editorial

In this third edition of the RETS Journal, we celebrate with our readers the launch of the Network's website (http://www.rets.epsjv.fiocruz.br), another important step in the consolidation of the experiential exchange process in the areas of education, research and technical cooperation, with a view to improving the area of health technician education. We have made a special invitation (page 5) to the RETS 2nd General Meeting to member institutions, which will be held in early December in Rio de Janeiro, Brazil, reminding all that the participation of everyone is essential to the success of the initiative and for the continuity of our work.

The migration of health workers and the Pedagogy of Competencies are the magazine's main themes. What are the causes and consequences of migration, both internal or to other countries, of the health workforce? What is being done to reduce the negative effects that migration engenders, especially to the more vulnerable populations? These are some of the issues identified in our cover article by Mario Roberto Dal Poz, Coordinator of the Department of Health Human Resources, World Health Organization (WHO) and Chief Editor of the journal Human Resources for Health, and by Magda Awases, Health Human Resources Development Advisor of the Afro/WHO.

In the interview, on the other hand, the reader will discover the opinion of Brazilian educator Marise Ramos, one of the greatest scholars on the subject, about the competency model, which for some 20 years has guided technical training throughout the world, as well as the possible results for education and society of the uncritical adoption of this healthcare proposal.

In addition, the journal presents the work of the Bolivian Chaco 'Tekove Katu' School of Health in the training of indigenous healthcare professionals, which, combining the views of classical and traditional medicine, respecting local customs and practices, and being cognizant of the local reality, experience and native tongue, is able to more effectively meet the immediate needs of the native population.

Further, the magazine provides an overview of the Strategic Plan for Cooperation in Health (Pecs 2009-2012), approved on May 15, with the objective of strengthening the healthcare systems of Member States of the Community of Portuguese-Speaking Countries (CPLP); once again ponders aspects of the latest World Health Report focusing on the workforce; and in the Glossary section launches a discussion on the polysemy of the term "Health technician education."

Happy reading!

RETS Executive Secretariat

acknowledgements

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Editor
Ana Beatriz de Noronha - MTB25014/RJ

Journalism Intern
Igor Mello

Designer
Zé Luiz Fonseca

Artist
Marcelo Paixão

Design Intern
Pedro Henrique Quadros

Circulation
1000 copies

EXECUTIVE SECRETARY OF RETS
Joaquim Venâncio Polytechnical School of Health

Director
Isabel Brasil

Coordination of International Cooperation
Anamaria D'Andrea Corbo

Coordination of International Cooperation Staff
Anakeila Stauffer
Christiane Rocha
Ana Beatriz de Noronha

Address
Escola Politécnica de Saúde Joaquim Venâncio, sala 303
Av. Brasil, 4365 - Manguinhos - Rio de Janeiro - RJ - 21040-360.
Telefone: 55(21)3865-9730 - E-mail: rets@epsjv.fiocruz.br

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Pedagogy of Competencies: “individualization and social fragmentation service ideologies”


Sandra Pereira

Educator Marise Ramos, author of the book “Pedagogy of Competencies: Autonomy or Adaptation?” (Sao Paulo: Editora Cortez, 2001) and one of the most-renowned Brazilian specialists in the subject, brings to the pages of the RETS Journal a brief but thorough and current reflection on the pedagogy of competencies. What societal and educational conceptions are behind the rhetoric that is driving professional education worldwide, including in healthcare? What are the possible consequences of uncritically embracing a training model which appears to serve the interests of businesses and which transforms the competencies, originally an aspect of individual differentiation, into an economic factor?

What is this often-discussed “pedagogy of competencies” and the reasons for its success?
The notion of competency is very polysemic, that is, it has multiple meanings. Section 16/99 of the National Council on Education, which proposes guidelines for professional education in Brazil, for example, defines competency as “ability to articulate, mobilize and put into action values, knowledge and skills necessary for the efficient and effective performance of activities required by the nature of work.” In the work environment, this notion becomes plural – competencies – and goes on to describe the particular contents of each function in an organization. The pedagogy of competencies, in turn, is that which seeks to transfer the contents to the training, based on competencies desirable in the development of students. This means that it is a pedagogy defined by its goals and validated by the competencies it produces, which, in my opinion, is a problem: how can a school define the competencies as a training goal if they can only be developed in a work setting? As for the reasons for its success, there are many, but one is that by highlighting the experience of students, the competencies rhetoric ends up representing an improvement with respect to the time in which only scientific knowledge, embodied in the professor, was recognized.

In what way and in what context does this idea arise?
Since the mid-1980’s, advanced capitalist countries have gone through major technological and organizational work changes, the result of which has

been production flexibility and the restructuring of occupations; integration of the production sectors; multifunctionality and versatility of workers; and appreciation of workers' knowledge that is not directly related to specific work requirements or formal knowledge. It is in this context that the phenomenon of conceptual displacement of qualifications vis-a-vis competencies begins to occur with two fundamental goals: rearranging the understanding of the work/education relationship, shifting the focus of jobs, occupations and tasks for the worker, with its subjective implications for work; and institutionalizing new ways of educating/training and employee management in organizations and in the labor market in general.

With this shift, professional insertion and social relations at work cease being based on degrees and diplomas, that is, on the training received initially, and in the abilities of the collective organization – corporate and political – of workers and ends up being supported by the abilities actually demonstrated by the subjects individually in situations faced at work, that is, the individual abilities of each employee which are wholly subjective. Therefore, what follows is a weakening of the conceptual dimension, relative to the value of the diplomas, and of the social dimension of qualification, as opposed to the strengthening of the experiential dimension. Experience, which determines the differential abilities of the subjects, has now become considered the most important dimension of qualification. The competencies of the workers become the main reference point for the education and management of workers.

The competencies model, therefore, has [neo] pragmatic origins and ethico-political content compatible with post-modern culture, which corresponds to the cultural logic of late capitalism, and has played a specific role in the representation of the processes of worker training and behavior in society. I would say that the notion of competency is located in the area of convergence between interactions theory of training individuals, in which the competency becomes a psycho-subjective characteristic of adaptation of the worker to contemporary life, and functionalist theory of social structure, which places competency as a consensus factor necessary for maintaining social structure.

These days, after so many studies on the subject, what kind of criticism do you reserve for pedagogy of competencies, which is defended by many as being able to approach the school of social practice?

Well, there are some internal inconsistencies in this model, since the only way that a competency constitutes a formal pedagogical reference is by objectifying it. This, however, makes the competency cease being a subjective attribute and transforms it into a conduct parameter. In other words, the virtuous dimension of the theory of competencies, which according to Gérard Malglaive is related to understanding and stimulus from the complex structural and dynamic processes of intelligence by which formal practical knowledge is articulated in the face of activities which trigger new learning, has become reduced by limitations and the influence of observable and controllable conduct.

There are many arguments favorable to the competencies model, including the one which posits that it allows for greater approximation between schooling and social practice, and also higher levels of curriculum integration. I, however, think that these arguments do not survive the process of objectification that I mentioned earlier. Instead of approximating school and reality, this model tends to transform schooling into an area of artificial reproduction of the day-to-day routines, reducing it to an area of knowledge. Moreover, instead of promoting higher levels of curriculum integration, it ends up promoting disintegration due to knowledge being reduced to instrumental resources. In this sense, the knowledge ends up being taken in a way which is unbound to the epistemological and historical universe in which it was produced, thereby acquiring purely pragmatic ends. The result, in my opinion, is that in a best-case scenario this model will achieve the training of people who deal well with practical knowledge, but are not very capable of producing new knowledge, since they do not know the "scientific method."

Using the work process as a reference for practical teaching is essential to vocational education, but wanting to reproduce the work area in the classroom is a mistake. The role of educational institutions cannot be that of improving upon the knowledge that people already have, but that of providing access to knowledge, articulating work, science and culture, and seeking to develop critical understanding in their students. The individual focus on the competencies collectively with experience overvaluation may result in the training of people quite capable of adapting to reality, but not of transforming it.

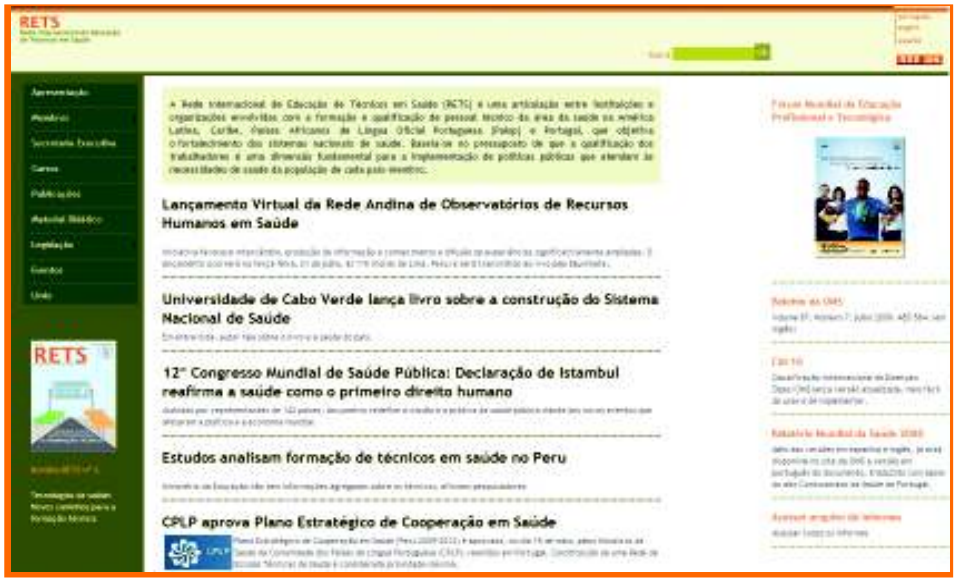
And as regards the ideological area? What has been the role of the competencies model?

With regard to ideological criticism, I believe that the use of this model in the work world is revealing. In our research we demonstrate, among other things, the rhetoric which contends, based on the recognition and appreciation of the subjectivity of workers, that the idea of competencies within the precepts of Taylor-Fordism was revised as a strategy of expropriation of those very workers and of appropriation by their knowledge capital. But that's not all. It also became a means of individualization in labor relations. The competencies model in this field ended up serving to construct a false consensus which made job protection policies responsible for the employment crisis, which workers faced at the individual level.

In summary, I think the competencies model and its pedagogy can be considered yet another ideology which serves the culture of individualization and social fragmentation rather than a scientific formulation capable of providing unity of work and education and of theory and practice, as is touted.

RETS website goes live

Site provides news and information throughout the network



Last May marked another important achievement for the International Network for the Education of Health Technicians: the RETS website (http://www.rets.epsjv.fiocruz.br) was inaugurated on the 22nd. "The site, which is an important tool of integration and dissemination of knowledge and information among network members, will also assist with the sharing of didactic materials and will provide more visibility to the scientific production of the institutions, as well as other sites and events essential to the field," explained Anamaria Corbo, Coordinator of International Cooperation of the Escola Politécnica de Saúde Joaquim Venâncio (EPSJV/Fiocruz) and Executive Secretary of RETS, who also discussed future goals: "We want to reach a level in which we can disseminate the course programs of the member schools, a measure that will stimulate discussions on the training of health technicians, especially at the regional level."

On the trilingual website, having Portuguese, Spanish and English versions, the user also will find the entire contents of the RETS Journal for viewing online or via download, including previous editions. Those who wish to may also receive site content update alerts content via RSS feed.

For the journalist Ana Beatriz de Noronha, editor of the RETS journal and website, the launch is only the beginning of a long process of work which will require the cooperation of all Network member institutions in order to reach its full potential. "The cooperation of all is essential so that the site always contains interesting updated content," she comments, mentioning that an electronic newsletter with news and other content is also being published on the site.

Getting to know the RETS website

Home: Once in the portal, visitors have access to the latest published news items. They appear on the main page with headlines, images and a short summary of the subject. Just click to read the full story. On the right are the reports: short tidbits of interesting information. The main page contains the search tools, the contact link, and links to versions of the site in other languages.

Members: This section contains basic information and contacts of all Network member institutions – educational institutions, government agencies, representatives of the World Health Organization and other institutions – organized by continent and country.

Courses: Display area for courses administered by member education institutions. The visitor has two search options: viewing results divided by region or by theme.

Publications: Section where you can find books, manuals and scientific journals of interest to health technicians, among other things.

Didactic Material: Here you will find materials that contribute to the training of health technicians, available in electronic versions or via traditional postal mail upon request.

Legislation: Compilation of the laws governing education and health in each Network member institution country.

Events: Information regarding assemblies, seminars and meetings related to health, education and employment, with a special focus on the events held by Network members.

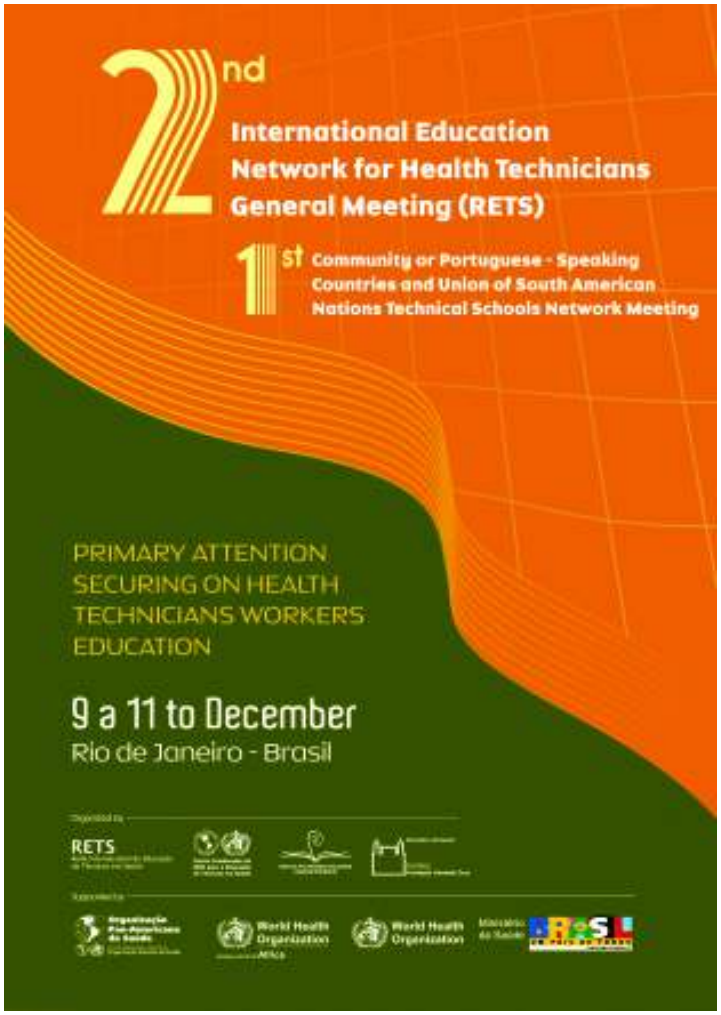
Links: List of interesting web pages within the realm of health, education and technician education and similar areas.

RSS is the English acronym for Rich Site Summary or Really Simple Syndication, a simplified way of presenting the content of a site. It is a feature that allows the user, via some browsers or specific programs, to access website and blog updates. By using RSS, the reader knows immediately when a notice of interest is published, without having to navigate to the news site. To use the tool, the user must click on the RSS icon on the site and add it to his or her feeder list.

2nd RETS General Meeting:

Event to strengthen cooperation strategies

The date for the 2nd RETS General Meeting has already been set and will occur simultaneously with the 1st Meeting of Technical Schools Subnetworks of the Community of Portuguese-Speaking Countries (CPLP) and the Union of South American Nations (Unasul), December 9-11, in Rio de Janeiro, Brazil. The first general meeting took place in 2006 during the International Forum for Health Technician Education, which mobilized approximately 70 representatives of various institutions linked to the network. "At that time, the RETS regulation and work plan for the period 2006-2008 was agreed upon," says the Coordinator of International Cooperation of the Escola Politécnica de Saúde Joaquim Venâncio (EPSJV/Fiocruz) and Executive Secretary of RETS, Anamaria Corbo.



With the theme "Consolidating the primary care in the training of health technician workers," the event will bring together representatives of RETS member institutions, national leaders responsible for health technician education policies and members of the Observatories of Human Resources of the Americas and Africa to discuss new ways to strengthen the strategies of cooperation within the Network.

"This second meeting, in addition to defining the Network Work Plan for 2010-2012, aims to define more operational processes that contribute to the consolidation of the area of health technician education in member countries, with the central point of discussion being vocational training in light of the precepts of the primary care model," explains Anamaria. The importance of this approach, she claims, is the need for the Network to contribute to the recovery of the ambitious prospect of primary care as the reorientation principle of health systems, based on the principle of rights and health and universal access to quality health care.

At the meeting, to be held at EPSJV/Fiocruz, discussion will also take place regarding ways to collaborate for the structuring of the technicians field in the Observatories of Health Human Resources and to strengthen the research among RETS institutions. In addition, participants will be divided into two groups: one that will prepare the Unasul subnetwork work plan, and another that discusses the operationalization of the CPLP subnetwork work plan.

Registration is free and those interested in participating should complete the form available on the RETS website (http://www.rets.epsjv.fiocruz.br).

2nd RETS General Meeting
1st Meeting of CPLP and Unasul Technical School Subnetworks
Date: December 9-11, 2009.
Place: Escola Politécnica de Saúde Joaquim Venâncio (EPSJV/Fiocruz)
Address: Av. Brasil, 4365 - Manguinhos - Rio de Janeiro - RJ - 21040-360.
Phone: +55 (21) 3865-9730
E-mail: cci@epsjv.fiocruz.br

Correction

On page 11 of the Portuguese printed edition of the RETS Journal No. 2, we erred by saying that "In Brazil, the technician is a mid-level professional, with post-secondary education (12 years of formal schooling), and the course has a minimum duration of 1,200 hours." The correct information is: "In Brazil, the technical course, whose duration is 1,200 hours, must be linked to high school, and may be achieved "concurrently" or "integrally," by students who have completed primary school (9 years of formal education) or "subsequently" for students who have completed high school (12 years of formal education). The technician is a mid-level professional."

Migration of the labor force definitively enters the global health agenda

The labor force is key to strengthening health systems and the success of national initiatives in meeting the Millennium Development Goals (MDGs). Because of this, many countries have been working hard to train professionals in quantity and with the qualities necessary to meet the health needs of its population. The effort, however, does not always give results due to, among other things, the migration of workers in the sector to other countries that offer more attractive working and living conditions.

In other countries, the issue of healthcare worker migration occurs internally and the great difficulty is to keep these professionals in the remote zones and rural areas where they generally are most needed.

These situations are but complementary aspects of the same complex, multidimensional challenge faced by local, national, regional and global healthcare authorities and managers. The task, however, is not simple: the number of migrant health workers has been growing exponentially in recent decades and the migratory models have become increasingly complex and involve more and more countries.

In African countries, for example, the phenomenon has reached the crisis level, according to doctor and Development of Health Human Resources of the Afro/WHO Advisor Magda Awas in the article "Migration of skilled health professionals in the African Region: An overview."* The biggest problem, according to the text, is that in some sub-Saharan African countries, the deficit of the health workforce is accentuated by a very high incidence of HIV/AIDS, tuberculosis and malaria among the population. The World Health Organization (WHO) estimates that it would take more than 800,000 workers – more than 130% of the current amount – to produce a workforce able to take care of the basic needs of the inhabitants of the region.

Mario Roberto Dal Poz, Coordinator of the Department of Health Human Resources of the WHO and Chief Editor of the journal Human Resources for Health, does not think it possible, however, to treat the migration of health workers simply as a problem to be tackled.

"First of all, you cannot stop migration, which is a human right. Everyone should have the right to seek better living conditions, to move freely from one region to another. No government can force someone to stay in a given place against his or her will. It is possible, however, to try to manage it by adopting policies that maximize benefits and reduce the negative effects that such migratory movements can bring," he explains.

Little information exacerbates ignorance about the subject

According to the 2006 World Health Report,* although the matter of migration of health workers has been brought to the global health agenda in recent years, there are still few reliable statistics on the issue. In the few countries that accompany migratory movements, the available information is, as stated in the report, usually limited to doctors and nursing personnel, with information about the movement of other professional groups being virtually nonexistent. "Ignorance about how many health workers are moving, where they come from and where they are going, makes it difficult to understand the size of the problem," says the report

In some OECD countries such as Australia, Canada, New Zealand, the UK and the USA, over 20% of doctors in the profession are trained in other countries. On the other hand, doctors trained in sub-Saharan Africa working in OECD countries represent on average 23% of the current workforce of doctors in their countries of origin. This means, for example, that there are more than 12,000 South African doctors working abroad while little more than 32,000 working in South Africa. The situation does not change much when it comes to nurses and midwives, whose contingent working in OECD countries represents about 5% of the current workforce of their countries.

The report, however, calls attention to the fact that the OECD data are not able to account for the complex patterns and reasons for the movement of health workers. "We need to expand knowledge on migration with data and information about flows

The Organization for Economic Cooperation and Development (OECD), established in 1961, is an international intergovernmental organization comprised of the 30 most industrialized countries in the world. Its goal is to promote policies that ensure sustainable economic growth and development of member countries.

and trends which involve the demographic characteristics of the migrants and the impact of migration on health services," adds Dal Poz.

What repels and what attracts workers?

For the specialist, the first question that must be asked when thinking about this issue is: Why do health professionals migrate? "They migrate for the same reasons other workers do: better jobs and better living conditions. No one migrates for the sake of migrating. Sometimes migration is a government policy. Sometimes people migrate because they do not have jobs in their home countries, because of wars, political persecution and even climate problems," Dal Poz affirms, adding, "People migrate in search of the security not found in their own countries."

According to him, the picture is more or less similar when it comes to internal migration from the countryside to the cities. "If the person does not have a home and there is no school for his or her children, he or she goes to where there are more opportunities, that is, to the more developed areas. "

Among the factors that encourage worker migration, Dal Poz highlights the trade and services agreements – in English: General Agreement on Tariffs and Trade, GATT – which contribute to the removal or reduction of barriers to the flow of labor between countries. "In healthcare, nursing has occupied a prominent position in the international agenda, due to the reduction of staff in core countries, particularly in Canada, the United Kingdom and the United States. The weaknesses of these countries, caused in part by the rapid aging of their populations, are increasingly being met with professionals from the developing world," he argues, noting that there is already a global market for certain categories of professionals, as verified by uniform education standards. "The curricula of nursing schools in the Philippines and South Africa, for example, are based on the curricula of nursing schools in the United Kingdom, which eliminates the need for nurses who come from these countries to take professional qualification examinations," he adds.

Another reflection of this scenario is the proliferation of medical recruitment agencies that end up stimulating the migration of health workers from low-income countries. According to the WHO, a 2004 study found that these agencies have stimulated the majority of the recruitment from Cameroon and a survey of nearly 400 migrant nurses in London confirmed that nearly two-thirds of them were recruited to work in Great Britain by agencies.

2nd Regional Meeting on Migration of Health Human Resources discusses outlook in the Americas

Gathering representatives of the Iberian-American countries to deepen the dialogue on migratory phenomena, establishing measures necessary for a systemic and integrated approach among the actors involved in the process: That was the objective of the 2nd Regional Meeting on Migration of Health Human Resources, held on June 1st and 2nd of this year in Uruguay. The event provided continuity to discussions on many other initiatives, including the Andean Reunion – Migration of Health Professionals, held in March in Peru, with support from the Pan American Health Organization (PAHO/WHO).

Some general facts presented during the event:

- Latin America and the Caribbean: The principal receiving countries of the region's workers are Chile, the USA, Canada, Spain and Portugal; the most important temporary migratory flows are from Cuba to Venezuela and Uruguay, and from Uruguay to Tahiti; there is massive recruitment of nursing personnel, and some countries also experience a migration of doctors.
- Argentina: Almost 90% of nurses who migrate to the country are from Latin America, which coincides with the migration flows of the population in general; 41% of nurses come from border countries and 21% from Peru; almost 40% of nurses who migrated to Argentina send money to their country of origin.
- Brazil: The country has a surplus of skilled human resources and, paradoxically, a deficit of professionals in some areas; limitations of the production system to employ qualified resources and diminished ability to provide professional stimulus packages; even in the face of language barriers that limit the mobility of professionals, Brazil is a potential exporter of health professionals.
- Paraguay: Migration is primarily of nursing staff (about 400 over a period of two years) in the direction of Spain, Italy and the USA.
- Chile: More than 30% of the 10,000 doctors working in Primary Care hail from other countries; of the approximately 1,300 foreign doctors who work in the APS, more than 950 are Ecuadorians, 135 come from Colombia, and 60 are from Cuba.
- Peru: The deficit in the health workforce in the country – more than 6,000 doctors, 7,000 nurses, 4,000 obstetricians, and 2,000 dentists – is similar to that found in sub-Saharan Africa; in 2006/2007 alone, 541 Peruvian doctors migrated to Spain, representing a loss of almost US$300,000 in investments in their training.
- Uruguay: Roughly 15% of the population lives abroad; the emigration represents an economic strategy for survival among young people, especially those of higher education levels; in many cases there are plans to return to the country after a period abroad; Spain and Chile are the primary destinations of the migrants.

The consequences of health worker migration

In some ways, as the WHO sets forth in its report, the movement abroad of health workers can save the economy of some countries. Each year, the report said, billions of dollars are sent by migrants to their country of origin. Because of this, migration may be associated with the decline of poverty in low-income countries. "There are countries where a third of the revenue comes from these migrant remittances," adds Dal Poz, recalling that this is one of the reasons why the Philippines decided to train nurses for the international market. Another aspect that can be considered "positive" is that if health workers return home, they bring skills and expertise of great importance to their country of origin.

Although it may have some positive aspects, there is also a very grave side to health worker migration. On the African continent, some of the worst consequences are: the exacerbation of access and equitable distribution of health care in rural areas, the increase in workload for workers who remain in the country, resulting in stress and absenteeism, and the provision of services by increasingly less-qualified personnel. "The effect is more devastating in small countries, where the loss of a cardiologist may result in the closure of a ward or cardiology clinic," stresses Awases Magda.

Moreover, when a large number of professionals leave a country, there is a significant loss of investments made in their training which, especially in developing countries, come from public resources. In a way, it is as if the poorest countries subsidized the training of professionals who will work in richer countries. "It is estimated that, while Ghana has lost about £ 35 million of its investment in training of healthcare professionals, the United Kingdom saved, since 1998, more than £ 65 million in training costs due to recruitment from Ghana."

The financial loss, however, is not the most damaging result, according to the WHO. "When a country has a fragile health system, the loss of its workforce can make the system as a whole approach near-collapse, and the consequences can be measured in lives lost. In these circumstances, the calculation of international migration shifts from disposal or acquisition of brains to "fatal flows," the report highlights.

"The most vulnerable countries are those with most to lose when workers migrate. For some countries, like Ethiopia, which graduates about 300 doctors a year, the migration of 150 of them causes an enormous impact. If 3,000 graduated, however, the consequences would be less. The issue is that those countries lose precisely their best professionals, those with better prospects of obtaining a job abroad. Thus the possibilities of meeting the health needs of their population are shrunk," adds Dal Poz.

Managing migration: increasing benefits and reducing damages

According to the WHO, the complex combination of worker, workplace and market forces that generate flows of health workers defies any simple or unique action related to migration. The idea is to develop several migration management initiatives that simultaneously protect the health workers and minimize inequalities and the negative impact that migratory movements have on the most vulnerable countries.

Managing the migration of health workers involves, as reiterated by Dal Poz, the "balance among individual freedoms, of those who go in search of better working and living conditions, and the need to prevent excessive losses to the countries, regarding internal migration – urban concentration and rural abandonment – as well as international flows from poorer to richer countries.

The WHO signals several strategies for managing migration, classifying them into: strategies for the country of origin; strategies for the receiving country; and international instruments.

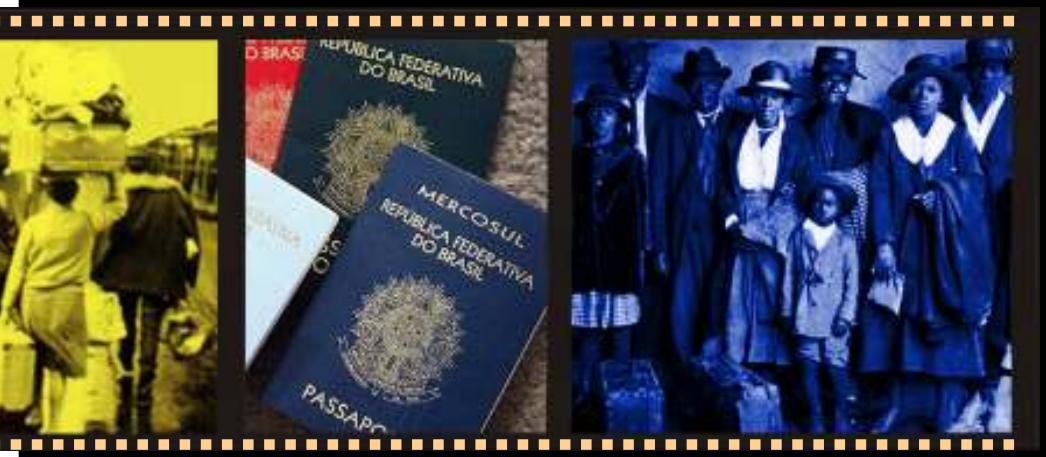
For countries of origin, migration management involves training directed to the local conditions and needs; improved working conditions; and measures to stimulate the return of migrants after a period of work in another country.

It is incumbent upon the receiving countries to be concerned about the rights and welfare of migrant health workers and to take responsibility for the negative consequences of recruitment of these professionals from their countries of origin, especially when it comes to countries that already have severe deficits in the workforce. Furthermore, global authorities recommend that the receiving countries lend more support to countries lacking in health professionals, sending workers who can serve in the most affected areas.

Finally, it is up to the national authorities, professional associations and international agencies to discuss development of ethical policies of international recruitment, codes of practice and guidelines that, although having no legal value, may establish important bilateral or global agreements regarding the international recruitment of health workers. The question is whether these standards would have enough influence to change current conditions.

The idea of creating a code of practice for international recruitment of health personnel has been widely discussed by the WHO in a process that began in 2004 (see box), and that according to Dal Poz faces numerous difficulties: "The problem is that there is no consensus. Some countries are against it because they depend on the importation of skilled labor. The USA, for example, has a quota for nurses, Canada imports nurses and doctors, and there are countries in the Middle East which do not train professionals in sufficient numbers. The idea of the code is to establish ethical principles of recruitment, such as 'not actively seeking workers from countries where the deficit of the workforce is already a problem,' which may or may not be adhered to."

As to the effectiveness of the code under development, the researcher is emphatic: "The code does not solve the problems, it merely creates some ethical principles that different recruiters should follow. It isn't magic. Simply having a code will not solve the problems; established principles must be followed."



The strategies proposed by the WHO are already being applied by several countries struggling to reduce the migration of its health workers. In the opinion of Magda Awases, however, the future is not promising, since the developed countries continue to need workers from developing countries. "The challenge for African countries is to overcome the macroeconomic, social and political issues that may affect the strategies and initiatives implemented to retard the migration and mitigate its adverse effects. They, however, cannot act alone since they find themselves a part of a global economy, strongly influenced by countries that are also the major recruiters. It is those countries that must act so that the global chain of healthcare becomes less unequal," he concludes.

***Additional reading:**

- World Health Report (OMS, 2006). Available at: http://www.who.int/whr/2006/en
- 'Migration of skilled health professionals in the African Region: An overview', by Magda Awases (African Health Monitor, janeiro-junho 2007). Available at: http://www.afro.who.int/press/periodicals/healthmonitor/jan-jun2007.pdf
- 'Does a code make a difference – assessing the English code of practice on international recruitment', by Buchan et al. Available at: http://www.human-resources-health.com/content/7/1/33
- 'The Kampala Declaration and Agenda for Global Action: Health Workers for All and All for Health'
- Workers' (1st Global Conference on Health Human Resources, Kampala, March,2008). Available at: http://www.who.int/workforcealliance/forum/2_declaration_final.pdf
- Practice code for the international recruitment of healthcare personnel (OMS, 2009). Available at: http://apps.who.int/gb/ebwha/pdf_files/EB124/B124_13-en.pdf

Practice Code for the International Recruitment of Healthcare Personnel

The need to increase control over the matter of migration of health professionals, which mainly affects the poorer countries, led the 57th World Health Assembly (WHA) to publish a resolution in 2004 requesting the establishment of a code that regulates the international recruitment of health workers.

On September 1, 2008, the WHO Secretariat published the first draft of the Code for consideration and comments by Member States and other interested parties. It then held a public consultation, through the WEB, which resulted in a second version of the document, presented at the 124th Meeting of the WHO Executive Council Board in January of this year, before being brought to the 62nd WHA in May.

The document consists of 11 articles and aims to: establish and promote voluntary principles, models and practices for the international recruitment of health personnel; serve as a reference tool for the establishment or improvement by the Member States of national legislation, bilateral agreements and other legal instruments; stimulate international discussion and advanced cooperation on issues related to the recruitment of health personnel.

Among its principles (Article 3), the Code states that international recruitment must be conducted with transparency and fairness while seeking mutual benefits. Moreover, it urges Member States to promote equal rights for migrant workers and develop training programs that take account of their health personnel needs, reducing the need for the importation of workers.

Education of Health Technicians · part 1

The mantra of the RETS constitution of is "education of health technicians." But what exactly does that mean? Who are the health technicians we are referring to when we use the word education?

As we saw in last issue, although the term "health technician" has several meanings, as it is used to describe a range of professionals with quite diversified levels of education, training and functions, it is possible, albeit with some effort, to identify them in different situations.

The other difficulty relates to the polysemy of the word "education," which can have as many meanings as there are partnership projects and, therefore, the concepts of education and work and the relationship between these two fields.

Education and work in close relationship

In Brazil, the "education of health technicians" is part of "professional education," defined in Law No. 9.394 of 1996 – Law of Education Guidelines and Foundations – as the educational process, developed in schools or in workplaces, which allows the individual to acquire and develop theoretical, technical and operational knowledge related to the production of goods and services. In this sense, health professional education includes both the initial and continuous training which takes place in health services or educational institutions, as well as mid-level technical training and the higher technological training which take place exclusively in training institutions. More specifically, the "education of health technicians" refers to the training of mid-level professionals in technical courses of at least 1,200 hours, concurrent or integrated with high school education, for those who have completed primary school (9 years of formal education), or afterwards, for those who have completed high school (12 years of formal education).

In some other contexts, however, the idea of professional education is used only to refer to top-level university training, as highlighted by Giovanni Guzmán Escalante and Manuel Nuñez Vergara in the article entitled "Issue of training health technician assistants in Peru."* According to them, in interviews with parties linked to Higher Technological Institutes (HTIs) who are responsible for training of technicians in the country, the "confusion in terms" is palpable: Many of the interviewees state that only those who graduated from universities can be called health professionals. In Peru, as in other Latin American countries, the technical courses are high-level but non-university.

Nevertheless, for the authors the definitions used by the International Labor Organization (ILO) make it perfectly feasible to use the term "professional education" to refer to the education of health technicians. "According to the ILO, the term profession means dedication to a craft, art or scientific discipline," they explain. "It is worth mentioning that the ILO has defined the concept of 'professional competence' as the ability to perform a task or carry out a work position effectively due to having the qualifications required for it."

More or less integrated into regular education in designs that mitigate or accentuate the supposed dichotomy between thinking and acting, technical-vocational education have undergone numerous changes and appear with distinct nuances, often quite subtle, according to the historical context into which it is inserted.

In the case of healthcare, according to Isabel Brasil, current Director of the Escola Politécnica de Saúde Joaquim Venâncio (EPSJV/Fiocruz), and Júlio César França Lima, in the 2nd edition of the Dictionary of Health Professional Education,* there continue to be ideas and practices that seek to adapt and conform workers to existing reality, to the labor market and to capital needs, even when there are counter-hegemonic initiatives that aim to train professionals who will be capable of collaborating in the building of a fairer and more solidary society. "These experiences take place in the historical and social background of late capitalism, a contradictory and complex background in which progressive positions which defend and reaffirm healthcare as a universal right confront the reality of the recent iteration of capitalism in our country [Brazil], which tends to package health as a commodity," they affirm

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Work training in history

In ancient Greece, intellectual functions were considered incompatible with any kind of work involving the body. Labor, defined by Hannah Arendt ("The Human Condition," 1983) as the body's effort to provide sustenance, was basically performed by slaves, and physical effort caused by work was seen as restrictive to freedom of thought. In the feudal world, the training of artisans and peasants continued to occur during the exercise of one's profession, preserving the schools for the intellectual training of the clergy and nobility. In both cases, professional training occurred in the very process of working and the worker did not have access to socially produced scientific knowledge.

With the rise of the bourgeoisie, the advent of capitalism and the Industrial Revolution, great changes occurred in this scenario: The issue of employment arises; new divisions and functions are

introduced into the social hierarchy of work; the factory is reinforced as a place of production; and school begins to take shape as a place for the transmission of the knowledge necessary to the exercise of those functions, reflecting the existing power relationships in the society that are expressed, for example, in the definition of the content to be transmitted and the knowledge required of workers. The idea of exploitation of labor as a means of accumulating wealth, does not translate into recognition of the value of the worker, whose production is expropriated by the bourgeoisie. In the schools for the masses, two dimensions take on equal importance: instruction, and time control with the use of the body to work at the factory. The bourgeoisie, in turn, are subjected to schooling models leaning toward a more solid training based on socialization of the socially produced scientific knowledge.

The introduction of the idea of "childhood" with its own time and statutes, unites the bourgeoisie and working class around the idea of separation between school and work, although for different reasons and with different objectives, according to Marx: the bourgeoisie want their children to become trained in business management, and workers believe that their children might become something more than common laborers. "Antagonistic plans, thus, in conflict maintaining the contradictory relationship between working and training, on one hand realized in school models espoused by liberal society, on the other hand inserted into the prospect of building a socialist society by revolutionary movements," says Marlene Ribeiro in "Work-based training: elements of a curriculum for adult and youth education."*

The relationship between work and training/education is strongly defined by the paradigm of society that supports this relationship. Therefore, it is clear to Marlene that in a capitalist society – focused on the individual and in which work is heteronymous and the market is extremely competitive – it is only possible to establish a training process based on solidarity, autonomy and cooperation, the contradictions of which, if explored, would among other things establish the capitalist mode of production and relations which permeate social institutions such as schools.

heteronymous: subject to a foreign law or the will of another person.

Education and its many meanings

The purpose of education, the meaning of knowledge, and the theories and practices utilized in the education process vary as widely as do the concepts of the world in which they operate. Historically, a dispute has been waged on the nature of education: humanistic for some, as the main door of access to the values and culture of an era, and economic for others, as what makes it possible to replicate the labor force necessary to maintain the production system.

In the midst of this dispute, there are many pedagogical currents, classified by the Brazilian educator Demerval Saviani as critics and non-critics.

The critics, as explained by Marise Ramos in the research report "Health Professional Education in Brazil: concepts and practices in the National Health System Technical Schools," are those who interpret education as "an ethico-political mediation of human training which enables the understanding of reality and empowers its subjects to action to overcome the exploitation and alienation of workers, transforming it into a benefit of human emancipation." The non-critics, in turn, are those who "consider reality as a natural and stable fact, about which the human being develops a representation that helps him to adapt to it."

According to the report, as will be seen further in the next edition of the magazine, Paulo Freire's pedagogy is an example of the critical current, while the theories of traditional pedagogy, technicality, pragmatism and even pedagogy of competencies (see page 2) serve to illustrate the non-critical current.

***Additional reading:**

• "Health Professional Education," by Isabel Brasil and Júlio César França Lima, in the 2d edition of the Dictionary of Health Professional Education (Rio de Janeiro. EPSJV, 2009). Available at: http://www.epsjv.fiocruz.br/index.php?Area=Material&Tipo=8&Num=43

• "Issue of training health technician assistants in Peru," by Giovanni Escalante Guzmán and Manuel Nuñez Vergara. Available at: http://www.rets.epsjv.fiocruz.br//home.php?Area=Noticia&Num=48

• "Health Professional Education in Brazil: concepts and practices in the National Health System Technical Schools" – Research Report, by Marise Ramos, Aline Buy, Ana Paula Blengini and Jonas Emanuel, available soon on the RETS website.

• "Work-based training: elements of a curriculum for adult and youth education," by Marlene Ribeiro (Anped, 25ª Reunião Anual, 2002, GT 09), available at: http://www.anped.org.br/reunioes/25/excedentes25/marleneribeirot09.rtf

Chaco 'Tekove Katu' School of Health

Last May 1st, the Pan American Health Organization (PAHO/WHO), through its representative in Bolivia, conferred the Model School Certificate upon the Chaco 'Tekove Katu' School of Health. To honor the dedication of the Bolivian School to the training of health personnel from indigenous communities and the social relevance of their health and pedagogical orientation, the PAHO officially recognized the result of a project that began in 1985 and has a long history, which is closely linked to the Guarani struggle for their rights.

In Guarani: full life; complete physical, mental, social and spiritual development.

"The minimum for everyone"

In the 70's, popular movements which inspired, among other things, the Declaration of Alma-Ata in 1978, also helped in the organization of the Guarani. During this time, to chart in detail the reality in which the native population lived, the Cordillera Province Diagnostic began, one of five which comprise the *Chaco Boliviano*.

The community held several meetings to discuss the results of the diagnosis which strengthened the idea of gathering all the Guarani in the search for solutions to the major problems identified in five sectors considered fundamental – Production, Infrastructure, Health, Education and Land-Territory, combined to form the acronym "Piset" – and which resulted in the creation of the Assembly of the Guarani (APG) in Bolivia in February of 1987.

At that time, according to Professor Aurelio Mèndez Candapuri who is responsible for Tekove Katu, one of the priorities identified was the training of workers for different sectors of Piset, a task undertaken by various institutions. "The Chaco 'Tekove Katu' School of Health was born to support the training of people from indigenous communities, particularly the inhabitants of the Bolivian East and of the Argentine and Paraguayan Chacos, in the health field. The goal was to train professionals who could meet the needs of communities, joining the classical view of medicine with the traditional, respecting local customs and practices, and that with knowledge of reality, of life and of the native language, to become agents of necessary change," Aurélio recounts.

Church and State: a partnership to face hardships

The achievement of the ideals of Alma-Ata as regards the health arena was hampered by numerous obstacles. In the fight for their rights, the Guarani communities in the region received the support of the Church, which according to Aurelius was his option of preference the Guarani and other indigenous peoples of the territory. "This is not about 'interference' because the Church seeks to assist the Guarani that they may recover and develop their own spirituality and religiosity," Aurelio asserts. "The fundamental concern of the Church is human promotion. The path of the Church and the people coincide in reaching for the same goals," he justifies.

In 1989, the International Labor Organization (ILO) adopted Convention 169 on indigenous and tribal populations, which states the obligation of governments to "make available to the indigenous peoples the necessary means to enable them to organize and provide health services under their own responsibility and control." In response to the hardships faced by the Bolivian State in complying with the determination, ratified in 1991 by Art. 25 of Law 1257, an agreement was signed between the Ministry of Health and the Vicariate of Cueva, coordinated by Pe. Tarcisio Dino Cibatti.

The APG, created on February 7, 1987, definitively entered the Bolivian scene on January 28, 1992, when it organized a national event to commemorate the 500 years of American invasion and honor the approximately 3,000 natives who had died 100 years prior, at the battle of Kuruyuki. Currently, the APG boasts more than 80,000 members from the more than 300 Bolivian Guarani communities.

Source: http://www.cidob-bo.org/regionales/apg.htm

Production: basic food for all and development that rationally utilizes existing community resources.
Infrastructure: basic services, schools, clinics, housing and roads that allow for the displacement between communities and urban centers.
Health: implementation of health programs in Guarani communities and harmonization of traditional medicine with Western medicine to improve services.
Education: intercultural and bilingual model (native language and Spanish), with the incorporation of elements for the analysis of regional history, the protection of the environment and intercultural participation.
Land-Territory: demarcation and titling of territories, a basic condition for the survival and development of the Guarani people.

Source: http://www.cidob-bo.org/regionales/apg.htm

According to Aurelio, the agreement, whose goal was to respond to the health needs of native peoples through training and qualification of appropriate personnel, to implement and strengthen health services according to their culture and to encourage scientific research, was executed to compensate for a State deficiency but, on the other hand, required that the State meet the demands of the people.

Training a modern Ipaye

"The teaching method can destroy or enhance the self-confidence and strength of the community," said North American biologist and educator David Werner in a motto that serves as an inspiration to those working in the Tekove Katu School.

The Tekove Katu School's objective is to train a modern Ipaye, capable of directing people to the point of departure for whole health and who works for natives to have access to health services with intercultural participation, knowledge and respect for traditional medicine.

Guarani word for the shaman, the healer; he who uses elements of traditional medicine to heal, to restore the health of community members.

La interculturalidad está considerada por la constitución boliviana como instrumento de cohesión y de convivencia armónica y equilibrada entre todos los pueblos que constituyen Bolivia, definida como un Estado Unitario Social de Derecho Plurinacional Comunitario.

To enroll in any of the Tekove Katu courses – training of nurses, nutritionists, clinical laboratory technicians, technicians in environmental health, nutrition and hygiene, all with complementary health education – the candidates must, among other things, be at least 18 and a maximum 25 years of age; have studied for at least eight years of compulsory education; be elected in the Communal Assembly; have good conduct and discipline in his community; be a volunteer and be aware of what it means to respect professors and colleagues; know and speak his native language; identify with his people, his culture and their indigenous Organization; be willing to work in his community or wherever the Organization needs him.

The courses are modular and of four years in duration, mixing periods of live presence with community practice and service. The whole process revolves around a boarding school modality, with academic activities during the day and part of the night. The planning of each module is the responsibility of the professor and should be based on three basic guidelines: the teaching should utilize Popular Education processes; classroom activities should be closely related to the reality of indigenous communities themselves; and the spirit of coexistence in the teaching-learning process should be indigenous, according to the way of the Guarani ("Nandereko").

Tekove Katu: policy, education and health

Having trained over 600 professionals as healthcare workers, as well as collaborated in other activities established in the Ministry of Health-Vicariate Agreement, the Chaco 'Tekove Katu' School of Health plays an important political, educational and social role in what constitutes "indigenous" Primary Health Care, which allows the National Health System greater cultural appropriateness.

"From a political point of view, it's a State school that seeks to strengthen the vision of whole health in which the health teams include more than just doctors and paramedics and does not exist only to heal the sick. We seek answers to basic needs that directly affect health and therefore advocate that the team should include technicians in health, nutrition, service facilitators, among others, focusing on prevention according to established goals and the principles of Alma-Ata," Aurelius highlights.

In the area of education, the professor points out that all professionals who graduate from the School are bilingual health educators and identify with their own culture, something essential for a population which lacks health education and has difficulties changing hygiene habits, for example. But that's not all. "For many years, the School has promoted the use of the School Health Passbook, institutionalized by the Ministry in 2005. The use of this document, which gives continuity to the Child Health Passbook and accompanies the child in the eight years of compulsory school, involves authorities, parents, teachers and health personnel, is very important in truancy control," he adds.

Finally, he emphasizes the incorporation of new professionals for health services, collaborating so that the national system reaches its goal of strengthening Primary Health Care and expanding the scope of coverage.

***Additional reading:**

Yasarekomo: An indigenous communcation experience in Bolivia (FAO, 2004): http://www.fao.org/docrep/006/y5311s/y5311s00.HTM

Health Technician Schools is a Pecs priority

Strengthening the healthcare systems of Member States of the Community of Portuguese-Speaking Countries (CPLP) to ensure universal access to quality healthcare is the central objective of the Strategic Plan for Cooperation in Health (Pecs 2009-2012), approved on May 15 in Estoril, Portugal, during the 2nd Meeting of Health Ministries of the CPLP.

CPLP: Angola, Brazil, Cape Verde, Guinea Bissau, Mozambique, Portugal, Sao Tome and Principe and East Timor.

Also in the meeting, a sector fund was created that will give financial support to cooperation activities, by contributions from Member States and international organizations, public and private.

The Pecs approval represents a collective commitment of strategic cooperation in the health sector and a milestone in a process officially begun in April of 2008, during the First Meeting of Health Ministries of the CPLP, held in Praia, capital of Cape Verde.

"In fact, the idea arose at a meeting of the then-President of the Oswaldo Cruz Foundation (Fiocruz), Paulo Buss, with the Director of the Institute of Hygiene and Tropical Medicine of Portugal (IHMT), Jorge Torgal, and with the Ambassador of Cape Verde, Luis Matos Fonseca who was at that time Executive Secretary of CPLP. Paulo Buss then asked the Directors of Strategic Planning (Diplan) of Fiocruz to develop an initial proposal for the plan which would be presented to ministries at the meeting in Cape Verde," says Julio Felix Rosenberg, Director of Diplan/Fiocruz.

Process involves political will and technical commitment

In Cidade da Praia, the guiding principles were defined for the project members of Pecs including, among others: the adoption of the Millennium Development Goals (MDGs); the respect for and defense of the principles of ownership, harmonization, alignment, management for results and accountability; the use of the National Health Plans for the setting of priorities for cooperation; and the reduction of quantitative and qualitative deficits of health human resources (RHS) in the Member States of the CPLP.

Regarding these principles, the Declaration of Accra, signed in July 2007, during the 9th Ordinary Session of the Assembly of the African Union says:

- Partner countries should exercise effective leadership over their development policies and strategies (ownership).
- Donors should base their cooperation on the development strategies of the partners and their local systems (alignment).
- Donors should coordinate their activities and minimize costs related to support (alignment).
- Partner countries and donors should orient their activities with the goal of achieving the desired results (managing for results).
- Donors and partner countries are mutually accountable for the results of better management of the cooperation (mutual benefit of all).

Source: Pecs/CPLP, May/2009

"Commissions on the focal points for development of the Plan were created. Fiocruz, represented by me, and IHMT, represented by Paulo Ferrinho, were responsible for the technical evaluation of the process, paving the way for Pecs," explains Felix Rosemberg.

Health care experts appointed by the Ministries of Health of Member States of the CPLP.

In July of 2008, after having established a proposal for the Structural Formulation of the Plan, the strategy for identification of priorities for cooperation was defined. At this stage, around August and September, it was IHMT's job to perform missions in Angola, Cape Verde and Guinea-Bissau, with Fiocruz responsible for consulting in Mozambique and Sao Tome and Principe, in addition to East Timor.

Also in September, in Rio de Janeiro, Brazil, the Technical Group, with support from Technical Assistance, discussed the priorities identified, approving the Founding Document of Pecs. In March of this year, another meeting was held for the discussion projects related to the Founding Document, to be examined and formally approved by ministries at the Estoril meeting.

Training the health workforce: strategic axis

Based on the guidelines and information provided by the countries, seven strategic axes of action were established, in which roughly 20 projects were defined, nine of which were considered priorities.

In Axis 1 (see box), one of the four

projects of high priority is the structuring of the Health Technician Schools Network of the CPLP, which will be coordinated by Fiocruz, through the Escola Politécnica de Saúde Joaquim Venâncio (EPSJV/Fiocruz) and which involves teacher training as well as advice for the formulation of politico-pedagogic projects, curriculum organization in priority areas and strengthening of the organizational structure.

"It is incumbent upon Fiocruz to coordinate four of the nine projects: the network of technician schools; the network of schools of public health, with particular focus on government schools; the public health research centers; and healthy communities. The IHMT will technically be in charge of three projects. The Observatories for Human Resources and Portal CPLP/Health will be in charge, respectively, of the World Health Organization (WHO) and the Executive Secretary of CPLP," recalls Félix Rosemberg, who also highlighted the performance of Fiocruz in politically mobilizing the process and the importance of Pecs for all involved.

According to him, Pecs is completely in agreement with Brazilian governmental policy, which it considers vital to the South-South International Technical Cooperation, mainly with Africa, particularly with Portuguese-speaking countries, and with Latin America, with priority for the Mercosur countries.

"South-South Cooperation is a different form of cooperation that is not based on the ideas of donor-recipient or of support and advice, but on the idea of an exchange in which everyone has something important to learn," he explains.

Context reinforces role of the Network of Technical Schools

In Portuguese-speaking Africa and in East Timor, the workforce in the health area is composed mainly of technical workers and assistants, often trained on the job. Living conditions, the epidemiological profile and the structure of national health systems require, however, the increasingly diversified provision of professional expertise.

The change in the current health picture of these countries requires expansion and improvement of primary care and strengthening of health surveillance which, in turn, depends on the training and permanent qualification of workers in the area.

All of the countries, nevertheless, continue to have trouble formulating policies and strategic plans for health human resources and the training of sector professionals. Overall, the five African countries and East Timor have, among other things, inadequate quantity and quality in the health workforce; poor management of personnel; and serious migration and retention problems with local workers.

Although Health Technician Schools (ETS) do exist in all CPLP countries, the reality widely differs among them. In Brazil and Portugal, these institutions train a wide range of professionals. In Cape Verde, Angola and Mozambique, courses in various specialties are now offered, many of which in technical cooperation with Portugal. In Guinea Bissau, Sao Tome and Principe and East Timor, however, training is much narrower, encompassing mainly the areas of nursing and laboratories.

A limited ability to develop politico-pedagogical projects and curricula tailored to the needs of health systems, shortage of qualified professors and problems with infrastructure, as well as a lack of laboratories, poor computer networks and restricted access to the Internet, are some of the factors that affect health technician training in the Portuguese-speaking African countries and in East Timor, causing shortages of professionals. Moreover, the lack of a coordinated system of technical training, the creation of courses to meet specific demands, strongly influenced by the availability of resources for international cooperation, and the lack of standardization of existing courses also negatively affect the quality of technical education in these countries

Before this framework and because of the structural character that the training schools for health technicians have under national health systems, the project of forming the Network of Health Technician Schools of the CPLP has become priority under Pecs.

Pecs: axés and priority projects

Axis 1. Training and development of the health workforce
- Project 1.1 – Creation of the Network Center for Health Human Resources in Health of the CPLP
- Project 1.5 – Structuring of the Network of Health Technician Schools of the CPLP
- Project 1.6 – Structuring of the Network of National Schools of Public Health of the CPLP
- Project 1.7 – Medical Training in Portuguese-speaking Countries

Axis 2. Information and communication in health
- Project 2.1 – Creation of Portal CPLP/Health

Axis 3. Health research
- Project 3.1 – Strengthening public health research in CPLP

Axis 4. Development of the productive health complex
- Project 4.2 – Technical Center Installation and Maintenance of Equipment (ctime)

Axis 5. Epidemiological surveillance and monitoring of the health situation
- Project 5.1 – Monitoring and evaluation of the Millennium Development Goals in CPLP

Axis 6. Emergencies and natural disasters

Axis 7. Health promotion and protection
- Project 7.1 – Healthy Communities: implementation of pilot projects in countries of the CPLP

Universal coverage: a skilled staff is essential

In its two previous issues, the RETS Journal addressed the importance that the 2008 World Health Report, "Primary Care: now more than ever," attributes to sector workers in the strengthening of Primary Health Care (APS) and the subsequent construction of stronger, more equitable national systems.

Starting with this edition, the goal will be to highlight what was said with respect to the health workforce in the reforms that the Report considers fundamental to improving the response of countries relative to primary care.

Equity in health: universal access is essential

In the report, the World Health Organization (WHO) emphasizes that the main causes of inequities in health arise from social conditions that are outside the direct control of Healthcare and, therefore, must be addressed in an inter-sectorial manner. For the WHO, however, it is incumbent upon the health sector to move toward universal coverage, adopting in its own context measures to promote equity in health. "While universal coverage does not guarantee health equity, it is one of the basic fundamentals," the Report insists.

"Differences in vulnerability and exposure to health risks added to the inequalities in health lead to unequal health outcomes which, in turn, contribute to social stratification reinforcement, the root of all inequalities," says the Report, pointing out that normative decisions in the area define health systems capable of exacerbating or minimizing the inequalities, and of mobilizing the government and society around the pro-equity agenda.

Moving toward universal coverage means working on three axes: gradually increasing its extent – proportion of population with access to healthcare; depth – number of basic services necessary to respond effectively to people's health; and level – increasing the fraction of healthcare costs covered by common funds and prepayment, with a reduction of direct payments by users. The manner in which countries will achieve this progress and the challenges to be faced heavily depend on specific national contexts.

Areas where there are no health services for the population and the infrastructure of basic healthcare needs to be built virtually from scratch, for example, pose a dilemma. Which is best: taking a gamble on the development of more or less immediate universal access to set of limited interventions, or gradually introducing more geographically restricted systems of more integrated primary care?

What to do when there are no qualified professionals?

According to the WHO, in the last 30 years a reasonable number of countries chose, based on the questionable concept of selective primary care, the option of making available a limited number of supposedly priority programs to everyone, achieved by a large number of workers with low-level technical training. Ethiopia, for example, employs about 30,000 agents for this task, giving positive emphasis to the fact that currently a large part of the agents is already benefiting from one year of post-secondary education.

The existence of poorly qualified staff, however, restricts the possibilities of assistance to a limited number of simple measures that in most cases do not meet the needs of the population. One of the many disadvantages of this option is to encourage the emergence of a large parallel healthcare market to meet the deficiencies of the official system. Moreover, the lack of supply of more comprehensive primary care tends to result in the deterioration of easily preventable situations, overloading the higher complexity levels and, consequently, considerably increasing the total costs of the system.

Stability and good training: more integrated systems

The option of gradually developing primary care, area to area, through a network of health centers with the necessary hospital support includes the priority interventions in a more integrated package of health care and has as its focal point the primary care center: professionalized infrastructure with problem-solving ability and the possibility of modular expansion of the range of activities.

To the WHO, the limiting factor of this option is the lack of stable frameworks of mid-level staff with the capacity to organize health districts and maintain, over the years, the effort required to achieve sustainable results for the whole population.

"In places where this type of expansion was conducted as only an administrative exercise, the results were disappointing," the Report warns. Success occurs, even when there are resource constraints, when the response balances supply and demand, and there is participation by the population and partners relative to the construction of robust networks of primary care.