.5 percent and, of the province's 214 available hospital beds, only 36.7 percent were occupied at any given time. The infant mortality rate was 71.8 percent, compared with the national average of 70.9. Of reported deaths in the province, 64 percent of those of known etiology were preventable [45]. Tables 1 and 2 illustrate the 11 principal causes of infant mortality and general mortality, according to the most recent MSP statistics.

Although significant advances have been made in the past 5 to 10 years and although funding exists for the construction of

new facilities, utilization rates remain low (see Table 3). This would indicate serious problems in terms of internal efficiency. The reasons are numerous and can be linked to problems that are endemic in any underdeveloped country; i.e., widespread poverty, illiteracy, cultural diversity of the population, etc., all of which are essentially outside the sphere of control of the Ministry. Nevertheless, it is the consultant's hypothesis that planners at the national level fail to take into account many of the factors that operate at the local level. Hence, national strategies for health care delivery and community development are often unrealistic or, at best, are too theoretical and often are not implemented at the provincial and local levels [19].*

By the same token, many realistic efforts at health planning fail due to the lack of trained personnel and necessary equipment at the local level. The educational background of the health professionals who serve in the rural areas is not responsive to national needs and includes little or no instruction in program development or administration. Graduates have little background in public health concepts and are ill prepared for practice in anything but a hospital setting.

There also appear to be certain weaknesses in the nation's public administration system that also affect the health care sector. These include ineffective budgetary processes or systems for control of resources; excessive centralization of authority at the national level coupled with regionalism at the provincial level; rigidity of personnel policies that preclude recruitment and retention of qualified personnel [43]; instability of decision-making processes due to political instability; lack of integration between technical and political levels of decision-making; proliferation of levels of predecision and lack of effective mechanisms for coordination; and, last, a lack of accurate statistical information on which to base planning activities coupled with a faulty communications system due to the nature of the organization, geographic isolation, and lack of infrastructure [19]. These problems inhibit the translation of national health plans into action at the local level. The lack of qualified personnel and funding for such personnel hinders supervision and evaluation of programs in the field that would feed appropriate information back into the decision-making process.

*A survey conducted by the Grupo de Coordinacion del Desarrollo Administrativo, which is cited in Revista de Desarrollo Administrativo [19], reveals that of 450 administrators surveyed, 77 percent felt that the National Development Plans were too theoretical and at best provided administrators with only a frame of reference which was difficult to translate into plans of action.

Table 1. PRINCIPAL CAUSES OF INFANT MORTALITY
IN ECUADOR, 1978

Causes of Death	Number	Per 1,000 Live Births
Gastroenteritis and other diarrheal disorders	3,655	15.9
Bronchitis, emphysema, and asthma	1,966	8.5
Pneumonia	1,370	5.9
Miscellaneous causes of perinatal mortality	1,330	5.8
Acute respiratory infections	675	2.9
Tetanus	589	2.6
Avitaminosis and other nutritional deficiencies	511	2.2
Anoxic and hypoxic conditions (not classified)	488	2.1
Whooping cough (pertussis)	441	1.9
Influenza	415	1.8
Other illnesses with poorly defined symptomatology	1,640	7.1
Others	1,752	7.6
Total	14,832	64.4

Source: CONADE. Indicadores Básicos de Salud: Causas Principales de Mortalidad. Quito: CONADE, 1978.

Table 2. PRINCIPAL CAUSES OF MORTALITY

IN ECUADOR, 1978

Causes of death	Number	Per 10,000 Population
Gastroenteritis and other diarrheal disorders	6,892	88.2
Pneumonia	3,755	48.1
Bronchitis, emphysema, and asthma	3,575	45.8
Senility (nonpsychotic)	3,249	41.6
Heart disease (general)	2,915	37.3
Cerebrovascular accidents (stroke)	1,863	23.8
Automobile accidents	1,817	23.3
Ischemic heart disease	1,386	17.7
Perinatal morbidity and mortality	1,330	17.0
Avitaminosis and other nutritional deficiencies	1,153	14.8
Other illnesses with poorly defined symptomatology	6,113	78.2
Other	22,553	288.6
Total	56,601	724.4

Source: CONADE. Indicadores Básicos de Salud: Causas Principales de Mortalidad. Quito: CONADE, 1978.

Table 3. PRODUCTIVITY OF HEALTH SUBCENTERS
IN ECUADOR, BY PROVINCE, 1981

Province	Population Surveyed	Number of Clinic Visits Per Year	Provincial Average
Carchi	28,513	19,151	0.7
Imbabura	40,524	36,999	0.9
Pichincha	101,216	75,146	0.7
Cotopaxi	63,075	27,771	0.4
Tungurahua	74,818	42,442	0.6
Bolivar	54,714	43,880	0.8
Chimborazo	80,283	34,652	0.4
Canar	41,383	36,670	0.9
Azuay	44,432	27,341	0.6
Loja	64,997	49,611	0.8
Esmeraldas	25,541	26,351	1.0
Manabi	158,662	55,301	0.3
Los Rios	114,457	18,240	0.2
Guayas	188,980	45,773	0.2
El Oro	60,085	30,936	0.5
Napo	6,194	4,842	0.8
Pastaza	3,548	2,429	0.7
Morona Santiago	8,831	8,392	1.0
Zamora	8,500	5,463	0.6
Galapagos	---	---	---
Total	1,168,753	591,390	0.5

Source: Moncayo Gallegos, Edgar. Medicina Comunitaria: Desarrollo o Desarrollismo. Unpublished monograph. Quito, Ecuador: SEDRI, 1981.

II. OBSERVATIONS AND FINDINGS: PHASE ONE

OBSERVATIONS AND FINDINGS: PHASE ONE

Problem Statement

A recent field study by the consultant on the planning and implementation of maternal-child preventive health programs in rural Ecuador revealed a lack of educational orientation toward primary health care in institutions of higher learning in that country, with a resultant lack of skills in the area of community health. These educational deficiencies have had serious consequences for health care delivery in the rural areas; namely, low productivity of health establishments, a lack of case finding and followup activities, and the absence of health education programs in many areas -- all resulting in low utilization of Ministry of Health facilities.

Cultural taboos and health beliefs have also attributed to low utilization rates (for example, bed occupancy nationwide reaches 59.9 percent, while occupancy in rural provinces with large indigenous populations such as Napo is only 37 percent). In the absence of widespread cultural change in areas with predominantly indigenous populations, the imposition of a regimen of westernized medical care, which brings with it a distinct system of health beliefs, will meet with only limited success. Economic constraints in the traditional agricultural sector also inhibit utilization of services, as peasants can ill afford to lose a day's labor in the fields to attend a clinic, especially when low internal efficiency makes waiting times excessively long. Thus, for example, the goal of nine prenatal visits for the pregnant woman is probably unrealistic, as the peasant woman's main interest regarding her pregnancy is the sex of the baby and the expected date of confinement. The woman may seek treatment if she is ill during her pregnancy, but otherwise will probably not seek consistent prenatal care. Among the Quecha Indians, male attendance at a birth is a cultural taboo, and the practice of remaining in bed for 40 days postpartum inhibits compliance with postpartum checks.

Thus, there are difficulties in controlling for cultural factors in the study of the effects of the training of health care personnel on the utilization of services by rural populations. In addition, the health status of the rural population depends on a myriad of inputs, such as educational level, environmental factors, income, etc., and not solely on the type of health service provided. Therefore, the effects of increased training in community health on the internal efficiency of the service units (i.e., productivity) are more reliably measured and evaluated.

The consultant's previous field study revealed that many of the preventive functions which were conspicuously absent in the field would typically be performed by community health nurses with the aid of auxiliary staff, such as auxiliary nurses and community

health representatives. These functions include case finding, facilitation of entry into the health care system, monitoring of patient compliance, followup (home visits), data gathering and epidemiological control for immunizations and communicable diseases, health education and the facilitation of community participation, program planning and administration, and supervision of auxiliary personnel. While the development of skills in these areas by physicians would be ideal, the political climate at the Central University School of Medicine precludes such a major change in the focus of medical education at this time. It should also be noted that the School of Nursing at the Central University is subordinate to the School of Medicine, and, consequently, is not an ideal site for a pilot project.

Hence, through discussions with Ecuadorian health experts, the School of Nursing of the Catholic University was selected. It is an independent institution (i.e., lacks affiliation with a medical school) and has a commitment to updating its nursing curriculum to better meet the health care needs of the Ecuadorian population. Thus, this institution is more likely to be able to implement a pilot study on (1) the effects of a community health orientation in the education of nurses on the internal efficiency of Ecuadorian health establishments in the rural areas, and on (2) the compliance with objectives of primary health care as outlined by the World Health Organization at the Alma-Ata Conference of 1978.

The present project is comprised of three components: (1) Assessment of needs in the area of planning and implementation of primary health care programs and appraisal of the role of community health nursing in meeting these needs (carried out in June and July, 1982--see Ruffing, Karen L., "The Planning and Implementation of Maternal-Child Health Services in Rural Ecuador"); (2) the development of a community health nursing curriculum for the Pontificia Universidad Católica del Ecuador; and (3) the integration of graduates of this program into the health component of USAID's Integrated Rural Development Projects, which operate in the provinces of Manabi, Cotopaxi, and Chimborazo, as well as the development of a method for evaluating their impact on the functioning of the projects.

Review of the Literature

Helen Preston Glass in her article, "Research: An International Perspective"[14], attributes the dearth of international nursing research to the status of the nursing profession, which has traditionally been linked with the status of women. The subservient role in nursing dates of the Christian era when

nursing was identified with religious orders and their accompanying slave-life routines. During the Renaissance, the intellectual enlightenment reached few women. Only the well-to-do were involved in intellectual pursuits and few well-to-do women involved themselves in nursing. With the closing of many religious orders, nursing sank to its lowest intellectual level. It was not until the Florence Nightingale era that nursing became systematic and scientific.

Research is usually associated with a university education, preferably on the graduate level. Nursing education only recently has moved into the university setting; hence, the acquisition of research skills on the part of nurses is a fairly recent development. Research strategies that have evolved in Western cultures have traditionally centered on professionalism, educational development, and nursing administration; only recently has research focused on nursing science as it relates to health care in a broad context. These problems are further magnified in underdeveloped countries, where women continue to occupy a more traditional place in society and where access to a university education is linked to socioeconomic status as well as sex roles.

Manpower studies, which focus on the education and training of personnel as well as community response studies, are cited as two of several international research priorities in nursing identified by a World Health Organization consultant group in 1968 [14]. Several articles have appeared in recent years that focus on the education and training of community health nurses and the relationship between nursing science and public health science. The role of the community health nurse remains somewhat controversial, in that community health nursing is often defined as any nursing that occurs outside the hospital setting and that is family-centered and geared toward the delivery of primary health care. Kark takes this concept one step further and states that community or public health nursing should focus on the health of population groups, such as the community. In other words, the nursing process must be applied at the aggregate level. Kurtzman and co-authors advocate including community health nursing courses at the baccalaureate level to incorporate this focus on aggregates into their nursing philosophy. They state that this is especially important in underdeveloped countries that lack master's level programs in nursing [34]. According to an APHA survey, nursing service agencies as well as faculty members at universities throughout the United States cite the need for a "block experience" in CH for all students at the baccalaureate level, along with an integrated curriculum with exposure to CH at all levels to adequately prepare students to function effectively within agencies and in the community [51].

Nursing education is closely linked with the nurse's perception of her role within the health team. As nursing education

shifts from an apprenticeship system to institutions of higher learning, the role of the nurse in relation to the health team also changes. Of six nursing functions identified by WHO, five are independent. In addition to helping the client to carry out the therapeutic plan initiated by the physician, the nurse is responsible for maintaining a physical and psychological environment conducive to health, involving the patient and his family in his treatment, carrying out measures for the prevention of disease, health education, and, last, coordinating nursing with efforts of other members of the health team and of other community groups.

In other words, the nurse helps other members of the team to plan and carry out the total program of care. This requires a high degree of competence in decision-making that only the well informed, well educated nurse can achieve. However, nurses in developing countries have not kept pace with other members of the health team in terms of preventive health care. Taylor stated in 1934 that we must look to the liberal arts and sciences for principles upon which to base the entire educational program for nursing [44].

Meleis presents a developmental model for the nursing profession that delineates major issues in nursing in developing countries by means of the following paradigm:

- I. The most significant social properties of the country.
- II. Dimensions of health care.
- III. Properties of nursing.
- IV. Potential paradoxes due to the interaction between and among parts I, II and III.
- V. The stated consequences of the consultations.

The consequences of developing a nursing model such as the one above is a curriculum design that can better meet the needs of a developing country [39].

Objectives

The objectives of this project, then, are the development of a model for community health nursing as well as an appropriate curriculum design. The graduates of the new program are to be placed in USAID's Rural Development Projects (DRI), as well as other sites which the Ministry of Health deems appropriate.

Preferably, these are the sites that are to be converted into microregions in the Ministry's efforts to regionalize health care delivery. Ideally, graduates could be placed in DRI projects and an equal number of control sites for purposes of evaluation. Evaluation of their effectiveness will be based on the hypothesis that the CHNs will increase the internal efficiency of the projects, which will increase utilization of services and the health status of the population. More appropriate diagnosis of the community as well as education regarding services and referrals to the appropriate level of care should increase attendances and thus lower the cost of services per person served and per attendance. Also, better organization of programs and increased supervision of auxiliary personnel should also increase productivity of the facilities in the microregion. More efficient epidemiological control in terms of case finding and followup of contagious diseases as well as better control of nutrition and immunization programs should lower the incidence of communicable diseases and other preventable causes of mortality and morbidity over the long term.

The design of the curriculum for CHNs will follow the "objectives model of curriculum design" presented by Gibson [13]. At the end of the course of study, the nurse will:

1. Be able to assess and meet the nursing needs of patients in the community.
2. Possess the ability to apply skills and knowledge acquired and impart them effectively to patients, relatives and other carers, staff, and the general public.
3. Be skilled in communications and in establishing and maintaining good relationships and be able to coordinate appropriate services for the patient, his family, and others involved in the delivery of care.
4. Have an understanding of management and organization principles within the multidisciplinary team and have developed a positive approach to further developments to meet health care needs.

Procedure

The attainment of these objectives will be reflected in overall program outcomes, as illustrated by annual evaluation of the following indicators of internal efficiency (see Table 4) and by assessment of program effectiveness by means of an instrument similar to the one used in the Maternal-Child Health Study (see exhibit 1).

Comparison of baseline morbidity and mortality statistics with annual statistics collected after project implementation should reveal trends in the effectiveness of preventive services and their impact on the health status of the population. The longitudinal nature of the study should correct for any initial bias in the data due to increased reporting of cases, rather than actual increased incidence of illness. The effects of other variables, such as better sanitation education, and increased agricultural production, which are indistinguishable from the effects of health services in a DRI project which incorporates these elements, can be controlled for by using other non-DRI areas as control sites. Also, initial community assessments done by DRI personnel can serve as baseline data and can be repeated after the CHNs have been functioning in the projects for a period of time.

The hard data should be complemented by reactive research. Questionnaires are not a feasible alternative, as even auxiliary nurses are required to have only a sixth-grade education. Hence, an interview strategy which would reveal aspects of program planning implementation, supervision, and evaluation similar to the one employed by the consultant for the maternal-child health study, would be the method of choice. The baseline data obtained through this study could be utilized for evaluation purposes, as graduates could be placed in six sites--three DRI projects (Quimiag, Jipijapa, and Salcedo) and three sites located near the DRI projects to control for geographic and cultural variance. The same interview format could be used to obtain data for other projected sites for the pilot project, according to MOH priorities. To control for rotation of medical personnel, one could interview physicians each year between now and the projected placement of the first CHN (3 years) and reinterview physicians for an equal number of years after placement. The other alternative would be to interview only permanent personnel, such as auxiliary nurses. Ideally, if the number of sites remains small (with the maximum being the three USAID projects used as test sites with three control sites), one could interview both physicians and permanent personnel, thereby gathering data from two professional levels within the health team. Also, the pretesting effect is thus eliminated for physicians, while it cannot be controlled for in the case of permanent personnel.

Table 4: INDICATORS OF INTERNAL HEALTH CARE
EFFICIENCY IN ECUADOR, 1980

Indicators	Quimiag		Salcedo		Jipijapa	
Attendances per 100 inhabitants:						
by Doctors	32.4	40.5	44.6	58.1	19.5	18.6
by Auxiliaries	52.4	79.3	46.8	68.9	19.0	23.4
by Promoters	N/A	81.6	N/A	27.5	N/A	13.7
Manpower/inhabitant:						
Persons/doctor	4,366	4,737	3,176	3,251	6,603	7,300
Persons/auxiliary	1,320	954	1,588	1,379	3,433	3,532
Cost per person served by:*						
S.C.S.	527	309	508.1	217.5	171.7	122.5
P.S.	468	297	64.0	83.1	112.8	30.7
Cost per attendance:†						
Doctor	109.0	78.8	110.2	82.8	93.1	76.5
Auxiliary	50.0	28.5	100.0	78.9	94.2	83.0
Promoter	N/A	22.4	N/A	---	N/A	22.4

S.C.S. = Health Subcenter

P.S. = Health Post

*1980 sucres

†1980 sucres - doesn't include investments

Source: USAID staff working paper:

"An Economic Analysis of Integrated Rural Development Projects."

Exhibit 1. INTERVIEW FORMAT UTILIZED FOR FIELD
EVALUATION OF MATERNAL-CHILD HEALTH AND NUTRITION PROGRAMS

- I. How do you organize and implement the Maternal-Child Program (MI) and the Nutritional Supplement Program (PAAMI) here?
 - A. Coordination of programs
 - B. Case findings
 - C. Patient compliance and attendance
 - D. Family planning
 - E. Health education - sanitation
 - F. Coordination between MI, PAAMI, and immunization (PAI) and control of common causes of morbidity programs
 - G. Community Development and Outreach
 1. Organization of clubs
 2. Liaison with church
 3. Liaison with Integrated Rural Development Program (DRI)
 4. Use of health promoters
- II. What type of supervision and assistance in administering these programs do you receive?
 - A. Ease of communication with higher authorities
- III. What administrative problems do you encounter with these programs?
- IV. How are these programs received by the patient population?
 - A. Cultural obstacles to compliance
 - B. Health beliefs
- V. Is there any cooperation between your agency and other government agencies?
 - A. Social Security (IESS)
 - B. Ministry of Education, etc.

OBSERVATIONS AND FINDINGS: PHASE TWO

Work Plan

The technical assistance to be provided fell within the framework of the original work plan of the School of Nursing for its curriculum design. The role of the principal investigator/consultant, as stated in the scope of work, was to integrate community health nursing concepts into the curriculum design and the overall philosophy of the School of Nursing, to offer suggestions for revision of said curriculum, and to design a model for implementation and evaluation in DRI projects. Subsequent evaluation was to be carried out by USAID personnel or personnel designated by them. The planning methodology, objectives of the school, functions of nursing, terminal objectives of licensure, and the conceptual framework for the curriculum design were to have been completed, or in the process of completion, upon the consultant's arrival. A complete chronogram of the consultant's activities is included in Appendix I, and a brief description of each phase of the project follows.

The first working sessions were dedicated to reviewing the philosophy and objectives of the School of Nursing so that the subsequent curriculum development might be consistent with the goals of the institution. The Curriculum Committee also included in the phase of the project a brief description of the health needs of the country and had succeeded in meshing institutional priorities with current priorities in the health care sector. These tasks coincide with parts I and II of Meleis' paradigm, and successful completion of these tasks is essential if the curriculum is to respond to the needs of the country. Only minor revisions of the philosophy and objectives were necessary. This activity served to familiarize the author with the attitudes of the faculty toward primary health care and community nursing. It was discovered that, even though the philosophy and objectives were elaborated prior to the consultant's arrival and prior to the faculty's awareness of the precise focus that the consultant would suggest, the objectives pointed directly toward the development of a curriculum that emphasized primary health care. (See Appendix II for a list of the objectives of the baccalaureate program in nursing.)

Having accomplished this, the committee proceeded to review various curriculum designs. The curriculum model from the University of New Mexico consists of a nonintegrated, preprofessional level complemented by an integrated professional level based on systems theory. The professional level begins with the care of the client in dynamic equilibrium and moves gradually toward the care of the client in severe disequilibrium. These equilibrium states serve as elements of horizontal integration, while five strands (the health care system, the nurse as a professional, the

nursing process, communications, and the recipient of care) serve to integrate the curriculum vertically. The teaching strategy used is the modular system, whereby a different submodule corresponds to each point of intersection of the vertical and horizontal elements.

De Back states that, while there are few pure curriculum designs, most fall into one of four categories: the medical model (now obsolete); the interactions model, which focuses on the nurse-client relationship; the systems model, which considers the biophysical, environmental, psychological and sociocultural dimensions of the individual or group; and the developmental model, which focuses on the developmental tasks or stages of each client or group of clients. Most curricula are a combination of two or more of the above models and may have various structural elements [10]. The UNM curriculum is based on systems theory and is totally integrated by means of a modular teaching method. The value of a totally integrated curriculum is presently being debated by nurse educators, some of whom advocate a return to a more traditional presentation of material by medical specialties or subject areas (i.e., medical-surgical, psychiatric, or obstetrical nursing). They feel that, while ideally integrated curricula present a more nursing-oriented, holistic view of the client, unless very skillfully organized and implemented, they can cause confusion on the part of the students [24].

The curriculum of the Northern Illinois University School of Nursing is a more traditional modular curriculum organized by subject areas, with semi-integrated field experiences. This baccalaureate program has a strong community health component.

The University of Washington utilizes a nuclear curriculum organized into three strata, including nursing theory and practice and supporting subjects from the sciences and humanities. This curriculum has a strong developmental component as well as a strong emphasis on transcultural nursing. The Universidad de San Marcos in Peru also employs the developmental model, but is organized around an interactional theory by Imogene King, which focuses on crisis intervention. The Israelis have also experimented with developmental curricula in the training of 2-year rural community health nurses.

Semi-integrated curricula, such as those employed at the Universidad Nacional de Colombia and the Universidad Nacional Autónoma de México, were also examined, as was an example of the curriculum by objectives model, which is being utilized in Brazil.

After examining each design, brief cost-effectiveness analyses and feasibility studies were conducted prior to final selection of the model. Pros and cons of each design were

discussed and resources needed to implement each were listed and quantified where possible.

Project Results

It was decided that, while a traditional nuclear or modular curriculum was really not a significant step forward for the school since the current curriculum was of this type and based on a U.S. model, a curriculum based on a specific theory, such as the crisis theory model at San Marcos, was too narrowly focused to meet the needs of the Ecuadorian health care system. The consultant also felt that, while it is important to keep abreast of recent developments in educational theory in nursing, there is a danger associated with adopting a particular theory before its impact on students has been evaluated.

According to a study by De Back, there was no demonstrated difference in the ability to formulate nursing diagnoses between students from systems or developmental programs and those from programs which employed a mixed curriculum design [10]. It was decided that the new curriculum should combine elements from several designs to achieve a balance between utilization of innovations in curriculum design and feasibility of implementation, considering the level of preparation of the faculty and the resources available. These project activities correspond to stages III and IV of Meleis' paradigm.

The result of this process is a nursing curriculum with an interdisciplinary preprofessional level and four semi-integrated professional levels (see Appendix III). The curriculum is focused on community health, and even during the hospital phase of the professional level, emphasis is placed on epidemiology of disease, discharge planning, and community followup by means of home health care.

The Preprofessional Level consists in part of the traditional science and humanities courses, but has been redesigned to provide more background in areas that support the public health emphasis of the professional level: new courses in cultural anthropology, community development and an introduction to the health care system that concentrates on national health problems and policies, health economics, and the interrelationship between the multiplicity of agencies providing health services in the country. This level was elaborated upon after the professional level to assure that students received adequate preparation for subsequent professional course work. Courses are grouped to build on each other and follow a logical sequence from semester I through semester III. While the number of credit hours appears to be

excessive according to U.S. standards, they have actually been reduced from previous levels to allow the student more study time.

The other major change was the replacement of the English-language requirement with three levels of Quechua. This change should facilitate nurse-client communication in rural areas, as the majority of Ecuador's indigenous population is Quechua speaking. This requirement may be satisfied by the equivalent number of courses in the Shuar language for students who are interested in working with indigenous populations in the Amazon Region (Pastaza and Morona-Santiago Provinces). For more detailed information on the Preprofessional level, see Appendix IV. A brief description of the professional levels follows. Detailed information is contained in Appendix V.

The integrated portion of the curriculum begins with Professional Level I. The emphasis at this level is primary health care in the community setting. The content areas as well as the integrating strands (research, administration, nursing process, health education, mental health, and transcultural nursing) are taught in units that correspond to each phase of the life cycle. This approach follows the organization of primary care according to the life cycle, which was completed by the MSP in 1982 and which is presently being implemented in the rural and urban clinics [37]. Rather than teaching the practical component of the level in the morning and the theoretical component in the afternoon as is currently being done, the consultant recommended that theory be taught on three designated days, leaving two 8-hour days per week open for clinical practice. This method of organization would not only solve the problem of short afternoon attention spans of students (a current faculty complaint), but would also provide a higher ratio of clinical time to travel time. If theory were presented Monday through Wednesday and field experiences took place on Thursday and Friday, then theoretical concepts taught each week would be immediately put to practice in the field. In the case of rural clinical experiences, travel time could range between 30 minutes to 1 1/2 hours, but still provide adequate time in the field. Clinical experiences will also be arranged in marginal urban areas. A detailed presentation of Level I can be found in Appendix VI. An example of the microcurriculum for the newborn unit of this level is also given in Appendix VI. The duration of Level I is one semester.

Professional Level II encompasses hospital-based nursing theory and practice (see Appendix VII). As four distinct patient populations are to be served, the level is divided into four sub-units: Care of the acute and chronic pediatric and adult patient, care of the obstetrical patient, care of the terminally ill patient (a totally new area for Ecuadorian nursing schools), and

care of the patient with problems of physical and psychosocial integration. The latter category includes psychiatric nursing, but expands the focus to include physical rehabilitation of handicapped individuals and psychosocial rehabilitation of previously ignored patient populations (alcoholics, drug addicts, juvenile delinquents, etc.). The school plans to pursue coordination of efforts with other university departments, such as law, social work, education, etc., for social action projects by means of a grant from the Organization of American States.

This level follows the life cycle as closely as possible and divides theory and practice time in a manner similar to Level I. While the integrating strands are basically the same in Levels I and II, it is in Level II that the nursing process takes on more importance. Basic assessment, diagnosis, planning, intervention, and evaluation skills are taught in Level I and exercised while caring for the "healthy" population. In Level II, assessment and diagnosis skills are sharpened and the planning and evaluation of the care of the sick individual are emphasized. While the nursing process is currently taught in Ecuadorian schools of nursing, it is not taught as a systematic means of administering care, nor is it uniformly applied throughout the course of studies.

The consultant gave a seminar/work session to members of the faculty on "The Nursing Process: Theory and Applications," which emphasized the benefits of utilizing the nursing process as a way of organizing the educational program, of facilitating the transition of the nursing graduate from student to professional, and of evaluating the curriculum. Appendices VIII and IX illustrate examples of assessment tools currently being used in the United States in hospital-based and community-based practice. The historical antecedents of the nursing process (i.e., decision theory, systems theory), current applications in the United States, and possible applications in Ecuador were discussed. An assessment exercise was included to illustrate the practical applications of the process. The nursing process was subsequently adopted by the faculty as the primary teaching strategy to be employed in the new curriculum. The participation of all faculty members in the curriculum development process, as illustrated by the above encounter, was elicited for each phase. Thus the model being discussed received faculty and university administrative approval prior to the consultant's departure.

Professional Level III focuses on nursing practice within the broader context of community development. The emphasis is on the application of the nursing process at the aggregate level. Strong epidemiological and research components are included. The administration of actual Government programs as well as the development of new health promotion plans are stressed. Appendix

X presents a schematic representation of Level III, while Appendix XI presents terminal performance objectives and a course outline complete with bibliography for each level. Terminal performance objectives for Levels I, II, and IV are to be elaborated upon by the faculty. It should be noted here that, while student performance in the preprofessional Level will be evaluated by means of a traditional grading scale, evaluation during the professional levels will be by objectives and on a pass/fail basis. Students must repeat the particular unit in which a "fail" was obtained until they master these skills. Unacceptable candidates for the title of RN will be screened out prior to the initiation of the professional phase of training. The duration of Level III is one semester.

As Appendix XII illustrates, Level IV consists of a professional option. While the current literature warns against specialization at the baccalaureate level [2], the faculty was of the opinion that the opportunity to pursue a special area of interest once basic nursing skills were mastered was appropriate at this stage in the student's education. As emphasis at this level was placed on applied research, health education, and advanced program administration, it was determined that these skills could be learned and applied in a variety of settings. Therefore, the professional option concept was consistent with overall program goals. As a senior thesis is required for graduation in any baccalaureate program in Ecuador, it was decided that the research proposal or change project, which is to serve as the basis for the thesis, should be developed during this semester (including strategies for project implementation and testing of any instruments) and implemented during the obligatory year of rural service.

Project implementation during the rural rotation has the following advantages:

1. It encourages nursing research, which is above and beyond the customary descriptive theses. (Note: Students receive a semester course in nursing research during the Preprofessional Level.)
2. It lends purpose to year of rural service, which has historically been characterized by a "get it over with" attitude on the part of the student, with resultant low employee productivity.
3. Joint supervision of research by PUCE faculty and MSP officials should ease the role transition from student to practicing professional (supervision of rural nurses has been practically nonexistent to date).

4. The gap between the education and service sectors should be narrowed, as research findings or results of change projects will be shared with MSP officials by faculty and should provide the MSP with valuable feedback into the program planning process.

IV. RECOMMENDATIONS FOR PROGRAM IMPLEMENTATION
AND EVALUATION

RECOMMENDATIONS FOR PROGRAM IMPLEMENTATION AND EVALUATION

General guidelines for curriculum implementation are outlined in Appendix XIII. Detailed strategies for implementation of each phase of the design form part of the schematic representation of the curriculum in Appendix V. These documents formed the basis for the overall development plan for the School of Nursing contained in Appendix XIV. Here, the plans for implementation of the new design, complete with a list of resources required for each phase, are presented as they relate to other objectives of the school. The information contained in these appendices will not be repeated here; however, it should be mentioned that the meetings with government and university officials resulted in unanimous approval of the program and strong support on the part of USAID, CONADE, and MSP officials for the incorporation of its graduates into the DRI projects, according to the model presented in Chapter II of this report. Possibilities for project support and funding were discussed and the following four grant proposals are in the process of elaboration:

1. A proposal to the Kellogg Foundation to extend the the curriculum development grant an additional 2 years to complete the curriculum implementation phase. The implementation strategy will include an integrated theory/practice or docente/asistencial project for the rural areas.
2. A proposal to the Fulbright Commission for a technical adviser to the Association of Ecuadorian Nursing Schools to evaluate the curricula of the other six schools of nursing, utilizing the staff of the Research Committee of the PUCE. It is hoped that the evaluation will serve as a basis for standardization of the curricula. Follow-up studies of placement of nursing graduates are also planned.
3. A proposal to USAID for staff training at the master's level for two faculty members, as well as short-term intensive training in community health, transcultural nursing, and program administration for all faculty members as part of the proposal for implementation of the curriculum in the DRI projects. Funding for operations research to evaluate the impact of the pilot project is also being requested.
4. A proposal to the Organization of American States for a social action project to be undertaken in conjunction with several other academic departments of the PUCE. One such project would consist of an integrated health,

continuing education, and client advocacy program in the country's prisons.

In evaluating the success of a curriculum change, both objective and subjective data should be used. In the United States, objective data such as student performance on state board exams can be used to evaluate the effectiveness of a specific nursing program in preparing students for professional practice. Since no licensure exam exists in Ecuador, another method for evaluating the end product of a nursing program must be devised.

Of the five steps in the nursing process, the nursing diagnosis is the most important, for an accurate nursing diagnosis is an illustration of an accurate data gathering and assessment process and serves as the basis for all nursing intervention. A study by De Back utilizes analysis of the nursing diagnosis as a means of evaluating the nursing curriculum. The following three characteristics are considered: (1) Is the diagnosis client- rather than disease-centered? (2) Is it stated in terms of client concerns and levels of competence or dysfunction? and, (3) Is the statement of client concern competence or dysfunction something that can be altered or maintained through nursing action? These characteristics differentiate a nursing diagnosis from a medical diagnosis and, thus, differentiate a curriculum based on nursing theory from one based on the medical model [10].

The consultant proposes the use of a longitudinal study of senior nursing care plans to be conducted by the Research Committee and which begins before the implementation of the new curriculum, to compare the effectiveness of the two curricula in terms of their ability to convey knowledge of the nursing process which can be applied in practice.

The other objective of the new curriculum is to integrate theory and practice early in the student's program of studies to increase the students' level of confidence in their ability to practice nursing effectively upon graduation. Koehler utilized survey research to ascertain California State University students' levels of confidence in their ability to perform certain nursing functions at particular points in their program of studies, to evaluate whether the curriculum change had achieved this objective. Students from both the old and the new programs were surveyed, and results were cross-tabulated to determine whether these functions were being performed comfortably at an earlier phase in the program of studies after the curriculum change was implemented. The skills evaluated were ability to make independent judgments that were correctly appraised by personnel in the clinical areas, ability to perform skills requiring manual dexterity, ability to think creatively in problem-solving nursing situations, and the level of confidence in nursing practice [31].

The final phase of the evaluation process should measure the extent to which the new community health orientation of the curriculum satisfies the needs of the service sector. This can be measured by means of performance evaluations based on the community health nursing skills listed in Appendix XV.

The impact that these nursing graduates have on the Integrated Rural Development Program can be evaluated by means of the operations research model presented in the Purpose and Objectives sections of this report.

APPENDIX I

PONTIFICIA UNIVERSIDAD CATOLICA DEL ECUADOR
 FACULTAD DE ENFERMERIA
 CHRONOGRAM OF ACTIVITIES WITH TECHNICAL ADVISOR

ACTIVITY	DECEMBER											JANUARY														
	M 20	T 21	W 22	T 23	F 24	M 27	T 28	W 29	T 30	F 31	M 03	T 04	W 05	T 06	F 07	M 10	T 11	W 12	T 13	F 14	S 15	M 17	T 18	W 19	T 20	F 21
Orientation																										
Revision of institutional goals																										
Revision of objectives of baccalaureate education																										
Revision of theoretical framework for curriculum development																										
Revision of curriculum models																										
Selection of curriculum design																										
Elaboration of curriculum design, selection of content areas and field experience sites																										
Strategies for curriculum implementation																										
Feasibility study																										
Curriculum evaluation																										
Development plan for the School of Nursing																										
Visit to possible field experience sites																										
Formulation of possible multisectoral projects																										
Professional profile of the community health nurse																										
Required follow-up																										

MEETINGS AND CONFERENCES WITH FACULTY

ACTIVITY	DECEMBER											JANUARY															
	M 20	T 21	W 22	T 23	F 24	M 27	T 28	W 29	T 30	F 31	M 03	T 04	W 05	T 06	F 07	M 10	T 11	W 12	T 13	F 14	S 15	M 17	T 18	W 19	T 20	F 21	
Working Session: The Nursing Process - Theory and Applications - Ruffing														PM													
Institutional goals and objectives for baccalaureate nursing education															PM												
Presentation of curriculum design - dialogue																AM											
<u>MEETINGS WITH OTHER OFFICIALS</u>																											
Dr. L. Izurieta, Facultad de Pedagogía, Technical Advisor - Curriculum Design										3-5			10-12				10-12					10-12					
Dr. Jose Castro, Ministry of Health								9-10																			
MAP International																											
Dr. Pedersen, Centro de Estudios Transculturales																											
Save the Children Alliance																											
HCJB/Vozandes																											
Minister of Health/CONADE/USAID/WHO																											
University Officials																											

APPENDIX II

PONTIFICIA UNIVERSIDAD CATOLICA DEL ECUADOR

SCHOOL OF NURSING

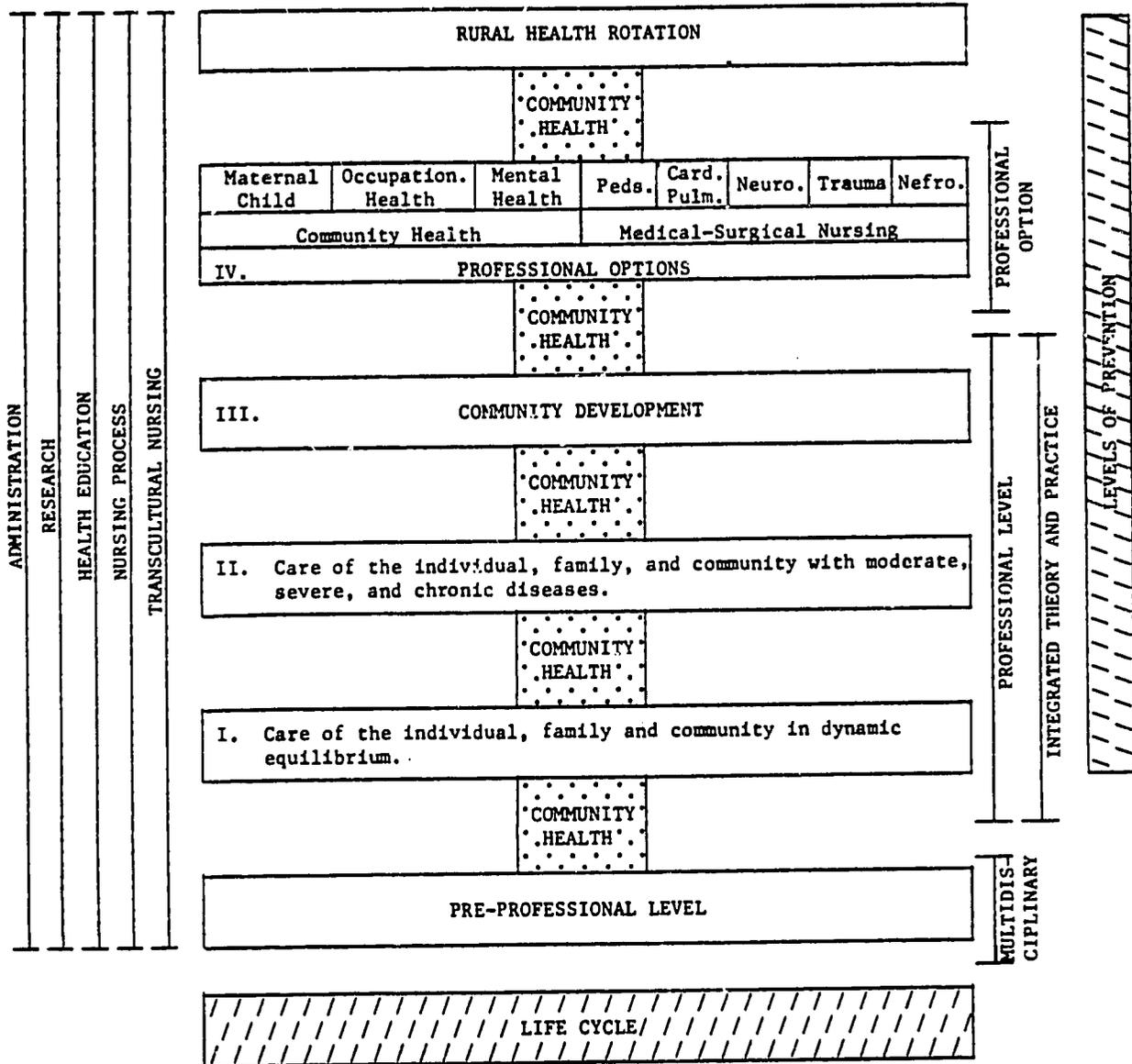
INSTITUTIONAL OBJECTIVES

To educate nursing personnel who have the capacity to:

- I. Promote, defend and apply Christian ethics and human rights in the health field.
- II. Provide nursing care to the individual, the family and the community, based on biophysical, psycho-social, spiritual and cultural needs.
- III. Apply principles of primary, secondary and tertiary care.
- IV. Carry out measures which satisfy the health needs and which maximize the potential of the Ecuadorian population.
- V. Administer nursing care in the service sector.
- VI. Promote the active participation of the individual, the family and the community in the identification and solution of their own problems.
- VII. Work within the multidisciplinary health team and coordinate the resources of the community in the implementation of multisectoral programs.
- VIII. Plan, implement and evaluate preventive, curative and rehabilitative health programs for the Ecuadorian population, as well as programs in continuing education for health professionals.
- IX. Participate in research efforts in the fields of nursing and health care.
- X. Promote constructive change within the health care system.

APPENDIX III

PONTIFICIA UNIVERSIDAD CATOLICA DEL ECUADOR
 FACULTAD DE ENFERMERIA
 CURRICULUM DESIGN OF THE BACCALAUREATE PROGRAM



KEY:

Horizontal and Vertical Structural Elements

Central Axis

Integrating Strand

APPENDIX IV

PRE-PROFESSIONAL LEVEL

SEMESTER I

SEMESTER II

SEMESTER III

BIOLOGY

MICROBIOLOGY

ANATOMY AND PHYSIOLOGY II

CHEMISTRY

PARASITOLOGY

ANATOMY AND PHYSIOLOGY I

LANGUAGE

LANGUAGE

LANGUAGE

RELIGION

RELIGION

RELIGION/PROFESSIONAL ETHICS

PSYCHOLOGY

INTERPERSONAL COMMUNICATION

EDUCATIONAL PSYCHOLOGY

CULTURAL ANTHROPOLOGY

INTRODUCTION TO COMMUNITY

THE HEALTH CARE SYSTEM

DEVELOPMENT

INTRODUCTION TO NURSING

NUTRITION

STATISTICS

NURSING RESEARCH

31

APPENDIX IV (Continued)

COURSES IN THE PRE-PROFESSIONAL LEVEL

FIRST SEMESTER		SECOND SEMESTER		THIRD SEMESTER	
<u>COURSE</u>	<u>CREDIT HOURS</u>	<u>COURSE</u>	<u>CREDIT HOURS</u>	<u>COURSE</u>	<u>CREDIT HOURS</u>
- Biology	3	- Microbiology & Parasitology	6	- Anatomy & Physiology II	6
- Chemistry	3	- Anatomy & Physiology I	6	- Language	3
- Language	3	- Language	3	- Religion (Professional Ethics)	3
- Religion	3	- Religion (Philosophy)	3	- Educational Psychology	3
- Psychology	3	- Interpersonal Communication	3	- Introduction to Nursing	3
- Cultural Anthropology	3	- Introduction to Community Development	3	- Nursing Research	3
- The Health Care System	3			- Statistics	<u>2</u>
- Nutrition	<u>2</u>				
<u>Total Credit Hours:</u>	23	<u>Total Credit Hours:</u>	24	<u>Total Credit Hours:</u>	23

ELECTIVE COURSES (Students are to choose one elective per semester during the Professional Level.):

- Art Appreciation
- Physical Education
- Sociology
- Anthropology
- Economics
- English
- Speech Therapy
- Occupational Health
- Oncology Nursing
- Geriatric Nursing
- School Health

12

LEVEL: I. CARE OF THE INDIVIDUAL, FAMILY AND COMMUNITY IN DYNAMIC EQUILIBRIUM.

POPULATION	FUNCTIONS	SKILLS	PREREQUISITES
<p>A. Newborn, infant, preschool, school-age, adolescent, young adult*, mature adult, geriatric patient.</p> <p>*Woman of childbearing age (conception, prenatal period, delivery, puerperium.)</p>	<p>1. Physical, psychological, emotional, socio-cultural and environmental assessment of the individual, family and community.</p> <p>2. Maintain or promote the health status of the individual, family and community.</p> <p>3. Detection and correction of uncomplicated morbidity</p>	<ul style="list-style-type: none"> - Ability to work within interdisciplinary team. - Communication, observation and interviewing skills. - Utilization of resources and referral systems. - Collection of data and utilization of diagnostic and evaluative instruments. - Knowledge of cultural characteristics of patient population. - Immunizations, health education, home visits, community outreach, referral system, participation in government programs. - Identification of risk factors. - Knowledge of pathophysiology and epidemiology of uncomplicated morbidity, detection and prevention of most common types of illness and accidents, first aid, information systems charting and referral, collection of laboratory specimens and interpretation of results, asepsia and antisepsia, pharmacology. 	<ul style="list-style-type: none"> - The Health Care System - Interpersonal Communication - Anthropology - Biostatistics - Anatomy and Physiology I & II - Biology - Chemistry - Psychology - Parasitology - Microbiology - Educational Psychology - Nutrition - Introduction to Community Development - Language (Quechu) - Introduction to Nursing - Principles of Research

SCHMATIC REPRESENTATION OF RURAL COMMUNITY HEALTH NURSING CURRICULUM

LEVEL: I. CARE OF THE INDIVIDUAL, FAMILY AND COMMUNITY IN DYNAMIC EQUILIBRIUM (Population A continued.)

REQUIREMENTS	FIELD EXPERIENCE SITES	DEMANDS TO BE MET	OBSERVATIONS
<ul style="list-style-type: none"> - Growth and Development - Nursing Process - Pharmacology I/Uncomplicated Morbidity - Nursing Procedures - Principles of Epidemiology - Pathophysiology - First Aid - Principles of Administration - Administration of medications - Mental Health 	<ul style="list-style-type: none"> - Day Care Centers - Schools - Fathers' Committees - High Schools - Community: Homes Neighborhoods - Mothers' Clubs - Sports Clubs - Nursing Homes - Health Centers - Sub Centers - Outpatient Departments - Factories 	<p>NURSING SCHOOL:</p> <ul style="list-style-type: none"> - Interinstitutional agreements - Coordination within the university - Selection of field experience sites <p>PERSONNEL:</p> <ul style="list-style-type: none"> - Continuing education - <ul style="list-style-type: none"> .Assessment of individual, family and community .Transcultural nursing - Physical assessment, research, epidemiology, traditional medicine - National health system 	<p>Need faculty member with specialization in transcultural nursing.</p>

SCHEMATIC REPRESENTATION OF RURAL COMMUNITY HEALTH NURSING CURRICULUM

LEVEL: II. CARE OF THE INDIVIDUAL, FAMILY AND GROUP WITH MODERATE, SEVERE, CHRONIC OR TERMINAL ILLNESS.

POPULATION	FUNCTIONS	SKILLS	PREREQUISITES
<p>B. Medical-surgical: Gastrointestinal, trauma, urology, nephrology, cardio-pulmonary, otolaryngology, hematology.</p>	<ol style="list-style-type: none"> 1. Assessment and nursing diagnosis. 2. Care planning. 3. Nursing intervention. 4. Evaluation. 5. Follow-up. 	<ul style="list-style-type: none"> - Admission history, assessment by systems and functions, interpretation of test results within specialty, nursing diagnosis, assisting with diagnostic tests. - Preparation of care plan with measurable short and long-term objectives. - Appropriate nursing care for disfunctions in following: sensory, environmental, motor, integumentary, nutrition, etc. - Care and procedures relating to diseases of various organ systems (musculo-skeletal, cardio-vascular, digestive, respiratory, genito-urinary) <ul style="list-style-type: none"> . Specialized assessment . Specialized examinations and procedures . Identification and management of most common pathology . Special medicine and diets . Special equipment and instruments . Information systems and charting . Special pre- and post-operative procedures . Operating room - Care of high risk patients in each clinical area. - Evaluation of nursing intervention. - Utilization of results in reformulation of care plan - Discharge planning - Participation of patient and family in continuous care, home care, referral. 	

SCHEMATIC REPRESENTATION OF RURAL COMMUNITY HEALTH NURSING CURRICULUM

LEVEL: II. CARE OF THE INDIVIDUAL, FAMILY AND GROUP WITH MODERATE, SEVERE, CHRONIC OR TERMINAL ILLNESS.

REQUIREMENTS	FIELD EXPERIENCE SITES	DEMANDS TO BE MET	OBSERVATIONS
<ul style="list-style-type: none"> - Pathophysiology (complex pathology) - Specific Diagnostic and Laboratory Tests - Nursing Procedures according to specialty - Nutrition - Pharmacology - Administration: <ul style="list-style-type: none"> . Decision-making . Problem solving - Information Systems - Referral System - Utilization of Resources - Ethical-Legal Aspects of Nursing Practice - Health Education - individual and family 	<ul style="list-style-type: none"> - General and specialty hospitals - Private clinics and institutions, according to specialty 	<p>NURSING SCHOOL:</p> <ul style="list-style-type: none"> - Selection of field experience sites <p>PERSONNEL:</p> <ul style="list-style-type: none"> - Physical assessment - Admission history - Operation of special equipm't - Familiarity with diagnostic tests and special procedures - Nursing process - Decision theory, problem-solving strategies 	

SCHEMATIC REPRESENTATION OF RURAL COMMUNITY HEALTH NURSING CURRICULUM

LEVEL: II. CARE OF THE INDIVIDUAL, FAMILY AND GROUP WITH MODERATE, SEVERE, CHRONIC OR TERMINAL ILLNESS.

POPULATION	FUNCTIONS	SKILLS	PREREQUISITES
<p>C. Hospitalized individuals and groups (family centered nursing).</p> <p>Maternal-child health:</p> <ul style="list-style-type: none"> . Normal pregnancy . High risk mother and newborn 	<ol style="list-style-type: none"> 1. Assessment and nursing diagnosis (including high risk patient). 2. Care planning. 3. Nursing intervention. 4. Evaluation. 5. Follow-up. 	<ul style="list-style-type: none"> - Admission history - Assessment of organ systems and functions - Assisting with diagnostic tests - Interpretation of specific diagnostic tests - Nursing theory, nursing diagnosis - Preparation of care plan (including measurable short and long-term objectives) - Prenatal control of high risk patient - Assisting with care of patient undergoing normal delivery and puerperium - Care of high risk labor and delivery and post-partum patients - Care of high risk newborn - Evaluating effects of nursing care - Utilization of data from evaluation in reformulation of care plan - Discharge planning - Participation of patient and family in nursing care, home care 	

SCHEMATIC REPRESENTATION OF RURAL COMMUNITY HEALTH NURSING CURRICULUM

LEVEL: II. CARE OF THE INDIVIDUAL, FAMILY AND GROUP WITH MODERATE, SEVERE, CHRONIC OR TERMINAL ILLNESS. (Population C cont'd)

REQUIREMENTS	FIELD EXPERIENCE SITES	DEMANDS TO BE MET	OBSERVATIONS
<ul style="list-style-type: none"> - Maternal-child Nursing - Administration - Transcultural Nursing (as it relates to maternal-child health) - Pharmacology - Pathophysiology (Obstetrics and Gynecology) - Health Education and Environmental Health 	<ul style="list-style-type: none"> - Maternity Hospital Isidro Ayora - Obstetrical units - Private clinics - Community follow-up 	<p>NURSING SCHOOL:</p> <ul style="list-style-type: none"> - Selection of field experience sites (especially new private sector sites) <p>PERSONNEL:</p> <ul style="list-style-type: none"> - Transcultural nursing in maternal-child health 	

LEVEL II. CARE OF THE INDIVIDUAL, FAMILY AND GROUP WITH MODERATE, SEVERE, CHRONIC OR TERMINAL ILLNESS. Population D.

POPULATION	FUNCTIONS	SKILLS	PREREQUISITES
<p>D. Individuals and groups with problems in the areas of physical and psycho-social integration:</p> <ul style="list-style-type: none"> . Physical handicaps . Loss of hearing or vision . Mental or emotional handicap . Difficulties with communication <ul style="list-style-type: none"> - Neurotic and psychotic disorders - Abandoned children - Alcoholism and drug addiction - Delinquency - Prostitution 	<ol style="list-style-type: none"> 1. Assessment and nursing diagnosis. 2. Care planning. 3. Intervention. 4. Evaluation. 5. Follow-up. 	<ul style="list-style-type: none"> - Physical, psycho-social, environmental assessment (knowledge of instruments used in psycho-social assessment) - Preparation of care plans with measurable short and long-term objectives and goals - Implementation of specific health education and rehabilitation programs - Group dynamics; motivational, occupational, and recreational therapeutic modalities - Administration of medications - Use of specialized equipment - Use of referral system - Evaluation of therapy and participation in treatment by professionals from other sectors - Continuity of care from institutional to community setting 	

SCHEMATIC REPRESENTATION OF RURAL COMMUNITY HEALTH NURSING CURRICULUM

LEVEL: II. CARE OF THE INDIVIDUAL, FAMILY AND GROUP WITH MODERATE, SEVERE, CHRONIC OR TERMINAL ILLNESS. (Population D cont.)

REQUIREMENTS	FIELD EXPERIENCE SITES	DEMANDS TO BE MET	OBSERVATIONS
<ul style="list-style-type: none"> - Mental Health and Psychiatric Nursing - Social Psychology - Psycho-pharmacology - Group Dynamics - Leadership - Utilization of Resources (Maximization of Resources) - Ethical-legal Aspects - Work in Multidisciplinary Group - Transcultural Nursing - Health Education - Rehabilitation 	<ul style="list-style-type: none"> - Youth homes - Institutions for the handicapped - Psychiatric hospitals - Geriatric institutions - Sub center at Luluncoto - Prisons - Reform schools - Rehabilitation centers - Alcoholics Anonymous groups - San Juan de Dios Rehabilitation Center - Home for single mothers 	<p>NURSING SCHOOLS:</p> <ul style="list-style-type: none"> - Coordination with other university departments for social action projects (such as Social Service, Law, Psychology, Medical Technology, Sociology, Education). <p>PERSONNEL:</p> <ul style="list-style-type: none"> - Advanced study in Psychiatric Nursing and Medical-Surgical Nursing. 	

SCHEMATIC REPRESENTATION OF RURAL COMMUNITY HEALTH NURSING CURRICULUM

LEVEL: II. CARE OF THE INDIVIDUAL, FAMILY AND GROUP WITH MODERATE, SEVERE, CHRONIC OR TERMINAL ILLNESS. Population E.

POPULATION	FUNCTIONS	SKILLS	PREREQUISITES
E. Individuals with chronic or terminal illness: a) Chronic	1. Assessment and nursing diagnosis.	- Physical assessment by systems and functions; emphasis on identifying psychosocial and spiritual needs.	
	2. Planning.	- Preparation of care plans in close collaboration with other members of the health team. - Recognition of cultural beliefs regarding chronic and terminal illness.	
b) Care of the dying patient	3. Intervention.	- Implement care plan for individual or group utilizing institutional and community resources.	
	4. Evaluation.	- Evaluate nursing interventions as well as the input of other sectors. - Use of result. as input into continuous planning.	
	5. Follow-up.	- Elaboration of plans for continuous care with measurable objectives.	
	1. Care of the patient.	- Care of the dying patient and his family, taking into account spiritual and cultural values. - Participation of the family in the patient's care. - Care of the patient who has expired. - Use of information and referral systems.	
	2. Evaluation.	- Evaluation of nursing intervention. - Utilization of results.	

SCHEMATIC REPRESENTATION OF RURAL COMMUNITY HEALTH NURSING CURRICULUM

LEVEL: II. CARE OF THE INDIVIDUAL, FAMILY AND GROUP WITH MODERATE, SEVERE, CHRONIC OR TERMINAL ILLNESS. (Population E cont'd)

REQUIREMENTS	FIELD EXPERIENCE SITES	DEMANDS TO BE MET	OBSERVATIONS
<ul style="list-style-type: none"> - Pathology - Administration - Ethical-legal Aspects - Psychology - Crisis Intervention - Transcultural Nursing - Administration of Medication - Working in Multidisciplinary Teams - Health Education for Individuals and Families 	<ul style="list-style-type: none"> - General and specialty hospitals - Specialty clinics and private institutions - Homes 	NURSING SCHOOL: <ul style="list-style-type: none"> - Coordination within the university and with other sectors. PERSONNEL: <ul style="list-style-type: none"> - Specialization in the care of chronic and terminal patients. 	
<ul style="list-style-type: none"> - Death and Dying - Crisis Situations - Ethical-legal Aspects - Information and Referral Systems - Health Education for Individuals and Families 	<ul style="list-style-type: none"> - Health care facilities - Community 	PERSONNEL: <ul style="list-style-type: none"> - Continuing education; spiritual and psychosocial care of the terminal patient 	

LEVEL: III. COMMUNITY DEVELOPMENT.

POPULATION	FUNCTIONS	SKILLS	PREREQUISITES
<ul style="list-style-type: none"> - Communities - Families - Individuals 	<ol style="list-style-type: none"> 1. Community diagnosis. 2. Planning, organization, implementation and evaluation of programs. 3. Community organization and participation in health care. 4. Promotion of constructive change. 5. Research regarding the needs of the community and participation in projects. 	<ul style="list-style-type: none"> - Analysis of the community as a field for nursing actions. - Definition of the community as a system and identification of subsystems. - Analyze patterns of interactions between subsystems. - Evaluate the impact of the different factors which affect the health of individuals, families, communities. - Evaluation of the family structure within the cultural context of the community. - Identification of available resources. - Preparation of the diagnosis - Program planning based on community diagnosis. - Identification, organization and utilization of resources - Administration of programs based on the criteria of cost benefit and cost effectiveness. - Development of programs for health protection and promotion. - Use of interpersonal communication skills. - Use of mechanisms of motivation to achieve community participation. - Application of transcultural nursing concepts. - Identification of areas where change is needed. - Identification of positive and negative forces affecting the change process. - Utilization of different strategies for change. - Modification of health-related behavior. - Knowledge of research methodology. - Conduct research incorporating ethical-legal issues. - Elaboration of small research projects. 	<ul style="list-style-type: none"> - All functions require background in decision theory, problem solving, and work within the multidisciplinary team.

SCHEMATIC REPRESENTATION OF RURAL COMMUNITY HEALTH NURSING CURRICULUM

LEVEL: III. COMMUNITY DEVELOPMENT.

REQUIREMENTS	FIELD EXPERIENCE SITES	DEMANDS TO BE MET	OBSERVATIONS
<ul style="list-style-type: none"> - Program Administration - Health Economics - The Health Care Team - Communications - Epidemiological Control - Transcultural Nursing - Health Education and Environmental Sanitation 	<ul style="list-style-type: none"> - Community groups - Families - Health centers - Outpatient departments - Educational institutions - Provincial health offices 	<p>NURSING SCHOOL:</p> <ul style="list-style-type: none"> - Coordination with other disciplines. - Committee for supervision of research and projects in community health. <p>PERSONNEL:</p> <ul style="list-style-type: none"> - Working in the community setting. - Program administration. - Epidemiological investigation. 	

APPENDIX VI

PROFESSIONAL LEVEL I

	NURSING RESEARCH		INTEGRATED				
	ADMINISTRATION		PRACTICE INTEGRATED THEORY TAUGHT SEPARATELY				
	NURSING PROCESS		INTEGRATED				
	HEALTH EDUCATION		INTEGRATED				
	TRANSCULTURAL NURSING		INTEGRATED				
	MENTAL HEALTH						
CONTENT AREAS	Nursing Intervention I	First Aid	Pathophysiology				
	Growth and Development	Accident Prevention - Home Safety	Pharmacology I				
	Nutrition		Nursing Techniques Epidemiology				
CURRICULUM CORE: COMMUNITY HEALTH	Assessment Health Maintenance and Promotion, Uncomplicated Morbidity						
	Newborn	Infant	Pre-School	School Age	Adolescent	Female of Child-bearing Age & Young Adult	Geriatric Patient
						Prenatal Period	
						Puerperium	
						Normal Delivery	
						Family Planning	
						Cancer Screening	

LEVEL OF PREVENTION - PRIMARY

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APPENDIX VI (Continued)

RESEARCH	ADMINISTRATION	TRANSCULTURAL NURSING
<p><u>Skills:</u></p> <p>Observation of newborn</p> <p>Collection of data: .Mother and other sources</p> <p>Interviewing</p> <p>Recording Information</p> <p>Direction of children with problems of growth and development</p> <p>Base nursing interventions on scientific principles</p> <p>Analyze risk factors in the newborn, reach conclusions and contribute to the search for solutions to improve the growth and development of the newborn</p> <p>Identification of uncomplicated morbidity: .Underweight or overweight children .Respiratory conditions .Diarrhea .Vomiting .Diseases of the skin</p> <p>Nursing interventions</p> <p>Monitoring of effects of nursing interventions on the patient</p>	<p>Characterize the nature of structured and unstructured organizations (i.e., formal and informal)</p> <p>Organizational planning</p> <p>Organization of personal time</p> <p>Administrative behavior</p> <p>Leadership</p> <p>Information</p> <p>Utilization of resources: .Material .Human</p>	<p>Cultural beliefs re. newborn</p> <p>Socio-economic barriers to obtaining health care</p> <p>Traditional medical practices with respect to the newborn</p> <p>Socio-economic impact of the newborn on the family</p> <p>Socialization of the new family and community member</p> <p>Cultural values re. the child and health care</p> <p>Alimentary patterns</p> <p>Collaboration between two health care systems (formal and traditional)</p> <p>Relationship between health care professional and patient</p>

APPENDIX VII

PROFESSIONAL LEVEL II

HEALTH EDUCATION			
RESEARCH			
ADMINISTRATION			
NURSING PROCESS			
TRANSCULTURAL NURSING			
ASSESSMENT PLANNING INTERVENTION EVALUATION FOLLOW-UP ACUTE-CHRONIC PEDIATRICS/ADULTS MEDICAL-SURGICAL	ASSESSMENT PLANNING INTERVENTION EVALUATION FOLLOW-UP NORMAL DELIVERY HIGH RISK MOTHER & NEWBORN MATERNAL-CHILD	ASSESSMENT PLANNING INTERVENTION EVALUATION FOLLOW-UP THE TERMINALLY ILL PATIENT	ASSESSMENT PLANNING INTERVENTION EVALUATION FOLLOW-UP PATIENTS WITH PROBLEMS OF PHYSICAL AND PSYCHO-SOCIAL INTEGRATION

LEVELS OF PREVENTION

L I F E C Y C L E

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APPENDIX VII Continued

PROFESSIONAL LEVEL II

SUBUNIT 1:

Medical-Surgical Nursing
(Operating Room)

CONTENT AREAS:

Administration
Pathophysiology II
(Acute and chronic diseases)
Nursing Intervention II
(Specialized procedures and treatments)
Diet Therapy
Pharmacology II
Health Education
Rehabilitation
Epidemiology II
Organization of Nursing Interventions
Ethical-Legal Aspects
Operating Room Techniques
The Nurse Within the Health Team
Referral System

SEMESTER V

PROFESSIONAL LEVEL II

SUBUNIT 2:

Chronic and Terminal
Illness

CONTENT AREAS:

Pathophysiology III

Pharmacology III

Nursing Intervention III -

Special Procedures and Treatments

Theories Regarding Death

Crisis Theory

Administration - Human Resources, Referral

Psycho-social and Spiritual Care

Nutrition

Health Education

Ethical-Legal Aspects

Epidemiology III

SEMESTER V

SUBUNIT 3:

Maternal-Child Health
(Labor and Delivery,
OB/GYN Pathology, High
Risk Newborn

Pathophysiology IV -

Obstetrics, Gynecology, Newborn

Pharmacology IV

Nutrition

Health Education

Nursing Intervention IV -

Special Procedures and Treatments

Administration

Ethical-Legal Aspects

SEMESTER VI

ELECTIVE:

Epidemiology IV

The Nurse Within the Health Team

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PROFESSIONAL LEVEL II

<u>SEMESTER VI</u>	<p><u>SUBUNIT 4:</u> The client with problems of physical and psycho-social integration. - Psychotic and Neurotic Disorders - Care of the Handicapped Client - Substance Abuse - The Alcoholic/Drug-dependent client - Abandoned Children Juvenile Delinquency Encarcerated Clients Prostitution Single Mothers</p>	<p><u>CONTENT AREAS:</u> Psychopathology Pharmacology V Nursing Intervention V - Special Procedures and Treatments Administration Ethical-Legal Aspects Mental Health and Psychiatric Nursing Rehabilitation Social Psychology Epidemiology V The Nurse Within the Health Team Pathophysiology VI Rehabilitation (Social and Physical) Nursing Intervention VI - Special Procedures and Treatments Administration and Utilization of Resources Ethical-Legal Aspects Transcultural Nursing Mental Health and Psychiatric Nursing Epidemiology VI, Pharmacology VI The Nurse Within the Health Team Psychopathology Epidemiology VII, Pharmacology VII Social Psychology Rehabilitation Nursing Intervention VII - Special Procedures and Treatments Administration Ethical-Legal Aspects Social Psychology, Psycho-social Rehabilitation Familial and Social Impact of These Problems Nursing Intervention VIII - Participation in Interdisciplinary Programs Administration Ethical-Legal Aspects</p>
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PREFERS TO BE CALLED: _____ ASSESSMENT COMPLETED BY: _____

AREAS	SUBJECTIVE/OBJECTIVE DATA
<p><u>Perceptions of the client regarding:</u></p> <p>Actual health status</p> <p>Objectives</p> <p>Services or resources required to meet objectives</p> <p><u>Functional Abilities:</u></p> <p>Respiration/Circulation status</p> <p>Elimination status</p> <p>Emotional/Psychological status</p> <p>Motor/Safety status</p> <p>Nutritional status</p> <p>Personal hygiene</p> <p>Sensory status</p> <p>Sexual function</p> <p>Sleeping patterns</p> <p><u>Resources - Support Systems:</u></p> <p>Environmental</p> <p>Personal/Social</p> <p>Other</p>	

Taken from: Mitchell, Pamela, Concepts Basic to Nursing, New York: McGraw-Hill Co., 1973.

- Complete List of Functions:
- Motor Status
 - Integumentary Status
 - Sensory Status
 - Nutritional Status
 - Elimination Status
 - Circulatory/Respiratory Status
 - Fluids and Electrolyte Status
 - Comfort/Sleep Status
 - Temperature Status

APPENDIX IX

GUIDE FOR ASSESSMENT OF THE FOUR DIMENSIONS IN COMMUNITY HEALTH NURSING

ENVIRONMENTAL	BIOPHYSICAL	SOCIO-CULTURAL	PSYCHOLOGICAL
Surname and name	Each member:	Sex	Feelings and opinions re:
Case number	Age	Ethnic origin	Basic human needs
Address	Sex	Religion	Family relationships
House, external	Genetic factors	Marital status	Security
House, internal	Basic human needs	Family structure in home	Physical conditions:
Space Allotment	Developmental status	Spouse	Own
Utilities	Nutritional status	Children (no., age, sex)	Others
Plumbing	Female reproductive status	Parents	Changes in body image
Housekeeping	General physiological status	Siblings	Pain
Health engendering		Others	Illness
Conveniences		Family interaction patterns	Death
Furnishings		Lifestyle	Health care systems
Basic human needs		Value system	Present health
		Occupation:	Intellectual capacity
Neighborhood		Self	Educational
General area condition		Spouse	Sensory reactions and perceptions
Sanitation		Others	Orientation (time, place, etc.)
Safety		Typical day:	Tensions or stressors
Health engendering		Customs	Response patterns
Transportation		Food/eating patterns	
Facilities		Activity	
		Recreation	
Stressors	Stressors	Community affairs	
		Basic human needs	
		Financial status	
		Health insurance	
		Attitudes - health and delivery systems	
		Stressors	

LEVELS OF PREVENTION

APPENDIX X
PROFESSIONAL LEVEL III

COMMUNITY DEVELOPMENT

ADMINISTRATION RESEARCH HEALTH EDUCATION NURSING PROCESS TRANSCULTURAL NURSING	Research and Data Gathering Community Diagnosis Community Participation Promotion of Change Program Administration Epidemiological Control	AGING ADULT PROGRAMS
	Research and Data Gathering Community Diagnosis Community Participation Promotion of Change Program Administration Epidemiological Control	MATURE ADULT OCCUPATIONAL HEALTH AND HEALTH MAINT- ENANCE PROGRAMS
	Research and Data Gathering Community Diagnosis Community Participation Promotion of Change Program Administration Epidemiological Control	YOUNG ADULT- CHILDBEARING FAMILY
	Research and Data Gathering Community Diagnosis Community Participation Promotion of Change Program Administration Epidemiological Control	ADOLESCENT PROGRAMS
	Research and Data Gathering Community Diagnosis Community Participation Promotion of Change Program Administration Epidemiological Control	SCHOOL HEALTH PROGRAMS
	Research and Data Gathering Community Diagnosis Community Participation Promotion of Change Program Administration Epidemiological Control	PRE-SCHOOL PROGRAMS
	Research and Data Gathering Community Diagnosis Community Participation Promotion of Change Program Administration Epidemiological Control	NEWBORN AND INFANT PROGRAMS

L I F E C Y C L E

APPENDIX X (Continued)

PROFESSIONAL LEVEL III

UNIT:

Community Development
Patient Population -
- The Community
- The Family
- The Individual

CONTENT AREAS:

Community Health
Epidemiology
Program Administration -
 Leadership
 Change Theory
 Health Economics
 Cost/Benefit and Cost/Effectiveness
Transcultural Nursing
Research Methodology
Nursing Intervention IX
The Nurse Within the Health Team

SEMESTER VII

APPENDIX XI

TERMINAL PERFORMANCE OBJECTIVES FOR LEVEL III

- I. Understand the role of the nurse within the health care system
 - 1.1 Formulate a personal philosophy of the role of the community health nurse (CHN)
 - 1.2 Apply the nursing process to the community setting
 - 1.3 Work effectively within the health team and effectively coordinate multi-sectoral community services
 - 1.4 Distinguish the differences between preventive and curative health systems
 - 1.5 Identify the functions of the nurse in primary health care
- II. Synthesize concepts from public health science and nursing science
 - 2.1 Compare and contrast the health care system in the community with the regional, provincial and national systems
 - 2.2 Recognize the influence of national policy on health care delivery
 - 2.3 Evaluate the impact of health policy on the health status of families and communities
 - 2.4 Define levels of prevention in a primary health care system
 - 2.5 Recognize own capacity for participation in primary health care activities
 - 2.6 Determine the need for, and recommend, necessary referrals
 - 2.7 Initiate case finding activities
- III. Utilize principles of epidemiology and their relationship to disease causation as well as their role in prevention and cure
 - 3.1 Apply epidemiological principles in communicable disease control programs
 - 3.2 Recognize the validity of research methodology as a tool in the prevention of disease and the maintenance and promotion of health
- IV. Understand and utilize the information system
 - 4.1 Familiarize self with the current information system in Ecuador
 - 4.2 Devise methods for improving the information system and multi-sectoral communication
 - 4.3 Familiarize self with forms and documents used in research and evaluation
- V. Analyze the community as a field for nursing actions
 - 5.1 Define the community and its functions
 - 5.2 Effectively utilize community assessment instruments
 - 5.3 Apply the nursing process in data gathering
 - 5.4 Analyze theories and methods for community assessment and assessment of the health status of the community

APPENDIX XI Continued

- 5.5 Identify the sub-systems within the community
 - 5.6 Identify patterns of interaction between sub-systems
 - 5.7 Describe the impact of various sub-systems on the health status of individuals, families and communities
 - 5.8 Describe the role of community assessment in program planning
 - 5.9 Discuss the contribution of community assessment in the development of programs and health services
 - 5.10 Recognize the importance of cultural factors in the process of community assessment and diagnosis
- VI. Demonstrate skill in family assessment
- 6.1 Identify instruments for family and individual assessment
 - 6.2 Collect data in a systematic manner
 - 6.3 Identify health needs on the basis of assessment and growth and development tests
 - 6.4 Discuss theories of family assessment
 - 6.5 Discuss the family unit as a context for health behavior
 - 6.6 Describe the different family forms
 - Nuclear
 - Extended
 - 6.7 Evaluate the objectives of family nursing practice
 - 6.8 Compare and contrast different theories of family dynamics
 - 6.9 Synthesize information regarding role differentiation within the family
 - 6.10 Analyze communication patterns within the family and their impact on health status
 - 6.11 Discuss patterns of influence and power within the family and their impact on health status
- VII. Analyze theories of care planning and nursing intervention for the individual and the community, taking into account the life cycle and cultural factors which have an impact on health status
- 7.1 Plan and implement nursing interventions for groups according to their developmental stage
 - 7.2 Formulate concrete, measurable objectives for nursing interventions
 - 7.3 Compare program results with stated objectives
 - 7.4 Relate therapy as well as referrals to other levels of prevention, to their effects on community groups
 - 7.5 Justify referrals within the system
 - 7.6 Interpret nursing care within its social, cultural and environmental context
 - 7.7 Analyze the definition of the health-illness continuum within each cultural group in the patient population

APPENDIX XI Continued

- 7.8 Identify health-protecting behavior in the community
- 7.9 Critically analyze the health belief model
- 7.10 Analyze the health-protecting behavior model
- VIII. Apply the community development process in order to optimize the health of individuals and families in the community
 - 8.1 Define the community development process and its applications in Ecuador
 - 8.2 Identify the various agencies which participate in community development
 - 8.3 Utilize community resources in the planning and implementation of health programs
 - 8.4 Encourage community participation in the development process according to established norms for the health sector
- IX. Apply change theory to the family and community setting
 - 9.1 Identify the health beliefs of the population
 - 9.2 Identify and utilize the sources of motivation for change which exist within the family
 - 9.3 Analyze and apply behavior modification theory as it applies to health-seeking behavior
 - 9.4 Compare and contrast the effects of different nursing interventions on the lifestyle of the patient population
- X. Evaluate the effectiveness of the community nursing process by means of operations research and program evaluation
 - 10.1 Define the role of the nurse in planning for health services
 - 10.2 Identify and implement strategies for health program administration, such as:
 - a. Concepts from health economics
 - b. Cost benefit and cost effectiveness analysis
 - c. Strategies for multi-sectoral coordination
 - 10.3 Evaluate the effects of multi-sectoral programs on the health status of the population
 - 10.4 Define the relationship between the evaluation process and the nursing process
 - 10.5 Identify factors which effect the success of program implementation

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CONTENT AREAS FOR LEVEL III:
COMMUNITY DEVELOPMENT

- I. The Role of the Community Health Nurse
 - a. History of the role of the CHN
 - b. Functions of the CHN
 - c. The nursing process and its applications in community health
 - d. Skills required of the CHN
 - e. Areas of utilization of the CHN
 - f. The CHN as a member of the health team

Suggested Bibliography:

- Borges, Maria V. "Nursing in Primary Health Care in Brazil", International Nursing Review, (27,6,1980), 173-177.
- Freeman, Ruth B. and Janet Heinrich. Community Health Nursing Practice. Philadelphia: W.B. Saunders Co., 1981. Chapters 2, 3, 11.
- Fromer, Margot Jean. Community Health Care and the Nursing Process. St. Louis: The C.V. Mosby Co., 1979. Chapters 4, 6, 13.
- Jaeger-Burns. "The Relationship of Nursing to Primary Health Care Internationally", International Nursing Review, (28, 6, 1981), 167-175.
- Kurtzman, Chana, et. al. "Nursing Process at the Aggregate Level", Nursing Outlook, (Dec. 1980), 737-739.
- Okunade, Bimpe. "The Nurse Within the Health Team", International Nursing Review, (March-April 1975), 46-49.
- Williams, C.A. "Community Health Nursing - What is it?", Nursing Outlook, (1977, 25), 258.

- II. Principles of Public Health and Health Policy
 - a. Concepts and principles of public health
 - b. Synthesis of public health and community health nursing concepts
 - c. Health policy and preventive programs

Suggested Bibliography:

- Archer, Sarah E. "Synthesis of Public Health Science and Nursing Science", Nursing Outlook, (Sept.-Oct. 1982), 442-446.
- Brownlee, Ann T. Community Culture and Care. St. Louis: C.V. Mosby Co., 1978. Chapter 7.
- Fromer, Chapter 8.

APPENDIX XI Continued

Green, L.W. "Health Promotion Policy and the Placement of Responsibility for Personal Health Care", Family and Community Health, (1979, 2), 51-64.

Green, L.W. "National Policy in the Promotion of Health", International Journal of Health Education, (July-Sep. 1979), 161-168.

Shamansky, Sherry. "Levels of Prevention; Examination of a Concept", Nursing Outlook, (Feb. 1980), 104-108.

White, María S. "Construct for Public Health Nursing", Nursing Outlook, (Nov.-Dec. 1982), 527-530.

III. Epidemiology and Research

- a. Definition of the concept
- b. Terminology
- c. Epidemiological principles in disease control programs
- d. Utilization of epidemiology in community health research - advantages and disadvantages

Suggested Bibliography:

Clemen, Unit 4, chapter 10.

Fromer, chapter 9.

Mausner, Judith S. and Anita K. Bahn. Epidemiology: An Introductory Text. Philadelphia: W.B. Saunders Co., 1974.

Rosenblum, Estelle. Submodule 1302, Albuquerque: University of New Mexico, 1981.

IV. Information Systems

- a. Importance of charting and the recording of data
- b. Current information systems in Ecuador
- c. Development of information systems
- d. Research and evaluation - data gathering

Suggested Bibliography:

Freeman and Heinrich, chapter 6.

University of New Mexico Submodule: The Chart Audit.

Woolley, F. Ross and Robert L. Kane. "Improving Patient Care Through the Interdisciplinary Record", in Reinhardt, Adine M. and Denise Quinn, Current Practice in Family-Centered Community Nursing. St. Louis: C.V. Mosby Co., 1977.

Resource People/Guest Speakers:

Srta. Renata Jara, Ministerio de Salud Pública, División Nacional de Informática.

Dr. José Castro, M.S.P., División Nacional de Desarrollo Comunitario.

V. Community Assessment

- a. Definition of the community
- b. Functions of the community

APPENDIX XI Continued

- c. Data collection - methodology
- d. Community diagnosis
- e. Theories of community diagnosis
 - 1. Systems theory
 - 2. Cultural method
 - 3. Discovery method

Suggested Bibliography:

- Anderson, C.L., et. al. Community Health. St. Louis: C.V. Mosby Co., 1978. Chapters 2 and 4.
- Brownlee, Ann T. Community Culture and Care. St. Louis: C.V. Mosby Co., 1978. Part 2; chapters 1-4 and 12.
- Clemen, Unit 4; Chapter 11.
- Dignan, M.B. and P.A. Carr. Introduction to Program Planning: A Basic Text for Community Health Education. Philadelphia: Lea and Febiger, 1981. Chapters 1 and 2.
- Freeman and Heinrich, chapters 17 and 18.
- Reinhardt and Quinn, Part IV, chapter 9.
- Shamanski, S.L. and B. Pezneckner. "A Community is...", Nursing Outlook, (1981, 29), 182-185.
- University of New Mexico Submodule #0502 - Guide for Assessment of the Four Dimensions in Community Health Nursing.

VI. Family Assessment

- a. Definition of the family
- b. Functions of the family unit
- c. Family assessment methodologies
 - 1. Structural/functional
 - 2. Growth and development
 - 3. Interactional
- d. Family assessment theories
 - 1. Geismar and La Sorte - the family with multiple problems
 - 2. Family development
 - 3. Communications
 - 4. Systems theory
- e. Factors which impact on the health status of the family

Suggested Bibliography:

- Brownlee, chapters 5, 10, 11.
- Clemen, Unit 3, chapter 6.
- Freeman and Heinrich, chapter 4.

APPENDIX XI Continued

- c. Data collection - methodology
- d. Community diagnosis
- e. Theories of community diagnosis
 - 1. Systems theory
 - 2. Cultural method
 - 3. Discovery method

Suggested Bibliography:

- Anderson, C.L., et. al. Community Health. St. Louis: C.V. Mosby Co., 1978. Chapters 2 and 4.
- Brownlee, Ann T. Community Culture and Care. St. Louis: C.V. Mosby Co., 1978. Part 2; chapters 1-4 and 12.
- Clemen, Unit 4; Chapter 11.
- Dignan, M.B. and P.A. Carr. Introduction to Program Planning: A Basic Text for Community Health Education. Philadelphia: Lea and Febiger, 1981. Chapters 1 and 2.
- Freeman and Heinrich, chapters 17 and 18.
- Reinhardt and Quinn, Part IV, chapter 9.
- Shamanski, S.L. and B. Peznecker. "A Community is...", Nursing Outlook, (1981, 29), 182-185.
- University of New Mexico Submodule #0502 - Guide for Assessment of the Four Dimensions in Community Health Nursing.

VI. Family Assessment

- a. Definition of the family
- b. Functions of the family unit
- c. Family assessment methodologies
 - 1. Structural/functional
 - 2. Growth and development
 - 3. Interactional
- d. Family assessment theories
 - 1. Geismar and La Sorte - the family with multiple problems
 - 2. Family development
 - 3. Communications
 - 4. Systems theory
- e. Factors which impact on the health status of the family

Suggested Bibliography:

- Brownlee, chapters 5, 10, 11.
- Clemen, Unit 3, chapter 6.
- Freeman and Heinrich, chapter 4.

Friedman, chapters 1, 2, 5, 6, 7, and 12 - 17.

Fromer, chapter 10.

Hollen, Patricia. "A Holistic Model of Individual and Family Health Based on a Continuum of Choice", Advances in Nursing Science, (July 1981), 27-42.

Horton, T.E. "Conceptual Basis for Nursing Intervention with Human Systems: Families", Distributive Nursing Practice: A System's Approach to Community Health. J. Hall and B. Weaver, ed., 1977. 101-115.

Reinhardt, Adina M. and Mildred D. Quinn. Current Practice in Family-Centered Community Nursing. St. Louis: C.V. Mosby Co., 1977. Part II; Part III, chapter 5.

Sedgwick, R. "Family Health Assessment", Nurse Practitioner, (March-April 1981), 37.

Streff, M.B. "Examining Family Growth and Development", Advances in Nursing Science, (July 1981), 61-69.

VII. Care Planning and Nursing Intervention for the Family

- a. The young family - programs in maternal-child health, pre-school and school age health
- b. The mature family - occupational health
- c. The aging family
- d. Health-protecting and promoting behavior

Suggested Bibliography:

Brownlee, chapter 8.

Clemen, Unit 3, chapters 7, 8; Unit 5.

Freeman and Heinrich, chapters 12-15.

Fromer, chapters 15, 16.

Oelbaum, C.H. "Hallmarks of Adult Wellness", American Journal of Nursing, (1974, 74), 1623-1625.

Pender, Nola J. Health Promotion in Nursing Practice. New York: Appleton-Century-Crofts, 1982. Chapters 1 - 4.

Reinhardt and Quinn, Part III, chapter 7.

VIII. The Promotion of Change in the Community

- a. Definition of community development
- b. The community development process
- c. Agencies which participate in community development
- d. Use of community organizations by the CHN

Suggested Bibliography:

Castro, José and Duncan Pedersen. Normas para la Participación Comunitaria. Quito: MSP, 1982.

Friedman, chapters 1, 2, 5, 6, 7, and 12 - 17.

Fromer, chapter 10.

Hollen, Patricia. "A Holistic Model of Individual and Family Health Based on a Continuum of Choice", Advances in Nursing Science, (July 1981), 27-42.

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Reinhardt, Adina M. and Mildred D. Quinn. Current Practice in Family-Centered Community Nursing. St. Louis: C.V. Mosby Co., 1977. Part II; Part III, chapter 6.

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Streff, M.B. "Examining Family Growth and Development", Advances in Nursing Science, (July 1981), 61-69.

VII. Care Planning and Nursing Intervention for the Family

- a. The young family - programs in maternal-child health, pre-school and school age health
- b. The mature family - occupational health
- c. The aging family
- d. Health-protecting and promoting behavior

Suggested Bibliography:

Brownlee, chapter 8.

Clemen, Unit 3, chapters 7, 8; Unit 5.

Freeman and Heinrich, chapters 12-15.

Fromer, chapters 15, 16.

Oelbaum, C.H. "Hallmarks of Adult Wellness", American Journal of Nursing, (1974, 74), 1623-1625.

Pender, Nola J. Health Promotion in Nursing Practice. New York: Appleton-Century-Crofts, 1982. Chapters 1 - 4.

Reinhardt and Quinn, Part III, chapter 7.

VIII. The Promotion of Change in the Community

- a. Definition of community development
- b. The community development process
- c. Agencies which participate in community development
- d. Use of community organizations by the CHN

Suggested Bibliography:

Castro, José and Duncan Pedersen. Normas para la Participación Comunitaria. Quito: MSP, 1982.

IX. The Change Process and the Family

- a. The CHN is a change agent
- b. The nature of change
- c. Motivation for change
- d. The process of change - factors which influence it
- e. Types of change
- f. Phases in the change process
- g. Methods for affecting change within the family
 1. Conflict as a force for change
 2. Social learning theory and its relationship to change
 3. Health belief model

Suggested Bibliography:

Becker, M.H., et. al. "Selected Psychosocial Models and Corralates of Individual Health-Related Behaviors", Medical Care, (May 1977, 15), 27-46.

Brownlee, chapters 10 and 11.

Fromer, chapter 11.

Goldfried, M.R. and D. Sobosinski. "The Effect of Irrational Beliefs or Emotional Arousal", Journal of Consulting and Clinical Psychology, (1975, 43), 504-510.

Harris, P.M. and S. Guten. "Health Protecting Behavior: An Exploratory Study", Journal of Health and Social Behavior, (1979, 20), 17-29.

Pedersen, Duncan, et. al., Bibliografía sobre creencias de salud en el Ecuador, Centro de Estudios Transculturales.

Reinhardt and Quinn, Part III, chapter 7.

Steckel, S.B. Patient Contracting. New York: Appleton-Century-Crofts, 1982. Chapters 3 and 4.

X. Program Planning, Administration and Evaluation

- a. National trends in health care delivery
- b. The role of the CHN in health planning
- c. Program administration
 1. Health economics
 2. Cost benefit and cost effectiveness analysis
 3. Multisectoral coordination
- d. Concepts in program evaluation
- e. Steps in the evaluation process
- f. Relationship between the evaluation process and the nursing process

APPENDIX XI (Continued)

Suggested Bibliography:

- Bruhn, J.G. "Planning for Social Change. Dilemmas for Health Planning." American Journal of Public Health, (1973, 63), 602-605.
- Crystal, R.A. and A. Brewster. "Cost-Benefit and Cost-Effectiveness Analysis in the Health Field: An Introduction", Inquiry, (Dec. 1966), 3-13.
- Dignan and Carr, chapters 5 and 6.
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- Lave, J.R. and L.B. "Measuring the Effectiveness of Prevention", Milbank Memorial Fund Quarterly, (Spring 1977, 55), 273-289.
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- Shapiro, S. "Measuring the Effectiveness of Prevention, Part II", Milbank Memorial Fund Quarterly, (Spring 1977, 55), 291-305.
- Simmons, H.J. "Community Health Planning With or Without Nursing?" Nursing Outlook, (1974, 22), 260-264.
- Shortell, Stephen M. and William Richardson. Health Program Evaluation. St. Louis: C.V. Mosby Co., 1978.

APPENDIX XII

PROFESSIONAL LEVEL IV

ADMINISTRATION

HEALTH EDUCATION

NURSING PROCESS

NURSING RESEARCH

Integrated Theory and Practice According to Area Selected

COMMUNITY

HOSPITAL

MATERNAL/CHILD
HEALTH

MENTAL HEALTH

OCCUPATIONAL
HEALTH

CARDIO-
PULMONARY
NURSING

PEDIATRICS

NEPHROLOGY

EMERGENCY
NURSING

NEUROLOGY

O P T I O N S

LEVELS OF PREVENTION

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APPENDIX XII (Continued)

PROFESSIONAL LEVEL IV

OPTIONS:

Individuals and groups
in the hospital or the
community.

CONTENT AREAS:

Area of specialization.

Administration of:

- 1) Personnel
- 2) Nursing Care (i.e., caseload management)
- 3) Organizational Management
- 4) Labor Relations
- 5) The Nurse as Manager

Applied Research

Elective



APPENDIX XII Continued

TERMINAL PERFORMANCE OBJECTIVES FOR LEVEL IV

Preparation of a health protection or promotion plan, including strategies for implementation during the rural rotation.

A non-experimental, descriptive research project may be substituted for the plan, with the approval of the research committee.

TEACHING METHODOLOGY FOR LEVEL IV

Small groups according to specialty area.

Three hours of professional seminar per week.

Reading assignments and discussion of theoretical concepts therein.

Written examinations will be replaced by the research project.

The remainder of the student's time will be spent doing field work and developing the final project under the supervision of the faculty advisor and the research committee.

APPENDIX XIII

GENERAL GUIDELINES FOR IMPLEMENTATION OF CURRICULUM

1. Continuing education for faculty according to needs at each level of curriculum, taking advantage of the time lapse before implementation at the Professional Level.
 - Coordinate with Committee on Nursing Education
 - Elaborate project by October 1983: duration - four months
Community Health course for instructors and practicing nurses
 - Options for faculty for specialization at the Master's Level (according to program priorities):
 - . Community Health
 - . Mental Health
 - . Medical-Surgical Nursing
 - . Anthropology-Sociology
2. Increment in departmental budget.
 - Technical assistance
 - Short courses for faculty
 - Implementation of new curriculum
 - Instructional materials
3. Elaboration of projects to obtain funding for implementation of curriculum.
 - Renew grant with the Kellogg Foundation
 - Fullbright Foundation
 - Proyecto Docente/Asistencial or Project for Integration of Theory and Practice
 - U.S.A.I.D.
4. Establish bilateral agreement with the Ministry of Health.
5. Establish mechanism for replacement of faculty during continuing education courses.
6. Establish organ for control and evaluation of curriculum.
 - Curriculum Committee to become permanent
 - Ms. Ruffing to send material for design of evaluation instruments
7. Establish regulations and norms for faculty selection, promotion and organization into departments (after completion of micro-curriculum).

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APPENDIX XIII(Continued)

8. Organization of faculty into specialty departments:
 - Public Health
 - Maternal - Child Health
 - Medical - Surgical Nursing
 - Mental Health and Psychiatric Nursing
 - Nursing Methodology (i.e., research, administration, etc.)
9. Restructure internal committees in the School of Nursing.
10. Prepare budget according to new program requirements - with aid of Planning Office of P.U.C.E.
11. Determine need for new educational materials.
12. Reorganize Educational Technology Center.
13. Prepare evaluation instruments.

CF/ma. 5/1/83

PONTIFICIA UNIVERSIDAD CATOLICA DEL ECUADOR
FACULTAD DE ENFERMERIA
PLAN FOR DEVELOPMENT OF THE SCHOOL OF NURSING
1983 - 1990

- OBJECTIVES:**
- Prepare nursing personnel according to the needs of the health care system.
 - Encourage and strengthen the participation of nursing in national development.
 - Create conditions in order that the School of Nursing may foster constructive change in the education and service sectors.

PROGRAM	CHARACTERISTICS	GOALS	REQUIREMENTS
I. Baccalaureate in Nursing - New Curriculum Design	<ol style="list-style-type: none"> 1. Based on the health needs of the country 2. Emphasis on prevention 3. Integrated theory and practice 4. Active participation of student in learning process 	<ul style="list-style-type: none"> - Implementation to begin in October, 1983 - Increase enrollment by 50% by October, 1985 - Follow-up study of graduates of new program to begin in September, 1987 	<ol style="list-style-type: none"> 1. Establish permanent committee for control of implementation and evaluation phases of curriculum change. 2. Increase in faculty and administrative personnel according to needs created by new curriculum and increased enrollment. 3. Budget increase for School of Nursing (according to changes in #2). 4. Reorganize administrative structure of nursing school into clinical departments. 5. New equipment and instructional materials. 6. Reorganization of the Center for Educational Technology and existing internal faculty committees. 7. Creation of the Center for Nursing Research. 8. Coordination of goals within the university and with external organizations. 9. Elaboration of national and international projects and agreements which support curriculum implementation. 10. Expansion of infrastructure. 11. Continuing education for faculty.
II. Master of Nursing Science	<ol style="list-style-type: none"> 1. Increase professional competence and broaden range of skills 2. Specialization in priority areas: (Short Range) -Community Nursing -Nursing Administration -Nursing Education (Long Range) -Medical-Surgical Nursing -Maternal-Child Nursing -Psychiatric Nursing 	<ul style="list-style-type: none"> - Needs assessment and planning to begin in 1983 - Implementation to begin in 1985 	<p>In addition to numbers 2 - 10:</p> <ol style="list-style-type: none"> 12. Technical assistance for curriculum development. 13. Bilateral agreements for international faculty exchange. 14. Specialization of faculty at the master's and doctoral levels. 15. Organization of the Committee for Graduate Studies.
III. Research	<ol style="list-style-type: none"> 1. Integrating strand of new curriculum 2. Supports the following activities: -Development of research in nursing and public health -Supervision of student thesis research -Data bank and bibliography in the health field -Publication 	<p>1983 - organization of Center for Research in Nursing</p> <ul style="list-style-type: none"> - Establish research priorities for the School of Nursing - Organization of data bank and health care bibliography <p>1984 - 1986</p> <ul style="list-style-type: none"> - Implementation and evaluation of projects - Publication of results <p>1986 - 1990</p> <ul style="list-style-type: none"> - Review of research priorities - New programming 	<p>In addition to numbers 2, 3, 5, and 8 - 13:</p> <ol style="list-style-type: none"> 16. Create the necessary administrative structure for implementation of research projects. 17. Training of specialist in nursing research. 18. Obtain national and international funding for nursing research.

PONTIFICIA UNIVERSIDAD CATOLICA DEL ECUADOR
 FACULTAD DE ENFERMERIA
 PLAN FOR DEVELOPMENT OF THE SCHOOL OF NURSING
 1983 - 1990

- OBJECTIVES:**
- Prepare nursing personnel according to the needs of the health care system.
 - Encourage and strengthen the participation of nursing in national development.
 - Create conditions in order that the School of Nursing may foster constructive change in the education and service sectors.

PROGRAM	CHARACTERISTICS	GOALS	REQUIREMENTS
IV. University Extension	<ol style="list-style-type: none"> 1. Auxiliary nurse training (urban and rural) 2. National continuing education for nurses 3. Extension of nursing program to other provinces (satellite schools) 4. Social action programs 	<ul style="list-style-type: none"> - Continue courses in auxiliary nursing - Plan extension of continuing education program (Kellogg Foundation) in 1983 - Implementation 1984-86 - Assist in establishing satellite schools - Implement nursing curriculum in satellite schools, 1985 	<p>In addition to numbers 2-6, 8-11, and 13:</p> <ol style="list-style-type: none"> 19. Strengthen the Continuing Education Committee of the School of Nursing. 20. Explore possibilities of technical assistance for creation of new nursing schools.

APPENDIX XV

THE ROLE OF THE COMMUNITY HEALTH NURSE WITHIN THE HEALTH SYSTEM: PROFESSIONAL PROFILE

Community health nursing purports to integrate principles of public health and nursing practice. In collaboration with other disciplines, the CHN assesses the health needs of the population, establishes priorities on the basis of risk factors and intervenes, utilizing the necessary health care and community resources.

The basic activities of the CHN include:

- A. Follow-up of communicable disease, including investigation of contacts.
- B. Prevention of communicable disease in infants and children by means of attainment and maintenance of optimum community health.
- C. Prevention of complications of pregnancy and improvement of the health status of the pregnant woman and the newborn by means of early detection of pregnancy, health education, continuous prenatal care and family planning.
- D. Reduction of infant morbidity and mortality by means of timely visits to the newborn with priority being given to high risk families.
- E. Development of health education programs for home care, hospitals, health posts and sub-centers, schools, and the community with the purpose of preventing disease, reducing the deleterious effects of existing disease and teaching the family to care for the sick or handicapped individual in the home; the promotion of customs and behavior which lead to an optimal state of health; and the improvement of the capacity of the family, group and community to confront their health problems and problems which effect the successful completion of their activities of daily living.
- F. Provision of counseling to the adolescent and young adult regarding health and family living.
- G. Tracking of clients with identified needs to assure that they are not "lost" within the health care system.
- H. Collaboration with other members of the health team, the community and other agencies in planning and coordinating comprehensive services.

APPENDIX XV Continued

The CHN fulfills this role within the health care system by completing the following tasks:

- A. Makes home visits, holds individual and group conferences, and teaches through demonstration.
- B. Informs individuals and groups of existing health services and makes appropriate referrals.
- C. Provides comprehensive nursing services to individuals, families and communities in the areas of health promotion and prevention of disease while maintaining their personal and cultural integrity and recognizing their right to make their own decisions.
- D. Provides nursing services in day care centers and schools.
- E. Coordinates the work of health promoters and other auxiliary personnel and supervises programs for different patient populations according to their developmental level.
- F. Familiarizes self with socio-cultural, political, geographic, demographic, economic, and epidemiological characteristics of the communities served.
- G. Participates in continuing education programs and multi-sectoral meetings with the objective of improving health care services in general and nursing services in particular.
- H. Maintains records and submits reports to the appropriate level with the purpose of improving the health information system.

Adapted from position descriptions and departmental objectives of the Field Health Department, US Public Health Service/Indian Health Service Acoma - Cañoncito - Laguna Service Unit, San Fidel, New Mexico.

APPENDIX XVI

LIST OF PERSONS CONTACTED

Center for Transcultural Studies:

Dr. Duncan Pedersen, Director

Ministry of Health:

Dr. Sarracín, Minister of Health

Dr. José Castro, Director - Community Development

Dr. Eduardo Rodríguez, Director - International Relations

Dr. César Troncoso, Director - Priority Programs

National Development Council:

Dr. Fausto Andrade

Dr. Eduardo Navas

Dr. Gustavo Estrella

Private Voluntary Organizations:

Amigos de las Americas; Ms. Cynthia Goodale, Director - Latin American Programs

Medical Assistance Program International; Mr. Robert Moore, Director

Save the Children Alliance; Mr. Tore I. Floden, Director

Vozandes Hospital (HCJB); Mr. Ben Cummings, Vice President; Ms. Sara Risser, Director - Community Development

Rural Development Secretariat:

Dr. Edgar Moncayo, Director - Health Programs

Dr. Jaime Valencia, Director - Health Programs/Salcedo Project

School of Nursing of the Central University:

Dr. Georgina de Carrillo, Professor and Representative of the Kellogg Foundation

United States Agency for International Development:

Dr. Kenneth Farr, Director - Health Division

World Health Organization:

Dr. Carlos Pettigiani, Director - Ecuador Office

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52. White, María. "Construct for Public Health Nursing", Nursing Outlook, (Nov.-Dec. 1982), 527-530.