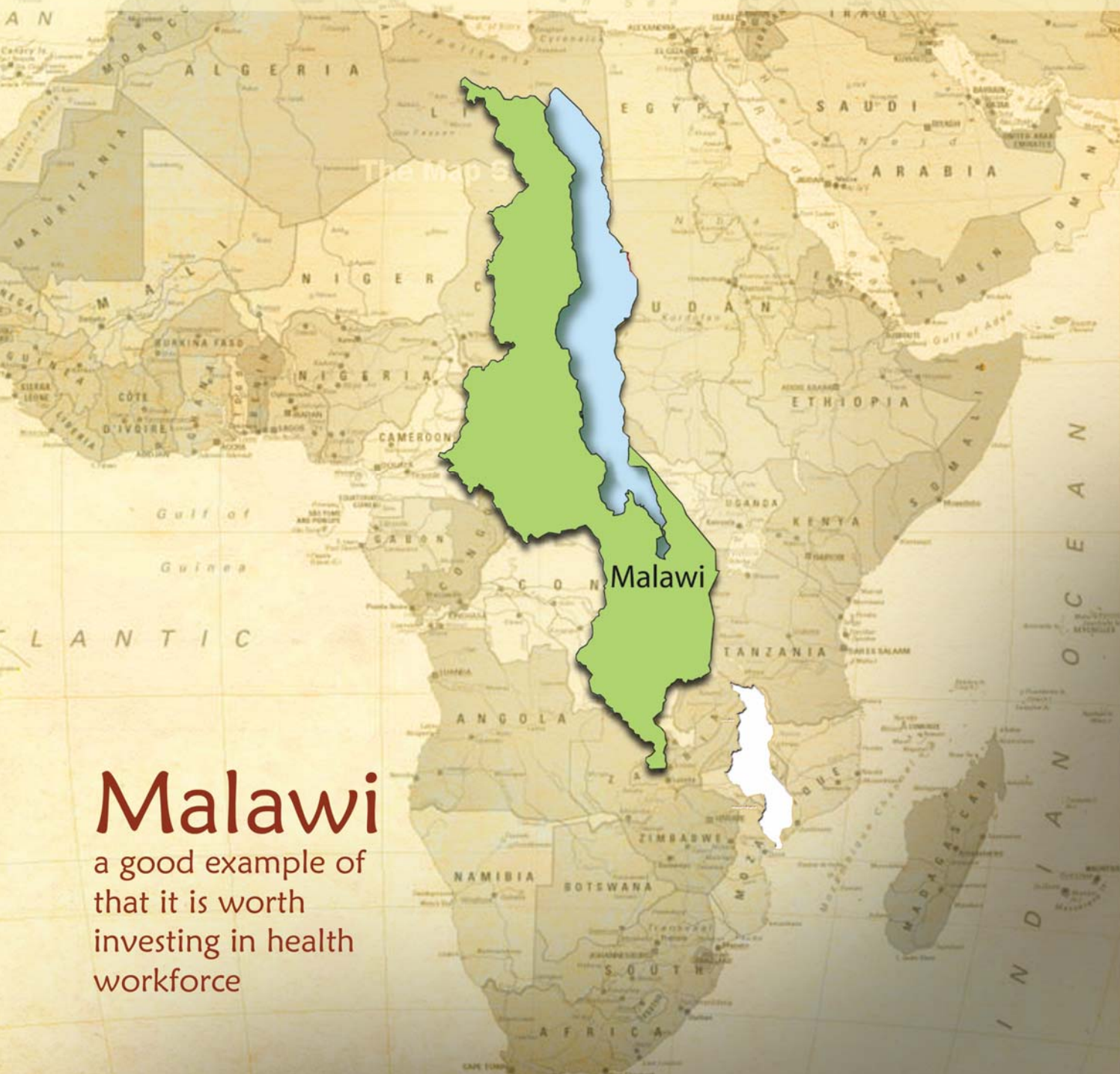


REVISTA

Year 3 – n° 10 – apr./may./jun. 2011

RETS

International Network of Health Technicians Education



The Map 5

Malawi

Malawi

a good example of
that it is worth
investing in health
workforce

Cover

Human Resources for Health Plan assessment in Malawi shows that there is still much 2

Interview - Isabel Dure

Health and Education: work intersectoval is still a challenge 11

New world strategy for Africa highlights teh importance partnerhips and the role of health and education 7

MERCOSUR discusses education and technical performance of health workers 9

WHO initiative to scale-up health professional education 12

RETS-UNASUR, RESP and RINS. Three network and a single goal: to strengthen health worker's education in South America 14

editorial

During his lifetime, Albert Einstein reiterated several times the importance of experience as a source of knowledge. English comedian and writer Douglas Adams, in turn, while lamenting the apparent unwillingness of humans to learn from the experience of others, made a point of emphasizing that this is one of the capabilities that differentiate us from other animals. By adding to that the express purpose of RETS to facilitate and foster the sharing, among other things, of information and experiences among its members, we see no impediment to disclose within the Network the successes and difficulties faced by Malawi, a small African country, in the execution of their daring emergency plan of human resources for health established in 2004.

Does a plan whose objective was to prevent the total collapse of a system “on the edge of chaos”, according to the Minister of Health of Malawi, can serve as an example for other countries? What was done? What went right and now makes it feasible for the country to achieve the Millennium Development Goals in Health? What endangers the achievements? Is it possible to provide sustainability and continuity to emergency measures? There are many questions and certainly many of them have no conclusive answers. What is left for us is to reflect on the subject and the expectation that, at some point, this “alien experience” might be useful to our own goals.

The networks of health systems structuring institutions of UNASUR – RETS, RESP and RINS – are the subject of a second story whose goal is to show our readers how the South American countries have sought to organize themselves to overcome some of the challenges faced by national health systems.

To complete the issue, we present the new World Bank strategy for Africa, with emphasis on partnerships and knowledge; the results of the workshop “Challenges for human resources in health training and professional practice in MERCOSUR”, held on April 7 and 8 in Asuncion, Paraguay; and, finally, the launching by WHO of a booklet about the process of developing the soon-to-be-published policy and technical guidelines designed to improve the education of health professionals.

Happy reading!

RETS Executive Secretariat

acknowledgements

Year III - No. 10 - apr/may/jun 2011

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

Editorial Board

Ana Maria Almeida (ESTeSL – Portugal)
Carlos Einisman (AATMN – Argentina)
Isabel Duré (MS-Argentina)
Julio Portal (Fatesa/ISCM-H – Cuba)
Olinda Yaringaño Quispe (MS – Peru)

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)

Circulation

1000 copies

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

Ana Beatriz Noronha

Anakeila Stauffer

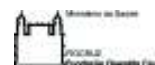
Kelly Robert

Address

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

Sponsor

TC41 - Secretaria de Gestão do Trabalho e da Educação na Saúde/
Ministry of Health of Brazil and PAHO-Brazil



Human Resources for Health Plan assessment in Malawi shows that there is still much to do

“Today, we are almost achieving the target set in the Millennium Development Goals to reduce child mortality and have managed to provide prenatal care service to 68% of women in the country. In six years, 13,000 lives have been saved”, said Malawi’s



Minister of Health, David Mande, at the seminar “No health workforce, no health MDGs. Is that acceptable?”, which was part of the Millennium Development Goals Summit program held by the United Nations (UN) in September 2010.

But what has happened to make this small country in southeastern Africa (see box) become a positive example when discussing the issue of health workforce? What still needs to be done in order to make this country overcome its major health problems?

The answer to these questions lies in the results presented in the six-year (2004–2009) assessment report of the Emergency Human Resources Program of Malawi (EHRP), released in July of that same year.

For the assessment, carried out through the technical and financial backing of the **Department for International Development** (DFID), the government of Malawi hired two independent companies - Management Sciences for Health (MSH) and Management Solutions Consulting (MSC). The main objective of the study, which began in the second half of 2009, was to enable the government of Malawi to

review the Program’s implementation progress and take stock of achievements?. The assessment also enabled to check the Program’s costs and its impact on utilization of health services. The observation was focused on five key points (or elements) making up the action plan:

- **Element 1:** establishment of salary incentives for the recruitment and retention of 11 professional categories in public hospitals and philanthropic hospitals, along with an incisive qualified personnel reemployment and recruitment action.
- **Element 2:** increase of domestic training capacity by over 50% of the total, including doubling the number of nurses and tripling the number of doctors and clinical assistants under training.
- **Element 3:** use of international volunteer doctors and nursing tutors to fill vacant posts in critical places while national professionals are being trained..
- **Element 4:** international technical assistance in capacity building and development of

UK government agency which is devoted to supporting the poorest countries with a view to eliminating extreme poverty. Created in 1997, it operates in about 90 countries through partnerships with governments, charities, companies and international organizations. Besides its headquarters in London and East Kilbride, DFID has offices in over 40 countries.

In low income countries, the Essential Health Package usually encompasses a very limited number of clinical and public health services that must be available to people in the lower complexity levels of the system. The existence of an EHP does not mean that people with other health needs are not being covered by the services, but rather that there are no guarantees that there will be resources - staffing, drugs and equipment - available for their specific needs. EHPs are generally developed based on epidemiological and technical but also economic (cost-benefit) and social factors. In Malawi, the EHP established by government in the early 2000s emphasizes the actions of immunization, reproductive health and nutrition.

Source: Essential Health Packages (EHP): What are they for? What do they change? (WHO, 2008)

About Malawi



Founded in 1891 as a British protectorate of Nyasaland, the Republic of Malawi became an independent nation in 1964. After three decades of one-party regime, the country held its first multiparty elections in 1994. Current president Bingu wa Mutharika took office in 2004 and was reelected for another five-year term in 2009.

A region with a subtropical climate, Malawi is bordered to the north and east by Tanzania, to the east, south and west by Mozambique and to the west by Zambia. The country, whose capital is Lilongwe, has a total area of 118,480 km², with 94,084 km² of land and 24,404 km² of water, especially due to the large Lake Malawi (formerly Lake Nyasa). It has a population of about 15.5 million inhabitants belonging to eight different ethnic groups: Chewa, who is the majority of the population, Nyanja, Tumbuka, Yao, Lomwe, Sena, Tonga and Ngoni Ngonde. The country's official languages are English and Chichewa.

Classified by the World Bank as a low-income country, Malawi had in 2009 a GDP per capita of less than US 300*. The rate of illiteracy among the population over 15 years of age is 25%. Regarding health, WHO said that life expectancy is 44 years for men and 51 years for women.

In the economy, the agricultural sector accounts for about 35% of GDP, employing nearly 85% of the national workforce and representing over 80% of foreign currency earnings. Agriculture is characterized by the coexistence of a few large commercial properties with a large number of mainly small farmers practicing subsistence agriculture. Maize is a staple and accounts for 80% of cultivated land. The main export crops are tobacco, sugar, tea and coffee.

* amount converted to U.S. dollars through the Atlas method (World Bank)

At the time, the inability of government to plan and invest in the production and retention of adequate numbers of health professionals in the public sector was considered one of the causes of the crisis. The public health sector in Malawi includes the units directly linked to the Ministry, which account for about 60% of services, and those belonging to the Christian Health Association, responsible for the remaining 40%.

Only about half of the 20 doctors who graduated from the only medical school of the country were still working in the public sector and less than 50% of the almost 9,000 jobs created for nurses were filled. The graduation rate could not keep pace with needs. Low wages, overwork and lack of conditions for the performance of their duties contributed to the crisis in the sector and the fast deterioration of health indicators for the country.

In 2004, while in sub-Saharan Africa, the average maternal mortality rate was 940 deaths per 100 thousand live births, the infant mortality rate was 76 per thousand live births and HIV/AIDS prevalence among adults 7.5%, in Malawi, rates were 984 maternal deaths per 100 thousand live births, infant mortality 102 per thousand live births and a 12% HIV/AIDS prevalence among adults.

Given this context, in separate visits to the country, [UNAIDS](#) executive director, Peter Piot, and DFID Permanent Secretary,

planning and management skills within the Ministry of Health.

- **Element 5:** increase of the ability to monitor and assess the health workforce, based on the existing management information systems which were strengthened to support the implementation of the **Essential Health Package**.

In addition to documenting and analyzing the results obtained until the time of the assessment, the team behind the report highlighted the lessons learned and made evidence-based recommendations for the strengthening of Human Resources for Health (HRH) systems and public health practices in Malawi.

Plan to reverse healthcare's collapse

In April 2004, the Ministry of Health of Malawi labeled healthcare situation in his country as a 'near collapse'. At that time, the insufficient staffing of workers for the sector was even smaller before the rapid growth in demand for services resulting from, among other things, population growth and high HIV/AIDS levels, as well as migration of health professionals abroad fostered by the globalization process. All this contributed to the country having only 1.1 doctors and 25.5 nurses per 100 thousand inhabitants.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) goal is to foster, mobilize and support countries to achieve universal access to prevention, treatment and care related to HIV. Launched in January 1996, it is coordinated by a group composed of representatives from 22 countries, other international agencies, among which are the World Bank, the World Health Organization and the International Labour Organization, the Secretariat of the Programme itself and five NGOs, including associations of people living with HIV.

Chakrabarti Suma, noted that the lack of skilled health workers rendered any effective response to control HIV/AIDS and even any attempt by government to undertake reforms in the sector impossible.

In response to the two bodies, traditional donors to Africa, and through their support, the government of Malawi developed an Emergency Human Resources Program (EHRP), whose central focus was the quantity and quality increase of health workforce through financial incentives and a strong increase in the training scale of new workers.

A plan ahead of its time

Since its launch, Malawi's HRH Plan drew international attention for its comprehensiveness and innovation. A comparative study which involved five countries - Cameroon, Indonesia, Malawi, Rwanda and Tanzania - showed that only Malawi had implemented both large and interconnected incentive systems aiming at the retention of workers in both public and private health sectors, in a scenario where several countries have not yet developed their HRH plans and many of the initiatives to solve the health workforce crisis still occur in a piecemeal fashion.

Another trait of the plan was the level of funding - about US\$ 95 million - and the support it received from donor agencies for six years, something that should not be underestimated, considering that any attempt to resolve the health workforce crisis should consider the time horizon needed to train new staff and implement new policies for the sector.

EHRP represents the first of the six pillars of the 2004-2009 Work Plan of the Ministry of Health of Malawi. The other five are: pharmaceuticals and medical equipment; essential basic equipment; infrastructure development; routine operations in health units; and central operations and policies and systems development. The Plan is managed by the Ministry through a highly effective sectoral approach due to the high level of collaboration between the various departments of the health sector.

Although it was built as an emergency response to an extreme situation, there was always the understanding that the plan would succeed only if an increased institutional capacity was developed and more efficient health work management systems were created.

Targets foreseen and strategies employed

The plan's overall objective was to reduce Malawi's health workforce deficit to a level comparable to that of Tanzania. That meant going from 1.1 to 2.3 doctors and 25.5 to 36.6 nurses per 100 thousand inhabitants. To that effect, specific goals for each of the five elements of the Plan were set.

Under the 'Element 1', which dealt with financial incentives and strategies for the recruitment and retention of staff, staff annual targets were set, which were expected to rise from just over 6 thousand professionals in 2004 to over 10 thousand in 2010, representing an increase of about 70%. Staff goals were established by the Ministry of Health's authorities in collaboration with a consultant in health economics. At the time, in partnership with professional associations and training institutions, the Ministry of Health selected 11 professional essential categories to implement the Essential Health Package: doctors, nurses (including midwives), clinical assistants, medical assistants, laboratory technicians, radiology technicians, pharmacy technicians, dental therapists, physiotherapists, environmental health officers and medical engineers.

Several initiatives have been taken for the identification and recruitment of graduates of educational institutions, as well as for the rehiring of health workers who had left the public sector for several reasons. In regard to recruitment, two large selections were carried out at national level, the first one in mid-2006 and the

second one in late 2008. However, the delay in the effectuation of recruited workers caused damage to the process, since some professionals ended up giving up or opting for other jobs.

One approach to the functional reclassification was an extension of the retirement age limit which was increased from 55 to 60 years. The reinstatement of the retired was done through three-year contracts. Furthermore, a benefits package was foreseen to foster the holding of posts in remote areas, which unfortunately was never implemented. The improvement in working conditions and the possibility of continuing education were other factors used to attract workers.

The objective of 'Element 2' was to significantly increase the number of health workers under training and improve the capacity of key educational institutions in the country: the Faculty of Health Sciences; the Kamuzu College of Nursing; the Faculty of Medicine and the Christian Health Association's institutes. To this end, the following were established: scholarships which, among other things, would help students pay for their tuition; and financial resources to help institutions to improve their infrastructure and, thus, receive more students. The idea was to double the number of doctors and triple the number of nurses and clinical assistants. The model projected an 82% increase in the number of graduates, which would rise from 842 in 2004 to 1,534 in 2009.

There were no specific targets set for 'Element 3', which addressed the use of medical volunteers to fill vacancies on an emergency basis, since this would be a palliative measure whose duration was tied to achieving the goals of 'Element 2'. The initial idea was that, in addition to providing clinical care, volunteers could transfer specific knowledge to local professionals. From 2004 to 2009, the number of volunteer doctors linked to the EHRP increased from 18 to 132.

The objective of 'Element 4' was to increase the capacity of the Ministry of Health in the management of human resources. The proposal was that the Ministry would hire experts to support

the development, implementation and monitoring of HR management systems, facilitate the development of skills and lead the revitalization of the HR Planning Unit of the Ministry. Out of a total of 23 consultants hired during the period April 2005 to December 2008, 4 belonged to an HR field. According to the report, the major difficulty in this element was the absence of a team from the Ministry itself with the capability and motivation to interact with the contracted professionals.

In the case of 'Element 5', the aim was to strengthen the monitoring and assessment of health workforce's capacity. However, there was no defined strategy to this effect and no specific goals were detailed for this Element.

In the early implementation of the plan, it had already be foreseen that these five interventions should be accompanied by the strengthening of infrastructure, management and leadership capacity of the system, since, failing this, it would be impossible to sustain achievements. The consensus was that increasing the number of health workers and students in training schools would be only the first step and that the achievement of long-term benefits for the population would still depend on the support these workers would receive for their maintenance and the provision of quality services with a good level of performance.

Lack of data hampers the assessment of the program

To achieve the proposed objectives in a more comprehensive, coherent and consistent way, the assessment process of EHRP - Malawi was carried out on several fronts under the supervision of a task force headed by Health Minister and composed of representatives from various sector agencies.

The task included a combination of field research and data collection traditional methods. Regarding quantitative data, the information systems of the Ministry and of educational institutions were used as primary sources, as well as published reports and documents. Qualitative data were collected in focal groups and interviews with key informants, as well as through research conducted with HR managers at the district level. Data analysis was performed in collaboration with the Plan's Task Force.

With regard to difficulties in the assessment process, the lack of quantitative data, especially related to periods prior to the implementation of the program, presented the greatest challenge, especially for the determination of trends and a

more accurate understanding of the ensuing impact of the EHRP. Another difficulty was the lack of computerized data. Some detailed information on the payrolls of units linked to the Christian Health Association was only available in a printed version, thus preventing access to individual data. It was also not possible to access payments data prior to 2005 at the Ministry due to changes in the system database and the lack of records backup.

Results justify investments

Experience shows that there is a positive and direct relationship of the increased numbers of health workers and improved health outcomes within a given population. In 2004, early in the implementation of the EHRP in Malawi, there were 0.87, i.e. less than one worker in the public health sector for every thousand inhabitants in the country. In 2009, this number increased to 1.44, representing an increase of 66%. During the same period, the total population in Malawi increased by 10%, showing that the density of health workers suffered a real increase that exceeded the rate of population growth.

Regarding the use of health services, the table opposite shows that there was a considerable increase in the six priority services of the Ministry - (1) prenatal visits; (2) deliveries performed by skilled personnel; (3) child immunization; (4) administration of Nevirapine to prevent the vertical mother-to-child transmission of HIV; (5) total outpatient visits; and (6) registrations in antiretroviral drug distribution programs -, resulting in more than 13 thousand saved lives, at an average cost of just over US\$ 7,200, considering that the program used about US\$ 95 million.

Overall, the assessment showed that although only four - doctors, clinical assistants, laboratory technicians and pharmacy technicians - of the 11 selected categories met or exceeded the targets set in the original document, the central objective of the Plan was fully met. From 2004 to 2009, the number of health professionals of the prioritized categories registered an increase of 53%,

Summary of Inputs, Outputs, Outcomes, and Impact of EHRP					
Elements	Inputs (USD)	Outputs	Outcomes	Impact	Lives Saved
1a. Incentive Payments	34,1 million	8,369 health workers at MOH and CHAM facilities by 2009 10,507 HSAs in community by 2009	1,44 Health Workers per 1,000 population; 0,02 Physicians, 0,37 Nurses, 0,8 HSAs per 1,000 population	49% increase in OPD service 15% increase in safe deliveries 7% increase in ANC 10% increase in immunisation 18% increase in PMTCT	6,433 265 2,842 3,647
1b. Recruitment	169,069	1,093 staff recruited			
2a. Training - Student Fees	29,9 million	6,316 health workers trained			
2b. Training Infrastructure	16,7 million				
3. International volunteers	6,4 million	552 person-years			
4. Technical assistance	1,5 million	HR Policies			
5. M&E system	112,529	N/A			

ANC: Antenatal Care
 CHAM: Christian Health Association of Malawi
 HSA: Health Surveillance Assistant
 MOH: Ministry of Health
 OPD: Out-Patient Delivery
 PMTCT: Prevention of Mother-to-Child Transmission of HIV

from 5,453 to 8,369. If we consider the **Community Health Agents** staff, which rose from 4,886 to 10,507, this increase reaches 83%.

Regarding education, in the four main institutions, there was an overall increase of 39%, from 917 undergraduates in 2004 to 1,277 in 2009. In the case of doctors, the increase was 72%, rising from 18 graduates in 2004 to 31 in 2009. In nursing, the increase was 22%, with the number of graduates going from 575 to 699.

Despite positive results, not everything can be cause for celebration. The suspension of scholarships payment by the Government of Malawi in September 2009 caused an immediate drop in enrollment at local health education institutions. In the Christian Association's institutions, enrollment dropped from 616 in 2008 to 87 in 2009, causing the postponement of the period to April 2010. Among graduates, 95% of students said they could not have completed the course without a scholarship paid for by the government.

What still needs to be done

Evidence shows that efforts in Malawi to overcome the emergency phase with respect to the health workforce have been worthwhile and should be used as an example, but gains, as the report states, are still meagre due to the lack of a sustainability plan, the structural weakness of the health system, population growth and an ever increasing disease burden. To that effect, the document makes several recommendations to be pursued by the government of Malawi to make permanent the successes achieved so far.

According to the document, it is still necessary, among other things, to perform a deeper analysis on the staff required in order to achieve the Millennium Development Goals and the effective implementation of the Essential Health Package established by the government, as well as to institutionalize a new pay structure at the Health Ministry to give support to the 52% staff salary increase. Regarding the 'Element 1' goals of the Plan, it is necessary to accelerate the implementation of the incentive package to attract health professionals to remote areas.

With respect to education, the report suggests that a commission be set up with leaders from the Ministries of Health, Education and Finance, educational institutions and donor agencies to try and balance the cost of health education and the tuition paid by students.

As part of management, the main recommendation is that the HR coordinating body occupies a higher position in the structure of the Ministry, with a core team of professionals with expertise and experience in this area.

A learning to be shared

Assessment of the EHRP of Malawi revealed, according to experts, at least ten key lessons for the country itself and all others who face problems and need to overcome similar challenges.

1. The government's commitment to take responsibility for actions is essential.
2. The successful implementation of a comprehensive HRH plan requires a multisectoral collaboration and commitment.
3. The joint implementation of short-term emergency interventions and long-term interventions is the cornerstone of success, since short-term measures alone will not produce a lasting impact.
4. Donor's support to sustain the 52% salary increase and the attitude of the government of Malawi to allow different pay scales within the system was providential.
5. All initiatives should be undertaken with a long-term horizon so that improvements can be detected.
6. Planning for sustainability should be considered from the outset.
7. The successful implementation of HRH plans should be based on a highly professional design of organizational systems and institutional arrangements. It also depends on the existence of well-prepared leaders and teams staffed by qualified and experienced professionals.

Although not part of the initial project, the additional Community Health Agents staff also received incentive pay as specified in 'Element 1' of the Plan. These workers are recruited from the community and provide various services, such as: immunizations, family planning, childcare visits and disease control. The target set by the Ministry of Health is one agent for every thousand inhabitants which, despite a growth of over 115% of the staff, has not yet been achieved.

8. An integrated and functional Human Resources Management system - recruitment, placement, transfer, promotion, performance management - is the foundation for the successful implementation of HRH strategies.

9. The accelerated increase of the training of traditional health workers - doctors and nurses - is not sufficient to meet all health systems' needs and is not always cost-effective. In the case of Malawi, the focus on the implementation of the Essential Health Plan requires skills from other staff, such as Community Health Agents and technicians from various specialties.

10. There must be clear and regular communication between all involved in the process, including undergraduate students and people who are already employed in the healthcare sector, about the goals and expectations of the HRH plan. Such a measure is essential to avoid confusion and backlash which can result in policy changes, especially those involving financial compensation or the payment of scholarships to students. ❌

Read more:

- The Emergency Human Resource Programme (EHRP) - Progress and Lessons from Malawi. (Dr Jason Lane)
 - Evaluation of Malawi's Emergency Human Resources Programme: final report and annexes (Management Sciences for Health - MSH)
 - Malawi's Emergency Human Resources Program: an Overview (Gordon Matt, 2008)
- The three documents are available at RETS website (<http://www.rets.epsjv.fiocruz.br>) at: 'Library' > 'Topics of interest' > 'Malawi'

New World Bank strategy for Africa highlights the importance partnerships and the role of health and education

After eight months of personal consultations or consultations via the Internet with over two thousand people in 36 countries, 31 of which from Africa, the World Bank launched on March 1 the final version of the document "Africa's Future and the World Bank's Support to It", with its new strategy for the region.

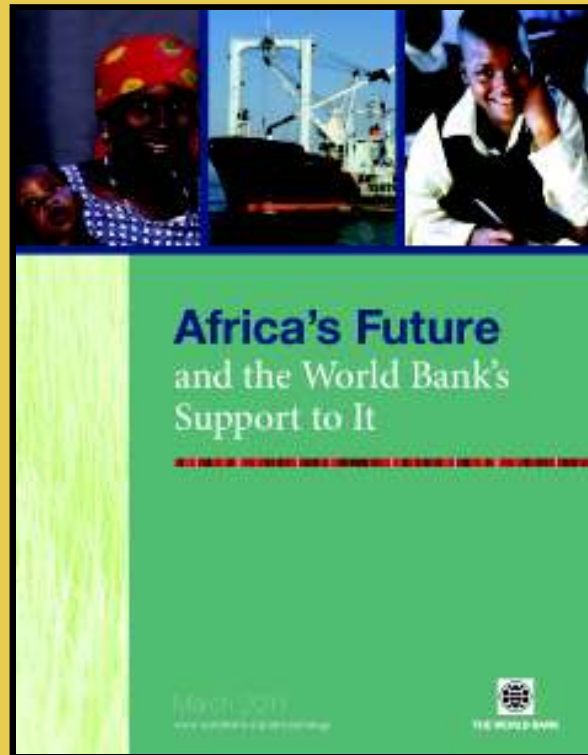
According to the World Bank, the idea is to seize the moment to transform the continent and improve living conditions of its people, helping African economies to become stronger, as did Asian economies 30 years ago. The new approach represents a significant change in how the organization looks at Africa and assesses its own role in supporting progress for the continent.

The strategy stems from a general proposal seeking economic stability to highlight the fundamental points:

Competitiveness and Employment

Thus, the document stresses the need for countries to diversify their economies and generate employment, especially

The drafting of the document "Africa's Future and the World Bank's Support to It" began in July 2010, when a first phase of consultation started, consisting of meetings, videoconferences and electronically-sent comments, whose initial goal was to collect initial contributions. From September to November, a review of contributions received was carried out and a preliminary strategy proposal was prepared. In November and December, public comments on the draft strategy were collected electronically. In 2011, the text to be approved by the World Bank's Executive Directors was written in the first two months of that year.



for the estimated 10 million young people who annually join the workforce. The proposal is to reduce the gap between needs and investments that are made in infrastructure - currently about US\$ 48 billion annually - by supporting efforts to facilitate the operation of enterprises and enhance the skills of workers, particularly in strategic areas. The document reaffirms the idea that Africa's growth depends on the health of its population and that this, in turn, depends on, among other things, a well-prepared health workforce.

Vulnerability and resilience

According to the World Bank, Africa's poor countries tend to be much affected by the crises that occur in global economy and health, as well as natural disasters and conflicts, something which tends to increase poverty in which they live. In this sense, the strategy proposes measures to strengthen national healthcare systems, prevent the effects of climate change through improved management of water resources and irrigation and strengthen public entities so that they can distribute resources more equitably and build

For the humanities, the concept of resilience refers to the ability of human beings to respond positively to the adversities they face, even when these pose risks to their development. Resilience can also represent the ability to recover the normal functioning pattern after experiencing a negative situation and suffering its consequences. In this sense, a resilient society is that which, even through times of crisis, is able to recover and keep the conditions necessary for its maintenance.

consensus. Therefore, the aim of the plan is to reduce the incidence of shocks and minimize the damage they can cause when they are unavoidable.

Governance and public sector training

Although considered essential, education, health and basic infrastructure services are often badly provided or not provided at all due the mismanagement of public resources. In this sense, the strategy foresees that the World Bank strengthens the population to defend their rights, either through information on the responsibilities that governments have towards people or by increasing society's organizing capacity, enabling it to expose cases where services are not well rendered. On the other hand, the strategy also provides for the World Bank's support to governments so that they may improve their systems and increase their capacity to deliver basic services and manage their accounts.

Significantly, the new strategy reverses the order of importance of the Bank's instruments to support the continent, making partnerships the more important factor, followed by knowledge and funding itself. The purpose of the change is to ensure that the Bank's interventions serve to complement the initiatives undertaken by African governments, the private sector and other agencies.

"This strategy is very representative of what we gather from the peoples and leaders, but also of the feeling of the World Bank itself", said Shantayanan Devarajan, World Bank Chief Economist for Africa at the launch of the document. "Although we are confident that this is the most correct approach at the moment, we also want to ensure that we are ready to make adjustments to the extent that Africa continues to evolve and develop. The continent has surprised many naysayers, achieving more than a decade of solid economic growth and gradual reduction of poverty. It is a historic opportunity", he said. 🗉

World Development Indicators 2011: much has been done in health, but there is still much to do

"World Development Indicators (WDI) 2011" is already available on the World Bank's website. Those interested can access the information directly in the publication or through the electronic database. The 15th edition of the publication now includes data from 2009 or 2010 on many indicators. Also available are a shortened version with the main regional highlights of indicators and a presentation of the publication in the form of slides.

With regard to the health goals of the **Millennium Development Goals (MDGs)**, the publication shows that 11 countries have already achieved the goal of reducing by two thirds the mortality rate and another 25 are close to reaching this goal, but that the situation is still out of control in 100 countries. With regard to maternal health, 30 countries are on track to achieve a 75% reduction in maternal mortality rate, but 94 still need to work hard to meet this challenge. Despite having declined in all regions of the world, the rate of maternal mortality is still high in middle and low-income countries - 580 deaths per 100,000 live births. The situation is even worse in Sub-Saharan Africa and the average rate rises to 650.

On the issue of HIV/AIDS, the good news is that the number of new cases has fallen by 21% since 1997. The bad news is that data available in 60 developing countries are not yet reliable.

With regards to the eradication of poverty, numbers are still alarming. The number of people living in extreme poverty decreased from 1.8 billion in 1990 to 1.4 billion in 2005, but, while the number of people living on less than US\$ 1.25 per day fell, the number of people living on a daily income between US\$ 1.5 and US\$ 2 increased. According to the report, the fact that 43 countries are about to end extreme

poverty (twice of 2005) may bring some positive outlook for this aspect.

Novelties and features to facilitate research

The new WDI edition brings many novelties and features, among which are the presentation of data on the mortality rate in the form of time series. Altogether, the WDI database now has over 1,200 indicators.

In 2011, the database also gained several features whose function is to expand and facilitate access to available information. Among other things, data can be accessed by country, topic or indicator and one can download the selected data in the form of Excel or CSV files or read the contents directly into the electronic book format. Access via CD-ROM will soon be made available.

The printed version of WDI 2011 is available on the World Bank's website (<http://web.worldbank.org>), at: 'Data & Research'. Those interested can also access WDI's web page directly at: (<http://data.worldbank.org/data-catalog/world-development-indicators>).

In September 2000, Heads of State and Government from 189 countries meeting at the UN signed the Millennium Declaration, through which they committed themselves to achieving eight goals (MDGs) within 15 years, for the future of humanity:

1. Eradicate extreme poverty and hunger;
2. Achieve universal primary education;
3. Promote gender equality and empower women;
4. Reduce by two-thirds the under-5 child mortality;
5. Improve maternal health, reducing by three-quarters the maternal mortality rate;
6. Combat HIV/AIDS, malaria and other diseases;
7. Ensure environmental sustainability; and
8. Create a global partnership for development.

MERCOSUR discusses education and technical performance of health workers

The First Regional Seminar on Human Resource in Health Development in the MERCOSUR - “Challenges of human resources in health training and professional practice in the MERCOSUR” was held in Asuncion, Paraguay, on April 7 and 8. Many issues and proposed actions that may allow the development of health education policies that are more integrated within the block were discussed in the event.

Context justifies the need to work together

It is vital to have enough workers with the quality that services demand in order to enable national health systems to meet the needs of the population.

However, training and managing the workforce are not simple tasks, especially when the issue is thought of in a regional context. In general, each country has a different educational and professional training system and other variations may occur in the length of education, the materials and methods used, as well as the topics covered. National education systems seek to adapt to meet the specific needs of each country but still have not succeeded in reversing the severe shortage of health workers, caused among other things, by the failure of former attempts to reform the management of human resources, the lack of financial resources fueled by the global economic crisis and the increasing migration which tends to aggravate the maldistribution of the workforce, which can represent up to 60 to 70% of sector's expenditure.

Given this context and the need to improve country health indicators, the issue of education and labour in the sector has become paramount in the MERCOSUR, serving as a guide to the platform of interagency work between the MERCOSUR Educational Sector (SEM) and the Subcommittee on Professional Development and Practice of the Working Subgroup for Health, the SGT11, with support from the Pan American Health Organization.

In this sense, the seminar convened by the Ministries of Education and Health of Paraguay, a country which holds the Pro Tempore Presidency of the bloc, tried to continue the discussion of the goals of actions oriented to human resources in health, through the broadening of discussions focused on:

- Promoting the development of activities that further the development of mechanisms to strengthen the accreditation of priority health careers;

- Formulating mechanisms for the accreditation and revalidation of professional titles;
- Defining comprehensive processes for the approval and enabling of new health careers; and
- Deepening knowledge about the situation of health technicians' education.

Lectures and presentations bring benefits to discussions

At the opening ceremony of the event, all table members were unanimous in highlighting the importance of the meeting and the determination and responsibility of everyone in the achievement of the proposed objectives.

Two lectures started the event's program. The first one, ministered by Alberto Fernández Ajuria, from the Andalusian School of Public Health, addressed the experience lived by EU countries throughout the Bologna Process, especially with regard to the accreditation of courses and approval of titles. In the second, the Executive Secretary of [UNA-SUS/Fiocruz](#), Francisco Eduardo Campos, presented an overview of the current situation of the education of human resources for health and professional

The Unified Health System's Open University (UNA-SUS) is a project of the Ministry of Health of Brazil, which seeks to develop conditions for the establishment of a collaborative network of institutions of higher education, health services and management of the Unified Health System (SUS), with a view to meeting the continuing training and educational needs of employees of the system. Among the specific goals of UNA-SUS are: the creation of a public and collaborative collection of health educational materials, aiming at the exchange of academic information of students for a shared educational certification; the promotion of the incorporation of new information and communication technologies processes into health education; the offer of presential support to learning processes in health; the undertaking of courses for health workers suitable to local conditions, using presential and distance interactions with a view to providing training in strategic areas of the SUS. The network's member institutions develop health workers training and qualification programs in strategic areas to consolidate the SUS, taking responsibility to achieve at least a thousand professionals, and a commitment to make public all produced material.

More information at: <http://portal.universidadeabertadosus.org.br>

practice in the MERCOSUR, pointing out the challenges of education and health systems of the bloc.

Drawing participants' attention to the importance of intersectoral work in seeking solutions to the human resources crisis affecting national health systems was the goal of Rosa María Borrell Bentz, PAHO/WHO Human Resources Adviser, who, based on principles and guidelines of the **Toronto Call to Action**, stressed the urgency of a coordinated work of Health and Education. She said there are many difficulties to be faced in the course of this interaction, but the regional context is favorable to the success of the venture.

There were also presentations on the status of health technicians' education in Argentina, Brazil, Paraguay and Uruguay and on the results of the research "Health Technical Workers Education in Brazil and MERCOSUR" conducted between April 2007 and March 2009 by researchers at the Joaquim Venâncio Health Polytechnic School (EPSJV/Fiocruz). The study sought to map the area of technical education in Brazil - number of courses (types and methods), professional qualifications and education institutions - also including, in its international phase, a survey about the bases of the organization of health professional education and health work in other countries of the bloc, along with an analysis on the issue within the institutional framework of MERCOSUR.

Based on the Brazilian research, representatives from Argentina, Paraguay and Uruguay presented proposals tailored to their own reality to continue nationwide the stage of mapping and analysis of health technicians' education. Following these studies, results are jointly analyzed by countries, including Brazil, as coordinator of the multicenter survey, and will be presented in 2012 at the 2nd International Seminar on Health

Technical Workers Education in the MERCOSUR.

A European example may guide actions in the MERCOSUR

Alberto Ajuria began his presentation with a historical background of the formation of the European Union, which acts as a representative democracy, based

on seven institutions: the European Parliament, the European Council, the European Union Council (the Council), the European Commission, the Court of Justice of the European Union, the Court of Auditors and the European Central Bank. He also spoke about the competence of the Union to support actions of States in respect to education and professional training and to legislate on its internal market.

He presented various aspects of the Bologna Process, a set of initiatives aimed at implementing the proposals contained in the Bologna Declaration, a document created in 1999, to which 47 European states have adhered. Among other things, the Declaration established the creation of the European Higher Education Area (EHEA) by 2010, characterized by the recognition of qualifications, the structure of titles, the credit system, the mobility program, whereby workers educated in one country can work in another country without any problem, the quality assurance and the lifelong learning.

Ajuria highlighted the importance of accreditation to promote excellence in educational institutions for education's quality assurance and for the gradual implementation of an assessment culture and used this topic to show how international agreements ended up influencing actions within countries.

Final results of the Seminar

At the end of two days of discussions, members of the Educational MERCOSUR and SGT11 ratified the strategic need for cooperative work and pledged to establish a common agenda for both groups, always with a view to achieving the established objectives: promoting the development of joint activities in the accreditation process of priority health careers; fostering the creation of mechanisms for the analysis and effectuation of proposals on the approval and revalidation of titles; establishing comprehensive procedures for the implementation of new health careers; and increase knowledge about the status of health technicians' education.

Accordingly, four activities have been established, whose progress is considered critical to the unfolding of the work: the formulation of a glossary of common terms to both Health and Education; the development of a matrix of title approval and revalidation processes; the preparation of a matrix of common issues to both fields; and the participation in a workshop for the assessment of the Regional Accreditation System for University Courses of the MERCOSUR (ARCU-SUR), to be convened by the Regional Coordinator for Higher Education (CRC-ES). 🇪🇺



The Toronto Call to Action for a Decade of Human Resources for Health (2006-15) gathers discussions held at the VII Regional Meeting of the Observatories of Human Resources for Health held in Toronto, Canada, from October 4 to 7, 2005. The 'Call to Action' aims to mobilize national and international stakeholders of the health sector, other relevant sectors and of the civil society to collectively build policies and interventions for the development of human resources in health directed to the Millennium Development Goals, the national health priorities and the access to quality healthcare for all peoples of the Americas by the year 2015.

Health and Education: work intersectoral is still a challenge

What would you positively highlight about the discussions held in Asunción?

Firstly, the recognition by MERCOSUR of the need for a sectoral plan to address the problems of professional education and practice of health workers. Labour problems in the sector cannot be treated in isolation from education, since they influence each other. When we discussed in the Working Subgroup for Health (SGT11) the issue of harmonization of professional qualification conditions to facilitate the movement of workers scheduled for 2015, as part of a common market, we can see in all countries of the bloc that the achievement of professional registration keeps close links with titles and, in turn, the achievement of titles is governed by the education sector, with little involvement of the employing sector, which is health.

At the same time, the Educational MERCOSUR, which has been working the issue of career accreditation in some universities of the four countries, already recognizes that in order to graduate from a university in Argentina, a doctor goes through a process equivalent to that experienced by their Brazilian counterparts. The point is that intervention is required in the field of health to enable this recognition to go beyond the context of Education and reach the scope of professional practice.

At Asunción, we managed to establish the extension of the negotiating agenda of the SGT11, incorporating technical professionals, which was discussed at a meeting held last year in Porto Alegre, Brazil. On that occasion, country representatives agreed to develop a matrix structure to highlight the educational and working structure of nursing, clinical laboratory, radiology and hemotherapy technicians. This is a great challenge, because as we have seen in RETS, education occurs in very diversified contexts and is highly heterogeneous, even if, as we approach the scope of work, one can find technicians from each field performing similar duties. The research for the development of this matrix, which will be of much use, is underway in the four countries of the bloc.

What are the major difficulties that you expect towards meeting the commitments made at the end of the Seminar?

There is an issue related to the interaction between sectors. The construction of this dialogue is so complex that one of the first proposals is the construction of a common glossary to both health and education. The two sectors work within different logics and times: in health, we are impregnated by urgency, whereas education works with long-term processes. Those of us working in the area of human resources have to learn to articulate these two logics. One challenge, therefore, is an intersectoral work within the MERCOSUR, while the same relationship is found in varying degrees of progress in each country. In Argentina, for example, we are moving that way, but there is still a long way to go.

Another problem has to do with the availability that the national teams have to work on the proposed agenda in between meetings. Although topics are not alien to the countries' agendas, there are always aspects depending on additional research and resources.

Although the meeting took place in the context of MERCOSUR, to which extent can these issues be addressed within the RETS?

RETS holds an important place in the whole visibility process of technical workers and is a source of information dissemination and exchange. While these discussions take place within MERCOSUR due the peculiarities of the integration process, the remaining Latin American countries also face education recognition problems from other countries in the region.

The magazine has published articles presenting information on the diversity of technicians' education in the member countries of RETS. Maybe it could help with an initial systematization or elaboration of a comparative matrix that allows us to observe not only educational routes, but also the tasks of technicians and the requirements for certification. While we are aware of the existence of diversity and the difficulty of translating into a synthesis, this would be a first step.

Another possibility is to map through the RETS how other regions have faced similar cases. For example, what is the result that European countries have had in the recognition of technical workers' skills, what difficulties have arisen during the course and how these are resolved.

*Isabel Duré is the National Director of Human Capital and Occupational Health of the Ministry of Health of Argentina and focal point of the Subcommittee on Professional Development and Practice of the Working Subgroup for Health, the SGT11, of the MERCOSUR.

WHO initiative to scale-up health professional education

In March this year, the World Health Organization (WHO) launched a small 20-page publication to publicize the work being carried out under the “Initiative on transformative scale-up of health professional education” for the development of technical and political guidance aimed at improving health professional education.

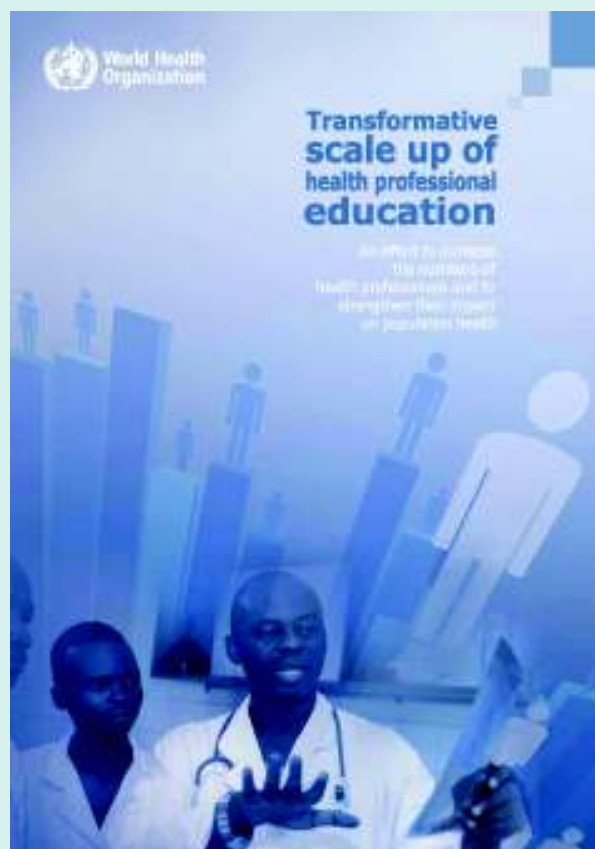
Focused on the health needs of people, the “transformative scale-up” involves the simultaneous reform of education and health systems in order to increase the quantity, quality and relevance of health workers and thus increase access of the population to services and achieving better national health results.

The idea to feature the work being carried out aims to establish an active involvement of new stakeholders with the proposed changes, since it is impossible to implement such profound changes without any commitment from those interested. The preparation of policy guidelines for the increase of health professional education aims at providing government and social movements with technical tools that can help convert ideals into concrete and well founded actions.

Health workforce: it is necessary to overcome the crisis

The issue of health workforce began to gain visibility in 2006, when it became the topic of the World Health Report. At that time, 57 countries were identified with fewer than 23 health professionals - doctors, nurses and midwives - for every 10 thousand inhabitants, the minimum required to meet the basic health needs of the population. In 2008, in the First Global Forum on Human Resources for Health held in Kampala, Uganda, several appeals were made for the implementation of an urgent health workforce strengthening process in these countries, all of which were under a severe threat of not achieving their health goals of the Millennium Development Goals due to the lack of health professionals. The final recognition of the importance of these workers by international bodies occurred in 2010 when in the launching of the Global Strategy for Women’s and Children’s Health, Secretary-General of the United Nations (UN), Ban Ki-moon highlighted the need to establish strong health systems, whose foundations are seated on an adequate size of a well qualified workforce.

This context ended up setting the question of human resources as a priority for WHO, which has sought, among other things, to promote the adherence of countries to the Global Code of Practice on the International Recruitment of Health Personnel; to support countries in implementing guidelines for the increase of access of the population living in remote and rural areas to health workers, as well as keeping these professionals in their jobs; to support regional and national observatories in the sharing of experiences and knowledge that can assist evidence-based decision-making; and to assist countries in implementing teamwork guidelines, so that the work done by community agents and health technicians is more appreciated within the system.



Regarding specific training of health workers, WHO has been developing, with the support from PEPFAR [U.S President’s Emergency Plan for AIDS Relief] the “Initiative on transformative scale-up of health professional education”, whose objective is to support and promote the improvement of national health systems so that they meet the needs of individuals and populations in an equitable and efficient way, improving the training of the workforce for the sector.

A long process towards consensus and adherence

Whenever Member States, partner institutions and other interested parties request WHO to develop a technical and political guidance on a particular topic, a study is conducted in several stages: consultation, evidence collection, analysis and consensus building. After setting the guidelines to be established, WHO has to support countries that choose to implement them, as well as to participate in the monitoring and

assessment of the implementation process.

To establish guidelines that seek to improve the quality of health professional training, work began in 2009 with a broad consultation involving representatives of key stakeholders - doctors, nurses, midwives, service users, managers, policy makers and development partners, among others. In 2010, two meetings of the Technical Reference Groups whose reports are available on the "Initiative" website (<http://www.who.int/hrh/education/initiatives>) were held. Earlier this year, a group was established which was responsible for assessing the evidence gathered and the development of an initial draft of recommendations which are repeatedly shared with the Technical Reference Groups for the inclusion of additional suggestions and consensus building.

This set of guidelines, aiming primarily at training university-level professionals, will be the first of a series whose objective is to promote the transformative scale-up of education of a full range of health workers, including community agents and mid-level staff.

Quantity, quality and relevance

According to WHO, training more doctors, nurses, obstetrics and other health professionals is urgent and essential. This, however, is not enough. Any attempt to overcome the current crisis should consider three main dimensions of the problem: quantity, quality and relevance of the health workforce.

With regard to quantity, it is necessary to overcome the global shortage of health professionals, which is more severe in middle and low-income countries. According to WHO, there are about 230 doctors per 100 thousand people in the United States, but only 1.1 in Malawi. Overall, sub-Saharan Africa is the region of the world that has the lowest proportion of health professionals per population - about one for every thousand people -, despite

having the largest burden of disease. Within countries, the situation is not much different. In South Africa, for example, rural areas are home to 46% of the population, but only 12% of physicians and 19% of nurses.

Poor working conditions and low pay also hamper the permanence of professionals in their jobs and eventually encourage the search for jobs abroad. Moreover, many national health systems cannot take advantage of professionals who graduate in the country due to the lack of financial resources to hire them and support them. The limited capacity for training new health workers in poorer countries and the low investment in the education of these workers - less than 2% of total spending on global health - are also issues that must be considered.

The problem, however, will not be solved merely by increasing the number of available professionals. These workers should be technically competent and able to work in teams, adapting their practices to ever-changing environments or implementing changes where and when they are needed. However, for this to occur, educational institutions must have adequate infrastructure and equipment, teachers in sufficient quantity, teaching methods that are more consistent with the reality of healthcare and less static and fragmented contents. It is necessary to regulate and standardize training and to create mechanisms that ensure the quality of education, especially in the private sector. According to WHO, it is no longer possible to cope with situations similar to those of the Philippines, where less than 40% of the almost 95 thousand nursing graduates have been approved in professional practice examinations.

WHO says it is clear that even well-trained health professionals may be ill-prepared to face the challenges they undergo in their daily work. To prevent this from happening, it is necessary to include additional information regarding the health reality of their country and their location to the scientific contents of their educational process. For example, it is not understandable that, in countries where

the majority of the population has access to the primary system and only a small portion receives care at more complex levels, more specialists than general practitioners are trained. Therefore, the reorientation of health professional education should not only consider the quality but seek a proper balance between global excellence and local relevance.

Another factor that, according to WHO, should be considered is that health professionals who do not represent the population in terms of language, ethnicity or other social and demographic factors face a greater difficulty to understand and address the specific needs of communities. It is recommended therefore that recruitment opportunities be created for students who, due to lack of resources, traditionally have more difficulties to attend health education courses.

Changes rely on intersectoral work

According to WHO, it is clear that the structural separation between education and health systems is at the root of the current crisis, generating a gross distortion between the needs of national health systems and the characteristics of training courses graduates for the sector. At governmental level, it is fundamental to seek a greater alignment between education and health institutions at all levels, but it is also necessary to count on the participation of the financing and labor sectors. The process should also add the various professional associations and bodies that perform regulatory and quality assessment functions, as well as representatives from private profit or non-profit institutions, especially in countries where they have significant presence in the provision of health and education services.

And if the effort is aimed at a qualitative health education scale-up with a view to strengthening healthcare systems, it is imperative to involve the population as a user of this system and also receive political support and financial support from the international community. 📌

RETS-UNASUR, RESP and RINS. Three networks and a single goal: to strengthen health workers' education in South America

In a meeting held in Asunción, Paraguay on 30 March and April 1 this year, representatives from member countries of the Union of South American Nations (UNASUR) signed the minutes for the establishment of the newest Network created under the organization: the Network of Public Health Schools (RESP), which joins the existing Network of Technical Schools of the UNASUR (RETS-UNASUR) and Network of the National Health Institutes (RINS). The meeting included delegations from Argentina, Bolivia, Brazil, Chile, Paraguay and Uruguay.

Coordination of the RESP was attributed to the Ministry of Health of Paraguay, through the National Strategic Directorate of Human Resources for Health, with the Ministry of Health of Uruguay as the alternate coordination. The Executive Secretariat of the new network will operate in Brazil, at the Sergio Arouca National Public Health School of the Oswaldo Cruz Foundation (ENSP/Fiocruz). The creation of the RESP, as well as the RETS-UNASUR and RINS serves to create networks of **structuring institutions** of national health systems, as expressed under Resolution 07/09 of the 3rd Extraordinary Meeting of the Council held in November 2009 at Guayaquil, Ecuador.

Institutions capable of effectively, efficiently and sustainably contributing to the development of health systems and services or training health professionals and manage the knowledge that facilitate decision-making within healthcare systems.

Health workforce training is a priority issue for UNASUR

The idea of creating UNASUR first appears in the Cuzco Declaration, signed in December 2004 during the III Meeting of South American Presidents. However, UNASUR was only formally established in May 2008 during a meeting of Heads of State and Government in Brasilia, capital of Brazil, with a view to “building, in a participatory and consensual manner, a setting for integration and unity in the cultural, social, economic and political context among their peoples, prioritizing political dialogue, social policies, education, energy, infrastructure, finance and environment, among others, with a view to eliminating socioeconomic inequality, achieving social inclusion and citizen’s participation, strengthening democracy and reducing asymmetries within the framework of strengthening the sovereignty and independence of States”.

In December of that year, the South American Health Council (UNASUR-HEALTH) formed by the ministers of industry was created to facilitate the adoption of joint measures for the health sector. On the same occasion, the Heads of State and Government established the South American Health Agenda based on five priorities: (1) the establishment of a South American epidemiological shield; (2) the development of universal and equitable healthcare systems; (3) universal access to drugs and other health supplies; (4) health promotion and the joint challenge of its social determinants; and (5) the strengthening of training and management of human resources in health. Technical Groups (TGs) responsible for the activities of each priority, among which the Technical Group for the Development and Management of Human Resources (GTRRHU-UNASUR), were also established.

RESP: mapping the situation of Public Health Schools is the first step

According to the Declaration of Asunción, the final document of the meeting, the creation of RESP is based on the need to strengthen and consolidate UNASUR as a space of integration in health which can gather the efforts and achievements of the various sub-regional and regional environments in search of a better quality of life for the population, equity

in the access to health, development of health systems and promotion of common policies and goals among member countries.

In this sense, the document reiterates the commitment of the Network to the improvement of health conditions of the South American population as a whole and in each country, contributing to the reduction in health inequities, the development of national healthcare systems and the effectuation of UNASUR-Health’s Five-Year Plan 2011-2015.

Signatories of the Declaration also reaffirmed the responsibility of the RESP with the training of workers by Public Health Schools or other educational systems for the health systems of the region, with production and management of knowledge and with the timely support and performance of scientific research. Within the Network, the first strategic objective is the mapping and diagnosis of public health schools in the region.

During the event, Deputy Minister of Health of Paraguay, Edgar Gimenez, said the big challenge for the RESP is to promote a highly functional integration process with a measurable impact. He said the network must abide by the pillars of ethics, politics and technique, always taking into account the identity of each country, the relevance and the pursuit of the Network's excellence.

At the end of the meeting, Gimenez noted that the establishment of the RESP tends to favor the emergence of an enabling environment for the exchange of professors, students, information and tools, as well as the inclusion of information technology and virtual communication for the promotion of public health.

RINS: joint support and work with other UNASUR networks

The 1st Meeting of the South American Nations' National Health Institutes was held on March 9, 10 and 11, 2010 in Lima, Peru, with the participation of representatives from institutions from Argentina, Bolivia, Brazil, Colombia, Ecuador, Paraguay, Peru, Suriname and Venezuela, as well as several international organizations such as PAHO/WHO, the Andean Health Organization - Hipólito Unanue Agreement (ORAS-CONHU), the Amazon Cooperation Treaty Organization (ACTO), the International Association of National Public Health Institutes (IANPHI), the Andean Network of Health Institutes (RAIS) and the U.S. Agency for International Development (USAID). Professionals from the Ministry of Foreign Affairs of Peru and members from the Technical Group for the Development and Management of Human Resources of UNASUR-Health also attended the event.

The Network of National Health Institutes in South America (RINS) was established at the meeting as a strategy for the strengthening of the institutions themselves and their development as structuring institutions of national health systems, as well as facilitating the development of integrated processes for the resolution of health problems in the South American continent. In the event, the National Health Institutes made a public commitment to implement the RINS and develop the objectives expressed in the UNASUR-Health's Five-Year Plan, through the realization of its own Five-Year Plan (PQ-RINS), whose draft would be submitted by September 2010. RINS General Coordination would be exercised by the National Health Institute of Peru and the Executive Secretariat will operate at the Oswaldo Cruz Foundation (Fiocruz), for a period of two years.

Public institutions of Health Ministries of Member States are part of the RINS-UNASUR, and they play a strategic role for health systems in the areas of: research and scientific and technological development in health; epidemiological and environmental health surveillance; education and training of workers in the industry; quality control of drugs and other supplies and healthcare products; reference laboratory diagnostic; production of strategic health supplies; preservation of health's biological or cultural heritage; health information and communication; health research regulation; health promotion and reference healthcare, among others.

The PQ-RINS was built based on five points of UNASUR's Health Agenda. With regard to item 5 - human resources -, RINS' strategic objective is to educate and train health workers in the region. The item includes two macro-projects: the Regional Plan of Health Education and Training, to be developed jointly with the South American Government Institute of Health (ISAGS) and with other networks of UNASUR; and the incentive to create health scientific publications in the regional editorial context. The idea is to develop cooperative actions for the

Multinational public agency belonging to signatory governments of UNASUR. It shall be based in Rio de Janeiro, Brazil, and its goal is to develop strategic and leadership human resources in health and to promote the governance of health systems of member countries.



creation and strengthening of Public Health Schools and Health Technical Schools and their respective networks within the UNASUR and establish a post-graduation regional plan in strategic areas for the Health and Science and Technology in Health Systems.

RETS-UNASUR: a RETS sub-network

The Network of Technical Schools of the UNASUR (RETS-UNASUR) was officially established during the 2nd General Meeting of the International Network of Health Technicians Education (RETS) held on December 9, 10 and 11, 2009, in Rio de Janeiro, with the presence of representatives from institutions from Argentina, Bolivia, Brazil, Colombia, Ecuador, Paraguay, Peru, Suriname and Uruguay, as well as PAHO/WHO. The RETS-UNASUR was set as a network of institutional exchange linked to the RETS, being coordinated by the Joaquim Venâncio Health Polytechnic School of the Oswaldo Cruz Foundation (EPSJV/Fiocruz).

RETS-UNASUR is comprised of government agencies responsible for the formulation of policies for health technical education and education institutions carrying out training programs for health technical workers, as indicated by the Ministries of Health of member States of the UNASUR. Its main objective is to strengthen the training of health technicians in the South American countries through the exchange of experiences and the development of technical cooperation aimed at scaling-up and enhancing teaching, research and technological development activities, always with a view to improving national health systems so as to adapt them to the needs of their populations.

To this end, institutions pledge to:

- maintain links with the counterparts of human resources of member States to ensure convergence of actions in the training of health technicians;
- promote technical cooperation among their peers and with other service, teaching, research and related services agencies, and
- develop and maintain workforce monitoring systems and the training of technical workers.

According to the RETS-UNASUR work plan, the four network's specific objectives are:

1. To permanently monitor and systematize information related to the training of technical health workers and its interface with the organization of health work so as to facilitate the identification of trends and educational needs and enable support for the definition of public policies for the field;
2. To promote technical and scientific cooperation among member institutions for the development of educational proposals, curricula projects, courses, teaching materials, methodology and teacher training in priority areas, seeking alternatives and experiences that can be shared;
3. To develop mechanisms that facilitate the production, dissemination and systematization of information and communication on health technicians education among network members; and
4. To foster the development of research among member institutions through the interface of Health, Education and Labor to increase and strengthen their teaching and technical cooperation.

The creation of RETS-UNASUR and RINS was officially recognized during the 2nd Ordinary Meeting of the South American Health Council (UNASUR-HEALTH) held on April 29 and 30, 2010 in Cuenca, Ecuador. 🗺

CVSP Paraguay's nucleus officially

On May 3, the official launch ceremony of the Public Health Virtual Campus of Paraguay (CVSP-Paraguay) - a network to create, share and collaborate in the educational processes of Public Health - was held. The event was attended by authorities and officials of the Ministry of Public Health and Welfare (MSPyBS), as well as PAHO/WHO technicians. News of interest to professionals and students of the field, and information about research, events and academic programs of the major training institutions in the country will be published on CVSP-Paraguay's web page (<http://portal.campusvirtualsp.org> > Paraguay).

Public Health Virtual Campus of Paraguay (CVSP) is a network of people and institutions whose purpose is to facilitate information and communication management to improve individual training and the building of institutional capacity in public health. Result of a partnership between PAHO and the countries of the region, CVSP is a setting for interdisciplinary cooperation in the field of training and a communicational and learning space enabling:

- The management of current available knowledge in order to incorporate and keep continuing health education programs updated;
- The exchange of information on principles, methods, operational schemes and lessons learned in the regional, sub-regional, national and institutional experience;
- The promotion of and support to alternative strategies of regional, sub-regional, national and institutional network cooperation;
- The validation and acquisition of experience in teaching, services and research initiatives built at different levels;
- The identification of new features and national and international technical cooperation settings.

With the launching, 10 other centers join the Regional CVSP, namely: Argentina, Brazil, Chile, Colombia, Costa Rica, Cuba, Mexico, Paraguay, Peru and the Inter-American Center for Social Security Studies (CIESS).

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 Health
National 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

Brazil

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

Portuguese Association for Technical Pathology
<http://www.apatap.pt/index.htm>

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

Instituto de Higiene e Medicina Tropical (IHMT)
(351) 213 652 600 / (351) 213 632 105 (Fax)

School of Health - Portuguese Red Cross
(351) 213 616 790 / (351) 213 616 799 (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)

The International Education Network for Health Technicians (RETS) is a liaison effort between different institutions and organizations involved in training and capacity building for health technical staff in Latin America, the Caribbean, the African countries whose official language is Portuguese (PALOP) and Portugal that strives for the strengthening of public health systems. It is based on the premise that the capacity building of the workers is a fundamental dimension for the implementation of public health policies that serves the population health needs of each country member of the RETS.

