# BASES FOR A HEALTH TECHNICIANS DEVELOPMENT PLAN[1]

## INTRODUCTION

The training of health technicians and ancillary staff as an institutionalised process flourished from the 1950s through to the 1970s, reflected in the establishment of a large number of educational centres offering a wide variety of technical careers. Their main guidelines kept pace with the specialisation processes of technological knowledge and the steadily expanding division of work in healthcare services, prompted by a steady rise in the absorption of technologies and emphasis on primary healthcare in most countries. These changes complied with the specific social, political, economic and epidemiological characteristics of the Latin American and African countries.

During the 1970s and early 1980s, the Human Resources Programme run by PAHO-WHO launched a line of work in this field. Several regional meetings were held at strategic venues such as Cuba, Venezuela, Washington and Quito, in order to discover common problems related to health technicians and ancillary staff.

As a result of these meetings, important knowledge was built up about the problems of fragmented criteria, concepts and definitions of the training and use of these health workers in Latin America. Additionally, there was also a clear need to share experiences among countries, and many of them launched

[1] This document is based on the document prepared for PAHO/WHO in August 2005 by Silvina Malvárez - Regional Advisor, Human Resources in Nursing and Health Technicians. Human Resources Development Unit, PAHO/WHO, and Maricel Manfredi - Former Regional Advisor, Human Resources in Nursing and Health Technicians. Human Resources Development Unit, PAHO/WHO. It contains contributions from a group of professors and researchers at the Joaquim Venâncio Polytechnic Health School – Fiocruz.

actions in response to these initiatives, encouraging some exchanges. However, the efforts undertaken through encouragement for co-operation or at the initiative of the countries themselves were not sufficient, in terms of the resulting actions. Nevertheless, the issue of Health Technician Training was added to the Agenda for Human Resources in Health in Latin America, with the support of PAHO/WHO. On the African continent, actions of this type still require greater visibility and firmer acknowledgement on the global agenda.

## 1 – THE CONTEXT OF TECHNICAL EDUCATION WORLDWIDE

The problem of technical education as a policy linking work and education has been studied and discussed intensively at the national and international levels, particularly after the social changes that have taken place all over the world since the 1970s. These alterations were triggered by the crisis in the economic and political model represented by the blend of Taylorism-Fordism with Keysianism, in parallel to the crisis in so-called real Socialism.

These changes appeared with specific characteristics in the fields of work and education. For the former, unemployment caused by the advance of production powers in the form of new technologies and new materials is associated with the deregulation of labour relations. Precarious jobs, outsourcing activities and the exclusion of large contingents of workers from the formal labour market are phenomena that occur all over the world, on different scales. This results in a trend towards the disqualification of work and workers as specific elements in a more complex process of deterioration in social relations, although existing in parallel to complex technologies and skilled labour niches.

On the other hand lies the inexhaustible capacity of humankind to turn knowledge into productive powers, fostering admirable technological

innovations, compressing space and time, virtual reality and other phenomena that in turn open up new production possibilities for human existence, if it were not for the private annexation of these possibilities and their respective benefits. Within this context, new social needs arise, together with new professions, new labour management models and with them, new requirements in terms of the knowledge, conduct and character of workers, demanding diagnostic abilities for solving problems, decision-taking skills, team work, dealing with constantly-changing situations and intervening in the labour process in order to upgrade the quality of processes, products and services.

The healthcare sector is also subject to the impacts of the macro-structural adjustment process, but is at the same time seeking to enhance processes and services through new forms of work organisation and investments in technical education programmes for workers.

Outstanding among these impacts are trends towards pruning State responsibilities for social rights, transferring them to the market in compliance with neo-liberal ideals. From this standpoint, the State would cease to be an executor and provider, limiting its functions to regulating and assessing policies, in addition to attracting international investments. The 2006 World Health Report shows that: “in many countries, healthcare sector reforms as part of these structural adjustments have lessened the supply of jobs in the public sector and curtailed investments in education for health workers” (page 6). Moreover, this paved the way for the expansion of healthcare services outside the public / state sphere, making way for private medical aid plans and group medicine models that countermand the consolidation of universal public health systems and remain bound to the paradigm centred on curing disease and individual care. Other consequences were the outsourcing of the work force the deregulation of labour relations that affected the rights acquired to the Social Welfare State, with these phenomena resulting in the precarisation of labour

and the deterioration of living conditions among large segments of the population.

The macro-structural adjustments arising from the neo-liberal model produced social contexts in which health hazards and risks are increased, reflected in low Human Development Ratings in several countries. On this aspect, the 2005 Human Development Report produced by the United Nations notes that massive inequalities were not resolved by the neo-liberal model, but were rather worsened. For the health sector, it identified what was called the "inverse care law", meaning that:

> "The availability of medical care is inversely proportional to needs. Inequalities in the resources assigned to healthcare are a core aspect of this law. *Per capita* outlays on healthcare vary between an upper average of US$ 3,000 in the high-income OECD countries with lower health risks, and US$ 78 in low-income countries with the highest risks, and far less in several of the poorer nations". (UN, 2005)

Driven by this concern, the WHO World Report (2006) highlights the crisis in the health work-force as a strategic issue, electing 2006-2015 as the Human Resources Decade. This Report underscores the need to build up strong institutions providing technical education that ensures good quality training. Together with this guideline, the Toronto Call to Action (2005) approved at the Regional Meeting of the Human Resources In Health Observatories [2] notes that the construction of human resources in health development policies targeting the Millennium Development Goals[3] should be

[2] Meeting held on October 4 - 7, 2005, Toronto, Canada.

[3] In September 2000, the largest meeting of Heads of Nations adopted the United Nations Millennium Declaration. Endorsed by 189 countries, this Declaration was translated, establishing the goals to be attained by 2015, called the Millennium Development Goals (MDGs). The eight MDGs were built up on the bases of agreements reached at United Nations Conferences during the 1990s, representing commitments to: I – reduce poverty; II – eliminate hunger; III – combat disease; IV – promote health; V – eliminate gender inequality; VI – bridge gaps in education; VII – resolve unequal access to clean water; VIII - eliminate environmental degradation. The MDGs are dense and compact, acknowledging the contributions that the developed countries can offer through negotiation, assistance in development, pardoning debts,

constructed collectively, redeeming the principle that "health-related work is a public service and a social responsibility" (page 4). Based on this assumption, it stressed two topics – among other aspects – that should be addressed properly when formulating interventions in the field of human resources, namely: strengthening the leadership capacities of public health systems and stepping up investments in the healthcare work-force.

Nevertheless, the document prepared by the PAHO Human Resources Observatory (2004)[4] affirms that, although the status of human resources and health varies among the countries in the Americas Region, Latin America as a whole is faced by marked imbalances in the availability, composition and distribution of the work-force. According to this organisation, these imbalances may develop into an acute shortage of healthcare personnel, with persistent and chronic problems caused by the inadequate distribution of the work-force in terms of needs, or inequalities in the composition of the healthcare service providers in terms of the assisted population. This crisis takes place in parallel to the deterioration of working conditions, inadequate incentive systems and a lack of appropriate strategies for maintaining health workers.

In Africa, it is widely acknowledged that the inadequacy of the health work-force is among the main problems and challenges for attaining the Millennium Development Goals, particularly in terms of reducing poverty and morbidity. Studies conducted by the WHO demonstrate that the density of the healthcare work-force reaches an average of 0.8/1000 inhabitants, which is significantly lower than the global average of 5/1000 inhabitants. This problem is worsened by the phenomenon known as the "brain drain", meaning the steady outflow of university-trained practitioners to other countries. Together with other health-related problems, this places Africa at the epicentre of the

access to essential medicines and technology transfers.
Available at: http://www.who.int/hrh/em/. Accessed on April 30, 2005.

[4] Document drafted at the 134th Session of the Executive Committee of the Pan-American Health Organisation (Washington. 2004, p. 1).

global healthcare work-force crisis. This scenario shows that dealing with health problems on this continent requires the strengthening of healthcare practitioner training policies, among other aspects, particularly technical staff.

This document presents the bases for discussing and agreeing on a Health Technicians Development Guideline, initially categorising these workers and then characterising the development and organisation of the Health Technicians Network.

## 2 - HEALTH TECHNICIANS

In September 2000, the Member-States of the United Nations accepted the commitment work towards a world in which sustainable development and the elimination of poverty were rated as top priority. In order to attain this commitment, seventeen goals were established as milestones for measuring the progress of development in this field. These goals focus on the efforts of the global community to introduce significant and quantifiable improvements in people's lives. They establish standards for measuring the results, not only for the poor nations, but also for the rich countries that help to finance these development programmes and also for the multilateral institutions that help the countries to implement them.[5] More specifically, seven of these goals are directly related to the healthcare area: Reduction in Infant Mortality, Improvement in Maternal Health, Combating HIV/AIDS, Malaria and other Diseases. The Millennium Development Goals offer an opportunity and a challenge to the countries. These goals place health at the heart of the drive leading to development. On the other hand, according to these goals. PAHO-WHO and their directive bodies have directed the strategy towards specific population groups that are adversely affected by more severe inequalities in health-related matters in the Region: low-income communities, and groups that are marginalised or subject to discrimination for reasons related to ethnicity,

race, gender or age. Some countries were rated as higher priority, including Bolivia, Guyana, Haiti, Honduras and Nicaragua. The Secretariat will continue to co-operate with the countries, but must step up its technical co-operation with the above-mentioned nations through new approaches that are designed to bridge the gaps among the countries.

The eight spheres rated as top priority for technical co-operation are: prevention, control and reduction of transmittable diseases, promotion of healthy lifestyles and healthy social surroundings, healthy growth and development, promotion of safe physical surroundings, disaster management, universal access to integrated and sustainable healthcare systems providing individual care and public health, and promotion of the effective intervention of health-related issues when drawing up social, economic, cultural and development policies.[6]

Within this context, human resources in health are a key factor for attaining the proposed strategies and goals, as they are in charge of implementing health-related actions.

In the processes reforming healthcare systems, the principle of equity and the drive towards equality require a skilled work-force within their educational levels, in addition to social and professional acknowledgement that involves issues such as the establishment of careers in the civil service and institutional links that ensure worker rights.

[5] UN (2002) Millennium Development Goals. Public Information Department.
[6] PAHO/WHO. (2003) Management Strategy for the Work of the Workshop on Sanitation for the 2003-2007 Period. 44th Steering Committee – 55th Session of the Regional Committee. Washington, DC.

There is also a trend in healthcare services to reduce certain types of employment in the hospital area, while there is trend towards growth in out-patient and community care within the institutional environment. This offers challenges for training human resources in health, as this indicates the need to qualify a work-force that has historically built up few or even no skills.

This is associated with the trend towards flexible types of labour agreements. Many of the draft labour laws proposed in this Region adopt flexibilisation as an essential criterion for lowering labour costs and generating a keener competitive edge.

In addition to shortfalls in worker training, the downgrading caused by these flexibilisation mechanisms is a factor that that lowers the quality of the care available. One of the most important processes is to establish healthcare teams within the various services that can offer healthcare to most of the population requiring it, in compliance with the goals adopted by various organisations and countries. These teams should consist of practitioners, technicians and ancillary staff, including health agents, health promoters and others who can help extend the coverage while at the same time handling Primary Healthcare actions, promoting health throughout the entire population, while fostering social development with quality and pertinence, within a healthcare system.

The publication on Public Health in the Americas affirms that there can never be too much stress on the diversity of the work-force. Essential public health functions are the responsibility of many professional categories and occupations distributed throughout the entire healthcare system structure: general practitioners, public health and primary care nurses, nursing aides, public health technicians, sanitary engineers, community workers, health educators, disseminators of sanitary measures, administrators, etc. Taking all

this into account, the inclusion of technicians and ancillary staff is a matter of much importance for Primary Healthcare Actions, as this group represents an important contingent.

The training of ancillary health workers and community agents in the Americas has a lengthy track-record, under many different names. Its main upsurge took place during the 1970s with the Ten-Year Health Plan for the Americas. The III Meeting of Ministers of Health of the Americas (1972) reached the conclusion that healthcare services were unable to deliver their benefits to most of the population. This gave rise to the coverage extension policy in order to resolve what was called the accessibility crisis, at that time. This plan laid particular stress on training human resources, recommending that a larger number of professional nurses be qualified, while at the same time urging that ancillary sanitary staff be trained in order to ensure real access to healthcare services for the population.

Tailored to its individual needs, each country undertook the training of ancillary sanitary and nursing staff, under many different names (sanitary assistants, community agents, health promoters, etc.). Several meetings were held specifically to define the functions and profiles of these workers, as well as the guidelines of the syllabus that would lead to the consolidation of the foundations for a basic Study Plan that would allow the inclusion of differences tailored to the needs of each country. The training periods for these ancillary healthcare workers varied from six months to two years, with a year of supervised practice. Several of these successful experiences were implemented and published in the PAHO journals.

At a meeting held in San José, Costa Rica in 1995 on the use of community leaders and ancillary workers in rural health programmes, the term “Rural Ancillary Staff” was defined as “the employee of the healthcare service

who received training and works with basic healthcare services for populations living in rural zones, performing specific tasks related to mother and child care, including nutrition and family planning, epidemiological surveillance and immunisations, primary care for prevalent diseases in first aid area, environmental sanitation, vital statistics and community enhancement".[7]

At the same time, within the post-independence context of the African nations whose official language is Portuguese (PALOP), the primary healthcare strategy was a priority goal, representing a major drive to extend healthcare services, backed by the mobilisation of the population to appoint community health agents, most of them volunteers and with no labour links to State institutions.

With the advent of the Primary Healthcare Strategy promulgated at Alma Ata in 1978, the need was presented to reach the Health for All Goal in 2000. This goal called for the mobilisation of political wills and triggered transformation processes in healthcare systems, offering good quality health-related services to the entire population on scaled bases and setting forth once again the problem of universal coverage and accessibility, using appropriate techniques shaped to the available resources. Once again, this strategy urged the countries to train professional, technical, ancillary and community workers, in compliance with the primary healthcare strategy principles. This resulted in the training of workers at the local level drawn from the same community, defined as volunteer staff performing functions related to promotion of health, education and benchmarking.

The Primary Healthcare Strategy continued to progress during the late 1980s and 1990s through new ways of organising healthcare systems, tailored to contextual changes at the national and global levels; the concept and actions

[7] PAHO/WHO. (1975) Use of ancillary workers and community leaders in Rural Healthcare

of this strategy were diversified, with more direct interventions focused on mother and child care, and more particularly environmental remediation and sanitation.

During the 1990s, the concept of the Primary Healthcare Model began to take shape – as it did in Brazil – as an organisation strategy for an integrated and articulated healthcare services system, in counterpart to a selective programme concept focused on specific population groups or understood as the primary level of the system, with low complexity and low costs, not connected to other levels of care. This tiered concept of the healthcare system reproduces the mechanistic and flexerian logic of the reification of medical specialties, without acknowledging the complexity of the work process and primary healthcare actions. Consequently, the functions and training of community workers must reflect the specific characteristics and challenges of the organisation of the work in the consolidation of current healthcare systems, which are aiming at universal access and grassroots participation.

The experience built up through the development of Primary Healthcare is quite positive, credited with progress in extending the coverage of basic healthcare services with better community protection, greater mobilisation of resources and the participation of community players, including immunisation campaigns, mother and child care programmes, access to essential medications, sanitary education, water supplies and basic sanitation, among other aspects.

However, there is a still a lack of equity in access to healthcare services, with a notable level of exclusion in terms of social protection mechanisms. People living in rural zones generally have less access to healthcare services and are economically needy; many of these communities belong to recently-

Programmes. Scientific Publication Nº 296. Washington, DC.

marginalised ethnic groups. Evidence also indicates difficulties in access and poor healthcare in peri-urban belts surrounding large cities.

Problems have been appearing due to the poor quality healthcare, and many countries in Americas Region are facing massive challenges in this field. Their many manifestations include poor supplies of primary healthcare, a lack of co-ordination among the various healthcare levels, insufficient use of resources, and user dissatisfaction, among other problems.

The Americas Region has been striving to include a non-medical work-force and community agents, while boosting social participation. However, this progress is insufficient. There are still many local situations where community participation is limited only to sporadic consultation processes. Many community workers operating at these levels do not receive proper support and supervision, functioning without the sanitary infrastructure required for their actions and their needs for ongoing education.

It is thus important that the experience of the countries be centred on reorienting the services towards promoting health and preventing diseases through a firm political will to reformulate the healthcare model, extending the concept of the assistential model through the inclusion of the territorial/community logic that encourages out-patient care, streamlining the production of services at the clinical level, such as in schools, work-places and homes, while deploying community and family-based approaches that allow proper knowledge of the physical, social, economic and cultural realities of the population.

Global and regional trends noted over the past 25 years indicate that it is possible to enhance the quality of healthcare services through the development and deployment of assistential models centred on the family and the

community, with examples such as that offered by Brazil. This trend is supplemented by the quest for models that offer more exhaustive and better co-ordinated regular all-round healthcare services, boosting the capacities of local health teams and communities for assessing and responding to healthcare demands and expectations, under the aegis of decentralisation processes.

This still requires sustained efforts to develop and upgrade personnel capacities through educational actions such as generating and ensuring the sustainability of incentive systems that maintain and retain personnel working with good quality sanitary practices at the local healthcare levels.[8] In parallel to the development of technical, clinical and health-related skills, social and professional acknowledgement are important strategies that will help ensure Health for All, attaining the Millennium Development Goals.

To do so, worker training and development programmes must be fine-tuned, together with modern management practices that spur changes. During this re-organisation of human resources programmes, it seems important to review the training offered to community personnel, as support for extending coverage and primary healthcare actions, analysing the quality of the training centres that are currently decentralised and deregulated. It is also important to explore the quality of existing staff and trainees, the many different programmes available, the definition of competencies and skills, and the development of permanent education programmes that ensure high-quality care.

During the process of reconstructing a community personnel training project, it will be important to analyze the positive experiences that are noted in some countries, as well as the difficulties encountered, in addition to insertion techniques and feasibility levels within the healthcare services. In Brazil, the

[8] PAHO/WHO (2003) Primary Healthcare in the Americas: lessons learned over 25 years and challenges for the future. 44th Steering Committee – 55th Session of the Regional Committee. Washington, DC

introduction of the profession of community healthcare agent and the inclusion in the healthcare system of these volunteer workers – with technical level training required – are examples of the acknowledgement offered to these workers, who form a professional category that is crucial for building up an organised healthcare system based on the Primary Healthcare Model.

Since 1995, the PAHO-WHO Human Resources Development Programme has returned to a line of co-operation for health technicians, in response to the needs expressed by the countries within the context of reforms of this sector. The kick-off for this new stage consisted of a survey entitled: "Study of the Current Situation of Health Technician Training".

This study covered seventy training centres in sixteen countries in the Americas. Its findings pinpoint some critical areas: shortfalls in the human resources planning processes and consequently health technicians; poor definition of the field of action of the technician and ancillary staff; and a lack of systematised information on health, work and regulation, in parallel to outdated study plans due to new changes produced by the reforms of this sector. It also noted a shortage of specific bibliographic materials, the absence of permanent education programmes, undervaluing the role of the technician in labour processes, and the absence of institutional policies and incentives fostering their development.

This study indicated that there are 390 "technical" training programmes in Latin America and the Caribbean, with many different training levels that range from ancillary staff to practitioners in specific technical specialties. Most of these workers are trained in the Ministry of Health and Social Security, with very few programmes at the university level. Over the past few years, and due to training flexibilisation mechanisms, training centres have proliferated for these workers in the private sector, some of them very poor quality. Together with the

lack of regulation mechanisms, this means that the quality of the services rendered by these workers is not adequate. This gives rise to the need to define the occupational profiles, establishing mechanisms for regulating teaching institutions, with an accreditation system, when pertinent.

Before reaching this stage, a definition must be drawn up of the Health Technicians. The 1995 PAHO-WHO Study proposed an operating definition of a Health Technician:

> "The Health Technician performs specific actions in the field of health, fundamentally systematised, and takes decisions within his sphere of competence. He co-operates with university level staff in order to ensure the best use and output for healthcare services. He performs his actions under the direct or indirect supervision of university level personnel, and may also perform supervision functions for personnel with the same or lower qualifications. The complexity of his actions is greater than that of the ancillary personnel and less than that of the professional level personnel or equivalent. "The technician qualifies through legally acknowledged courses that are given at teaching centres approved in compliance with the legal requirements of each country".[9]

This definition is coherent with the organisation of work in the healthcare field, which still features a strong Taylorist/Fordist component, based on separate work posts, simple routine tasks, generally stipulated, marked technical division of work, with concept and execution clearly separated, and a vast contingent of workers with very limited autonomy for intervening in the work process. This type of work division endows the technical worker with functions that are located at an intermediate level in the hierarchy. In the healthcare field, this appears more clearly due to the influence of the so-called medical-industrial complex, where medical equipment manufacturers and pharmaceutical companies are often involved in the qualification and training of technical staff.

Nevertheless, since the 1980s, the influence on healthcare policies of strategic planning and participative management has become apparent. This gives rise to a concern with the type of training provided to health workers,

[9] PAHO/WHO (1996) Report of the Meeting on the Training and Use of Mid-Level Health Technicians in the Americas Region. Human Resources in Health Development Series Nº 1. Washington.

fostering higher levels of commitment, engagement and participation, in order to upgrade healthcare quality. These trends have been accompanied by the introduction of technological innovations in work processes in the more developed countries, whereby the work of these technicians – although they hold mid-level positions – tends to become more complex in other countries, although it is precisely the shortage of technological resources that requires these technicians to perform multi-faceted activities with some level of initiative and creative flair. In either case, it is stressed that these workers must be able to handle unforeseen situations with autonomy and responsibility.

Moreover, it is necessary to bridge the gap between the curative and preventive models, challenging healthcare systems to develop policies and actions grounded on all-round healthcare that becomes an attribute of professional practices, and the organisation of services and the system. From this standpoint, technicians must know and understand determining social factors for healthcare and adopt the guidelines that steer healthcare policies, as well as their main problems and challenges. This means that, in addition to technical skills, these workers require an overview of the work process and healthcare policies in order to anticipate problems, propose solutions and introduce improvements, acting with responsibility and autonomy when faced by unforeseen situations. In order to do this, technicians must understand the scientific and technological grounds that underlie the healthcare work process and the determining social and political factors of the epidemiological status of their countries, in addition to knowledge that allows them to construe the reality within which they live, contributing to the changes needed to upgrade the quality of life of the population.

It would thus be appropriate to extend the definition of the technician beyond the operating dimension, incorporating the sphere of knowledge, expertise and values that structure the work process in its prescribed and non-

prescribed dimensions, as well as social relations in general. The expansion that we propose is summarised objectively as follows:

> *The training of a technician is grounded on a solid base of general knowledge provided by basic education and technical training, to which scientific, technological, social and political expertise is added, required to perform technical, professional and social duties with responsibility, autonomy, commitment and ethics.*

By extending this definition, we believe that, within the context of the current changes in rendering healthcare services, the syllabus design should be re-thought for technical training, due to its qualitatively different characteristics in today's world. In order to reformulate the approaches to training health technicians and ancillary staff, it is important to bear in mind social changes in healthcare and education in the countries. They include changes in labour processes, reforms of healthcare and education systems, needs for professional development and recycling, training workers to deal with restructuring processes in the production sector, participation in different work teams, end-product quality grounded on competent personnel, internationalisation and new occupational roles, as well as integrating school and work.

Thus, ethical personnel training is required, underscoring principles such as equality and respect for individual dignity. Emphasis is also needed for the processes that regulate and accredit programmes, as well as the adoption of ongoing enhancement programmes for quality of healthcare services.[10]

Based on all the aspects mentioned above, the Health Technicians Education Network must be strengthened at the level of Latin America, the Caribbean, the Portuguese-speaking nations of Africa (PALOP) and Portugal,

[10] Davini, C., Borrel, R. & Castillo, A. (2000) *La formación de personal técnico en salud: el diseño de instituciones abiertas*. Chapter 1.: *El desarrollo de técnicos en salud, un desafío para la calidad*.

within a context of change that complies with the postulates of the new public health reforms and the renewal of the Primary Healthcare Strategy.

At the last RETS Network projects assessment meeting, held in 2001 in Porto Rico, and also at the meeting held in Brazil in 2005, it was affirmed that there is a need to ensure the continuity of this Network while at the same time recommending that its structure be strengthened, providing support for the Executive Secretariat, enhancing its visibility, buttressing the information and communication systems, updating the work-force study, including personnel categories not encompassed by the first study (which may be required for the primary healthcare strategy renewal processes), compiling experiences conducted on occupational profiles, regularising syllabus-related training processes and establishing the accreditation guidelines, while also encouraging the appearance of new projects.

The appointment as a WHO Co-operation Centre of the Joaquím Venâncio Polytechnic Health School at the Oswaldo Cruz Foundation in Brazil in 2004 was a crucial milestone for renewing and enriching technical co-operation in the health technicians field.

## 3 – RETS NETWORK: STRATEGY FOR CO-ORDINATED ACTION AND INTERNATIONAL CO-OPERATION

The "Study of the Current Situation of Healthcare Technical Staff Training" conducted by the PAHO-WHO Human Resources Development Programme as mentioned above, resulted in a new type of co-operation among the countries: building up a Latin American Health Technicians Network called RETS, in order to streamline faster feedback with nimble, effective and continuous communication of current and potential knowledge in the training area of health technicians and ancillary staff. This Network was established

with an agile and dynamic structure that allowed activities to be co-ordinated while encouraging the work to be carried out. This structure consisted of: a driving group consisting of the founder nations (Brazil, Colombia, Costa Rica, Cuba, Mexico), a Technical Secretariat headquartered in Costa Rica, Development Centres (NUDES) in each of the countries, a bulletin that serves as a mechanism for dissemination and exchange, and a reference database for educational institutions in this field.

The efforts of the driving groups and Development Centres prompted several projects whose implementation varied, depending on the support received from respective institutions in the countries. Colombia and Brazil conducted studies of regulatory mechanisms in the health technicians training field. The methodology used in this study allowed a questionnaire to be drawn up in order to diagnose the regulations in the countries in the region, which was presented at a meeting on this topic held in Porto Rico (1999). The Development Centre in Mexico conducted the project on Human Resources Planning for Health Technicians, co-ordinated by the Technical and Vocational Education Administration of the Public Health Bureau in Mexico, with the participation of the Mexican Social Security Institute (IMSS), the Syllabus Development Administration of the National Technical and Vocational Education College (CONALEP) and the Teaching Administration of the State Workers Social Security and Healthcare Institute (ISSTE). One of the major achievements of this group was to establish a dialogue area for co-ordinating actions among institutions under the aegis of the Reform.

The Development Centres in Argentina, Costa Rica and Cuba suggested organising a meeting of authors, bringing out a publication portraying experiences in technician training in Latin America. The outcome of these efforts was the publication of a book on the Development of Health Technicians: a Quality Challenge. The efforts required to compile and edit this work offered

an opportunity for some RETS players to systematise experiences, learning how to prepare a written text and finding a place to public their knowledge in this field. The Development Centres in Argentina and Brazil implemented a Health Technician Instructor Training Project jointly with the Regional Programme, which was submitted by Brazil to the W.K. Kellogg Foundation for financing. The Development Centres in Peru and Paraguay implemented an occupational profiles project based on the competencies of the different health technicians training projects. In Paraguay, occupational and educational profiles were drawn up for its health technician study plans. A nursing technician profile was defined in Peru. The Central American countries and the Dominican Republic prepared a project defining competences in high priority areas: radiology, physiotherapy, clinical laboratory, environmental health, ortheses and prostheses. The first stage covered the definition of these competencies and an initial validation was completed. Belize, El Salvador, Guatemala, Honduras, Nicaragua, the Dominican Republic and Costa Rica prepared the project on Detecting Technical Staff Training Requirements, which was soon converted into Health Technicians Management Development. Although approved, it was unable to move ahead, due to constraints on obtaining financing

During these years of co-operation, several meetings were held as part of the RETS Network work plan. The outcomes of these meetings were published in the PAHO/WHO Human Resources Development Series. At the first meeting, an analysis was carried out of the situation of these workers, according to the study, with suggestions set forth for establishing the RETS Network. At a second meeting defined the basic concept of the RETS Network and its work methodology. A third meeting established projects in four areas: educational programme accreditation, occupational profile definition, teacher development and information technology network with specialised bibliography.

With the acknowledgement of the EPSJV/FIOCRUZ as a WHO Co-operation Centre for Technical Education in Health, stipulating co-operation with the countries of Latin America, the Caribbean and Portuguese-speaking Africa as a priority milestone, and bearing in mind the need to re-establish the RETS Network, the PAHO-WHO Human Resources Development Programme administration decided that it would be pertinent to transfer the Executive Secretariat of the RETS Network – until then located at the Public Health School in Costa Rica – to EPSJV/FIOCRUZ. This transfer was formally undertaken in 2005 at a meeting held in Brazil attended by these institutions, at which a commitment was signed to link the technical healthcare schools in Latin America, the Caribbean, Portuguese-speaking Africa and Portugal in 2006, in order to discuss the bases for adopting approaches to the development of health technicians, as well as the RETS Network work plan. We are now attaining this goal.

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