# editorial

Technical workers represent a significant portion of the healthcare workforce, their qualification being a fundamental dimension of public policies that aim to meet the health needs of their populations.

In order to systematize and socialize knowledge that subsidizes the development of international cooperation policies, favoring the discussion and sharing of experiences and demands relative to the training of health technicians, the International Network for the Education of Health Technicians (RETS) was created.

The idea for RETS came about in 1996, arising out of two meetings organized by the Human Resources Program of the Pan American Health Organization (OPS). In its first five years of operation, it encompassed countries only in the Americas region, and the School of Public Health of Costa Rica was its executive secretary. Recommenced in 2005 by an OPS initiative, the Network switched its executive secretary to the Joaquim Venâncio Polytechnical School of Health (EPSJV), the techno-scientific branch of the Oswaldo Cruz Foundation in Brazil, and the Collaborating Center of the World Health Organization (WHO) for the Education of Health Technicians. In this new phase, RETS took on the challenge of expanding its geographical area of activity by incorporating all the countries that identified needs for cooperation.

The launch of this publication, collectively identified as one of the chief strategies articulated by the Network, seeks to increase the production and dissemination of information and knowledge by addressing issues that are important for the challenges of a type of training that recognizes the complexity of the work of the health technician and focuses on the quality of public healthcare.

In this edition, published in Portuguese, Spanish and English, we focus on the discussion of the social determinants of healthcare, which was the subject of a recent WHO study. In addition, we consider the different conceptions of technical cooperation, narrate the experience of the Mozambique Medical Journal, and present a summary of the report on Primary Healthcare. In the interviews section, Khaled Bessaoud discusses the challenges of training workers in Africa. Additionally, we include news about the institutions that comprise RETS.

Enjoy your reading!

**RETS Executive Secretariat**

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# ‘One of our major recomme the countries develop a nati

Khaled Bessaoud, public health doctor and epidemiologist, is the health human resources advisor of the African Regional Office of the World Health Organization (Afro/WHO), which is comprised of 46 countries of the region and is based in Brazzaville, Congo. In this interview, he assesses the situation of the training of health workers in African countries, the organization of human resource departments within ministries of health, strategies for the maintenance of the professionals on a national level and the focus on primary care and the work with the communities. Moreover, Khaled Bessaoud talks about the Center for Human Resources in Africa and the importance of technicians in the fight against inequalities in health.

**Considering the extreme poverty and crisis in healthcare systems in many African countries, how do you think the reform of the different areas of education of health workers should be undertaken?**

The issue of human resources is a major challenge for all African countries. Almost ten years ago, in 1999, the 46 Afro countries adopted what we call the Regional Strategy for the Development of Health Human Resources, in which we set aside a large chunk to deal with education. One of the strategies relating to this consists of training members of some communities to work in healthcare in the places where they live. They are called on to participate in government healthcare programs. Once they accept, they begin training in which they learn to promote and prevent certain diseases. With the help of these community workers, many pathological indicators have been reduced. Furthermore, the population began to rely more on the health programs of their countries.

**To what extent are the actions related to the promotion, strengthening and development of the health workforce undertaken as State policies by the Afro member countries?**

One of our major recommendations is to request that the countries develop a national human resources plan. This is because the majority of African countries do not have a strategy for the development of their workforce. And it is really necessary to outline concrete objectives: a long-term plan which includes all of the challenges to be faced. And this work guide must be constantly updated. Only then can a regional strategy in the area of human resources be developed, knowing which workers will be needed for a particular health program and what will be the career plans. Because one of the major challenges in Africa is the migration of the workforce. And we need to attract and motivate healthcare workers to stay in their countries; providing good working conditions so that they stay motivated. Currently, a few countries, such as Zambia, Uganda and Mozambique, have a strategic plan for ten or 15 years. Those who have not yet designed a work strategy have small programs. One of the main problems to think about in this more structured work is the large turnover of ministers of health. Because the change in the ministry destabilizes the sector. And for human resources to be organized in an efficient manner, there needs to be, at a ministerial level, a department devoted only to this. This is very important so that careers are regulated. Another point of extreme importance, which is also an Afro recommendation, is that these human resource departments be dovetailed with those of education. Only this way can we well train our professionals.

**The Ouagadougou Conference of 2008 urged Member States to implement strategies for the area of health human resources. What new initiatives for the formulation of effective national policies and plans for the training of workers — especially technicians — have been adopted by Afro member countries?**

The Ouagadougou Conference, held in May 2008, was a regional meeting in which the 46 Afro member countries participated. They decided to place the Primary Care strategy as a priority. Now, the next step is to discuss how to implement all the agreed-upon resolutions. The countries were asked to organize national debates to decide how they would tackle this new paradigm. The issue of human resources appears in the Ouagadougou Declaration, outlined at the end of the meeting. But, with respect to technicians specifically, nothing was discussed. Generally, in the documents there are always many recommendations for doctors and nurses. Definitely a mistake. Since the

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technicians do not have strong professional associations, like doctors and nurses do, many countries do not take them into account when developing healthcare policies. I think that is why they do not attain their strategic goals. The technicians must be included in this work. This is one of the great challenges of the strategy for human resources. We have many partners ready to help us. Regarding the training of health technicians, we have problems. There are technical schools, for example, that are within universities, and there are ten types of technical courses but, when asked about their curricula, they say they have no course program. That is the reality. So, the technicians that we have do not possess training at a good level. Afro's recommendation is that the countries establish mechanisms for evaluating the curricula of the technical schools.

### Afro is developing an African Health Center whose goal will be to monitor and evaluate progress in this field. What place will the theme of human resources occupy in this initiative?

In 2005, we organized a large meeting with large institutions to consider human resource development. Being that information is scarce, one of the recommendations was to establish, within the countries, national centers for human resources. And, coordinated by Afro, a regional center for human resources, which we have already been able to implement. In it, you can find extensive information about the countries such as, for example, the total number of doctors, nurses and technicians. We offer the possibility of having access to good information. Many countries have already started the process — Ethiopia, Ghana and Tanzania. There is a large commitment from ministries of health to do so. We have many sectors that are contributing information. And the idea is for each of the 46 countries to have its own center.

### What type of relationship does Afro think exists between the increase in the quantity and improvement of the training of health workers and improvements in the health conditions of a country?

This issue is under discussion. The problem of the number of workers is at all levels. There is a need for specialists, nurses, technicians. Chad, for example, only has three pediatricians and one anesthetist for the entire country. What usually happens is that the general practitioners do the work of specialists. Nurses too. So their work goes to the technicians, and their work goes to community workers. It's a cycle. And an unresolved question. We are still trying to figure it out.

### What plans, programs and measures has Afro adopted to handle withthe migration of professionals?

There really is a huge migration. This happens with all professionals, not just doctors. In some countries, all nurses leave as well. This is very difficult. We are convinced that the resolution of this issue depends on a long process of work. It's necessary to motivate health professionals, to have a career plan for them, a good salary, social assistance. Today, it is difficult to keep them in cities. Even in the capitals. They want to go to other countries. But the 'brain drain' is not a fact tied solely to the health sector. It has to do with politics as well. It is very difficult to keep professionals in countries that are politically unstable, in conflict, at war. Thus, the northern countries keep absorbing the labor force of Africa, South America and Asia. We do have, however, some successful experiences with respect to guarantying the permanence of these professionals. Some countries have experiences in retaining professionals. In northern Mali, for example, there was a shortage of doctors. The government offered better wages for these workers and managed to avoid emigration. Kenya also had success using the same strategy. Afro is monitoring and documenting these experiences.

### How do you assess the current status of Technical Cooperation with respect to the training of health workers among African countries? And among Latin American and African countries?

There are recent examples of this. We just approved cooperation projects among Portuguese-Speaking African Countries (Palop), the European Community and the Brazilian government. These are very good experiences. The assessment of medical schools in Angola, for example, will be organized with the help of a Brazilian university. Afro, however, recommends that African countries retain leadership in any cooperation. Good strategies are necessary, a work plan so that they know how other countries can assist them. If the do not have a national strategy, the will not know how to organize the cooperation. Many countries lose out on cooperation for lack of a 'compass', because they don't know where they want to go.

### In what way is the theme of social determinants of health being incorporated into Afro strategies and plans with respect to the area of health human resources and, more specifically, the Health Technicians?

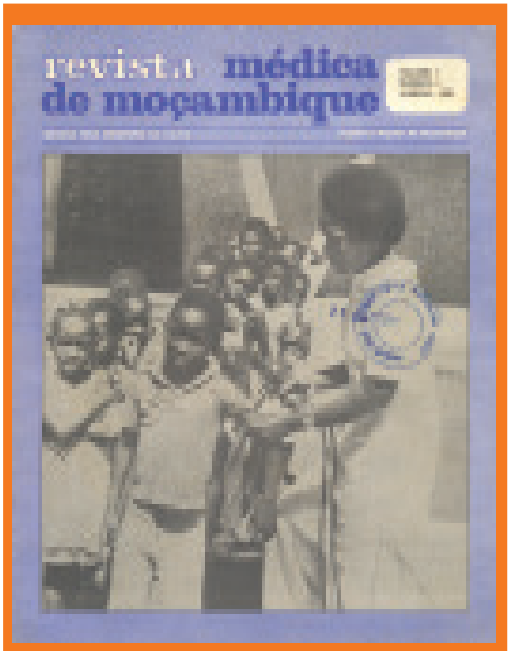
When we decided to develop primary healthcare, we were thinking about the social determinants of health: basic sanitation, water etc. But not only in the health sector. We have to obtain help from other areas for the development of transportation, agriculture. Healthcare cannot develop in a vacuum. And the Ouagadougou Declaration emphasizes this point of view.

# Founding the Medical

Creating a scientific publication is never an easy task. It demands planning, organization, coordination, and mainly, all kinds of resources, including economical ones. All of this is even harder to achieve in a context of civil war, and in one of the poorest countries of the world. The Medical Magazine of Mozambique, founded in 1982, is a good example that it is possible to create and diffuse knowledge in an absolutely unfavorable context for the practice and popularization of scientific matters.

When the Brazilian professor, Luis Rey, arrived at Mozambique in 1980 — in order to reorganize the National Institute of Health of Maputo, in a mission for the World Health Organization—, he found a devastated and disorganized country with no resources for health care. The counter-revolutionary guerrilla of the *National Resistance of Mozambique* (Renamo) — financed and supported by South Africa, England and the United States—, had intensified the war against the socialist government of the *Liberation Front of Mozambique* (Frelimo). The war time economy, as well as the frequent attacks by the Renamo, forced the government to use most of its resources maintaining and strengthening military machinery. The country´s sanitary conditions were catastrophic, due to the consequences of armed conflict and humanitarian crisis. What is worse, independence lead to a massive exodus of technicians and professionals of all areas to Portugal and South Africa. For instance, there were barely 290 doctors registered in the country in 1972. Five years later only 60 remained. Since its independence from Portugal , in 1975, Mozambique became the scene of one of the bloodiest internal conflicts in the second half of the twentieth century. The war lasted nearly 16 years, causing drought, hunger and infectious diseases such as cholera, tuberculosis and malaria. Over a million died. According to the Refugee World Report in 1993, two million fled to neighbooring countries, and another 3.5 million people migrated internally. The economy was devastated. Between 1982 and 1986, over 40% of hospitals were destroyed, as well as thousands of schools and other public facilities. According to Unicef, between 1980 and 1988, the food shortage, drinking water and sanitary assistance lead to 490.000 children´s deaths that lived in areas involved in the war. During that period, thousands of young people had to give up the schools to take part in the popular army. 'Imported' doctors, coming from the socialist block (mostly, Cubans and Russians) arrived voluntarily to occupy the vacuum left by the Portuguese colonialists. Exiles committed to the fight for the liberation of the Third World, as Dr. Rey, apart from being revolutionary government's sympathizers, they also arrived from the most unknown whereabouts of the planet with the mission of contributing to the construction of the Popular Republic of Mozambique. The itinerant professor, who was exiled for about 20 years due to the military dictatorship that ruled his country, remembers: "My motivation was to contribute to the progress of socialism, to increase the level of health of the countries, which is a basic need, wherever I go". "When a person has an ideology, she has a motivation", affirms the doctor that was militant of the Communist Party for 12 years, advocating that the diffusion of knowledge, that articulates health and education, is his "machine gun".

Regardless, the international solidarity was not enough for a new, poor and convulsed nation like Mozambique. In that moment, in accordance with Luis Rey's opinion, the formation of a new technical structure turned out to be indispensable. Besides, local professionals' formation appeared to be much more complex than in other decolonized countries of the Third World: to have an idea, in 1975, year of the independence, more than 93% of Mozambique's population were illiterate. Notwithstanding, that was not just a consequence of the lack of resources. During the Portuguese colonial period, only whites had access to secondary and higher education. The same policy had been applied for the directorships and technicians of all the areas of the public administration, as well as in industries and farming. There were few black Mozambicans that had the chance of enjoying the basic teaching, except for some of them that could travel and be graduated abroad. "During the Portuguese dominance, to get into Maputo", reminds Dr. Rey, "any black man or




**Passage of the Editorial of the Medical Magazine of Mozambique**

...In fact, the first number of a scientific magazine is not an easy task. Even when there is the coexistence and experience, what is not the case. We are aware of the inadequacies in organization, shape and presentation, which do not match up to the value of the works here presented. Firstly, our apologies go to the authors. From now on, we are already waiting for any criticisms or suggestions from them and you, readers.

Let's make the Medical Magazine of Mozambique another instrument to *dominate* science and technology. Furthermore, a magazine that represents, in the area of health, one more weapon to combat underdevelopment.

# Magazine of Mozambique

woman should have a safe-conduct". After the independence, together with most of workers and qualified technicians, a great number of university professors — all of them white, native or foreigners—, left their positions in the universities and schools of secondary and higher education. There was anybody for the vacant chair of Parasitology of the University of Medicine of Maputo. When Dr. Rey arrived at Maputo, he assumed the position, and decided to continue with the activities that he loved: teaching and training health care professionals. "One of the main problems in Africa is to teach people; the problem of the creation of medical profiles is essential. When I arrived, there was a lack of health care professionals. Mozambique welcomed me like this", remembers today the professor, in his 90s. In this way, Rey took advantage once again of what he calls "machine gun of knowledge", and so that he idealized and created an instrument to support those workers' qualifying training: the Medical Magazine of Mozambique.

## A Magazine to teach, to diffuse science and to combat underdevelopment

When Luis Rey arrived at Mozambique was not long in feeling that it was necessary to create a communication vehicle for the area of tropical diseases. Taking advantage of all the experience acquired with the Magazine of the Institute of Tropical Medicine of São Paulo and with the Latin American Magazine of Microbiology of Mexico, the Brazilian professor began the task of planning a publication adapted to the local reality. "The research demands diffusion. Therefore, I thought of diffusing knowledge and stimulating the research, as it was indispensable to found a magazine", he explains, recalling the enormous difficulties faced at that time. "There, professionals' qualifying training in the area of health, the scientific composition, was starting by zero level", summarizes Dr. Rey. He didn't just participate actively as an editor, but he also used to help directly the authors to write and to structure scientific articles in a proper way. For this reason, he distributed among his casual writers his book 'How to write scientific articles'. This book was elaborated ten years before with the objective of assisting those interested people in writing for the Magazine of the Institute of Tropical Medicine of São Paulo. The Medical Magazine of Mozambique was founded, exactly in response to those local professionals' needs, who had elaborated works, but they lacked the opportunities of conferring them the appropriate popularization. For the group of professional teams of the Institute of Health of Maputo, that participated actively for the elaboration of the magazine, the purpose of the publication was, mainly, to contribute to the knowledge and the popularization of the sanitary reality of the country. They didn't intend to introduce clinic specialties, as most publications of the area use to do, but fundamentally to diffuse those health specific problems of the community.

With a four-month periodicity, the magazine began to publish scientific works on subjects of health directly linked to the problems of public health of the Mozambican population, such as the epidemiology of tropical diseases, its geographical distribution, etc. "Basically, it was about a magazine elaborated by and for the Mozambicans. Because a scientific magazine has to respect even the cultural characteristics of the people to whom is destined", remarks Dr.Rey.

### Get to know who Luis Rey is

He was always committed to humanitarian causes, exile in the decade of 1970, during the Brazilian military dictatorship, the parasitologist worked in Africa for many years, at the service of the World Health Organization (WHO). He spent about three years in Mozambique, where he helped to create the Medical Magazine of Mozambique, which exists until today. He also taught parasitology, amid a civil war, in the University of Maputo, that was almost empty because of the white teachers' exodus after the independence of the country. In Tunisia, he was in charge by the WHO of combating the schistosomiasis epidemic, and he accomplished the task.

### Medical publications in Africa

Nowadays, local scientific publications face enormous difficulties in many countries of Africa. The financial situation is complicated and costs are high. It still exists little interest by universities in maintaining their own magazine. Another impediment is that most of the African editors do not show an integral dedication to take care of their magazine, and they usually work for free. What is worse, national researchers prefer to publish in international famous magazines, what inhibits the exchange and diffusion of the knowledge generated in Africa. Besides, the situation of the media is generally precarious, which hinders the exchange among researchers, and between them and editors. Popularization, at a national and regional level, is also difficult in that context. In spite of the mentioned obstacles, the Medical Magazine of Mozambique continues to be active. In fact, it is the only medical magazine of the country and one of the only publications of that type that exists among the five African countries with Portuguese as an official language.

# Social Determinant Health Conditio

Differences in housing, employment, schooling, income and transportation affect an individual's health. That explains why the life expectancy of some is 80 years while for others it is less than 45, depending on country of birth. But equally as important as place of residence is social position. This is because even if the person lives in a place that, in general, offers good health conditions, if the person is a member of the poorest social strata, he will be in worse health. These health-affecting factors are called social determinants of health (DSS) and returned to the center of global concerns in August of this year when the Commission on Social Determinants of Health (CDSS), created in 2005 by the World Health Organization (WHO), released a report on the subject.

The document, entitled 'Ending Inequalities in One Generation: Achieving Equity in Health by Acting on Social Determinants of Health' analyzes the health conditions of various countries and proposes actions to end the inequities. "The result is that by making such data available, the WHO is not only institutionalizing the matter, but also stimulating initiatives to confront DSS and proposing the continuation of its work of monitoring this area's activities in the entire world", says Paulo Buss, a member of the Brazilian CDSS, representative of Brazil in the WHO Executive Committee, and President of the Oswaldo Cruz Foundation (Fiocruz).

One of the points highlighted in the document is the training of health professionals, which is the subject of one of the chapters. For Alcira Castillo, Coordinator of the Inter-American Network of Training in Social Determinants (Redet), which seeks the inclusion of this topic in the contents of health-related courses, the emphasis on training represents an excellent opportunity for universities and training centers to rethink their study plans. "Until recently, the issue of social inequality and inequities in health were only reported on by specific groups. I think that the suggestions of an agency as important as the WHO will encourage the adaptation of the courses to the new proposals", she says.

## Three Recommendations to Improve Global Health

What would solve the problems caused by DSS? A new focus on development, according to the Commission on Social Determinants of Health: "It is without question that economic development is important, especially for the poorest countries, as it provides the opportunity to obtain resources for investing in the improvement of people's lives. But growth by itself, without adequate social policies to ensure that benefits are distributed equally, contributes little to equality in health."

Therefore, the CDSS makes three broad recommendations to change the status of worldwide health, "improve living conditions; fight against the unequal distribution of power, money and resources; and measure the magnitude of the problem, analyze it and assess the effects of the interventions". To achieve these objectives, the document suggests the development of integrated actions: "Policies and programs must encompass all key sectors of society. Meanwhile, the minister of health and his ministry are essential to making a global change. They can focus their strategies on social determinants, demonstrate its effectiveness and provide support to other ministries in the formulation of policies that promote equality in health," wrote the Commission.

## Socioeconomic Conditions

Employment and working conditions directly affect the health of an individual. According to the CDSS report, the mortality rate is higher among temporary workers, whose physical and mental health is compromised more than those with steady employment. In India, for example, 86% of women and 83% of men work in the informal market. People who are subjected to stress in the workplace are 50% more at risk of having heart problems. Moreover, excessive working hours and exerting heavy efforts to meet goals are factors that contribute to the onset of physical and mental illnesses. As regards this determinant, the Commission proposes that governments and employers contribute to the reduction of poverty, generate jobs and promote good working conditions.

As with the lack of employment, income also contributes to a person's poor health. The 40% of the world's population who live on just $2 USD or less per day do not have access to the same health services as richer people — the minority. According to the document, belonging to a low social

The United Nations (UN), in 2000, established eight objectives that must be achieved to change the world in this millennium: ending hunger and poverty; providing basic quality education to all; gender equality and elevation of women's status; reduction of child mortality; improvement in the health of pregnant women; the fight against SIDA, malaria and other diseases; quality of life and respect for the environment; and working together for development.

# ts of Health Affect ions Worldwide

class means low quality of education, unemployment or unstable employment, poor working conditions, housing in dangerous locations. All with direct consequences to health.

Social assistance is another important determinant of health conditions signaled in the report. Places with a system of universal social protection have a healthier population, including less mortality among the elderly and among disadvantaged social groups. This is because a large part of the government budget is invested in that area, unlike other countries which tax the poor. "Extending social protection to all, within countries and globally, will be a major step to ensure equity in health. This includes providing social protection to those with unstable and informal work conditions," said the CDSS.

Poverty is another factor that must be taken into consideration. In 2007, for the first time, it was noted that most of the world's population lives in urban areas — 3 billion people. Of this amount, 1 billion live in slums, where there is no basic sanitation. Urbanization also caused other problems such as climate change, deaths by accidents or violence. Since the 1990's, armed conflicts have killed 3.6 million people. And all this affects the health of the population. With this international context in mind, the Commission on Social Determinants affirms that health must be promoted in an equal manner in rural and urban areas, in addition to policies for the cessation of poverty in the fields, so that citizens do not have to migrate. In cities, health conditions, safety, transportation, food and the environment must be improved. In short: what is needed is the universality of social benefits.

## Health for All

The healthcare system is, by itself, a health determinant. Access to it is fundamental for a good life condition, along with other factors — or DSS — such as education, employment and income. Only universal coverage and its good management will contribute to achieving the Millennium Development Goals, says the WHO document. "Universal

access means that all inhabitants of a country may enjoy the same provision of good-quality services, depending on their needs and preferences," the report explains.

Healthcare for all also requires financing with public funds rather than direct payments for health services, which is characteristic of non-universal plans. According to the CDSS report, in countries with low or average coverage, the policies require the user to pay directly for the service received. This practice throws more than 100 million people per year into poverty due to the large expenses associated with their health and that of their families. Some data even show that socioeconomic development of rich countries is enhanced by an infrastructure financed by public funds and the development of universal public services because the market is unable to provide essential goods and services in an equitable fashion.

Beyond the public sector, the WHO draws attention to the fact that multilateral agencies, civil society, the private sector and research institutions should also collaborate on the reduction of worldwide inequalities in health. Civil society can, for example, participate in the development and evaluation of policies related to the DSS, with a goal of assessing the quality, equity and impact of health services. The private sector must recognize and respect international standards of employment, health and work safety.

The report, in fact, echoes a former WHO request, made in 1978 when some nations met in Alma Ata to ponder of a way of solving the world's health problems. It was at that time that the conclusion was reached regarding the necessity of constructing universal healthcare in countries, focusing on Primary Care – but not to the detriment of other levels of care – and taking into account the social, political and economic conditions of the population. In subsequent years, however, this model was not put into practice in much of the world. With market pressure and an economic ideal of decreasing the role of the State, healthcare became a commodity. "But the goal of having universal health has not died. Primary Care remains central so that care is focused on health promotion and prevention and not only on the treatment of diseases. This is the way we will achieve wholeness, equality and the well-being of everyone," the document affirms.

As examples of countries that improved their health conditions as a result of focusing on the first level of care and increasing coverage, the Commission on Social Determinants cites Costa Rica, which reduced infant mortality from 60 (in 1970) to 19 per 1,000 newborns (in 1985) – for every five subsequent years of health reform, the country reduced the death of children by 13% – the Congo Republic, China, India, Sri Lanka, Cuba and Brazil. "Since social determination issues are played out locally, we must organize a healthcare system that pays attention to individuals from that perspective. That is what, for example, the Brazilian Family Health Strategy does, promotion and prevention focused on families. Health professionals visit people's homes, raise their socio-environmental conditions. And that is what makes the difference in services," says Paulo Buss.

## Professional Training

Along with the expansion of access to health services and improvement of other socioeconomic conditions, the report discusses the training of professionals who can deal with social determinants – the healthcare bodies currently employ 59 million people. In the chapter entitled 'Knowledge, Monitoring and Skill: the Backbone of Action', the CDSS recommends that the educational institutions place social determinants as compulsory material in health professionals curricula. "Doctors and health professionals such as nurses and aides need to understand that inequalities in health are an important public health problem. They must recognize social inequality as an influencing factor in the distribution of care to the people and understand how the structure and funding of services affect the health of citizens. As such, they will understand its importance and be able to better communicate with their patients," writes the CDSS.

Also, part of the curriculum should include disciplines that study differences in gender as social determinants and devote more importance to health prevention and promotion. Interdisciplinary training and research also play a major role in such training. Moreover, the Commission points out the need for new teaching materials, including virtual ones with free downloading.

For Alcira Castillo, there is no doubt that this should be a practice with training: "The epistemological, ideological and methodological training foundations involve knowledge and practices that should start off as academic knowledge about the causes of disease and surpass it, going from technical disciplines to health policy actions aimed at changing the reality produced by inequities," says the representative of Redet, a network started in 2000 with the objective of strengthening the teaching of DSS in the upper-level training of universities of Chile, Cuba, Costa Rica, Dominican Republic, Brazil, Nicaragua, Peru, El Salvador, Guatemala and Honduras. "The Network provides educational materials for nine modules of DSS training", she says, adding that plans already exist for the extension of this to the technical courses. "Workshops with academic groups of mid-level will be necessary to reshape the course plans from the determinants perspective," she concludes.

In Mozambique, according Moisés Mazivila, Director of the Regional Center for Health Development of Maputo – member of the International Network of Education of Health Technicians (RETS) – the issue of social determinants is addressed in all the health courses in the country. "The DSS constitutes the backbone for the global understanding of health problems and its relationship with the environment. Therefore, our educational institutions include this issue across the board in their curricula

## History of Social Determinants of Health

The concept of social determinants of health (DSS) is not new. Initial theories that addressed health problems through a social, extra-biological approach date back to the second half of the Nineteenth Century, a period that coincides with the peak of industrialization and urbanization of the major European cities. However, the DSS only made its debut in international discussion at the beginning of the 1970's, at the height of the anti-imperialist movements. At that point it gained momentum, in large part owing to the dissemination of a series of studies that emphasized the limitations of vertical health programs, supported by the creation of campaigns for the eradication of specific diseases. They did not take into account the social and economic environment in which the diseases had spread, focusing solely on the individual biological point view. Thus, scholars began to defend the idea that public policies needed to be transformed so that they could contemplate the wider issues that affected the lives of different social groups. Above all, it was an attempt to end the structural causes that promote inequality in health, with a commitment to achieving social justice.

at the secondary level and above," he states. Social determinants of health are also addressed in the continuing education courses 'Epidemiology applied to solve health problems', 'Planning and Management', and 'Education for Health', which introductory modules have a multisectoral approach: "These courses, with an average duration of three months, are offered once a year for service professionals. In as early as the introductory module, we discuss the role of agriculture, social policies and the economy with respect to the health of the population", Moisés explains.

According to Paulo Buss, keeping the DSS in view will make a difference in health work: "The moment a professional talks with his patient, he will know how to identify which socio-health circumstances exist and, if he has prior knowledge of the determinants, he will write prescriptions and give guidelines different than those would who are not trained in this issue," he says. Additionally, according to him, this knowledge will enable health workers to assist in the formulation of public policies to tackle social determinants. "Programs will be created which will depart from seeing the individual only as a biological being in favor of analysis of the influence of the environment in which the individual resides", he concludes.

### Knowing the Data

One way to tackle the social determinants that adversely affect healthcare is to get to know them. Thus, the CDSS argues for the creation of basic databases – such as civil registries and programs to observe the health inequalities – and mechanisms to ensure the interpretation of such information. "Many countries do not even have systems for registration of births and deaths. The lack of basic data hinders the development of policies to combat health inequalities. You have to know the data to figure out how to improve them", says the Commission.

It is by means of the information mined and consolidated in the report that the CDSS makes the call for change in social health determinants to be made "within one generation". According to the document, health conditions change substantially in a short period of time. Forty years ago, infant mortality in Greece and Portugal, for example, was 50 per 1,000 newborns. Today, it is near the low rates of Japan and Sweden, which are close to zero. Egypt as well, during the same period, saw a reduction from 235 to 35. On the other hand, between 1970 and 2000, life expectancy has fallen four years in Russia.

The data also show that countries with universal policies focused on equal access to services, full employment and low levels of social exclusion, have excellent health conditions. This happens in both developed countries – such as the Nordic ones – as well as in Costa Rica, China, India, Sri Lanka and Cuba, which although not rich have good health conditions. The differential of these countries, according to the Commission, is making health a priority, guiding its development through social issues, enabling social participation, having universal coverage and approaching health in an intersectoral fashion.

One of the countries that has already aggregated data relative to the DSS is Brazil, whose National Commission on Social Determinants released, also in August of this year, the report entitled 'The Causes of Social Inequities in Health in Brazil.' For Paulo Buss, such a response to the call of the WHO should take place in other countries as well. "Brazil was the only country that established a committee to address the determinants. I believe that with the final WHO report and its presentation in various global health forums, this example will be followed in other parts of the world", he says.

### Only One Generation?

To achieve the goal of reducing the harm to health caused by social determinants, the CDSS proposes that the changes begin immediately. And the list of changes in the world political structure is enormous. It begins with the making the right to health universal, through redistribution of income and reduction of social disparities between rich and poor countries and within each nation. But is it possible to do all of that so quickly? "With new ways of governing. Health must be a policy priority", suggests the Commission. The result of this action would at the very least be the attainment of three main goals by 2040: reduction of the infant mortality gap to ten years between countries with the lowest and highest rates; reduction of mortality rates by 50% in all countries and in all social classes; and reduction of the mortality rate of children and those under five years old by 90% and of mothers by 95% in the entire world and in all social classes.

# International Technical Cooperation

At the end of World War II, most European countries were on the verge of economic and social collapse. To prevent the worsening of political instability and the advance of communism, the United States developed an ambitious economic and technical assistance plan in 1947, which was organized to accelerate Europe's recovery. In less than five years, the Marshall Plan had earmarked millions of dollars for economic cooperation and assistance projects directed to 16 European nations.

Some years later, the world realized that such assistance was not altruistic. It concealed pressures and 'contingencies' that reinforced political, economic and cultural dependence on the countries that received the assistance. Rudolf Buitelaar, current head of the Project Management Unit of the Economic Commission for Latin America (Cepal), says that technical cooperation between countries with very different degrees of development (or North-South cooperation) often has objectives of an economic-strategic nature: "This type of 'partnership' sometimes corresponds to the need for a developed country to impose a technical standard of one of its industries on one or more nations of a lower technological level".

Cepal was established in 1947 by the Secretary of the United Nations and remains active until today. It was based on theoretical socioeconomic structuralist ideas of Latin American intellectuals, such as Raúl Prebisch, who were sensitive to the state of underdevelopment in the Third World and in Latin America in particular. For several decades, Cepal ideals emphasized, among other things, the need for finding specific solutions that would overcome the economic stagnation of the underdeveloped nations of the Periphery through the pursuit of State-induced industrialization and other interventionist policies.

It was in Latin America that, almost three decades later, another type of international aid surfaced. Its goal was to promote collaboration among countries with similar levels of development. It pertained to South-South cooperation, and was developed by Cepal to assist countries that did not have the 'support' of a Marshall Plan. The success of some Latin American nations in having achieved appreciable levels of growth since the 1960's enabled them to share their experiences with less fortunate countries. It was in this context that the idea of Technical Cooperation among Developing Countries (CTPD), or South-South Cooperation, gained recognition, which idea sought the constant and systematic transfer of experience from developing countries that were more advanced to those that were less advanced.

However, this does not mean that South-South cooperation is merely an act of solidarity among countries. According to Rudolf, the country that provides 'help' always benefits because it acquires knowledge, contacts and experience. The Brazilian Foreign Affairs Minister, Celso Amorim, in an article entitled 'The Prospects of International Cooperation', explains that when no large imbalance exists between the partners, cooperation is based on complementary resources and similar objectives, and it becomes an important element of national policy for scientific and technological development. Felix Rigoli, Regional Human Resources Consultant of the Pan American Health Organization (Opas), recalls that what is most important is to have a long-term, whole-process outlook.

Such a cooperation model was consolidated in 1978 at the UN Conference on CTPD, held in Buenos Aires with the participation of 138 nations. Based on the ideas proposed by CEPAL in previous decades, the goal of the conference was to enhance the ability of these countries to find solutions to their growth problems, strengthen the exchange of experiences and identify common alternatives, in addition to increasing South-South political dialogue. As a result of the conference, the CTPD obtained even more prominence in Cepal's regional programs.

## International Technical Cooperation in Health

In the health area, the story was not much different. According to Felix Rigoli, the developed countries and international organizations decided by the 1950's to promote a type of cooperation regarding health based on funding programs focused on combating specific diseases. It was the 'Official Development Assistance' (AOD), motivated by the 'charity' of rich countries.

At the end of the Cold War, when the role of the United Nations and the reordering of international order were brought into question, the AOD went through some changes. At that time, the 'private charities' began to replace international cooperation led by intergovernmental organizations. The emergence of new global leaders such as Brazil, Russia, India and China, for example, offered an opportunity to recover the third-world spirit of CTPD. "It was a new phase of international cooperation: the new leaders learned from past experience and created a synergy that is neither domination nor charity," says Rigoli.

In Latin America, South-South cooperation was strengthened in the area of health, as the traditional donors from the North, due to international

## Types of International Technical Cooperation

There is no single typology for classifying the different modalities of International Technical Cooperation (CTI). It is possible, though, to identify currently-existing specific categories. Cooperation is defined as **bilateral** when an agreement exists between two countries through their respective official, financial or technical agencies. Cooperation is **multilateral** when between a country and multilateral international organizations (development councils, UN agencies and bodies, etc.).

Cooperation is **horizontal** (or CTPD) when the participating countries are two or more developing nations. Since 1998, Opas, for example, has approved more than 200 CTPD projects in areas such as disease control, risk management, environmental health, family and community health, health services, emergencies and disasters, and humanitarian aid. **Triangular** cooperation is comprised of the association of a bilateral or multilateral source and a country of medium development, granting horizontal cooperation, to jointly create acts in favor of a third nation (the beneficiary). The "Forum for Mexican-African Triangular Cooperation in Education and Health", organized by the Mexican Ministry of Foreign Affairs with the support of UN agencies, funds and programs to strengthen cooperation with African countries bilaterally and regionally, is an example of this model.

Finally, cooperation is **decentralized** or **non-governmental** when performed by civil society institutions. It includes the public decentralized CTI, which is handled by local and regional governments. Chile, a Latin American pioneer in this modality, has more than 80 cooperation agreements in science and technology and social development, signed between the country's local governments and 16 world nations or multilateral agencies.

### Ten charactristics of South-South cooperation

1) Similarity of developmental challenges faced by countries on a local and global scale

2) Common aspirations and experiences in national construction and development

3) Historical likenesses and cultural bonds

4) Geographic proximity

5) Demographic advantages

6) Already-established cooperation, regional and interregional milestones

7) Relevant availability of skills development

8) Respect for sovereignty and mutual benefit

9) Philosophy of 'neighbor helping' as opposed to the idea of 'charity helping'

10) Numerical majority of southern countries in all global forums

Source: Latin American Economic System (SELA)

pressure, decided to give priority to other regions of the world. Thus, between 1998 and 2003, Opas approved 175 health cooperation projects among various Latin American and Caribbean countries. "The challenge was to encourage networking among countries and solicit institutions to learn to cooperate horizontally", recalls Rigoli. For him, one of the advantages of the Americas region as regards technical cooperation is, among other things, the fact that there is not much difference between rich and poor countries. He cites as an example the TC41 international cooperation project and the many triangulations that Brazil, Canada, Opas, the Andean Healthcare Organization and the other countries of the Southern Cone have been able to achieve in the past two years. "We have been able to train hundreds of leaders in human resources, unify criteria and create links among 15 countries to reform the directions or branches of RH in the Americas; to develop a network of researchers in human resources that are linked through common Internet protocols in the Andean area and Brazil; to support Brazil's cooperation in the training of technicians in Paraguay and Bolivia; and to integrate dozens of academic centers in the Virtual Campus of Public Health. We made large advances in little time," he states.

TC 41 is a cooperation initiative established in December 2005 among Brazilian institutions and OPAS member countries to qualify health management in intersectoral and international contexts, to mobilize Brazilian collaborative networks for cooperation with other states, and to support CTPD projects.

# Technical Cooperation Project Promotes Experiential Exchange Among Bolivia, Brazil and Paraguay

The need for updating the technicians and assistants able to handle the challenges of the health sector and its systems in South America has led schools in Brazil, Bolivia and Paraguay to come together and plan, in 2005, the Technical Cooperation Among Countries (TCC). The joint project was approved by the Regional Office of the World Health Organization (WHO), Americas Region - in May 2006 with the title 'Interinstitutional Collaboration Agreement to Strengthen Training of Technicians and Assistants as Essential Agents for Health Care'.

The objective was to exchange experiences and intensify cooperation between Mercosul countries, with a view to improving its health systems as well as strengthening the International Network of Education of Health Technicians (RETS).

In addition to sponsorship by the Pan American Health Organization (OPS), the participant institutions were the Andean Technical School of Bolivian-Japonese Health in Bolivia; the Joaquim Venâncio Polytechnical School of Health (EPSJV) in Brazil; and the National Institute of Health (INS) in Paraguay. Subsequently, other governmental institutions of the three countries were added, such as the Paraguayan Health Ministry through its Department of Biostatistics and the Paraguayan Education Ministry, both technical institutes associated with the INS; the Secretary of the Department of Labor and Health Education Management of the Brazilian Health Ministry; and the Bolivian Chaco Boliviano-Tekove Katu Technical School of Health.

One of the TCC's main actions was the cooperation between the EPSJV and the INS in the area of Health Records and Information. In December of 2006 and August of 2007, a group of researchers from the Brazilian school went to the Paraguayan institute to assess the creation of country's first course in this area, articulated in the deployment of the National System of Information on Vital Statistics. "When you know where the flaws of the system are, the government also knows what areas have the most urgent need for investment. If these indicators do not exist, the country policy becomes lost. Hence the importance of a course such as the one in Paraguay which was deployed as part of a larger policy in the area of health (the Vitals), and it opened the possibility of the structuring of information services", explains Ana Margarida Barreto, an EPSJV Research Professor who participated in the mission.

As part of working together, the professionals involved exchanged information about the organization of such training in both countries. The main difference identified, according to Ana Margarida, was the fact that the training in this area was given at an average level in Brazil and a high level in Paraguay. In Cochabamba, Bolivia, workshops were held to review and update the Health Information and Records course already in existence in the country, to develop the design and validation of the Health Equipment Maintenance course, and finally to assess the processes of integrating intercultural issues and traditional medicine into the various ETSBJCA courses. As for Paraguay, the workshops took on the review and adequacy of courses for nursing assistants and technicians, with the help of professionals from the Brazil Ministry of Health and the Bahia Technical School of Health (Brazil), the development and validation of the Health Information and Records course of the INS, and the development of the design and validation of the Health Equipment Maintenance.

Both in Bolivia and Paraguay, workshops were held on the development of educational materials and the updating of educational methodology, curriculum planning, design and educational programming, and monitoring of learning assessment. In addition, the EPSJV donated teaching materials (books and texts) to the Bolivian ETSBJCA and the Paraguayan INS.

## New Prospects

In October 2007, an meeting was held in Brazil to assess the first phase of the TCC. With representatives from the three countries, as well as from the OPS, the consensus was that the objectives of the three countries had been met, and a new TCC was developed to expand the work and include cooperative tasks in other areas of health technician training. For this new phase of the TCC, new activities were agreed upon, with priority to areas of Health Information and Records, Health Equipment Maintenance, and Health Surveillance, in addition to discussing Primary Health Care, which permeates all of the areas. Other demands were identified in the field of training and regulating the work of community-based professionals and experiential exchange on indigenous and intercultural health, as well as more structured discussions on the conceptions of the education of health technicians in the countries involved. During the meeting, the representative of the Bolivia Ministry of Health and Sports, Miryam Gamboa, emphasized that the construction of a new model of aid based on family and community health which respects cultural differences is the priority of the country's policy restructuring plan. According to her, the cooperation made possible by the TCC is of fundamental importance because one of the major strategies for this change is the training of staff already working in the system.

## Malaria Reduction Program

In September of this year, 36 health area professionals in Angola designed a course which aims to improve the reporting system of cases in the country.

The course, which includes technical content, such as the definition of the disease in areas of risk and epidemiological information, also contains socio-political concepts that could work together to control malaria, education and social mobilization initiatives, and the specific contribution of several governmental partners involved in the fight against the disease.

The initiative is part of Angola's effort to improve surveillance, monitoring and evaluation of statistical data, with a goal of reducing mortality rates.

The National Malaria Coordinator of the country, Filomeno Fortes, said in an interview on the Angola Press website that reducing the impact of malaria by 60% by 2012 by improving the implementation of the control interventions is one of the main objectives of the Angolan government. The number of cases, which stood at 3,246,258 in 2003, dropped to 2,726,530 in 2007.

## ETSBJCA Conducts Training Courses

In Bolivian, the Andean Technical School of Bolivian-Japonese Health (ETSBJCA) held in June of this year a course for Technicians in Health Statistics. The course took place in the afternoon to allow students to continue working in the morning. According to the school's director, Rosario Polo, the course's curriculum was expanded and improved based on the exchange of experiences with Brazil's Joaquim Venâncio Polytechnical School of Health in 2006.

In April, the school also promoted a course to teach airport employees to take X-rays of people suspected of transporting drugs in their stomach. If they would like to continue training, those employees may complete the X-Ray Technician course.

The course, which lasted three months, was by request of the Special Task Force Against Drug Trafficking in Bolivia.

## Institutional Cooperation between Cuba and Costa Rica

In October 2008, two professors from the School of Health Technologies of the University of Costa Rica visited the College of Health Technologies of the Higher Institute of Medical Sciences of Havana, Cuba, in order to share training and research experiences in the area of Health Technologies. It is expected that the visit will strengthen relations between the two institutions through an agreement that provides for the development of activities and the sharing of experiences.

## Sena Launches Blood Donation Program

On August 15th in Bogotá, National Learning Service (Sena) launched a 360-hour training program to certify Voluntary Blood Donation Promoters, in alliance with the Blood Banks Council of the Columbia National Institute of Health.

The program, which is a product of the Center for Health Training of Human Talent and is considered Complementary Training offered by the organization, was addressed to baccalaureates, nursing assistants and health professionals linked to institutions that work with the country's blood banks.

The standards of competence and structure of the training program were results of a collaborative effort among Sena professionals and the National Coordination of the Blood Banks Network located at the National Institute of Health, and with a goal of promoting the culture of voluntary donation as a social responsibility.

## Forum Discusses Training of Health Technicians in Paraguay


On October 30th, the First National Forum of Higher Education in Health, with support from the Ministry of Education and Culture and the National Institute of Health of Paraguay, was held.

The goal was to promote discussions about the challenges of higher education, the regulatory framework of that level of education, and its connection with the labor market.

The forum, held in the city of Ypacaraí, was organized by member institutions of the Paraguay Association of Technical Institutions of Health, among which is the Higher Education Center.

## 'Technology and Health' Convention Causes Debates

The first 'Technology and Health' convention will be held from March 23-27, 2009, in the Palacio de las Convenciones in Havana, Cuba.

The event, given by the School of Health Technology, the Superior Institute of Medical Sciences of Havana, and the Ministry of Public Health, aims to bring together health technology professionals to discuss issues of interest, contributing to the development of teaching services and quality assistive services.

For more information, those interested can contact the organizers via telephone — School of Health Technology (FATESA) (537) 406505 and (537) 410664 — or via email — daimary.mendoza@infomed.sld.cu (Dr. Daimary Mendoza Rodriguez, Vice President of the Organizing Committee); arencibia@palco.cu (M. Sc. Dr. Arencibia Figuerosa, Professional Organizer of Events). The phone numbers of the Palacio de Convenciones in Havana are (537) 2087541 and (537) 2026011. The fax number is (537) 2028382.

## WHO Launches Electronic Newsletter in Mozambique

The representative office of the World Health Organization (WHO) in Mozambique has launched a quarterly electronic newsletter to disseminate some of the actions taken by the government in collaboration with its Health Development partners.

The objective is to share information with health sector professionals and institutions and similar organizations in addition to national and international partners and the public sector.

The first newsletter has nine subjects whose purpose is to arouse readers' interest in cooperating with Health Promotion, preventing and combating diseases like maternal and neonatal mortality and malaria, and strengthening the partnership for health

In this edition, issues are covered such as Mozambique's adherence to the global alliance for patient safety and information on the strategic plan of the country's Ministry of Health for the prevention and control of noncommunicable diseases.

To view the newsletter, please visit the following website: http://www.who.int/countries/moz/publications/ebulletin_march_june_2008.pdf

## EPSJV lauches technical course of Health Communitary Agent

On October 1, 2008, the Community Health Agent technical course began at the Joaquim Venâncio Polytechnical School of Health. The result of a partnership among the EPSJV with the Germano Sinval Faria Health Center School (CSEGSF), the National School of Public Health (Ensp), the Fiocruz, and the Rio de Janeiro Municipal Secretary of Health, the course is a pilot project that has as students members the ACS who work at the Ensp/Fiocruz Health Center, in conjunction with the Rio de Janeiro Municipal Secretary of Health. It was developed by doctors, nurses and the very ACS members of the Family Health Team. "We incorporated the workers' perspective into this course from its inception as part of the methodology of the pilot project," explains the coordinator Marcia Valeria Morosini.

Divided into three modules that will lead the worker to technical proficiency, the course encourages research related to this issue and collaboration in the development of experiences and reports that can be shared with the other SUS Technical Schools responsible for ACS training across the country.

## III Expoesp Discusses Public Health Issues

The School of Public Health of Ceará, Brazil, held 'III Expoesp' on September 3rd of this year. Around 500 graduate and postgraduate students and healthcare professionals participated. Registration and work submittal also took place.

Expoesp gathered more than 50 speakers from institutions across the country, addressing issues related to strengthening the Brazilian Public Health System (SUS), whose 20-year anniversary is in 2008.

One of the event's round tables was on the topic "Education and training of human resources for the SUS," which provided a specific discussion on the Training Program for Mid-Level Health Professionals (PROFAPS).

## International cooperation in Colombia

Fundación Universitaria del Área Andina is going to accomplish, in October 2009, the XXII Congress of Alasbimn (Latin American Asociation of Molecular Biology and Nuclear Medicine Societies) in the city of Cartagena de Indias (Colombia). The event will take place at the Conventios Center of Cartagena de Indias.

## Convention Gathers Technicians From All of Latin America

The School of Health Technologies of the College of Medicine of the University of Costa Rica and the Costa Rican Association of Medical Imaging Technologies of Costa Rica sponsored, in September of this year, the Eleventh Convention of Latin America and the Caribbean and Second National Convention of Medical Imaging Professionals. The event had the support of the Latin American and Caribbean Association of Medical Imaging Technologies. The convention brought together some 400 technologists of the field from throughout Latin America. The objective was to promote continuing education and updating of medical imaging professionals in the different areas of their training.

## Seminar debates 20th anniversary of Brazilian Public Health System

On September 9-11, 2008, the Joaquim Venâncio Polytechnical School of Health (EPSJV) held a seminar entitled "State, Society and Professional Training in Health - 20 Years of the Single Health System: Contradictions and Challenges."

The event had five thematic tables and ten speakers who encouraged discussions about the current state of the SUS and public policies in Brazil and abroad, two decades after being codified in the Federal Constitution of 1988. The table names were 'State, social policies and health', 'Health and society', 'Democracy, participation and health management', 'Work and health work', and 'Work and educational relationship in health'. Among the speakers were researcher Emir Sader, coordinator of the Latin American Council of Social Sciences (CLASCO), Jairnilson Paim, professor at the Institute of Collective Health of the Federal University of Bahia (ISC/UFBA) and Sergio Lessa, philosophy professor at the Federal University of Alagoas.

On the last day of the seminar, after the close of the discussions, the EPSJV launched two books: 'Market of Knowledge and the Knowledge of the Market - from Training to Complex Work in Contemporary Brazil', written by researchers Lucia Neves and Marcela Pronk, and 'State, Society and Professional Training in Health: Contradictions and Challenges in 20 Years of the SUS', a collection of texts presented at the seminar organized by Gustavo Matta and Julio Lima.

# Publications

## Globalization and Health

*Ichiro Kawachi* and *Sarah Wamala* - Oxford University Press

In this book, Ichiro Kawachi, professor of Social Epidemiology at Harvard University's School of Public Health, and Sarah Wamala, General Director of the Swedish National Institute of Public Health and professor of Social Medicine at the Karolinska Institute, talk about advances, problems, challenges and opportunities posed by the globalization of healthcare.

The authors analyze the medical threats most common to this new context and the tools used to assess them. They also explain how socio-political occurrences influence population health. Additionally, they examine the role of institutions like the World Health Organization (WHO), the International Monetary Fund (IMF) and the World Bank in the health sector.

## Transformaciones sociales y sistemas de salud en América Latina (Social Transformations and Healthcare in Latin America)

Edited by *Betty Espinosa* and *William Waters* - FLACSO Ecuador, 50 year trajectory

The characteristics of the development of healthcare in Latin America are addressed in this book by researchers who participated in the Latin American and Caribbean Social Sciences Congress, held in Quito in October 2007 to commemorate the 50th anniversary of the Latin American College of Social Sciences (FLACSO).

Organized by Betty Espinosa, FLACSO Ecuador professor, and William Waters, co-director of the Quito Institute for Research in Health and Nutrition of the University of San Francisco, the book divides its articles into three parts: healthcare systems and services in Ecuador and Latin America, healthcare policies and provision of services on a national and international scale, and practices in health professions.

The authors present an analysis of the various responses given over the last two decades by Latin American countries to the health problems of their people. As explained in their articles, health policies go from the strengthening of public power in the sector through decentralization or municipalization, to the privatization of care. Moreover, they recall that biomedicine and alternative practices coexist in many places.

## As causas sociais das iniqüidades em saúde no Brasil (The Social Causes of Inequality in Healthcare in Brazil)

*National Commission on Social Determinants of Health* - Editora Fiocruz

This publication is the final report of the Brazilian National Commission on Social Determinants of Health, created in March of 2006 and whose Executive Secretary is located in the Oswaldo Cruz Foundation (Fiocruz), an agency of the Brazilian Ministry of Health. The Commission, with 16 members, is comprised of healthcare managers, research professors, sanitarians, artists, healthcare professionals and other representatives of civil organizations.

The book presents data on the impact of social determinants on the health of the Brazilian population and makes recommendations based on in-depth analyses of the status of healthcare and the actions that are already being undertaken in the area, so that inequality in the health sector can be overcome.

# Primary Care Is at the Heart of the Global Agenda

The World Health Organization (WHO) celebrates the 30-year anniversary of the Alma-Ata Conference in Kazakhstan, recalling its ideals by again drawing world attention to the importance of primary healthcare. That was the theme of the 2008 annual report entitled 'Primary Care: Now More Than Ever'. The WHO is calling on healthcare systems to begin organization starting at the first level of care and to achieve universal coverage. "This report reiterates the ambitious prospect of primary care as a set of values and principles that guide the development of healthcare systems. It is an opportunity to identify problems and reduce the disparity between aspirations and reality. The time has come, more now than ever before, to promote the exchange of experiences among countries and draw a more direct route to ensure healthcare for everyone," wrote Margaret Chan, General Director of the WHO.

According to the document, the countries' responses with respect to primary care have been "slow and inadequate". That's because most of them have a fragmented, commercial and hospital-centric model of healthcare. "The focus on hospitals and specialists has made the system inefficient and inequitable," says the report.

This focusing of aid began in the 1980's, when primary care was made through a "basic plan of interventions," as the goal of neoliberal governments was the reduction of social costs. The concern was with the fight against a reduced number of diseases - mainly infectious – maternal-infant healthcare and the improvement of the water supply and sanitation. According to the WHO, an end must be put to "centralization in a tight supply of specialized curative care; fragmentation of services; and the lack of governmental intervention, which leaves the door open for commercial care".

## Four Guidelines

To make real changes in the world health situation, the WHO's study signals the development of a structural alteration based on four main points: guaranty of healthcare which contributes to equitable health outcomes, social justice and an end to exclusion for the sake of universal coverage; organization of services for primary care, that is, around the needs and expectations of the people; development of new public policies; and ending the lack of State control, giving rise to leadership capable of confronting the complexity of problems with healthcare. Most important, however, is the universality of services, which will foster a climate in which the other subsequent actions can take place. "That is the priority goal, as it was 30 years ago", says the WHO.

But the World Health Organization points out that the solution only begins with primary care. "It can greatly contribute to improving the health of communities, but it's not enough to ensure equality in healthcare. It is necessary for the governments to adopt a series of public policies to address the challenges in healthcare. A reinvestment in public leadership will be necessary", mentions the WHO in its annual report.

According to the document, the universality of healthcare and the changes in the other public policies cannot be made, though, in the same way in every country. "In countries with high costs for healthcare, as is the case in almost all developed countries, there is plenty of financial margin to accelerate the shifting of focus to primary care from tertiary care, to regulate the system in a healthy way, and to decrease exclusion by means of universal care. The challenge is much greater for the two billion people who live in the countries of Africa and eastern Asia, where the healthcare sector grows slowly, and for the 500 million who live under fragile governments. And these locations have the need, more than any other, to start the immediate change to primary care", remarks the WHO.

## 'Now more than ever'

According to the report, the world is at a good point for real changes in the health conditions of the population. "Global health is the object of unprecedented attention, as highlighted by the increase in requests for whole and universal care. There are clear and positive signs of willingness to cooperate in the establishment of sustainable healthcare systems as opposed to partial and fragmented approaches". The improvement of the economic situation of countries should also contribute to changes: "The GDP growth – which is certainly vulnerable to the slowing of the economy, the energy and food crises, and global warming - is boosting healthcare expenditures worldwide. This could be the opportunity to introduce reforms in primary care that were not possible in the 1980's and 90's".

Moreover, according to the WHO, in the last ten years the world community has taken on poverty and inequality in a more systematic manner. "One example is the establishment of the Millennium Development Goals and formulation of social policies which take social inequities into account. This presents the opportunity to be more efficacious with regard to healthcare measures and create the conditions necessary for establishing strong alliances outside the health sector. Intersectoral measures are at the forefront once again."