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IMPERIALISM IN NURSING IN A DEVELOPING COUNTRY: LESSONS FOR AUSTRALIA ?

INTRODUCTION

What place does the educational technology, research and development of the most advanced nations have in the less developed or peripheral countries? This is a question that should not be addressed by not only a few concerned educators writing in obscure journals of comparative education. While Australian nurse academics seek to use locally generated teaching information for substantive areas of courses, they are often questioning about the use of paradigms, theories and models from metropolitan centres. Some senior nurse academics at a World Health Organization (WHO) Collaborating Centre in Brazil have been aware that the curriculum is a transmitter of culture and as a consequence they have endeavoured to

develop curricula which are cognisant of local conditions, while also complying with the prevailing "international" model of primary health care. Their quest for culturally appropriate curricula has been jeopardized however, by two competing needs, one of a practical nature, the other, a quest to maintain their status. Both of these result in part from Brazil's place in the international order and class differences within.

Like academics in other peripheral countries nurse academics in Brazil are dependent on teaching materials, including reference and research materials, from metropolitan centres. This dependence is caused in part by the lack of funds for local production which in turn has an impact on the development of local scholarship. Paradoxically, WHO Collaborating Centre status, could be an impediment to the development of indigenous scholarship. In some ways the school has become a slave to the dictates of external censors thus impeding efforts to achieve better health.

Despite the rhetoric of primary health care, entrenched class differences in Brazilian society make it unlikely that health status will improve for the disadvantaged majority. Saunders (1986), has argued that existing social orders needed to be changed, with health workers showing solidarity with disadvantaged groups if health was to improve. Indications are that academic criteria, rather than those related to improved health status, have determined selection and continuing designation as a Collaborating Centre.

This case study, based on interviews, informal discussion and documents will explore the detrimental effects of metropolitan health policy and educational developments on Brazilian nursing education. Before concluding, a series of questions will be asked about the cultural appropriateness of nursing curricula in Australia.

THE REPUBLIC OF BRAZIL - BACKGROUND

Some 500 years of exploitation, (starting with the Portuguese colonists), political instability and ineptitude, have resulted in approximately 70% of the Republic's population living in poverty (Chompre, 1986). While being more politically stable than other countries in the region, Brazil has nevertheless had three periods of military dictatorship, the last being from 1964 to 1985 (Wood, 1988).

Brazil's population derives from its indigenous Indian population, African slaves, migrants from many parts of Europe and to a much lesser extent from Asia, especially Japan. Generally class differences reflect skin colour with those of European or largely European descent constituting the corporate and middle classes and blacks, Indians and those of mixed race making up the majority and the underclass (Wood, 1988). Sharp social and economic inequalities have resulted in entrenched and widespread poverty and malnutrition (WHO,1990) despite Brazil being the third largest food producer in the world (Chompre, 1988). The term "Third World" has been used to describe Brazil, in spite of it being the tenth largest economy in

the world (Chompre, 1988), because of the landlessness, powerlessness and poverty experienced by a substantial percentage of the people. Brazil now pays approximately four fifths of its entire annual export earnings on repayments of interest and capital (Hancock, 1989).

It is not surprising that in this context a range of urban and rural popular movements has evolved (Malnarring, 1987), including liberation theology (Adriance,1986) and programmes based on the work of the famous educator Paulo Friere (1972). Sadly, conservative forces and a lack of unity have meant the demise of many.

The new, democratically elected populist president, from the right of politics like the majority of state and federal politicians (O'Connor, 1991), has no cohesive policies to address the worsening social and economic conditions. A 1988 report noted that some 50% of homes had no drinking water, sewage or toilets (Chompre, 1988). Health workers are challenged not only by the diseases of poverty resulting from these living conditions but also those of industrialization. Of note are schistomiasis, malaria, diarrhoeal diseases, Hansen's disease, cerebro-vascular disease, neoplasms, traffic accidents, mental disorders, violence and more recently AIDS (Chompre, 1988; Ministerio da Saude, 1988; PAHO, 1990; Ministerio da Saude 1990; de Oliveira, 1990). See Figure I for the main causes of mortality.

[Insert Figure I about here]

Following the return to civilian government, attempts have been made, with the introduction of new health legislation, to address the excesses and neglect of the past. To be challenged is an entrenched and powerful private sector which in the past was heavily subsidized and supported by the government (McGeevey, 1989). Present attempts to strengthen public health initiatives are a challenge, due to entrenched practices. Brazil has the highest rate of cesarean section in the world (Janowitz, 1982; McGeevey, 1989) and the overuse of technology, such as ECG's and X-rays, and drugs, both by overprescription and self prescription, is of alarming proportions (McGeevey,1989).

Nurse educators were becoming increasingly critical of such practices, but were sceptical about the possibility of positive outcomes resulting from the new health legislation. Of particular concern was the strength of the medical profession which outnumbered nurses by seven to one, they claimed. This select, but diminishing group, represented only a minority of nurses too. Registered nurses comprised only some eight percent of the highly stratified nursing workforce in 1983. See Figure II.

[Insert Figure II about here]

WHO COLLABORATING CENTRES

The inappropriate use of the health expenditure has been a world wide

phenomena which precipitated the heavy emphasis on primary health care by WHO. The establishment of a network of Collaborating Centres was seen as an important initiative in achieving the primary health care goals enunciated in the Alma Ata declaration, Health For All by the Year 2000 (HFA 2000). The process of the collaboration, co-ordination and mobilization of resources in the areas of nursing education, research and practice (Kim, 1990) was seen as a means of promoting the primary health care model.

Only one School of Nursing in Brazil has been designated part of this network of Collaborating Centres. The designation took effect in December, 1988. The School gained that designation in part due to its considerable research output and also because it met the WHO criteria. These include:

(i) Scientific and national standing (both national and international):
(ii) The quality of scientific and technical leadership;
(iii) Prospective stability in turns of personnel, activity and funding;
(iv) Ability, capacity and readiness to contribute to WHO programme activities (Kim 1990).

The three areas nominated by WHO as their focus in achieving HFA 2000 goals, namely education, research and practice, will be examined to determine the Schools ability to promote primary health care.

EDUCATION

An awareness of the need for courses which reflected Brazilian needs was expressed proudly by some senior public health nurse academics. The new Masters programme in Public Health Nursing scheduled to commence in 1992 was held up as an example of this. Primary health care featured in a number of the subject descriptions. Furthermore, the course acknowledged the significance of Hansen's Disease in Brazil and the special importance of maternal and child health. Critique also featured widely, as a few of the staff had studied Marxist sociology, and a range of political, social and economic issues were addressed. (Refer Table I for a list of subjects - both core and elective represented in the course).

[Insert Table I about here]

What seemed to be significant, however, was the absence of the very important process skills needed for effective public health nursing. Interventions such as health promotion, health education, community and organizational development, and political activities such as lobbying and the use of media (Milio, 1981) were not included.

Attempts had been made to use local reference material. In nine of the nineteen subjects listed, only Brazilian references were used, yet in six, US reference material was used more widely than local material (See Table I). The extensive use of US literature in the women's health area was commensurate with what was seen in the study, quoted below, of menopausal

women. Perhaps this resulted from one of the senior staff having an extended stay at a WHO Collaborating Centre in the US. The appropriateness of the US literature, with its own cultural, political and economic interpretations of Women, Culture and Society and Women's Health, is questionable (refer Table I).

The references used were current in most cases reflecting the access staff had to some 92 journals. In some areas such as English language Maternal Health, and Portuguese Ecology and Health, the material was dated (See Table I). Library holdings reflected a dependence on literature from the US (See Tables II and III). Brazilian journals have been poorly funded and production is spasmodic and limited. As a consequence an article can take as long as three years to be published. Because of this imported journals are more important than the figures attest. A problem experienced in many peripheral countries, increasing their dependence on metropolitan materials.

[Insert Tables II and III about here]

At least half the world's one hundred thousand scholarly journals are in the English language, as are most data bases and international scientific meetings (Altbach, 1986; Kunstadter, 1982; Swee Hin, 1983). While the Brazilians remain dependent on overseas literature, because of their limited capacity to publish, the development of indigenous form of knowledge will be impeded and metropolitan methodological paradigms and substantive topics will continue to dominate both the curricula and research agendas. Apple claims the "texts often become one aspect of the systems of control" (1986,p. 82) and they have a negative effect on local scholarship.

A striking juxtaposition of metropolitan and Brazilian paradigms was evident in a class for undergraduate students. The young professora explained that she would conduct a health education class using the work of Brazil's internationally known educator Paulo Friere. The class, of three hours, was the only health education theory included in the new undergraduate programme. Half an hour was devoted to role play with the remaining time used didacticaly by the professora, who used the blackboard extensively.

The students graphically role played the realities of the Brazilian health care system. They portrayed the hopelessness of the patients' circumstances, the apathy of health care providers (including the nurses) and their ignorant and clumsy health education practices. Following brief discussion the class proceeded with minimal interaction from the students.

Certainly some of Friere's (1972) concepts were presented e.g. "promotrer o outre" or promotion of the other person, however these were lost in terms such as "objectives", "teaching and learning", "behaviour change" and "evaluation". Friere's work was incorporated into the scientific method rather than being presented on its own terms. Instead, a provider centred,

systematic-problem-orientated approach was presented. Friere's vocabulary, where it was used, did nothing to change what was essentially Western. Moreover, the health education model resembled the work of the US educator, Malcolm Knowles (1975), more than that of Friere .

Friere's model, developed from his own and others experience of poverty and disempowerment, is a political strategy aimed at the empowerment of disenfranchised groups. Its political focus is its attempts to provide such groups with the skills and confidence to challenge powerful forces such as health workers (1972). Deliberate depoliticization was probably not the intention. It was more likely that the professora had accepted the organized systems and rules of Western health education practices, a problem identified by Selvaratnam (1988). Apple (1986) referred to the "cultural capital" of the dominant classes in determining what is considered the most legitimate knowledge . The plethora or texts and journals which reach Brazil help to legitimate Western models of health education and uphold and safeguard Western interests (Selvaratnam, 1988; Altbach, 1989).

Traditional didactic teaching practices also appeared incongruous in the presentation of Friere's model, if teaching by example is regarded as a powerful teaching strategy (Dalton, 1989). The power relationship between those in power and the poor is central to Friere's writings. Moreover, the model was presented as a intervention in the hospital setting where the power relationships between patient and health care provider are well documented (Willis, 1989). The student role play had illustrated this point graphically.

Unfortunately, the implications of this professora's work went further than the classroom. The class was based on the professora's Doctoral thesis which at that stage was nearing completion. Reputedly the first doctoral thesis in nursing in Brazil which used Friere's teachings, it could unfortunately prejudice the work of students, practitioners and researchers in the future. Just as texts from metropolitan centres have controlled local teaching and scholarship, the text written by that professora has the potential to control further applications of local knowledge in Brazil.

RESEARCH

A reliance on metropolitan paradigms was evident in a research project observed at the School. Where Western medical knowledge and to some extent Marxist critique were evident in the School's scholarship in the past, it seemed that these were being replaced by the research agendas and methodologies important in metropolitan nursing schools. A senior nurse academic became involved in a large project during an eight month stay at one of the three WHO Collaborating Centre in the US. She was responsible for gathering extensive Brazilian data which was part of a large cross-cultural study being conducted in half a dozen countries, most of them peripheral. The respondents were pre-menopausal and menopausal women and the researchers were keen to ascertain women's "self care" practices. Such

research might be seen as a worthy project in the US, but it was not a priority area for investigation in Brazil. Significantly also, important social groups such as Indians and other coloured people were not included in this cross-cultural project. When questioned, the researcher indicated that Brazilian society was homogeneous. Altbach has described how methodological paradigms (in this case a phenomenological study) and substantive topics (self care of menopausal women) come to dominate the research agendas in peripheral countries (1989).

This type of endeavour, where the research agendas are set and orchestrated in metropolitan centres, has also been addressed by Selvaratnam. He has described how collaborative research often met the political and economic agendas of Westerners rather than those in the participating peripheral country. He claimed that such activity "reinforced Western intellectual imperialism" and "hindered the growth of indigenous scholarship" (1989). It could be argued that such research does more to advance the careers of academics in advanced countries than promote the health status in countries such as Brazil. Perhaps such offerings, however, are attractive also to staff in a School keen to receive international and WHO recognition.

The School had a national and international reputation based on its research on breast feeding when it became a Collaborating Centre. Earlier research was experimental and quantitative, being based predominantly on the medical model. Now, a research method prominent in metropolitan schools of nursing (phenomenology) was being adopted, although the vestiges of the medical model were evident. A senior nurse academic explained that she had a hypothesis about why women were not breast feeding their babies.

Much contemporary research combines methods which formerly would have been viewed as coming from competing paradigms. A hypothesis implies a predictive study, whereas phenomenological research is an interpretative or exploratory method (Bhaskar, 1989). Phenomenological research which rests on a hypothesis presents a deeper contradiction. The problem is perhaps not so much the mixing of paradigms as a confusion about what can be achieved in research of the social world. By having a hypothesis, the researcher might preclude herself from looking beyond the outcomes anticipated by that hypothesis. Secondly, a phenomenological approach is individualistic, inadequate in explaining the social domain, and could lead to a victim blaming interpretation. Hence the move to methodologies more favoured by nursing in metropolitan centres could prove unhelpful in determining the real reasons why Brazilian women are not breast feeding. The fact that research is being conducted, and is being conducted according to prevailing fashions in nursing, could be seen as a benefit of closer co-operation with, and security from metropolitan centres.

Despite a recognition that the curriculum is a transmitter of culture, attempts to make it so have proven difficult. Where possible, efforts are made to use local material, but this appears to be in the substantive areas only. In one example where a local methodology was used, it was incorporated into an existing Western paradigm. Metropolitan nursing

theories, namely Orem and Roy, were also used (see George,1980).

What are the chances in the longer term? The ex-Dean of the School noted "that the construction of knowledge is a slow and complimentary process and that the most important aspect is the quality and social significance attributed to it" (Angerami, 1990:95). This can be difficult for a School endeavouring to prove itself in the international network. They must overcome the very problem cited by the same author i.e. "the classic dichotomy between knowing and doing" (Angerami, 1990:95).

PRACTICE

Nursing practice was observed in a range of health care settings - hospitals, clinics, health centres, schools and psychiatric facilities. The researcher was able to observe both practitioners and nurse academics working in these settings. The School of Nursing stressed the community service role of its academic staff and their work involved a range of commissions and contracts with government instrumentalities as well as what was termed philanthropic involvement with groups, such as Rotary Clubs. Not surprisingly, nursing practice reflected nursing education and research and represented nursing as a product of its environment. It was a product of these forces in the wider Brazilian society and of its relationship with international nursing.

Primary health care was practiced (with very few exceptions) in clinical settings. Despite the ratio of medical practitioners to Registered Nurses their role was always subordinate and most frequently a supportive one. The nurse practitioner role was very highly regarded and clinical skills such as diagnosis and accurate taking of blood pressure were prized. These clinical skills were seen as the mark of the professionally orientated and educated nurse.

Only one of the professoras worked closely with a group of activists, a group of clients with Hansen's Disease. This group worked to improve health services to sufferers and break down community prejudice and government and organizational barriers (Movimento de Reintegracao do Hansenano, undated). This professora claimed she knew of no other nurse in the city who worked in this way. Social stratification seemed a barrier to any close involvement with people from the lower classes.

Health services were not taken to people in the favellas (shanty towns) by the nurse academics at this School, although this was done in some other cities visited. When queried about this, one professora indicated that the Registered Nurse "could train six auxiliary nurses to do such work". She claimed that nurses who worked in such a setting were not paid well and such work should be done by the local council. However she was speaking of work done in the poorer suburbs, not the shanty towns. Only a few church workers appeared to visit these in this city.

Saunders has noted that "concerned health workers must show solidarity by

putting their skills at the disposal of those acting with the poorest and the most powerless" (1985, p.136). How possible is this for Registered Nurses in a highly stratified society? The nurse academics encounter this stratification daily in their private and professional lives. Indeed, one measure of one's position in Brazilian society is based upon the number of servants one has. Yet it is people from this class, and those worse off, who suffer the worst health. Social distance would make it almost impossible for the status conscious nurse academics to show solidarity with the poor.

Even within the school, junior staff claimed that until recently the staff did not use first names when addressing other staff. Absolute deference to senior staff especially the Professora Doctora (academics staff with PhD's) had been customary. Slowly these barriers were breaking down, and junior staff especially were beginning to challenge the position and power of senior nurse academics and the medical profession.

In such a stratified society where there is little meaningful association between classes it is perhaps not surprising that Registered Nurses prefer a clinical relationship with their clients. It is probably not surprising that the North American role of the Nurse Practitioner, has such widespread acceptance, even though it came about as a result of a shortage rather than a possible excess of medical practitioners in that country.

OUTCOMES

The School of Nursing is proud of its Collaborating Centre designation and works diligently to retain the title. Much effort is expended in achieving the objectives which entitle it to retain that status. Continuing education programmes, research, community involvement, visits to and hosting visits from nurses from elsewhere in Brazil and international centres are a priority. But what are the consequences of having this designation, both intended and unintended?

Smart (1989) refers to unintended consequences or effect, of human action. To ascertain the consequences one needs to know what the intended outcomes were. The stated aims are about using primary health care methods to advance Health for All. Yet one must ask how serious are such aims when the problems causing the ill health in Brazil are not being addressed. How can nursing, or health services generally, compensate for the living conditions of the majority of Brazilians when they remain disenfranchised?

Werner refers to the rhetoric of participation, empowerment and decision making which he claims is now centred in the capital cities in the advanced countries, namely the "global power bases" in Geneva, New York and Washington (1990). No doubt the officials, responsible for administering the Collaborating Centres, read the right WHO publications about "bottom up" programmes. Sanders claims that the intentions of such people are frequently the best, however their programmes do nothing to "challenge the social order that produces ill health and usually do little to improve the

health of the people" (1985, p. 218).

This WHO programme in Brazil could be argued to be having very little impact on the health status of the poor. The only beneficiaries appear to be the nurse academics. Hancock (1989) would argue that this is the case for most of those involved in all of the major agencies which come under the auspices of the United Nations. Academics in the School of Nursing now have international recognition and access to a range of benefits they did not previously have - travel, opportunities to study abroad to conduct "international" research and to have work published. It is claimed elsewhere in Brazil by nurse academics, that these benefits are not shared but more importantly they claim there is little information sharing. These later examples are probably an unintended consequence. However the question must be asked "How serious is WHO in achieving Health for All?"

Socialization of the nurse academics was probably an unstated but desired outcome and this socialization appears to be progressing well. Whether this is a desirable outcome is open for debate. The author would argue against the general endorsement of such an outcome, arguing that what is deemed legitimate in metropolitan centres may not be legitimate in a peripheral country such as Brazil. There is a growing body of literature which suggests that "modernization" of the professions in these countries is not having the desired effect (see Donaldson, 1981).

More importantly, how legitimate is the information? It could be argued that unless primary health care programmes lead to a redistribution of wealth and power (Werner, 1979 and 1990) they are not legitimate. (It could also be argued that current orthodoxies in primary health care are as ineffective in raising the health status of coloured people in Washington D.C. as they are in Brazil, as they do not challenge the existing social order).

How relevant is the programme if the nurse academics cannot work with the poor in addressing the real health problems and prefer to work in a curative mode? Werner has argued that health workers with minimal formal education can provide remarkably competent health services - entailing treatment, prevention as well as community education and institutionalization (1977). He has had decades of experience in Latin America to verify these claims.

The current orthodoxy at the school is that Registered Nurses need post-graduate education to prepare them for their roles, a viewpoint endorsed by WHO. Research conducted within the School will no doubt not challenge such assumptions because the assumptions which underpin their endeavours are not being challenged (see Lather, 1986).

Experts such as Navarro (1986), Werner (1990), Saunders (1985) and Hancock (1989) challenge public health workers and educators to question the assumptions, underpining and sometimes even the motives of WHO's primary health care agenda. As noted above, the intentions of staff overseeing

Collaborating Centres and using the rhetoric of primary health care are probably sound, yet as Saunders (1985, p. 218) noted, these foreign experts are often ineffective in guiding such developments. He identified constraints such as "culture", "training" and "Social Class" and "language". Printed material that is sent to Collaborating Centres is in the English language, an important imperialistic mechanism according to Altbach (1989) in such programmes.

Class issues seem to have been ignored or not recognized as an issue when the School was selected as a Collaborating Centre. On-going monitoring would appear to have not noticed this serious obstacle to the changes in health service delivery which are promoted in the primary health care literature.

COMPARISONS WITH AUSTRALIAN NURSING

Time and space do not permit an indepth analysis of Australian nursing and a comparison with Brazil.

Nursing and nursing education in Australia is more robust than it is in Brazil. Numerically Registered Nurses outnumber Enroled Nurses by almost four to one and medical practitioners by four to one (Grant and Lapsley, 1990). Despite this, does it recognize that its continued viability is dependent on it meeting the needs of the community? To do this, it should provide quality services which are culturally appropriate and responsive to the needs of all groups. Despite the difficulties experiences by nurse educators in Brazil they have made an important first step. They have recognized that their courses should be "Brazilian" and in that are expressing concerns which are still not recognized in this country.

Australian nursing and nursing education reflected English trends until the Second World War but increasingly have adopted developments from the US. These developments reflect patterns in the wider Australian society.

Australians perceive themselves as part of the developed world rather than, perhaps more realistically, as a peripheral country. In terms of language and culture there are similarities with many of the advanced countries. As a consequence Australians are probably less questioning than Brazilians about the adoption of innovations from metropolitan centres. The recognition of a problem is surely the first stage in finding a solution.

The following questions are posed for nurse educators to consider:-

1. Are Australian nursing curricula hybrids or are they uniquely Australian?

2. How much are Australian nursing curricula based on overseas models?

3. To what extent do these curricula ignore local culture?

4. Do Australian nursing students experience difficulty with the language and cultural expression used in overseas texts?

5. What percentage of current nursing texts, journals and other library holdings originate in overseas centres?

6. How supportive are Australian nurse academics of local scholarship which does not reflect dominant overseas paradigms?

7. How many senior academic positions are held by people who have studied nursing in an overseas country?

8. Do visiting overseas academics expect that Australian curricula will reflect models, theories and paradigms used in metropolitan centres?

CONCLUSION

The health of disadvantaged groups, not only in peripheral countries but also in advanced countries, has been the centre of considerable debate over the past two decades. The WHO initiated guide-lines for member countries to promote primary health care services as means of addressing this problem. A number of Schools of Nursing throughout the world have been designated WHO Collaborating Centres as a means of redirecting the focus of nursing education and practice to a model of primary health care.

The study of one of these Schools, in one of the most affluent cities in Brazil, has highlighted the difficulties involved in the development of primary health care nursing that meets local needs. Expectations of academic excellence by WHO could be a major impediment to achieving HFA 200 goals as it has been noted that much lesser trained workers are probably more likely to work with the poor to bring about change. Moreover, it could be argued that WHO (a Predominantly US funded agency) has little desire to see real change in the world order. Perhaps WHO's imperialistic and elitist involvement could be viewed as an impediment to real change in the delivery of health services in Brazil.

Writers on comparative education have documented the imperialistic nature of much educational material which peripheral countries, such as Brazil, are compelled to use. The development of independent indigenous scholarship is not promoted by metropolitan centres, be they WHO, or publishing houses.

Australian nursing and nursing education, while perhaps not bearing a strong resemblance to the situation identified in Brazil, have been dependent on theories, paradigms and teaching materials from metropolitan centres. A series of questions was asked. How comfortable are Australian nurse academics with the answers?

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Table I

Master of public Health Nursing Course - Subjects and References

Subject	References					
		English		Brazilian		
		No.	Dates		No.	Dates_
Politics of Health					12	80 - 89
Nursing and Society				11		80 - 89
Leadership		6	86 - 88	4		84 - 88*
Analysing Statistics (Collective Health)	3		74 - 80	1		80
Health Sampling	3		65 - 80			
Analysing & Planning Projects	1		82	1		86
Information Applied to Health	7		84 - 88	15		80 - 88
Ecology & Health					6	73 - 82
Methods of Epidemiological Investigation				10		74 - 86

Politics of Health (S.T.D.s)			7	77 - 87	
Hansen's Disease				8	75 - 82
Women's Health	8	79 - 87	2	87	
Women Culture & Society	10	80 - 85	2	78 - 81	
Reproduction & Human Sexuality	2	80 - 84	16	72 - 89	
Maternal Health I		4	47 - 84	18	77 - 88
Maternal Health II		33	43 - 79	17	65 - 87
Evolution of Nursing				7	36 - 85
School Health				8	20 - 89
Children's Health				10	77 - 88

*All published in Washington D.C.

Table II

Language of Nursing Journals Held in the School Library

Language	Number	%
English	74	80
French	3	3
Poruguese	14	15
Spanish	1	1

Table III

English Language Journals Held in the School Library

Country of Origin	Number	%

Canada	3		4	
Germany	1		1	
Switzerland		1		1
U.K.		11		14
U.S.		58		78