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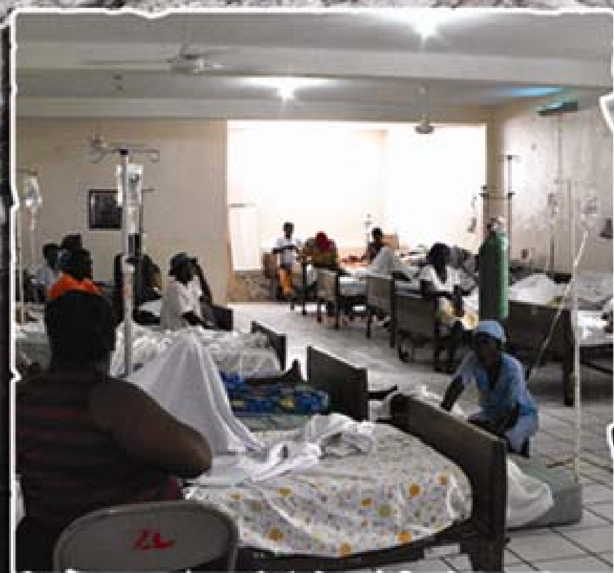
AFTER THE DISASTER, attention to health



editorial

In early 2010, two earthquakes of large magnitude hit countries in the Region. On January 12, a quake of just over 7.0 on the Richter scale practically destroyed the Haitian capital – Port au Prince – and the surrounding cities, killing over 220,000 people, displacing nearly 1.5 million residents and razing the already troubled health system. Forty-five days later, on February 27, it was Chile´s turn. Hit by a tremor of 8.8 degrees, the country accounted for slightly more than 500 deaths. The temporal proximity of the two events, whose consequences were completely different, was the starting point for a large international reflection on the importance of building well-structured and physically safe national health systems.

"International Cooperation in rebuilding Haiti's health system and the importance that the training of health technical workers is having that process" – that is the focus of issue No. 7 of the RETS Magazine, whose cover story also addresses the issues of Safe Hospitals and of timely and reliable information in times of crisis, in addition to showing the important work that Via Campesina is carrying out in Haiti.

In the "Glossary" section, the discussion is about "Health Surveillance" and how this concept is being consolidated in many countries. What changes does this bring to health systems and to what extent it defines new professional profiles? How should we consider training workers for the area?

The magazine also introduces the first of a series of texts that seek to bring to the RETS issues discussed at the Online Forum on Health Technicians – "Mid-level Health Workers" – conducted by the Global Health Workforce Alliance (GHWA) in May this year.

The news is the creation of RETS Twitter (@ rets_epsjv) – announced in the "Network News" – and the launching of the "Dear Editor" section in the magazine, where some of the messages we receive will be published. The purpose of both initiatives is to increase the channels of interactivity with our readers in order to improve our performance and provide a service that is increasingly adjusted to RETS' mission and goals.

Happy reading!

RETS Executive Secretariat

acknowledgements

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RETS Magazine is a quarterly magazine edited by the Executive Secretary of the International Network of Heath Technicians Education
E-mail: rets@epsjv.fiocruz.br

Editorial Board
Ana Maria Almeida (ESTeSL – Portugal)
Carlos Einisman (AATMN – Argentina)
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Journalism
Editor: Ana Beatriz de Noronha - MTB25014/RJ
Trainees: Samantha Chuva

Graphic Production
Design: Zé Luiz Fonseca
Layout: Marcelo Paixão

Translation
Curso de Línguas Espaços Sem Fronteiras Ltd.
(Jean-Pierre Barakat)

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EXECUTIVE SECRETARY OF RETS
Joaquim Venâncio Polytechnical School of Health

Director
Isabel Brasil

Coordenation of International Cooperation
Anamaria D'Andrea Corbo

Coordenation of International Cooperation Staff
Anakeila Stauffer
Kelly Robert

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: cci@epsjv.fiocruz.br

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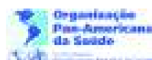


International Cooperation:
from humanitarian aid to structuring projects

On January 12 this year, 35 seconds were sufficient for a 7.0 magnitude earthquake to devastate the most densely populated region of Haiti. Outcomes for the population of capital Port-au-Prince and surrounding cities has been drastic: over 1.5 million homeless, around 200 thousand deaths, 300 thousand injured and 4 thousand suffering amputations. Around 80% of the city of Leogane was destroyed. In the area of health, according to the Haitian government, 60% of hospitals totally collapsed or were severely damaged, as did Ministry's installations. Half of the students, various professors and directors of the National Nursery School lost their lives when the building crumbled.

"The extent of physical destruction caused by an earthquake depends on many factors. In addition to the seism's magnitude are the epicenter's location, the geology of affected areas and, especially, the existence and application of anti-seismic construction norms. Countries such as Chile, who faced very strong earthquakes in 1960 and 1985, tend to improve buildings over time. In Haiti, where the last major earthquake occurred in 1750, the population had no historical memory of an earthquake and there was not great care with the standards and methods of construction", said Philippe Montagut, PAHO/WHO consultant for the development of Human Resources for Health in Haiti.

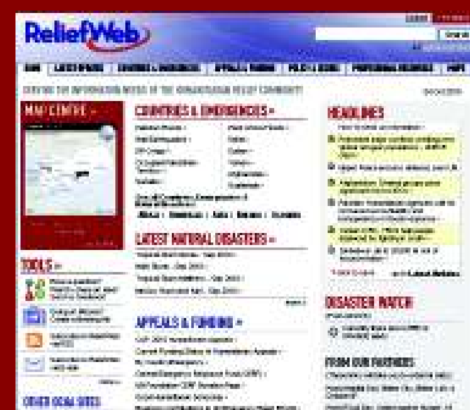
At first, save lives

Immediately after the earthquake, the international community united in an "unprecedented humanitarian response", as stated in PAHO/WHO's report "Health Situation: nine months after the earthquake in Haiti". According to the document, at the end of January, 396 international health agencies had arrived in the country to offer a wide variety of services.

On occasion, one of the most important actions was that of the Cuban Medical Brigades, whose work was described by Mirta Roses, PAHO/WHO Director, as "excellent and wonderful". According to her, some 400 volunteers of the Cuban brigades were responsible for the most important health care to the Haitian people during the first 72 hours following the earthquake.

The Cuban government has been developing cooperation actions in Haiti since 1998 through a Comprehensive Health Plan. In addition, nearly a thousand Haitian professionals, among which are more than 500 doctors, have graduated in Cuba. According to Mirta Roses, all this has been fundamental to the swift response of Brigades after the disaster.

ReliefWeb: timely and reliable information in crisis situations



To gather, organize and disseminate updated and reliable information that support humanitarian action in cases of natural disasters, conflicts and major accidents, among others. This is the goal of ReliefWeb, a site created in October 1996 and administered by the Office for the Coordination of Humanitarian Affairs (OCHA) of the United Nations (UN).

Interested parties have access to reports, maps and other documents generated by governments and organizations involved with humanitarian aid through the website (http://www.reliefweb.int). It is also possible to register in order to receive information about new contents via email, RSS, Twitter, Facebook or mobile phone.

Hours after the earthquake, Cuba deployed to Port-au-Prince over 60 disaster experts, members of the "Henry Reeve" Contingent, along with drugs, serum, plasma and food. Thanks to Cuban doctors and the humanitarian aid provided by various countries, thousands of lives were saved and are currently being saved in Haiti, but that is not enough.

Cooperation activities in disaster situations vary over time. At first, the priority is to save lives and try to reduce, for example, the number of amputations as well as perform vaccination and epidemic control actions. In a second stage, the provision of health care that meet the key daily needs of the population is essential. "We must address the lack of services no longer provided by the local health system because of the loss of the existing capacity – buildings destroyed and reduced number of health workers due to death or disability", explains Montagut.

"Finally, we must establish a coordinated transition shifting from emergency operations to those of reorganization and restructuring of the local health system, which in the case of Haiti involves the construction of a care provision system that considers accessibility of the population, funding and governance issues, decentralization of services and human resources training, among other things", he adds.

Long-term cooperation

The earthquake's impact was huge. About 300,000 homes were totally or partially lost, more than 1,300 schools were unusable. The difficulties of access to food and basic services increased due to the loss of human and institutional capacity of public and private sectors, leaving the Haitian people even more vulnerable. According to the Haitian government estimates, the total value of the damage caused by the earthquake exceeded the value of 7 billion dollars, equivalent to 120% of GDP in 2009.

Because of the magnitude of problems facing Haiti, the "International Donors Conference Towards a New Future for Haiti" was held on March 31 at the United Nations (UN) headquarters, with the participation of representatives from 140 countries. During the event, a US$ 5 billion donation within 18 months was established and the Interim Committee for the Reconstruction of Haiti (CIRH), chaired by former U.S. president Bill Clinton, was introduced.

On that occasion, the Memorandum of Understanding between Brazil, Cuba and Haiti to support the strengthening of health systems and epidemiological surveillance of Haiti, in which the three countries take joint responsibility for the reconstruction of the Haitian health system, was presented. According to the memorandum, Brazil's responsibility will be rehabilitating hospitals and health centers, sending equipment and ambulances, structuring basic health care programs, with staff training, creating an epidemiological surveillance center and assisting in the broadening of vaccination coverage. Cuba, in turn, will send specialized personnel in the medical field and provide operational support. Haiti will be responsible for the choice of units to be refurbished and the location of newly-built health centers, the infrastructure to carry out works and payment of health technicians.

There are also plans to train Haitian doctors graduated from the Latin American School of Medicine (ELAM) in Cuba to work in Emergency Care Units (ECUs) to be constructed. It is estimated that 200 scholarships will be offered by Brazil for this process.

Health in Haiti

Even before the January's earthquake, according to the "Interim Plan for the Health Sector for the period April 1, 2010 to September 30, 2011", prepared by the Ministry of Public Health and Population (MSPP) in Haiti, the country already had a very weak **health system** and characterized, among other things, by:

- low coverage – 47% of the population had no access to services, mainly for geographical or financial reasons (¾ of the population lives on less than $ 2.00 per day-UNDP-2005) and significant inequities;
- low level of funding – 5.7% of GDP spent on health (2005-06) and US$ 32 annual spending per capita (MSPP 2009) –, high degree of centralization – of the six university hospitals that operated in the country, five were in the capital – and organizational dysfunction;
- shortage of human resources for the sector – average of 5.9 doctors and nurses or 6.5 health workers per ten thousand people, well below the minimum number of 25 professionals/10 thousand inhabitants set by WHO.

Due to all that, the country had the highest rate of infant mortality in the Americas (57/1000 live births) and the highest rate of maternal mortality (630/100 thousand) in the world. HIV/AIDS, with a prevalence of 2.2%, and tuberculosis, with a detection rate of 70%, represent serious public health problems.

Under the Plan launched to try to reverse the worsening of the health situation after the earthquake, the government should:

- Ensure universal access to health services, especially for the more vulnerable groups;

Structured in three levels, the health system in Haiti was composed of 600 health facilities with and without beds and 45 community reference hospitals (first level), many of which are linked to NGOs and religious institutions; ten district hospitals (second level) and six university hospitals (third level). At the formal level, however, the system was organized in 54 municipal health units, each serving a population of 80 thousand-140 thousand inhabitants. Three private laboratories nationwide produce drugs and cover only a small part of the market.

• Strengthen MSPP's leadership and coordination role, as well as its role as facilitator of decentralized management of the health sector;
• Restore and strengthen the human resources of the sector;
• Strengthen governance at the central level and other levels, ensuring the establishment of a solidarity financing system based on results, and
• Ensure effective and efficient management of supplies and essential drugs, establishing mechanisms for their gratuity.

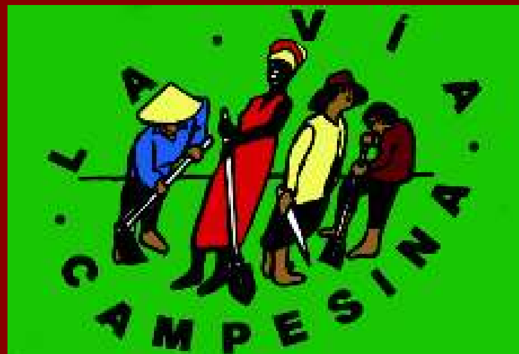
The importance of health workforce

Although it has brought disastrous consequences for a health system that has always faced serious structural problems, January's earthquake also brought an enormous potential for the restructuring of this system. Defining how best to harness the flow of international humanitarian assistance and global attention to build a more resistant and more resilient health infrastructure became crucial and it was in this context that the issue of human resources in health became relevant.

During the 37th Conference of the Global Health Council, held in Washington, DC, from June 14 to 18, Alex Larsen, the Haitian Minister of Public Health, was emphatic in saying that the focus of this process should be

Chimen Peyizan* - "Helping farmers means attacking the root of the problem"

"With the earthquake, the historic problems of Haiti – lack of food sovereignty and people's lack of access to education and health, among many others – have deteriorated rapidly, leading the "international community" to look more seriously at the country, severely punished by forces of nature and international powers". With these words, the coordinator of the Via Campesina Brigade-Brazil, José Luis Patrola, describes the situation in Haiti.



According to him, who is in Haiti since 2009, after the emergency aid, it is necessary to help the process of rebuilding the country and the activation of food production, seizing the possibility that the country has of rebuilding itself in a solid and sustainable fashion.

"Haiti urgently requires a procedure to encourage the swift production of food and the construction of dams, as well as an urgent reforestation plan. The already poor rural area has been receiving about one million more people who have fled from the most affected centers and will have responsibility to produce food for this new public as well as for the population which remained in the cities", he explains. He says that peasant social movements in Haiti, along with the progressive governments of the continent and the world, must implement an agrarian revolution to disallow a further increase in hunger and the possibility of an imminent and historically unprecedented demographic catastrophe. "Solidarity is to help solve the most serious and structural problems of the Haitian society. Helping farmers means attacking the root of the problem", he emphasizes.

According to Patrola, the military occupation through MINUSTAH – UN Stabilization Mission in Haiti – is in check, especially after the earthquake evidenced more serious problems than the "security" which, if not tackled, will result in over ten years of occupation without a solution. "The reconstruction process which is being carried out, imposed and coordinated from top to bottom, can produce two undesirable consequences: increased rural exodus, due to the offer of temporary jobs in the metropolitan area in the reconstruction work sector and, simultaneously, an increased urban concentration with the establishment of "bidonvilles" (slums) stemming from homeless camps", he warns.

In this sense, Haitian social movements have a big challenge ahead: to build internal unity and, thereafter, to propose national policies in a unified manner. Patrola says that external social movements should seek to understand what is happening in the country to be able to demand from their governments solidarity support measures to help address the structural problems of Haiti. In his view, the movements must also establish a major exchange process, sending support brigades to the country and accepting Haitian brigades in their countries. "We must break through language barriers and unite as people", he says.

"Cuban doctors, for example, do an outstanding job with people. Solidarity partnership actions developed by Cuba in Haiti show that the structural problems faced by the country in the health area should be treated with the participation of the people as protagonists", says Patrola, stressing: "All that ignores this logic is useless to the country's efforts in the achievement of its sovereignty".

Officially established in 1993, Via Campesina is an international movement which coordinates peasant organizations of small and medium farmers, agricultural workers, rural women and indigenous and black communities in nearly 70 countries in Asia, Africa, America and Europe. Its main policy is to protect food sovereignty, namely, peoples' right to decide about their own agricultural and food policy.

*Chimen Peyizan is the Kreyòl (Creole language spoken by around 80% of the Haitian population) translation of Via Campesina.

on workers of the sector. "With the earthquake, the lack of health workers has increased because many health professionals have lost their lives or were seriously injured", he said, noting that the lack of doctors is only part of the problem, since the lack of nurses, community workers and other mid-level professionals is even more serious. "Mid-level professionals and not buildings. A hospital has little value unless there is a sufficient number of health workers", stressed the minister.

According to Larsen, in addition to the numerical scarcity it is also necessary to solve the countless factors affecting the productivity of existing personnel and therefore the quality of services. "We must face the problems of low wages and lack of career plans, appropriate working conditions and performance assessment mechanisms, as well as the issue of low retention capacity of the public sector", he added.

According to the minister, it seems that some training programs run by organizations that set up in Haiti only serve to develop talent that will ultimately be recruited. "It is hard to keep workers in the country because many are hired to work in the United States and Canada. On the other hand, those who stay end up seeking jobs in NGOs or the private sector, on account of salaries", he said.

Health training within the Tripartite Agreement

The first meeting of the Tripartite Steering Committee – responsible for the international cooperation plan between Brazil, Cuba and Haiti – was held in Brazil on April 22 and 23. On the occasion, the group formed by representatives from the three countries made a technical visit to the Emergency Care Unit (ECU) of Rocinha in Rio de Janeiro and met later in Brasilia to develop a joint work plan based on proposals made by Haitian authorities. The creation of priority Technical Groups was also defined, among them the Training of Human Resources in Health, whose coordinators (focal points) are: Clarice Ferraz (Brazil), José Caridad Cabrera (Cuba) and Gadner Michaud (Haiti).

Due to the Brazilian experience with the training of middle level technicians for the Unified Health System (SUS), the Ministry of Health of Brazil had to present a health technical education project for Haiti.

From June 5 to 11, a Brazilian mission visited Haiti to investigate, along with Cuban representatives, the current context and assess the health technical training needs for the country. Among various activities, the group participated in a workshop organized by technicians and managers from the Ministry of Health of Haiti, in order to establish the guiding principles of the training plan.

In July, the Ministry of Health of Brazil presented a proposal based on the provisions of the Memorandum and the information received during the mission to Haiti.

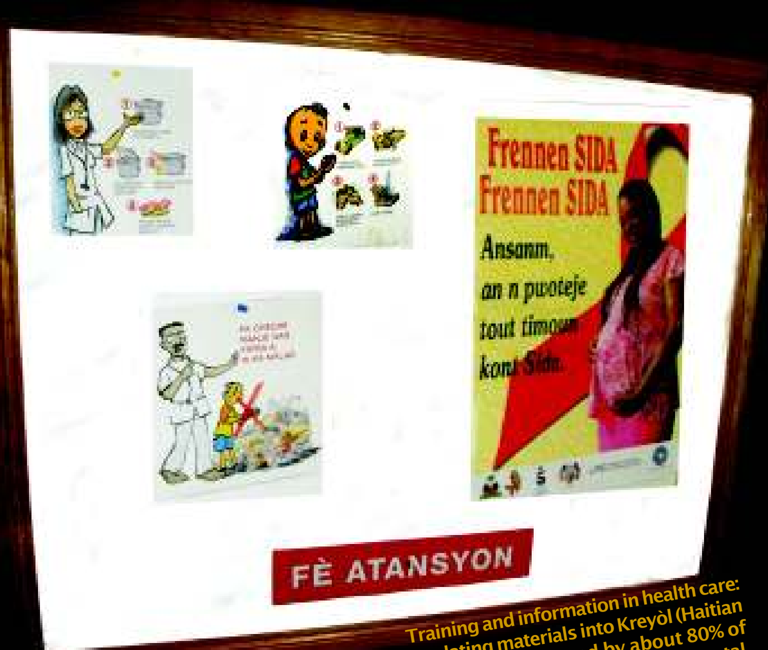
"After the prospective analyses carried out in visits to Haiti and considering the definitions agreed upon with the Ministry of Health of that country, it was established that the initial training priorities would be for **Community Health Agents (CHA), Nursing Technicians (NT) and Health Officers (HO)**", says Clarice Ferraz.

She said the idea is to work with the reality of the country's infrastructure, with the prospect of reorganizing the system according to the bases of Primary Health Care, with a view to implementing a Public Health Policy.

Community Health Agent: He develops actions of health care and protection of individuals and social groups in homes and communities. He operates in health promotion and disease prevention through health education of the population, promoting access to actions and information services within the health and social context. He is linked to the primary health care network.

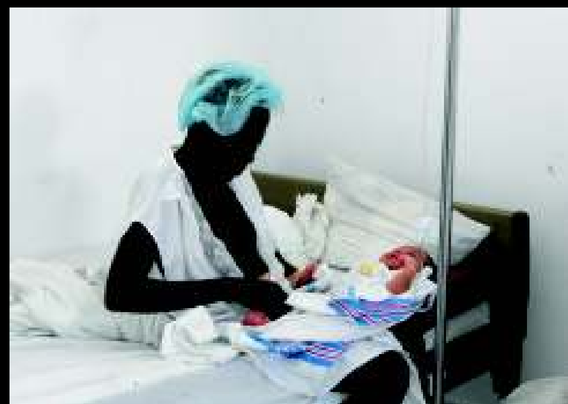
Nursing technician: It is a complementation of the nursing assistant who already works in primary health care: he performs activities, procedures and techniques required to provide nursing care in the health units and services (low, medium and high complexity hospitals, polyclinics, primary health care units and pre-inpatient/rescue services).

Health Officer: He develops actions aimed at improving the quality of life, the preservation and use of nature, the development and innovation of the support and health care technological apparatus. He performs actions for the protection and preservation of living beings and environmental resources, for the safety of people and communities, for the control and risk assessment and for the implementation of environmental education programs.



Training and information in health care: translating materials into Kreyòl (Haitian Creole language used by about 80% of the population) is fundamental.

Maternal and child care: the reconstruction of the system will focus on Primary Health Care actions.



According to the document, professional health education should be based on the perspective of the health work process and in the contextualization of practices as a source of production of meaningful content, requiring, therefore, rapprochement between the daily working activities and teaching methodologies developed. In this sense, the idea is that the training methodology should promote a reflection on the professional practice of students by identifying their weaknesses, and at the same time provide new knowledge to improve the performance of professionals and hence the quality of health care provided to the population.

In August, at a meeting in Havana, Cuba, the Brazilian project was approved unanimously by the Tripartite Steering Committee and the training of 2680 CHA, 1080 NT and 480 HO was established from October 25, 2010 to April 16, 2011. "In early September, we submitted to the Technical Group in Haiti responsibilities maps, curricular guidelines frameworks and plans for the activities of the community health agents training course, with textbooks, prepared by the Network of Technical Schools of the SUS, to be validated and translated into French", says Clarice.

The courses will involve Brazilians, Cubans and Haitians teachers, and one of the challenges to be faced is the need to communicate in Portuguese, Spanish, French and even the Haitian Creole language (*kreyòl ayisyen*), also known as "créole". "To try to overcome this difficulty, some Haitian professionals are taking Portuguese classes at the Brazilian Embassy in Port-au-Prince", she adds.

To continue the project, a training workshop for teachers was held from October 4 to October 10 in Fortaleza, Brazil. Representatives from the MSPP and teachers from the Haitian Institute of Community Health (INSHAC) participated in the activity for Haiti. Members of the Medical Brigade in Haiti and Havana teachers formed the Cuban delegation. The Brazilian group included, among others, those responsible for the tripartite cooperation, members of PAHO/WHO office in Brasilia, leaders of the Public Health School of Ceará and teachers of the first groups who will teach in Haiti.

One of the objectives of the workshop was to establish a schedule for the training of CHA, and the onset of activities in Port-au-Prince was confirmed for October 25, after a meeting of all teachers involved in the project from 20 to 22 at the INSHAC. In Palland and Aquin, the project will start a month later. Training in Gonaive is scheduled to begin in January 2011.

In the general framework of the Tripartite Agreement, the establishment of a permanent office at the Brazilian embassy was confirmed, with the logistic task to support the process.

Mission in Haiti (jun/2010): the tripartite cooperation Brazil, Cuba and Haiti requires constant dialogue and mutual understanding

PAHO-Brazil also announced the hiring of a consultant who will work at the organization's office in Haiti, with the task of assisting the development of the training program. In addition, resources will be transferred for the translation and adaptation of educational material.

According to Philippe Montagut (PAHO/WHO-Haiti), who attended the workshop, the outcome of the meeting was very positive and all the cultural differences and language difficulties were solved quickly. "Brazil has very firmly expressed the desire to train professionals who can contribute to the creation of a comprehensive and integrated health system from Primary Health Care. The proposal is designed to train professionals to be immediately inserted in the functional network services, according to the planning of the national health authority in Haiti", he said.

In the next meeting of the Tripartite Steering Committee in Haiti, MSPP will have to present, among other things, the administrative decisions related to these new professionals – statute, compensation, career plans – and the review and update of profiles already existing in the system. The concern is assessing the possibility of the Ministry to absorb an increase of 33% of its workforce (62% if the administrative staff is not considered).

Safe Hospitals: topic becomes a priority at the 50th Meeting of PAHO/WHO Directive Council

January 12 earthquake strongly affected Haiti's infrastructure. Several government buildings, among them the Presidential Palace, the Parliament and various ministries collapsed. In the health area, eight hospitals were totally destroyed and another 22 located in the most affected areas were severely damaged. The case in Haiti was emblematic but was not the only one.

In New Orleans, USA, in 2005, the flooding caused by Hurricane Katrina disabled 17 of the 20 hospitals in the city. In Mexico City, in 1985, an earthquake destroyed a wing of the Hospital Juárez, killing some 560 people including patients and health workers.

Also this year, in Chile, the February 27 earthquake damaged, to a greater or lesser degree, 79 of the 130 hospitals in the affected area, causing the loss of nearly 5,000 beds. The most damaged hospitals, the oldest which had not undergone works that would reduce vulnerability to disasters, were in many cases very close to facilities built according to the "hospital safety standards" which suffered almost no damage.

There are countless examples and they serve the purpose of putting the focus on safe hospitals once more, a topic that has already been at the center of the World Health Day in 2009: "When disaster strikes, safe hospitals save lives".

On October 1, at the 50th Meeting of PAHO/WHO Directive Council, health ministers of Member States reaffirmed the need to make hospitals safer against disasters so that they can continue providing services in times of emergency. The risk of death and disability increases when a hospital ceases to operate following a disaster. However, the problem remains over at least two years, when part of the population tends to be deprived of proper medical care.

According to the Organization, 67% of health facilities in the Region of the Americas are located in disaster risk areas and the construction of health facilities in risk areas in Latin America and the Caribbean without adequate protection measures is still common. Of the 327 hospitals assessed in 17 countries, only 39% would most likely withstand a disaster and 16% would only have some chance of resisting if urgent improvement measures were taken.

For all these reasons, the Council adopted a new regional plan for investment and control systems to ensure that new hospitals and healthcare facilities are already built according to the existing safety standards and that the older ones are upgraded to meet the standards. The Council states that the existence of a series of national and international commitments in this area shows that the issue is already on the agenda of several countries.

PAHO Directive Council meets annually to set priorities in the Pan American cooperation in the area of health and guide PAHO's technical cooperation programs in its Member States.

"Virtual journey through a safe hospital"

Just over a year ago, PAHO launched a multimedia training program – available in English and Spanish – which combines video, bi and tri-dimensional animation, images and sounds, as well as presentations and technical publications, to create a virtual learning environment about "safe hospitals".

Contents are divided into modules, which can be used independently to explore specific aspects of the topic or sequentially to perform a complete view. The DVD includes a library for consultation and download of support materials. To order the DVD, those interested should write to: disaster-publications@paho.org.

More information at:

- In English: http://www.paho.org/english/dd/ped/viajevirtualhospitalseguro.htm
- In Spanish: http://www.paho.org/spanish/dd/ped/viajevirtualhospitalseguro.htm

Leia mais:

- Haití: Resumen de la Evaluación de necesidades post desastre (PDNA) del terremoto del 12 de enero de 2010 (Gobierno del Haití, marzo/2010): http://www.eclac.org/mexico/noticias/noticias/0/38920/EvaluacionPNDAHaitiEspP.Cote.pdf
- Plan Interimaire du Secteur Santé – avr/2010-sep/2011 (MSSP-Haiti, mar/2010): http://www.mspp.gouv.ht/site/download/plan_interimaire.pdf
- Situação de Saúde: nove meses após o terremoto no Haiti (Opas/OMS, out/2010): http://g1.globo.com/VCnoG1/0,,MUL1444936-8491,00.html

Information at the service of health worker training

The shortage of resources in poorer countries normally results in a lack of books and medical magazines in the libraries of many educational institutions and health services. Changing that situation has been the target of several initiatives that aim to use knowledge to improve professional training and hence quality of services, thus increasing the odds of these countries achieving the health goals of the Millennium Development Goals (MDGs).

"Blue Trunk Libraries": information overcoming distance

The will to bring practical and basic knowledge on some fundamental issues to areas lacking information led the World Health Organization (WHO) to launch the Blue Trunk Libraries project in the late 1990s. Originally created in English, these libraries, whose collection is organized per topic into cardboard boxes and placed in a blue metal box for easy transportation and storage of publications, initially had French and Arabic versions. In 2006, with the support from the Brazilian Ministry of Health and the High Commissioner of Health of Portugal, the Portuguese version of the Library was created and includes over 180 books, documents and manuals on public health and other areas related to health sciences. "This content was chosen based on country needs. It is not merely a translation of libraries into other languages", emphasizes Regina Ungerer, coordinator of the **ePORTUGUÊSe Network**. In the Library, there are publications targeted at different groups of professionals – doctors, nurses and community agents – on medical, health and administrative issues faced in their daily work.

To order a Blue Trunk Library, the institution concerned should contact WHO in their country, or the WHO Publications Department in Geneva (bluetrunk@who.int). The cost, which includes assembly, purchase of the blue box, printing of a few manuals and personnel training varies. English and French versions are sold for about US$ 2 thousand, whereas the Portuguese version bears half that price. "The price reduction was made possible because most publications are donated by the governments of Brazil and Portugal", Regina explains, noting that the buyer must also cater for costs related to the transportation of Libraries to the countries.

The success of the Blue Trunk Libraries project – which in December 2009 accounted for 1,968 units shipped to 82 countries, totaling around 250 thousand publications – is due, among other things, to the requirement of local officials for each installed unit and a national officer who, in addition to coordinating the work at the country level, collaborates with WHO in assessing the use and impact of these libraries. "Despite its particularities, Blue Trunk Libraries operate similarly to regular libraries. Thus, it is necessary that someone remains in charge of the place, checks out what has been borrowed and takes care of the material,

Established within WHO, the ePORTUGUÊSe Network offers to eight countries – Brazil, Portugal, East Timor and the five African Countries of Portuguese Official Language (PALOP), namely, Angola, Cape Verde, Guinea-Bissau, Mozambique and São Tome and Principe – the opportunity to receive updated and relevant information on health in their own language. The initiative is part of WHO global strategy to extend the principle of multilingualism to developing countries with a view to improving the development of human resources in health.

besides divulging the existence of the Library and its contents", says Regina, citing Mozambique, a country that has already received 46 of the 92 units that are made available by the ePORTUGUÊSe Network, as an example: ""Governmental and non-governmental organizations operating in the country have joined in to acquire libraries and train staff. Last August, a course for future managers of 20 Blue Trunk Libraries that will be sent to the province of Zambezia was held". The training goal is to make these managers become active partners and ensure that information is actually disseminated.

The great success of Blue Trunk Libraries in Portuguese, the most ordered item from WHO in 2009, and the increasing demand for materials on special topics led ePORTUGUÊSe to create the Red Library, a thematic mini-library – smaller than its blue predecessor – prepared according to specific demands. The first two units, with publications on HIV/AIDS, were sent to Mozambique.

"Mobile Libraries": a solidarity project

By statute, the Order of Nurses (OE) of Portugal must promote cooperation at the international level, within the science of nursing. To that effect, inspired by the "Mobile Library" project of the International Council of Nurses (ICN), the OE created the "Mobile Library", with publications in Portuguese.

The idea is that, in developing countries, the nurses, who play an extremely important role in national health systems, often work in locations with difficult access to updated information about health care.

As the Blue Trunk Libraries, Mobile Libraries contain practical and reference materials relevant to the daily work of nurses and other materials adapted to local needs.

Created in 1967, the Latin American and Caribbean Center on Health Science Information, whose acronym BIREME derives from its original name – Regional Library of Medicine –, is a specialized center of the Pan American Health Organization (PAHO/WHO). Its headquarters are located in Brazil at the central campus of the Federal University of São Paulo (UNIFESP).

The forwarding of mobile libraries requires a contract between the CIE/OE, which are responsible for the overall management of the project, and the National Association of Nurses of the country concerned, which is responsible for the management and maintenance of libraries in the country.

BVS: dissemination of knowledge and digital inclusion

The Virtual Health Libraries (BVS) are online libraries where users have easy access to millions of technical and scientific documents generated in academic institutions and health services.

BVS story begins in the 1980s, when the Latin American and Caribbean Center on Health Sciences Information (BIREME) begins to develop projects that use new communication technologies to disseminate health information. In 1988, a CD-ROM of the Latin American and Caribbean Literature on Health Sciences Information (LILACS) was released, one of the first CD-ROMs of scientific information produced worldwide. Ten years later, BIREME reaches a new level by transforming information from the CD-ROM into the virtual world, thus enabling the BVS.

The BVS, which in 2009 received over 20 million monthly hits, is now consolidated in over 20 countries, including Brazil, which until recently was the only BVS in Portuguese. With the support from the ePORTUGUÊSe Network, the BVS model is currently being presented to other members of the Community of Portuguese Language Countries (CPLP).

"The unit is one of the main strategies for the popularization and democratization of access to information. This initiative, not only contributes to the spread of knowledge but also assists in providing an increased digital inclusion", said Eliane Santos, general coordinator of the Documents and Information Department of the Brazilian Ministry of Health.

Besides national libraries, there are thematic BVS, among which Health Professional Education, where one can find relevant information in the area of technical training for the sector. The BVS-EPS is maintained by the Joaquim Venâncio Health Polytechnic School (EPSJV/Fiocruz).

Future managers of the Blue Trunk Libraries in Mozambique

For more information:

Blue Trunk Libraries: http://www.who.int/ghl/mobile_libraries/bluetrunk/en/index.html
Mobile Libraries (Order of Nurses of Portugal): http://www.ordemenfermeiros.pt/projectos/Paginas/BM.aspx
Virtual Health Library: http://regional.bvsalud.org/local/Site/bireme/P/historia.htm
BVS-EPS: www.bvseps.icict.fiocruz.br
ePORTUGUÊSe: http://www.who.int/eportuguese/en/

Health Surveillance

"Health surveillance", "surveillance of health", "surveillance to health". Considered by many to be conceptually distinct, these three terms are most often used indiscriminately to refer to an area of public health that is being consolidated in many countries. In general, the idea of health surveillance should include: surveillance and control of communicable diseases; surveillance of non-communicable diseases and injuries; health situation surveillance; environmental health surveillance; workers health surveillance and health surveillance.

In Cuba, broadening the responsiveness of the health system

In Cuba, the propose of Health Surveillance arises, in the early 1990s, to continue the advances in health. In this sense, in the first half of 1993, according to Infomed [Health Portal of Cuba], the Ministry of Public Health sought to define a strategy capable of responding more effectively to the country's health situation. A system was therefore established that would allow a "greater integration of information from surveillance and a greater level of analysis and use of generated information, in line with existing knowledge about surveillance at international level, in order to achieve a greater benefit for decision making, scientifically based at different levels, according to the policy of decentralization of government bodies."

The implementation of health surveillance in Cuba stemmed from some basic assumptions, among which are:

- close ties with policies, strategies, programs and health services, as well as with the processes of research and education and human resource training;
- improvement of existing information and epidemiological surveillance subsystems and creation of new subsystems that may be required;
- mobilization of available technical resources based on the analysis and the swift and efficient response;
- periodic review of information from other industries for health reasons; adequate integration of health promotion, conditions and lifestyles aspects;
- continuous exchange of selected information with other national systems or subsystems and intercommunication with other health and epidemiologic surveillance systems at the international level; and
- transmission to professionals responsible for the area at all levels of fast methods of epidemiological assessment and methodology to deal with acute situations.

Powered by statistical information sources from the Ministry, the health surveillance system allowed the creation of national and local infrastructure necessary to the implementation of systems of early warning and quick response to threats to the national health situation.

In Brazil, reorganization of practices and democratization of labor relations

In Brazil, the concept of health surveillance begins to be established in the wake of the health reform movement, which resulted in the creation of the Unified Health System (SUS) in 1988.

Initially developed in the academic world, the discussion on the care model that would best meet the principles and guidelines of the SUS – universality, comprehensiveness, equity, decentralization and popular participation – reaches, in the mid-1990s, managers and technicians of the system who are concerned about the need for reorganization of health practices at all three levels of the system. The central porpuse was to develop a model that encompassed both the ethical and cultural and the technical and organizational aspects involved in providing health care, as well as health policies that emphasized health promotion and surveillance actions.

The reorganization of services, in turn, was intended to replace the old logic of "attention to the spontaneous demand" and "special programs" with an "organized offer of services" based on health needs of territorially defined populations and focusing on the quality of life.

Discussions ended up creating three different views regarding health surveillance: (1) as an "analysis of health situations", idea which favors the monitoring actions of health status at the expense of actions aimed at addressing the problems; (2) as a proposal of an institutional "integration" between epidemiological surveillance and health surveillance; and (3) as a proposal to redefine health practices in view of the principle of comprehensiveness of health actions, both with regard to its object and purpose – promotion, protection, diagnosis, treatment and rehabilitation – and its levels of technological and organizational complexity.

"At the time, hegemonic care arrangements – the physician-centered, focused on hospital care and medicalization, and the sanitarist, supported by campaigns, programs and epidemiological and health surveillance actions – were no longer sufficient to meet the health needs of the population", explains Grácia Gondim, professor and researcher at EPSJV/ Fiocruz and coordinator of the Health Surveillance Technical Course. "Health surveillance ends up redefining the subject, the object, the practices and the process of health work and incorporating into health actions and the system's management the concept of democracy, the flattening of knowledge and new forms of relationships among health professionals and between them and the population, which is now seen as a partner in defining health needs and the planning of actions", she adds.

In Argentina, integration of knowledge

In Argentina, according Raúl Forlenza and Jorge Chaui, doctors from the Department of Epidemiology of the Ministry of Health of the Government of Buenos Aires, health surveillance – defined as "identification, systematic collection, analysis and interpretation of data about health events or related conditions, for use in the planning, implementation and evaluation of Public Health programs, including the basic element of dissemination this information to all who need to know them" – gives the epidemiological surveillance system a broader concept.

"Broadening the field of epidemiological surveillance to public health surveillance occurs with the inclusion of demographic surveillance, surveillance of health events, surveillance of the health system and the opinion of the population, with its level of satisfaction, and environmental surveillance", adds Forlenza, noting: "Rather than simply replacing and adding the traditional areas of epidemiological surveillance, health surveillance and environmental surveillance, the new concept aims to integrate areas of knowledge, avoiding the fragmentation of existing data and providing a holistic reading of the information".

In this sense, the demographic surveillance considers the identification of factors that are related to changes in the health status of the population – age and sex, structure and social function, size and population growth, spatial distribution, structure and family function and migration. "Health events are viewed from the angle of incidence of disease and injury to health, disability and death, as well as risk factors stemming from the physical environment, biology, lifestyle and behavior and socioeconomic conditions", highlights Chaui.

Monitoring the health situation, in turn, includes among other things, identifying the loss of health – disease, mortality and disability burden –; individual, community and environmental risk factors; health inequity – resources, access and outcomes –; health-related quality of life – physical, psychological and socioeconomic –; and quality of health-related services – education, water, sanitation and nutrition.

Surveillance of health services aims to identify the issues that affect its quality, considering use, accessibility, human resources, cost-effectiveness, policies and their implementation. According to Forlenza, it should consider services and institutions that influence health, even when not under direct control of the public health system, that is, social works, the private and international sectors.

A final element is the awareness of population about their health and the services. Health surveillance emphasizes the belief that people have about their own health and about the services offered by the health system.

Health Surveillance's work

Despite showing some differences, the different conceptions of Health Surveillance have in common the idea of ongoing review of the population's health situation as a starting point for the organization and implementation of health practices. In this sense, it gathers traditional surveillance actions, as well as actions of promotion, prevention and control of diseases and health risks, thus establishing itself as a space for articulation of techniques and expertise from different areas, for example, epidemiology, planning and social sciences.

The complexity of the working object of health surveillance, consisting of the social determinants related to the health-disease-care process and materialized territories-population, ends up setting a very specific worker's profile, as Grácia explains: "The work of this subject requires both a closer look at the specific situations of the territory in which he serves and the ability to relate to these situations to the more general context. He should, in his daily work, continually articulate tacit and technical knowledge of health sciences and social sciences in order to act on reality".

This view is shared by Forlenza and Chaui, who reiterate the need for the

worker to be able to intervene at different population levels – from neighborhoods to greater jurisdictions – in fluent communication with the community, identifying and analyzing contexts, health risks and health-disease events, georeferencing data and helping to prioritize interventions.

Despite the importance that health surveillance workers bear in strengthening national health systems, the training of technicians and technologists specific to this area is still not common. In Cuba, for example, a course of Hygiene and Epidemiology exists in the area of Health Technology. In Portugal, on the other hand, the training would be in Environmental Health.

"There is not a technical career in epidemiology and health surveillance in Argentina", said Forlenza, and added: "But a technical career of this kind would provide skills for the articulation of knowledge – health sciences, epidemiology, social sciences, etc. – and practices – health surveillance, environmental surveillance, field work, database management, processing and analysis".

In Brazil, the story of a training specifically geared for health surveillance begins in late 1998, when the Ministry of Health requests EPSJV/Fiocruz to provide a proposal for the training of about 24 thousand endemic agents from the National Health Foundation (FUNASA) who would work for states and municipalities with the decentralization of health control and epidemiology services.

In Brazil, the technician is a mid-level professional and the technical course can be done in three ways: **integrated education** (secondary education and professional certification in the same institution with single registration for both courses) and **concurrent education** (high school and professional qualification in different institutions) apply to students who have completed basic education (nine years of formal education). **Subsequent education** applies to those who have completed high school (12 years of formal education).

Sees man as a social, ethical and political being, an autonomous subject who can develop manual, scientific and intellectual skills, regardless of education level, in order to exercise them in society and contribute to the transformation of rules, behaviors, ideas and practices from the perspective of collective welfare. Source: Estudos de Politecnia em Saúde, volume 3, pag.: 155 – EPSJV, 2008.

At the time, the aim was to transform the until now disease-focused health practices of these professionals to understand the social determinants of health and the social production of the quality of life in the territories-population. The proposal of the Health Surveillance Local Agents Training Program (Proformar) is then presented, whose first course began in late 2001 through the modality of distance learning and attendance, and which, in five years, trained 35 thousand workers of the Unified Health System (SUS).

In 2002, from some proposals from existing curricula, the Health Surveillance and Environmental Health Technical Course is created as a mid-level technical training, in the **integrated, concurrent and subsequent** modalities, which enabled the coexistence and exchange of experience between workers of the SUS and high school students. Finally, in early 2008, a new course is implemented at EPSJV – the Health Surveillance Technical Course (CTVISAU) – whose curriculum is grounded in the integration and interdisciplinarity.

Today, several other public and private educational institutions in the country now offer training courses for public health surveillance technicians.

Interdisciplinarity and autonomy

According to the National Catalogue of Technical Courses of the Brazilian Ministry of Education, the health surveillance technician: develops health inspection and supervision actions; applies norms relating to products, processes, environments – including labor – and services of interest to health; investigates, monitors and assesses risks and determinants of injuries and damage to health and the environment; participates in multidisciplinary teams of planning, implementation and assessment of health, epidemiological, environmental and occupational health surveillance; acts in the flow control of people, animals, plants and products at ports, airports and borders; and develops disease, endemics and vectors control and monitoring actions.

"The complexity of the purpose of health surveillance work and the specificity of its work ended up defining the interdisciplinary and cross-cutting organization of the CTVISAU curriculum, where various elements interweave and constitute the teaching-learning process – general and specific contents; theory and practice; education and research; school and society – as a requirement of the work process in health", explains Grácia.

Polytechnic Education, integrated training and interdisciplinarity were theoretical and methodological assumptions used in setting the course's structure. "This resulted in a unique design that combines curriculum components and different didactic-pedagogic and organizational strategies. Thus, it is possible to build the necessary links between the theoretical and practical contents in order to reconstruct and (re) define knowledge in daily work and student's life", she stresses.

She said the design and curricular components of the course consider the need for ongoing dialogue between general education and technical training. "Our goal is to try and ensure that professional education has not an end in itself or is guided by the interests of the labor market. It should represent an opportunity in constructing the student's life projects: of autonomy, emancipation, freedom and overcoming", points out the coordinator.

All the material used in the elaboration of this text is available on RETS website (http://www.rets.epsjv.fiocruz.br) at: "Library" > "Topics of interest" > "Health Surveillance"

GHWA Forum: the health technician (Part 1)

To share evidence and examples of good practices related to health technicians, or mid-level workers, as defined by the World Health Organization (WHO), and highlight political and programmatic issues of importance to the subject, encouraging reflection and discussion about them. These were the goals of the online forum on the professional segment – Mid-level Health Workers – conducted by the Global Health Workforce Alliance. The initiative held on May 4-18 this year and made possible by the IBP Knowledge Gateway, as part of HRH Exchange, brought together experts and professionals in public health, research and health education from various countries and institutions.

Who are the mid-level health workers? What is their role in the broader context of human resources and strategies for the sector? How can they contribute to improving access to services? What kind of training is most appropriate for these workers and what are the best ways of managing their work? What health policies and system organizations enable a greater success in the use of these professionals?

Discussions were based on reference texts and suggested readings previously sent to the participants by the organizers of the event. At the end of each day, everyone received a summary of discussions along with conclusions of the expert responsible for the topic.

With this issue, rather than simply reporting the Forum, the RETS magazine seeks to bring to the Network some of the discussions held. The intention is to show other views on the matter, deepening the discussion a little. All material on the forum is available at RETS' website (http://www.rets.epsjv.fiocruz.br) in "Library" > "Events" > "Mid-Level Health Workers (Online Forum)".

"Unfortunately, due to time and format constraints and even language barriers – the forum was held in English –, discussions turned out to be superficial and focused mainly on technicians more connected to health care actions, leaving aside those working in other activities, such as diagnostic support, for example", complains Anamaria Corbo, International Cooperation Coordinator of the Joaquim Venâncio Health Polytechnic School (EPSJV/Fiocruz) and Executive Secretary of the RETS. "Nevertheless, the event was very important in that it helped to increase the visibility of education and work issues that affect the universe of health technicians", she said.

"Implementing Best Practices (IBP) Knowledge Gateway" is a communication electronic tool. Directed to virtual communities of practice, it gathers individuals and groups around the world, facilitating the exchange of information, communication and the sharing of knowledge on a wide range of health-related topics.
For more information: http://my.ibpinitiative.org/home/default.ashx

Coordinated by the GHWA, the "HRH Exchange" is a community of practice for human resources in health. Its goal is to establish a connection between health professionals from all levels and regions of the world and strengthen the importance of the workforce in the development of health policies.
For more information: http://www.who.int/workforcealliance

What is a mid-level health worker?

The first discussion held was about the need to develop a consensus on the definition of mid-level health workers. The issue is that this group may include internationally recognized categories, such as midwives, as well as specific occupations in certain countries, such as surgical technicians, in Mozambique, for example.

According to Helen de Pinho, from the Public Health School of Columbia University – USA, who brokered the subject, there is a growing movement in all countries to use this workforce to increase people's access to health services She says that the lack of a comprehensive definition that spans countries and continents hampers the organization of these workers, the defense of their profession and even the achievement of professional recognition and visibility. "Some still see the mid-level workers (or technicians) as those who, in the traditional hierarchy of health providers, are above community agents and assistants but below

doctors and specialists", she explained. She said the current trend is that the definition of such workers is not made based on their staff position anymore, but rather their qualification level and the scope and degree of autonomy of their practice.

Cecilia Acosta and Felisa Fogiel, of the Higher Institute for Health Technical Degrees, body linked to the General Directorate for Training and Research of the Ministry of Health of Buenos Aires, agree with the fact that health technicians currently have a widely spread professional identity. They say that this definition would help to consolidate the operation field of these workers, also contributing to important aspects in the determination of their professional responsibilities and allowing their free movement at the international level. "It is necessary to reach a consensus on basic and broad aspects, because the technical training is quite diverse and there is also a need for a certification that identifies this education field in a more homogeneous way, without losing the specificity of each career", said Cecilia.

Isabel Duré and Alejandro Valitutti, of the National Directorate of Human Capital and Occupational Health of the Ministry of Health of Argentina, add that any definition must consider the needs of national health systems and define the scope of professional practice, thus avoiding confusion at the workplace.

Another issue discussed on the first day of the Forum was whether the definition of Paramedical Practitioners, as inserted in the latest version of International Standard Classification of Occupations (ISCO - 2008) published by the International Labour Organization (ILO), could capture the essence of the work performed by the so-called "mid-level workers" as a basis for establishing some consensus.

They provide advisory, diagnostic, curative and preventive medical services for humans more limited in scope and complexity than those carried out by medical doctors. They work autonomously or with limited supervision of medical doctors, either in the field or in institutions and apply advanced clinical procedures for treating and preventing diseases, injuries and other physical or mental impairments common to specific communities.

In the opinion of Helen de Pinho, the ISCO-2008 can serve as a mechanism for mapping the various mid-level careers that currently exist in different countries. The classification is based on a distinction between health professionals – those who directly provide curative, preventive and health promotion care – and health-associated professionals – who perform support tasks to the diagnosis and treatment of diseases and whose goal is to provide means of aggregating data and information regardless of the national variations of required training, standards and classifications. "We are not proposing that countries change the current names of the available careers, but rather use a classification based on the ISCO to map their resources, thus allowing the comparison of results between countries", she added.

With regard to the ILO definition, Cecilia and Felisa believe that it is very focused on a technician who is still very dependent on the physician, a kind of collaborator. "However, the current trend is that the technician has autonomy and can make decisions, performing complex activities and getting a comprehensive and not just instrumental training", emphasizes Felisa, reminding that not all health technical careers perform advice, diagnosis, prevention and cure of people.

"Technical careers in the field of health are considered professional families since they share a common core of basic professional skills – attitudes and values, knowledge, skills and abilities –, similar training contents and experiences that provide work contexts that are alike", completes Cecilia.

Per Isabel and Valitutti, ILO's definition is broad and complex but could be reviewed in light of various conflicting situations and demands present in this field.

A picture that does not usually match reality

It is possible to find mid-level health workers among health staff in developing and developed countries and, in general, experience shows that the use of these workers enables the increase of access to and coverage of health services, particularly in the most deprived communities.

However, the situation of technicians varies widely from country to country, depending, among other things, on the size of the workforce in the industry, the economic and development levels of the country and the adopted health policy. Thus, although the scope of practice of this staff may be similar in different realities, there are many variations with regard to their job description, contents, duration and quality of their training and their position in the work process.

Experience also shows that, despite the importance of their work, these workers often end up working outside the health system, which can result in an inadequate work management process that does not give due attention to, for example, issues of training, career

development and professional regulation and working conditions.

Though quite limited, some **"perception" studies** point towards resistance and reluctance on the part of other professional groups, especially doctors and nurses, with respect to the use of mid-level workers in the health sector. Indeed, even the term "mid-level workers" tends to reduce the credibility of these professionals before others.

In psychology, perception is the brain function that assigns a meaning to sensory stimuli from past experience in a process that involves the acquisition, interpretation, selection and organization of information obtained through the senses. In this regard, perception studies are very important in that people's behavior is based on an interpretation of reality that and not in the reality itself. Therefore, even when they are inserted in one reality, individuals construct different perceptions of objects and situations according to the aspects that are particularly important to themselves.

Based on these assumptions, the forum's second day of debates began. The main issue was to know whether it is possible and desirable to try and establish the convergence of countless mid-level health workers models into a single one that is internationally recognized. In addition, an attempt was made to map some of the causes of resistance to the deployment of mid-level staff and suggestions on how to undo some of the misconceptions about this segment of health workers were collected.

According to Mozambican Amelia Cumbi, responsible for the synthesis of debates of the day, one could say that there is some agreement on the need for some kind of standardization and international recognition of those professionals who for decades have played an important role in providing health care.

She said there was a consensus in that standardization and international recognition should be based on broader – and not on narrow and strict – aspects of having exactly the same training or the same curriculum. "In this sense, standardization would aim to enable these workers to exercise their profession in other countries, namely, the standardization would be the passport that would enable the professional to "fly" across the borders of his country of origin", she summarized.

"Even for the "traditional" nursing and medical staff, which are internationally recognized professions, there are variations from country to country, with different curricula and training time spans. However, if someone says "I am a doctor" or "I am a nurse", that is perceived as such, regardless of existing variations", she argued.

According to Isabel and Valitutti, there seems to be, at least in South America, a desire to promote the convergence of the models of these workers, given the growing political and economic integration of the region. There are, however, some issues that may hinder the process.

In Brazil, technical training can be done simultaneously with high school by students who have completed nine years of elementary school or by those who have completed high school (12 years formal education). In both cases, the professional is considered as mid-level. "Even if he continues to study, attending specialization courses or master classes, he remains a mid-level professional. To become a higher education level professional, even in the same area, he must pursue college education or technological training. Therefore, there is not a continuous training itinerary", says Anamaria Corbo.

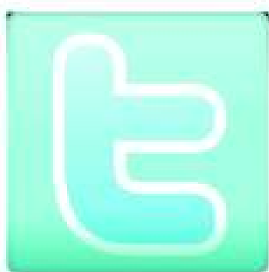
There are two different levels of workers in Argentina which are repeated in the health systems of all provinces: the assistant and the technician. "The training of health technicians occurs after the completion of secondary education, in higher education level university and non-university courses", explains Alejandro Valitutti.

Regarding the causes of resistance in the training of mid-level workers personnel, corporatism seems to be predominant. "This resistance occurs mainly in some areas where there are already higher education courses or in those where professional associations and unions are trying to legitimize some trainings over others", said Isabel.

According to panelists who participated in the Forum, the important thing is that international organizations, among which WHO, broaden the defense of this staff, reinforcing some important concepts. It is necessary to show, among other things, that technical workers are an integral part of health systems, in which they perform specific duties, and not merely temporary substitutes used in the shortage of college level staff; that they have always played a vital role in providing health care, especially for the neediest populations; and that the visibility of technicians tends to increase as national health authorities establish criteria to allow to consider this staff in the evaluation of availability of health workers in countries.

"The way to dispel the misperception that exists about health professionals is by demonstrating the effectiveness of actions of these workers in areas where they are located", added Alejandro Valitutti.

RETS on Twitter (@RETS_EPSJV) and more news on the website



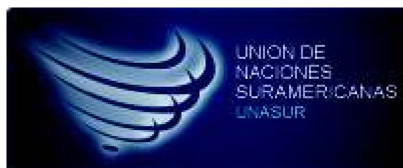
The ability to share information more quickly with everyone who is interested in issues related to the training of health workers and health work has led to the creation of a Twitter for the RETS (@ RETS_EPSJV).The idea is to disseminate contents published on the website and other relevant knowledge that will strengthen both our coverage area and Network.

Created in 2006, Twitter enables the use computers or cell phones for the real-time sending and receiving of text messages of up to 140 characters – the so-called "tweets" – simultaneously to several people. According to estimates, Twitter, which is one of the most widely used social networks around the world, has more than 15 million users.

On the other hand, the section – "Countries" (side menu) > "General Information" –, which provides some data on the countries that are part of the network, is now ready on RETS website. The goal is to provide information that would assist in the cooperation actions, as well as to facilitate contact between professionals from member institutions. "Our aim is to support professionals also on their travels, with practical information on weather at the destination country and even the currency exchange. However, the important thing is that people assess the current content and provide us a feedback on what they would most like to find", said Anamaria Corbo, Coordinator of International Cooperation of the Joaquim Venâncio Health Polytechnic School (EPSJV/Fiocruz) and the Executive Secretariat of the RETS.

Another goal is the inclusion of more specific information about the training of health technicians in the countries, as established under the provisions of the Work Plan of the Network.

RETS-UNASUR: Minutes of the establishment and the Work Plan are now available on the new UNASUR-SALUD website



In September, the South American Health Council (UNASUR-SALUD) launched a new website (http://www.unasursalud.org) developed by the Ministry of Public Health of Ecuador – a country currently holding the Pro Tempore Presidency (PTP) of the Council.

On the website, interested parties will find documents, videos, articles and many other materials, as well as various information about the Council's member countries and the Technical Groups responsible for the activities of each of the five points of South American Health Agenda: (1) to establish the South American epidemiological shield; (2) to develop universal and equitable health systems; (3) to provide universal access to drugs and other health supplies; (4) to promote health and jointly tackle its social determinants; and (5) to strengthen the training management of human resource in health.

Among the available archives which will be inserted shortly are the minutes of establishment and the work plan of the RETS-UNASUR. The document, drawn up at the 1st Meeting of the South American Health Technical Schools, held during the 2nd General Meeting of the RETS in December 2009 in Rio de Janeiro, were the basis for official recognition of the RETS-UNASUR, which occurred in April this year, in Cuenca (Ecuador) during the 2nd Ordinary Meeting of the Council.

Prezado Sr. Editor,

RETS Magazine and doctoral research

I am a professor of the Health Technical School and concluding a Ph.D. in Geography at the Federal University of Uberlândia. I got acquainted with the RETS Magazine (issue No. 06, April/May/June/2010) in the school hallways, and that was very good. Both the interview with Ineke Dibbits on health interculturality and the text published in the Glossary section ("Health Technicians Education – Part 4") are very relevant for my doctorate, whose topic is "Community mobilization as a prevention of Aedes and dengue in the district of Martinésia, Uberlândia, Minas Gerais". I wonder if you could send me earlier copies because I think they will also have a lot of representativeness for my research. *João Carlos de Oliveira* – ESTES/UFU (Brazil)

RETS LIST OF INSTITUTIONS

AFRICA

Angola

Technical Professional School in Health of Luanda
(222) 35 78 79 / 222 35 72 04

Technical Professional School in Health of Lubango
(923) 53 74 06

Intermediate Health Institute of Benguela
cfs-b@nexo.ao

National Direction of Human Resources – Ministry of HealthNational Direction of Human Resources – Ministry of Health
(244) 924 215 344 / (244) 923 489 923 / (244) 222 391 281 (Fax)

Cape Verde

Cape Verde University
(238) 261 99 04 / (238) 261 26 60

Directorate of Studies, Planning and Cooperation - Ministry of Health
(238) 261 0900 / (238) 261 3620

Guinea Bissau

National Health School
0021 245 663 98 80 / 0021 245 587 88 64

Human Resources Direction – Ministry of Public Health
(245) 722 3402 / (245) 20-1188

Mozambique

Regional Center For Sanitary Development of Maputo – CRDS – Ministry of Health
(258) 212 470 543

Human Resources National Direction – Ministry of Health
(258) 21 310429

Sao Tome and Principe

Dr. Victor Sá Machado Health Sciences Institute
212 239 910 536

Afro Representation
regafro@afro.who.int

CENTRAL AMERICA

Costa Rica

Health Technology School – Medical School – University of Costa Rica
(506) 2511- 4493 / (506) 2225-8322 (Fax)

Cuba

Faculty of Health Technologies (Fatesa) – Higher Institute of Medical Sciences of La Havana
(053-5) 2860389 / (053-7) 6400192

El Salvador

PAHO Representation
(503) 2298-3491 / (503) 2298-1168 (Fax)

Honduras

The National Autonomous University of Honduras
(504) 232-2110

Mexico

The Integral Applied Clinical Nursing Department / CUCS – University of Guadalajara
(52-3) 10585200 / (52-3) 10585234

Nursing School - The Autonomous University of the State of Morelos
(52 -7) 322 9632 / (52-7) 322 9642

Faculty of Nursing – Autonomous University of Tamaulipas – Tampico Campus
(834) 31 8 17 00 Ext. 3380

PAHO Representation
(52) (55) 5980-0880

Panama

PAHO Representation
(507)262-0030 / (507)262-4052 (Fax)

SOUTH AMERICA

Argentina

Technicians for Health Superior Institut - Ministry of Health of the Autonomous City of Buenos Aires
(54) 11 4807 3341 / (54) 11 4807 0428

Professional Capacity Building, Technical and Research Direction – Government of the city of Buenos Aires
(54) 11 48073341

The National Direction of Human Resources for Health policies - Ministry of Health
(54) 11 43799184 / (54) 11 43799185

Professional Capacity Building, Technical and Research Direction – Government of the city of Buenos Aires
0221 483 8858 / 0221 421 0709

Association of Buenos Aires Surgical Technologists
aib@netverk.com.ar

Argentine Association of Nuclear Medicine Technicians
54 1 4863-4449 / 54 1 4865-9774 (Fax)

TecnoSalud Magazine
54 (011) 4794-8216

PAHO Representation
(54-11) 4319-4242 / (54-11) 4319-4201 (Fax)

Bolivia

National Health School - La paz
(591-2) 2444225 / (591-2) 2440540

Bolivian-Japanese Health Technical School of Andean Cooperation
(591-4) 4257501 / (591-4) 4233750 (Fax)

The Bolivian Chaco Health Technical School "Tekove Katu"
(591) 3 952 2147 / (591) 3 954 6074 (Fax)

Human Resources Unit – Ministry of Health and Sports
(591-2) 248 6654 / (591-2) 2481406

PAHO Representation
(591-2) 2412465 / (591-2) 2412598

Brasil

Technical Schools Network of SUS (Brazilian Public Health System)
(61) 3315.3394 / (61) 3315.2974

Joaquim Venancio Polytechnic Health School
(55) 38659797

General Coordination of Technical Operations for Health Education – Secretariat of Management of Education and Work in Health (SGTES) – Ministry of Health
(61) 3315.2303 / (61) 3315-2425

PAHO Representation
55 61 3426 9595 / 55 61 3426 9591

Chile

Division of Management and Development of People – Ministry of Health
(56 2) 5740345 / (56 2) 5740608

PAHO Representation
(56-2) 4374600 / (56-2) 2649311 (Fax)

Colombia

Association for the Teaching of Dental Techniques
57 1 310 29 71 / 57 1 313 08 73

Center for Health Administration Studies (Ceads)
(57-1) 284-4777 / (57-1) 284-5810

Faculty of Odontology – University of Antioquia
(57-4) 2196718

San Gil University Foundation (UniSanGil)
(57) (07) 7245757 / (57) (07) 7246565

University Foundation of the Andean Region
(57-1) 2497249 / (57-1) 2100330 Ext: 104

Learning National Service (Sena)
(57- 1) 5461500 Ext. 12011

General Direction of Analysis and Human Resources Policy – Ministry of Social Protection
(57-1) 3305000 / (57-1) 3305050

PAHO Representation
(011-57-1) 314-4141

Ecuador

PAHO Representation
(593 2) 2460330

Paraguay

Health Higher Education Center – Health Sciences Faculty
(595) 513 432029 / (595) 513 432009

National Health Institute
(595 21) 294 482 / (595 21) 283 798

Higher Technical Institute of Knowledge
(595 21) 583647

Direction of Higher Technical Institutes – Ministry of Education and Culture
(595 21) 498 716

National Direction of Human Resources for Health – Ministry of Public Health and Social Well-being
(595) 21 – 204601

PAHO Representation
(011-595-21) 450-495 / (011-595-21) 450-498 (Fax)

Peru

General Direction of Management of Development of Human Resources - Ministry of Health
(51-1) 333-2899 / (51-1)623-0000

PAHO Representation
(511) 319 5700 / (511) 437 8289 (Fax)

Uruguay

Health Technology School – Republic University
(00598-2) 487 1323

General-Direction of Health – Ministry of Public Health
(598-2) 400 1002 / (598-2) 4097800

PAHO Representation
(5982) 707-3590 / 5982) 707-3530

EUROPE

Portugal

Higher School of Health Technologies of Lisbon
(351) 218 980 400 / (351) 218 980 460 (Fax)

General-Direction of Health – Ministry of Health
(351) 218 430-500 / (351) 218 430 530 (Fax)

WORLD HEALTH ORGANIZATION (WHO)

Department of Human Resources for Health
41 22 791 2542 / 41 22 791 4747

PAN-AMERICAN HEALTH ORGANIZATION (PAHO)

Human Resources Development Unit
(202) 974 3000 / (202) 974 3612

WORLD HEALTH ORGANIZATION FOR AFRICA (AFRO)

Division of Health Systems & Services Development
(47 241) 39 416 / (47 241) 95 39 511 (Fax)