

REVISTA

Year 3 – nº 12 – oct./nov./dic. 2011

RETS

International Network of Health Technicians Education



WORLD CONFERENCE ON SOCIAL DETERMINANTS OF HEALTH

Rio Declaration seals international ethical commitment in
the fight against social inequalities and for equity in health

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editorial

December has come and with it we end another year of work at the RETS, in which we published four issues of the magazine and over 50 articles and 70 reports on our website, sent 16 electronic newsletters and posted countless messages on Twitter and, more recently, on Facebook. It is true that we still did not manage to achieve everything we have planned with the desired quality, but we are sure that, to some extent, we fulfilled our role to produce and disseminate to increasingly wider audience information relevant to the strengthening of the Network and of education and work of health technicians and international technical cooperation.

It is also true that we will be together again in 2012, with a firm purpose of improving our working processes and, consequently, developing increasingly more interesting products to our readers, “without rushing, but also without wasting time”, as Portuguese writer José Saramago said.

In this last issue of 2011, we go back to the topic of materials for the training of health technicians in an interview with Anakeila de Barros Stauffer, professor and researcher at the Joaquim Venâncio Health Polytechnic School (EPSJV/Fiocruz). Moreover, we highlight some important recent events – the World Conference on Social Determinants of Health, the Summit of the United Nations (UN) on Noncommunicable Diseases and the Workshop on Human Resources for Health Information Systems –, whose debates ultimately have a direct or indirect impact on the education of health workers.

Happy 2012!

Under the “Network News” section, we share some of the important work that some institutions members of the RETS are developing in favor of public health, reiterating our invitation to all other members to also take advantage of our space to share experiences and achievements.

Happy reading!

RETS Executive Secretariat

acknowledgements

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E-mail: rets@epsjv.fiocruz.br

Editorial Board

Carlos Planel (EUTM/UdelaR – Uruguay)
Elba Oliveira (ENS-La Paz – Bolivia)
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Journalism

Editor: Ana Beatriz de Noronha - MTB25014/RJ
Trainee: Julia Neves de Farias

Graphic Production

Design: Zé Luiz Fonseca
Layout: Marcelo Paixão

Translation

‘Espaço sem fronteiras’ (Jean-Pierre Barakat)

Circulation

2 copies

Executive Secretary of RetS

Joaquim Venâncio Polytechnical School of Health

Director

Cristina Araripe

Coordination of International Cooperation

Anamaria D'Andrea Corbo

Coordination of International Cooperation Staff

Ana Beatriz de 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

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“Everyone has a right to know and to know everything he wants”



To continue discussions on teaching materials in the education of health technicians, RETS magazine interviewed Anakeila de Barros Stauffer, researcher and teacher at the International Cooperation Coordination (CCI) of the Joaquim Venâncio Health Polytechnic School (EPSJV/FIOCRUZ).

Elementary school teacher and educator with master's and doctorate degrees in Education, Anakeila became interested in the subject when, as a teacher, she was conducting an analysis of these materials with students of the pedagogy course. At EPSJV, she participated in some of the **Paltex** making processes and the series of books **“Professional Education and Teaching Health: the training and work of community health agents”**. At CCI, she has actively participated in cooperation activities related to this issue with South American educational institutions, especially Paraguay, Bolivia and Argentina and African Countries of Portuguese Official Language (PALOP).

As we saw in the previous issue, teaching materials are all that can be used to facilitate the educational process. But speaking specifically of those materials especially prepared for this purpose – brochures, textbooks, manuals, booklets and CDs, for example – what would their primary purpose be?

Indeed, the concept of teaching materials is quite broad, but thinking about these materials that are more traditional in education, I would say that they have the task of socializing knowledge, considering that the way we socialize knowledge directly depends on the way we conceive it.

What is the educator's role in mediating between the textbook and the learning process?

Historically, teaching materials tend to become a guide to what should be taught. In a more traditional sense, a good teacher would be the one using teaching materials from beginning to end, without modifying them; the one working like

a replicator of knowledge prescribed in textbooks that is supposedly written by a great expert on the subject. The teacher does not operate in the work field; he hardly acts as an intellectual in the Gramscian concept of the term. In this case, concepts present are those of knowledge as something static, of a teacher acting like a repeater and student acting as a recipient of knowledge that this teacher transmits with the support of teaching materials prepared by an expert. On the other hand, when we conceive knowledge as a dynamic and collective process, the teacher starts to perform the role of the

intellectual, he dialogues with various materials in order to select those who can contribute to the learning of students.

Over time, what changes occur in these tasks and the criteria for the production of textbooks?

We must remember that teaching materials are a cultural artifact and this implies a constant process of change. In Brazil, this story begins with the 'little reading and learning cards', a catechesis material developed in Portugal and used by parents in the literacy process of their children. Thus, the logic instituted at that time was of a more religious discourse. Over time, this is not abolished, but changed due to many influences. The Enlightenment, for example, brings a more scientific and technicist vision, and educational materials gain a supposedly neutral and objective language. Therefore, language also changes depending on the conception one has about the act of teaching and learning.

In the 1970s, teaching materials developed within this technical concept suffer much criticism, based on the Marxist theory, for bolstering prejudices and stereotypes. In the 1980s, they suffer some changes in contents and language due to these criticisms and, in the same period, public policies aimed at the educational materials that begin to be established in the country open a new market niche. In order to sell their books to the government, publishers

begin to reformulate their materials. This is the Brazilian history, but serves to show that several factors contribute to change in the textbooks over time.

Do these changes only occur due to factors related to national contexts or are there some aspects of a global nature?

In 1995, the World Bank published the document "Education priorities and strategies – sectoral study", in which the textbook is ranked as the 4th component in the order of importance in the learning process, even ahead of the teacher himself. This shows a technicist remnant, i.e. the idea that one can create teaching materials that forego the mediation of human beings for the collective construction of knowledge. This document, for example, boosted a whole teaching material policy.

UNESCO, in turn, published a paper dealing with the issue of multiculturalism and asserted, among other things, the importance of respect for African languages, because people build their identity through language. This speech had a great impact. Today, for example, people are more aware that, although Portuguese is the official language of some African countries, not all the people from those countries speak this language. Thus, to some extent, these international bodies are spreading their ideas and countries will also absorb these commands and countermands in different ways.

And what about the learning materials focused on health technical training?

Thinking more specifically about the health technician, the most common are teaching materials with little theoretical basis, probably because the dominant thinking still views the technician as the one who should know what to do and does not need to think about what he is doing. This results in depleted contents, with often also an impoverished and fragmented language. It could not be otherwise, because teaching materials carry a certain conception of knowledge and the type of student one wants to graduate. Thus, in the training of health technicians, there is a trivialization of knowledge and one regards this worker as someone of lower status and less value in the work chain.

What would you highlight as key aspects in the analysis of teaching materials?

When speaking of teaching materials, you have to appreciate that the concepts of human and professional training and education and health as social practices are present, that commitments exist with public health and public education. All this is crucial and cannot be ruled out. As I mentioned before, the material focused on the education of health technicians show a concept that that human being that is graduating does not have the right to all the knowledge. For me, working at a primary school and believing that everyone has a right to know and know everything he wants, it is still a shock to hear that the technician may not know this or that because it is the nurse's or doctor's responsibility. It still causes me a great estrangement, since I view education and health as rights.

In terms of contents, some questions are compulsory. Is what I want to address in line with the public to which the material is intended? What do I want to achieve with that text? Is the material achieving the goals that I set out? Is the text presenting a stereotyped view? Are contents technically correct? Do they allow the construction of other meanings? We usually have to make

The Expanded Textbook and Instructional Materials Program (<http://new.paho.org/paltex>) is a non-profit program developed by PAHO/WHO with the support from the Pan American Health and Education Foundation (PAHEF). Its primary goal is to support the training of quality human resources in health. All materials provided (text and basic tools) are transferred at a more accessible price to students, encouraging them to obtain materials and tools needed for their college education.

Created in 2001, the Development and Technological Innovation in Public Health Program (PDTSP) is an institutional strategic research-inducing program which aims at fostering research and development activities mainly focused on technological innovation in the field of public health and with prospects of contributing to and promoting public health in Brazil.

Technological innovation in the field of public health is defined as the transformation of ideas into products, processes and approaches that are technologically new or significantly improved that could potentially offer major improvements to existing ones. (<http://www.castelo.fiocruz.br/vpplr/pdtsp.php>).

choices, because there is a page number limit, for example. But are contents correct within that limit? Is this text making connections with other fields of knowledge? Is it historically contextualized? If there is no such contextualization, the student will learn the contents without knowing their origin and a great wealth will be lost. The text should not give ready-made answers for students, but rather lead them to think, and that is what makes the teacher's mediation more important.

Contents and language turn out to be inseparable, especially if we consider the possibility of collective construction, the need to present various viewpoints on the same subject. This is fundamental when we are educating in health as a social practice. There is certainly a technical knowledge to be transmitted, but in health work there is much more than technical knowledge. Oftentimes, the worker may even know the correct technique, but, on the job, he does not always achieve the ideal working conditions or the materials needed. Therefore, teaching materials cannot just teach the technique for the technique, they have to bring in a little of the services' reality so that they can be problematized and transformed, where necessary.

In the case of the proposed activities, the annotated bibliography is quite interesting because it enables the student to increase his knowledge and be the researcher of his own practice. If the material provides summaries of key ideas and brings references of and pointers on other materials, such as topic-related films or books, the student can build his own path, ceases to be the reader of only the specific contents and becomes a reader of the world. A question whose answer is in the text just to be copied is too little to human knowledge. It is more interesting to human education to propose an activity that questions the very contents presented, that requires the student to think. It is essential that the proposed activity goes beyond what is in the text of the educational material.

You have participated in countless activities related to the issue of teaching materials, including within PALOP and MERCOSUR countries. What scenario would you describe?

Since the technician is seen as the one who has to know what to do, that ultimately results in curricula and materials geared to professional practice and with little theoretical basis. For example, this may be justified in the case of a dengue epidemic, as recently discussed in Argentina. In that workshop, the staff of the Ministry noted that there is not always time to discuss materials for the guidance of workers and they ends up being more prescriptive. This shows that the character of teaching materials must conform to a certain goal. Here at school, where it takes us two or three years to develop teaching materials, based on a 25-year practical experience, they have to have a different tone. In the case of African countries, where there is great difficulty in teacher training, teaching materials end up with a narrower character, of controlling not only the learning process, but also the teaching process, with prescriptions for teachers. Materials have different configurations, according to the historical reality of each country, but end up reflecting a common concern: the poor quality of teacher training. In the case of health, many teachers come from the services and the big complaint is that this teacher knows very well the technique but cannot teach. Thus, the risk lies in trying to overcome such poor teacher training through the teaching material.

How can this situation be changed?

The teacher is also a being under development. It is not enough to make a single training process, i.e. a 40-hour course for these teachers. This is not good because the learning process must be monitored in daily life. If the teacher is not well trained, the teaching materials cannot make up for this deficiency. The teacher who comes from the services is very

important because he brings the reality of health into the training of technicians, but one should ensure that this teacher also thinks about the process of which he participates. How can he take care of two such different journeys? How can he take time to prepare his class after working 20, 30 or 40 hours? Is he teaching because he wants to or is it just because he needs to complement his salary? I really believe that we need to think the possibility of restructuring health technical schools. We have to rethink what health technical schools we want, what training process we want and what to do to make the teacher coming from services learn to be a trainer, because this can neither be done with specific actions, nor through teaching materials and fast-track training.

What are the drawbacks of using materials produced in other countries and realities?

In countries subordinated to developed countries, we often develop a sense that knowledge of the other is better, that knowledge is neutral and has nothing to do with reality. Thus, we often use the material from another country without the proper coordination with our specific needs. This leads to the notion of scientific knowledge as one that is independent of where it is introduced, which is often not true. This is paramount in health. Many times in my daily work, I need to patch and I do not have all the necessary materials.

So, how to adapt what is prescribed, what was taught as the correct way to the reality at hand? If contents of teaching materials show an ideal that is out and completely divorced from the reality we work in, this may result in a great frustration and the blocking of knowledge production capacity which allows to bring learned contents to reality. It is not that the knowledge produced in other countries does not serve us, the important thing is to see how it can be inserted into the logic of my country. ■

NCDs become the central issue of the global health agenda

Julia Neves

Noncommunicable diseases (NCDs) are already the leading cause of death worldwide. Annually, more than nine million people under the age of 60 die from cardiovascular disease, cancers, chronic respiratory diseases and diabetes. These and many other data published recently by the World Health Organization (WHO) have alarmed the authorities worldwide (see box).

Over the years, the negative impact of unplanned urbanization, an aging population, trade globalization and the exacerbated incentive for consumption resulted in the increase in the risk factors for these diseases. The situation has reached epidemic proportions and concerns about the effects of NCDs in the society and economy have been on the agenda of several discussions of countries and international bodies.

Changes are shaping new challenges to public health which needs to find solutions to deal with NCDs, taking into account the strong impact on the quality of life of affected individuals, premature death and adverse economic effects generated for the society in general.

World leaders meet to reduce NCDs risk factors

The United Nations (UN) has been concerned about the consequences of NCDs for some years now, resulting in the publication, in May 2010, of a resolution providing for the holding of a high-level meeting on the issue. In April 2011, a new resolution of the 65th General Assembly confirmed the event for September 19-20 this year in New York. By justifying the meeting, President-elect of the 66th UN General Assembly Nassir Abdulaziz Al-Nasser explained that these diseases are changing demographics and impacting on the economic growth of nations. He also stressed the need for international cooperation to address the issue. "The global community must work together to monitor, reduce risk exposure and strengthen health care for people living with noncommunicable diseases", he said at the opening of the event.

To get an idea of the magnitude of the problem, it is important to remember that this was the second time in UN's history that health assumed the centre-stage of discussions on the global agenda. The first one occurred back in 2001, when international cooperation and orchestrated action to combat the AIDS epidemic were determined.

The meeting which brought together 30 heads of State and Government and over 100 ministers was held in order to ensure the commitment of countries for a coordinated global response to NCDs. The proposal is to increase significantly the amount of resources allocated to the control and prevention of these diseases, an effort that could save millions from premature death and limitations caused by these diseases.

During the meeting, which introduced NCDs in the international agenda, discussions were held on the global guidelines to be released in 2013 to guide governments, industry and civil society organizations to establish plans and actions to contain the risk factors related to the four groups of NCDs, such as alcohol and tobacco.

Poor countries suffer the worse consequences

In a recent report, UN Secretary-General, Ban Ki-Moon stresses that NCDs are a major cause of poverty, a hindrance to economic development and a global emergency. In the same document, he makes some recommendations for global progress, such as the need to train countries in order to monitor diseases, their risk factors and determinants, the adoption of an efficient level of primary health care and the association

Prevention and control of noncommunicable diseases. Available in UN's website (<http://www.un.org>), at: 'Documents' > 'Search' ('Documents by Symbol') > A/66/83

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. (Alma-Ata Declaration, 1978)

of different sectors of society in the fight against NCDs.

Considered a threat to global development, NCDs strike with even more intensity the less developed countries, resulting in increasing poverty. According to the UN, deaths due to these diseases will increase by 17% over the next decade, and in Africa this increase could reach 24%.

The idea that NCDs particularly affect the poorest countries was strengthened by WHO Director for Noncommunicable Diseases and Mental Health Ala Alwan, during the UN event. He says that in low-and middle-income countries, about 30% of deaths from NCDs occur in people below the age of 60, while in rich countries, the figure lowers to 13%.

While there is still much to be clarified about the determinants of these diseases, several risk factors susceptible to preventive measures are already well defined, among which are smoking, alcohol consumption, unhealthy diets and sedentary lifestyles.

NCDs can be prevented and controlled through collective and intersectoral action. In health, the control of these diseases is directly related to the existence of universal systems enabling their citizens' access to quality care. In this respect, international cooperation gains importance and becomes crucial in providing financial support and technical assistance to least developed countries.

NCDs and the health workforce

“Addressing noncommunicable diseases – it takes a workforce”. That was the subject of one of the parallel events held during the UN meeting on these diseases. Its purpose was to display and foster reflection and discussions on the importance of the health workforce in the fight against NCDs. It was jointly organized by the Global Health Workforce Alliance (GHWA), the governments of India

WHO Atlas shows NCDs situation in the world

The situation of NCDs has reached epidemic proportions, has alarmed world leaders and has become the focus of debates and forums around the world. In 2008, for example, NCDs killed more than 36 million people, equivalent to 63% of all deaths worldwide. Cardiovascular diseases accounted for 48% of these deaths, cancer for 21%, chronic respiratory diseases for 12% and diabetes for 3%.

The growing threat posed by noncommunicable diseases (NCDs) has led the World Health Organization (WHO) to publish the report “Noncommunicable Diseases Country Profiles 2011” with information about the situation of these diseases in its 193 member countries.

The document highlights areas in which each government should focus on to improve services for prevention and treatment of NCDs and what countries need to do to reduce people's exposure to risk factors. In addition, it features graphics bringing details of the proportion of death due to these diseases and data on the ability of each country to fight them, showing what governments are doing to address them in terms of institutional capacity, specific funding and actions for treatment.

According to the publication, NCDs and their consequences

are directly linked to countries' income. In rich countries, NCDs are responsible for more than 70% of total registered deaths and, 8% and 10%, respectively, of premature deaths – before the age of 60 – of men and women. In low-income countries, in turn, these percentages increase to 22% among men and 35% among women.

Hypertension (high blood pressure) is the risk factor with the highest proportion of deaths worldwide (13%), followed by the use of tobacco (9%), increased blood glucose (6%), sedentarism (also 6%) and overweight and obesity (5%).

According to the Atlas, 41% of men and 48% of women lead sedentary lives in developed countries, contrasting with 18% of men and 21% of women in less developed countries. In the U.S., for example, where NCDs come to cause 87% of all deaths, 16% of the population smokes and 43% does not practice physical activities.

Overall, data show that in the richest countries actions aimed at controlling blood pressure and cholesterol levels are having a positive impact in the fight against NCDs, but it is still necessary to increase actions aimed at reducing weight and control of diabetes. WHO Atlas was published in English and is available at: http://www.who.int/nmh/publications/ncd_profiles2011/en.

and Japan, the Touch Foundation and the Health Workforce Advocacy Initiative (HWAI) and held on September 19th.

In several panels, speakers from different countries presented and discussed the complex issues arising from the combination of a large increase in the burden of NCDs in a setting of insufficient workforce.

Ugandan doctor Michael Ebele Omeka opened the event by highlighting the situation in less developed nations. He pointed out

that in his country, which has no effective NCDs prevention and control policies, most public health services have less than 50% of required staff. In addition, he said that most existing workers were trained before the epidemiological transition, resulting in a mixed communicable and noncommunicable diseases situation. “In this scenario, it is apparent that health workers have little time and knowledge to offer preventive services for NCDs,” he added.

GHWA's chairman of the board and vice minister of Global Health in Japan, Masato Mugitani, talked about the impact of NCDs in society and the need for a skilled workforce. The Japanese government has committed to the training of 10 thousand health workers and professionals specialized in policies for the sector. Mugitani said he believes it is necessary to ensure innovative and sustainable health systems that give due importance to the workforce. However, he noted that this is not a task to be performed by GHWA or government of his country alone. He says that this will only be possible if all available resources in global health, including donors, governments, civil society and the private sector are mobilized.

During the event, the need for unity of different sectors of society and effective government policies and the importance of prevention at the primary level and a competent workforce was highlighted. India's Health Minister, Shri Keshav Desiraju emphasized: "It's not that we don't have the numbers of trained health workers, we don't have them trained in the areas we want them trained in and we don't have them in the places we want. One big message which has come out of the NCD summit is that prevention of non communicable disease is best done at the primary level. Treatment may be at the second and tertiary level but prevention is a primary level activity."

GHWA's Executive Director Mubashar Sheik, closed the session focusing on the need for an inclusive approach. He said society should unite to prevent verticalization of NCDs. "On behalf of the Global Health Workforce Alliance, we'll keep urging the policymakers to stay committed to ensure that we have the right kind of health workforce and the right competencies as well as the right support mechanisms. The right tools to provide good quality chronic care must become available", he emphasized. ■

Human Development Report 2011 – Sustainability and equity: a better future for all



Guaranteeing the right of present and future generations to healthy and fulfilling lives is the great challenge of development of the twenty-first century. The Human Development Report 2011 offers new and important contributions to the global dialogue on this challenge, showing how sustainability is inextricably linked to equity, i.e. issues of fairness and social justice and greater access to better quality of life.

Published by the United Nations (UN), the report highlights links between sustainability and equity, showing how human development can become more sustainable and equitable. Moreover, it reveals how environmental degradation harms more the poor and vulnerable groups in relation to others.

A political agenda is able to correct these imbalances is presented throughout the document, devising a strategy to combat the current environmental problems in a way that promotes equity and human development.

The report is available on: [_http://hdr.undp.org/en/reports/global/hdr2011/download/en](http://hdr.undp.org/en/reports/global/hdr2011/download/en).

State of World Population 2011 Report – People and possibilities in a world of 7 billion

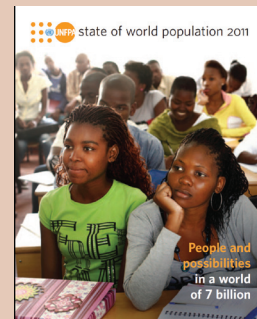
The world has reached seven billion inhabitants in a feat marked by achievements, setbacks and paradoxes. Showing some of these paradoxes from the perspective of individuals and describing the obstacles they face – and overcome – in an attempt to build a better life for themselves, their families, communities and nations is the purpose of the report of the State of World Population 2011 report published by the United Nations Population Fund (UNFPA).

According to the report, whose issue is "People and possibilities in a world of seven billion", despite problems, the unprecedented size of the population can be considered a success for humanity, because it means that people are living longer and more children are surviving throughout the world.

UNFPA says there is much to celebrate in the world's population trends over the past 60 years. Among other things, the average life expectancy hiked from around 48 years in the early 1950s to around 68 years in the first decade of the new century; infant mortality fell from about 133 per thousand births in the 1950s to 46 per thousand births in the period from 2005 to 2010, and vaccination campaigns reduced the prevalence of childhood diseases worldwide.

The State of World Population 2011 is primarily a report where demographers, politicians, governments, civil societies and individuals discuss various demographic trends ranging from aging to increase the number of young people, high rates of demographic growth to the decrease of populations and from high urbanization rates to increases in international migration. Reports present cases from China, Egypt, Ethiopia, Finland, India, Mexico, Mozambique, Nigeria and the Former Yugoslav Republic of Macedonia.

The report published in Spanish, English, French, Russian and Arabic is available on UNFPA's website (<http://www.unfpa.org/swp>).



World Conference highlights the importance of policies to fight health inequalities

Julia Neves

About a thousand participants and official delegations from the 125 member countries of the World Health Organization (WHO) made the World Conference on Social Determinants of Health (WCSDH) held in Rio de Janeiro from October 19th to 21st one of the biggest global health events since the Conference on Primary Health Care held in 1978 in Alma-Ata.

The purpose of the event, whose motto was “Equity for All”, was to promote the discussion of strategies, methodologies and experience to guide the development and implementation of policies to fight health inequalities by acting on its social determinants.

The program, which included roundtables, plenary sessions and several stakeholders events, was divided into five topics: “Governance to address the causes of health inequities: implementing action on social determinants of health”; “Promoting participation: community leadership for action on social determinants of health”; “The role of the health sector, including public health programs, in reducing health inequities”; “Global action on social determinants of health: aligning priorities and partners”; and “Monitoring progress: mediation and analysis to support policies on social determinants of health”. Subjects followed guidelines of the discussion paper drawn from extensive analysis on the global situation of Social Determinants.



Conference reiterates intersectorality as a solution to health problems

The opening session of the conference was attended by Brazilian Vice-President Michel Temer, representing the Presidency of the Republic, the Director General of the World Health Organization (WHO), Margaret Chan, and several government and health officials.

In his speech, Minister of Health of Brazil, Alexandre Padilha, stressed the importance of the event and Brazil’s role in its organization. The minister said that Brazil has implemented effective policies to fight noncommunicable diseases, which confirms the country’s commitment to develop actions on SDH. He also stressed the importance of the Unified Health System (SUS), remembering that, despite crises faced throughout history, Brazil has not abdicated the design of a public and universal health system. The Minister ended his speech by saying that the conference would be considered a milestone in health’s history. “We are together for equity in favor of universal health care and quality access for all”, he added.

Margaret Chan, in turn, stressed the importance of promoting a global strategy for action on SDH and fight their inequities. “This is a challenge that concerns not only Health Ministers. It is a responsibility that falls upon all governments, at their highest levels, and the entire society”, she said. After drawing the attention to the huge expenses that chronic diseases can pose to governments – “Chronic diseases, for example, have a major impact on society and the economy of countries.

Over the next 20 years, these diseases will cost US\$ 30 trillion, about 48% of global GDP” – she pointed out that these diseases, usually associated with people’s habits and behaviors, are also directly related to SDH.

WHO Director-General also participated in the main event of the first day of the Conference – the “Social Determinants of Health and Development” round table – along with the Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), Michel Sibidé; U.S. Secretary of Health and Human Services, Kathleen Sebelius; the Brazilian Minister of Social Development and Fight against Hunger, Tereza Campello; the Administrator of the United Nations Development Programme

(UNDP), Rebeca Grynspan; and the Greek Minister of Health and Social Solidarity, Andreas Loverdos. The table coordinated by BBC's World journalist Zeinab Badawi addressed, among other issues, the importance of intersectoral collaboration and good governance. "The U.S. share the belief that joint work is always best. Health is not only the doctor's clinic, it is where we eat, breathe, work and move around", said Kathleen Sebelius.

The issues of intersectorality and good governance were again in the agenda at the "Governance to address the causes of health inequities: making coherent policies at national level" round table coordinated by the Ministry of Public Health of Uruguay and UNASUR-HEALTH Pro Tempore President, Jorge Enrique Venegas, who stressed the opportunity that the Conference could represent to the exchange of experiences on governance. During the debate, table members – the Ministers of Health of Slovenia, Dorijan Marusic, and Peru, Alberto Tejada Noriega; the Ghana's Vice-Minister of Health, Robert Joseph Mettle-Nunoo; the Norwegian Health and Care Services Minister, Anne-Grete Strom-Erichsen; and Don Matheson, Professor at Massey University, New Zealand – reiterated the need to consider health as a one of the priorities for governments and the importance of intersectoral work to reduce inequities.

Declaration of Rio: countries commit to the reduction of social inequities

The last day of the event was marked by the signing of the "Political Declaration of Rio on Social Determinants of Health" (see page 10), a document whose importance has been compared to the Declaration of Alma-Ata. During the closing ceremony of the Conference, WHO Innovation, Information, Evidence and Research Director, Marie Paule Kieny committed on behalf of WHO to assist countries in the implementation of SDH policies.

WHO of Ethics, Equity, Trade and Human Rights Department

Director, Rüdiger Krech, said that the Conference was very successful in highlighting how the experiences of such actions on social determinants can be implemented, but its great merit was to have governments, civil society, UN agencies and Academic members take on the joint commitment to develop a meaningful action to reduce health inequities. "The signing of the Political Declaration of Rio on Social Determinants of Health by many countries is a significant milestone in the fight against health inequalities", Krech said in a message received by member of the "Equity, health and human development" (PAHO/WHO) list. He said it is up to each person to fight so that the Rio Declaration turns into action and that the idea of a world with equity in health ceases to be just a utopian dream and becomes reality.

SDH's paradigm involves changes in the training of health workers

Without directly addressing the education of health technicians, the panel organized by the Commission for the Education of Health Professionals for the 21st century has shown that great changes are required in the training of the health workforce in order to face new issues that arise in the global context.

In the panel, Sabina Rashid, from the James Grant School of Public Health, BRAC University, Bangladesh, said that the main global challenge for the education of Public Health professionals is to make the process more meaningful and relevant to the current situation and more focused on the real needs of the communities in which these professionals will act. She says that, in Bangladesh, curricula are neither concerned with the community, nor with its social, economic, cultural and demographic reality. Another problem highlighted by Sabina was the rampant increase of private educational institutions that occurs without regulation and without the existence of mechanisms capable of measuring the quality of the new schools. The good news is that some

universities are already gathering to reflect on the changes to be made.

In the second panel, Chilean Jeannette Vega, from the Faculty of Medicine of the Universidad del Desarrollo proposed redesigning the Public Health graduate courses in the country with the use of information and communication technology. She said that the idea is to generate a consensus on the academic contents and methodologies for the training of physicians that incorporate Public Health in their daily professional activities.

The need to establish a greater contact between medical students and the community was consensus among those present. A Chilean student mentioned the results of a survey conducted in his faculty to show that there is something wrong in the training of health professionals. "In a survey of first-year medicine students, 70% responded that their goals were to help people after graduation. When the same question was asked to last-term students, this percentage dropped to 10%", he said, asking shortly afterwards: "What is happening which changes so much our values during the seven-year course?"

A doctor, also from Chile, said she had performed a similar survey 30 years ago, obtaining the same results. "That is just how our education is. People enter willing to help and exit wanting to make money. We must change this way of training, but there is a great resistance to change. We need a global commission to advocate these changes and push them", she said.

"Showing that we form the best values when working with another approach may also be evidence to foster change", suggested one student from Scotland. He believes that if such surveys were made in progressive schools that are already changing their curricula and results were different through them, these results could serve to emphasize the need for change. ■

Read more about the Conference and SDH on RETS' website (www.rets.epsjv.fiocruz.br), at: 'Library' > 'Topics of interest' > 'Social Determinants of Health'

Rio Political Declaration on Social Determinants of Health

Rio de Janeiro, Brazil, 21 de October 2011

1. Invited by the World Health Organization, we, Heads of Government, Ministers and government representatives came together on the 21st day of October 2011 in Rio de Janeiro to express our determination to achieve social and health equity through action on social determinants of health and well-being by a comprehensive intersectoral approach.

2. We understand that health equity is a shared responsibility and requires the engagement of all sectors of government, of all segments of society, and of all members of the international community, in an “all for equity” and “health for all” global action.

3. We underscore the principles and provisions set out in the World Health Organization Constitution and in the 1978 Declaration of Alma-Ata as well as in the 1986 Ottawa Charter and in the series of international health promotion conferences, which reaffirmed the essential value of equity in health and recognized that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”. We recognize that governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate health and social measures and that national efforts need to be supported by an enabling international environment.

4. We reaffirm that health inequities within and between countries are politically, socially and economically unacceptable, as well as unfair and largely avoidable, and that the promotion of health equity is essential to sustainable development and to a better quality of life and well-being for all, which in turn can contribute to peace and security.

5. We reiterate our determination to take action on social determinants of health as collectively agreed by the World Health Assembly and reflected in resolution WHA62.14 (“Reducing health inequities through action on the social determinants of health”), which notes the three overarching recommendations of the Commission on Social Determinants of Health: to improve daily living conditions; to tackle the inequitable distribution of power, money and resources; and to measure and understand the problem and assess the impact of action.

6. Health inequities arise from the societal conditions in which people are born, grow, live, work and age, referred to as social determinants of health. These include early years’ experiences, education, economic status, employment and decent work, housing and environment, and effective systems of preventing and treating ill health. We are convinced that action on these determinants, both for vulnerable groups and the entire population, is essential to create inclusive, equitable, economically productive and healthy societies. Positioning human health and well-being as one of the key features of what constitutes a successful, inclusive and fair society in the 21st century is consistent with our commitment to human rights at national and international levels.

7. Good health requires a universal, comprehensive, equitable, effective, responsive and accessible quality health system. But it is also dependent on the involvement of and dialogue with other sectors and actors, as their performance has significant health impacts. Collaboration in coordinated and intersectoral policy actions has proven to be effective. Health in All Policies, together with intersectoral cooperation and action, is one promising approach to enhance accountability in other sectors for health, as well as the promotion of health equity and more inclusive and productive societies. As collective

goals, good health and well-being for all should be given high priority at local, national, regional and international levels.

8. We recognize that we need to do more to accelerate progress in addressing the unequal distribution of health resources as well as conditions damaging to health at all levels. Based on the experiences shared at this Conference, we express our political will to make health equity a national, regional and global goal and to address current challenges, such as eradicating hunger and poverty, ensuring food and nutritional security, access to safe drinking water and sanitation, employment and decent work and social protection, protecting environments and delivering equitable economic growth, through resolute action on social determinants of health across all sectors and at all levels. We also acknowledge that by addressing social determinants we can contribute to the achievement of the Millennium Development Goals.

9. The current global economic and financial crisis urgently requires the adoption of actions to reduce increasing health inequities and prevent worsening of living conditions and the deterioration of universal health care and social protection systems.

10. We acknowledge that action on social determinants of health is called for both within countries and at the global level. We underscore that increasing the ability of global actors, through better global governance, promotion of international cooperation and development, participation in policy-making and monitoring progress, is essential to contribute to national and local efforts on social determinants of health. Action on social determinants of health should be adapted to the national and sub-national contexts of individual countries and regions to take into account dif-

ferent social, cultural and economic systems. Evidence from research and experiences in implementing policies on social determinants of health, however, shows common features of successful action. There are five key action areas critical to addressing health inequities: (i) to adopt better governance for health and development; (ii) promote participation in policy-making and implementation; (iii) to further reorient the health sector towards reducing health inequities; (iv) to strengthen global governance and collaboration; and (v) to monitor progress and increase accountability. Action on social determinants of health therefore means that we, the representatives of Governments, will strive individually and collectively to develop and support policies, strategies, programmes and action plans, which address social determinants of health, with the support of the international community, that include:

11. To adopt better governance for health and development

11.1 Acknowledging that governance to address social determinants involves transparent and inclusive decision-making processes that give voice to all groups and sectors involved, and develop policies that perform effectively and reach clear and measurable outcomes, build accountability, and, most crucially, are fair in both policy development processes and results;

11.2 We pledge to:

- (i)** Work across different sectors and levels of government, including through, as appropriate, national development strategies, taking into account their contribution to health and health equity and recognizing the leading role of health ministries for advocacy in this regard;
- (ii)** Develop policies that are inclusive and take account of the needs of the entire population with specific attention to vulnerable groups and high-risk areas;
- (iii)** Support comprehensive programmes of research and surveys to inform policy and action;

(iv) Promote awareness, consideration and increased accountability of policy-makers for impacts of all policies on health;

(v) Develop approaches, including effective partnerships, to engage other sectors in order to identify individual and joint roles for improvements in health and reduction of health inequities;

(vi) Support all sectors in the development of tools and capacities to address social determinants of health at national and international levels;

(vii) Foster collaboration with the private sector, safeguarding against conflict of interests, to contribute to achieving health through policies and actions on social determinants of health;

(viii) Implement resolution WHA62.14, which takes note of the recommendations of the final report of the Commission on Social Determinants of Health;

(ix) Strengthen occupational health safety and health protection and their oversight and encourage the public and private sectors to offer healthy working conditions so as to contribute to promoting health for all;

(x) Promote and strengthen universal access to social services and social protection floors;

(xi) Give special attention to gender-related aspects as well as early child development in public policies and social and health services;

(xii) Promote access to affordable, safe, efficacious and quality medicines, including through the full implementation of the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property;

(xiii) Strengthen international cooperation with a view to promoting health equity in all countries through facilitating transfer on mutually agreed terms of expertise, technologies and scientific data in the field of social determinants of health, as well as exchange of good practices for managing intersectoral policy development.

12. To promote participation in policy-making and implementation

12.1 Acknowledging the importance of participatory processes in policy-making and implementation for effective governance to act on social determinants of health;

12.2 We pledge to:

(i) Promote and enhance inclusive and transparent decision-making, implementation and accountability for health and health governance at all levels, including through enhancing access to information, access to justice and public participation;

(ii) Empower the role of communities and strengthen civil society contribution to policy-making and implementation by adopting measures to enable their effective participation for the public interest in decision-making;

(iii) Promote inclusive and transparent governance approaches, which engage early with affected sectors at all levels of governments, as well as support social participation and involve civil society and the private sector, safeguarding against conflict of interests;

(iv) Consider the particular social determinants resulting in persistent health inequities for indigenous people, in the spirit of the United Nations Declaration on the Rights of Indigenous Peoples, and their specific needs and promote meaningful collaboration with them in the development and delivery of related policies and programmes;

(v) Consider the contributions and capacities of civil society to take action in advocacy, social mobilization and implementation on social determinants of health;

(vi) Promote health equity in all countries particularly through the exchange of good practices regarding increased participation in policy development and implementation;

(vii) Promote the full and effective participation of developed and developing countries in the formulation and implementation of policies and measures to address social determinants of health at the international level.

13. To further reorient the health sector towards reducing health inequities

13.1 Acknowledging that accessibility, availability, acceptability, affordability and quality of health care and public health services are essential to the enjoyment of the highest attainable standard of health, one of the fundamental rights of every human being, and that the health sector should firmly act to reduce health inequities;

13.2 We pledge to:

(i) Maintain and develop effective public health policies which address the social, economic, environmental and behavioural determinants of health with a particular focus on reducing health inequities;

(ii) Strengthen health systems towards the provision of equitable universal coverage and promote access to high quality, promotive, preventive, curative and rehabilitative health services throughout the life-cycle, with a particular focus on comprehensive and integrated primary health care;

(iii) Build, strengthen and maintain public health capacity, including capacity for intersectoral action, on social determinants of health;

(iv) Build, strengthen and maintain health financing and risk pooling systems that prevent people from becoming impoverished when they seek medical treatment;

(v) Promote mechanisms for supporting and strengthening community initiatives for health financing and risk pooling systems;

(vi) Promote changes within the health sector, as appropriate, to provide the capacities and tools to act to reduce health inequities including through collaborative action;

(vii) Integrate equity, as a priority within health systems, as well as in the design and delivery of health services and public health programmes;

(viii) Reach out and work across and within all levels and sectors of government by promoting mechanisms for dialogue, problem-solving and health impact assessment with an equity focus to identify and promote policies, programmes, practices and legislative measures that may be instrumental for the goal pursued by this Political Declaration and to adapt or reform those harmful to health and health equity;

(ix) Exchange good practices and successful experiences with regard to policies, strategies and measures to further reorient the health sector towards reducing health inequities.

14. To strengthen global governance and collaboration

14.1 Acknowledging the importance of international cooperation and solidarity for the equitable benefit of all people and the important role the multilateral organizations have in articulating norms and guidelines and identifying good practices for supporting actions on social determinants, and in facilitating access to financial resources and technical cooperation, as well as in reviewing and, where appropriate, strategically modifying policies and practices that have a negative impact on people's health and well-being;

14.2 We pledge to:

(i) Adopt coherent policy approaches that are based on the right to the enjoyment of the highest attainable standard of health, taking into account the right to development as referred to, inter alia, by the 1993 Vienna Declaration and Programme of Action, that will strengthen the focus on social determinants of health, towards achieving the Millennium Development Goals;

(ii) Support social protection floors as defined by countries to address their specific needs and the ongoing work on social protection within the United

Nations system, including the work of the International Labour Organization;

(iii) Support national governments, international organizations, nongovernmental entities and others to tackle social determinants of health as well as to strive to ensure that efforts to advance international development goals and objectives to improve health equity are mutually supportive;

(iv) Accelerate the implementation by the State Parties of the WHO Framework Convention on Tobacco Control (FCTC), recognizing the full range of measures including measures to reduce consumption and availability, and encourage countries that have not yet done so to consider acceding to the FCTC as we recognize that substantially reducing tobacco consumption is an important contribution to addressing social determinants of health and vice versa;

(v) Take forward the actions set out in the political declaration of the United Nations General Assembly High-Level Meeting on the Prevention and Control of Noncommunicable Diseases at local, national and international levels – ensuring a focus on reducing health inequities;

(vi) Support the leading role of the World Health Organization in global health governance, and in promoting alignment in policies, plans and activities on social determinants of health with its partner United Nations agencies, development banks and other key international organizations, including in joint advocacy, and in facilitating access to the provision of financial and technical assistance to countries and regions;

(vii) Support the efforts of governments to promote capacity and establish incentives to create a sustainable workforce in health and in other fields, especially in areas of greatest need;

(viii) Build capacity of national governments to address social determinants of health by facilitating expertise and access to resources

through appropriate United Nations agencies' support, particularly the World Health Organization;

(ix) Foster North-South and South-South cooperation in showcasing initiatives, building capacity and facilitating the transfer of technology on mutually agreed terms for integrated action on health inequities, in line with national priorities and needs, including on health services and pharmaceutical production, as appropriate.

15. To monitor progress and increase accountability

15.1 Acknowledging that monitoring of trends in health inequities and of impacts of actions to tackle them is critical to achieving meaningful progress, that information systems should facilitate the establishment of relationships between health outcomes and social stratification variables and that accountability mechanisms to guide policy-making in all sectors are essential, taking into account different national contexts;

15.2 We pledge to:

(i) Establish, strengthen and maintain monitoring systems that provide disaggregated data to assess inequities in health outcomes as well as in allocations and use of resources;

(ii) Develop and implement robust, evidence-based, reliable measures of societal well-being, building where possible on existing indicators, standards and programmes and across the social gradient, that go beyond economic growth;

(iii) To promote research on the relationships between social determinants and health equity outcomes with a particular focus on evaluation of effectiveness of interventions;

(iv) Systematically share relevant evidence and trends among different sectors to inform policy and action;

(v) Improve access to the results of monitoring and research for all sectors in society;

(vi) Assess the impacts of policies on health and other societal goals, and take these into account in policy-making;

(vii) Use intersectoral mechanisms such as a Health in All Policies

approach for addressing inequities and social determinants of health; enhance access to justice and ensure accountability, which can be followed up;

(viii) Support the leading role of the World Health Organization in its collaboration with other United Nations agencies in strengthening the monitoring of progress in the field of social determinants of health and in providing guidance and support to Member States in implementing a Health in All Policies approach to tackling inequities in health;

(ix) Support the World Health Organization on the follow-up to the recommendations of the Commission on Information and Accountability for Women's and Children's Health;

(x) Promote appropriate monitoring systems that take into consideration the role of all relevant stakeholders including civil society, nongovernmental organizations as well as the private sector, with appropriate safeguard against conflict of interests, in the monitoring and evaluation process;

(xi) Promote health equity in and among countries, monitoring progress at the international level and increasing collective accountability in the field of social determinants of health, particularly through the exchange of good practices in this field;

(xii) Improve universal access to and use of inclusive information technologies and innovation in key social determinants of health.

16. Call for global action

16.1 We, Heads of Government, Ministers and government representatives, solemnly reaffirm our resolve to take action on social determinants of health to create vibrant, inclusive, equitable, economically productive and healthy societies, and to overcome national, regional and global challenges to sustainable development. We offer our solid support for these common objectives and our determination to achieve them.

16.2 We call upon the World Health Organization, United Nations agencies and other international organizations to advocate for, coordinate and collaborate with us in the implementation of these actions. We recognize that global action on social determinants will need increased capacity and knowledge within the World Health Organization and other multilateral organizations for the development and sharing of norms, standards and good practices. Our common values and responsibilities towards humanity move us to fulfil our pledge to act on social determinants of health. We firmly believe that doing so is not only a moral and a human rights imperative but also indispensable to promote human well-being, peace, prosperity and sustainable development. We call upon the international community to support developing countries in the implementation of these actions through the exchange of best practices, the provision of technical assistance and in facilitating access to financial resources, while reaffirming the provisions of the United Nations Millennium Declaration as well as the Monterrey Consensus of the International Conference on Financing for Development.

16.3 We urge those developed countries which have pledged to achieve the target of 0.7 percent of GNP for official development assistance by 2015, and those developed countries that have not yet done so, to make additional concrete efforts to fulfil their commitments in this regard. We also urge developing countries to build on progress achieved in ensuring that official development assistance is used effectively to help achieve development goals and targets.

16.4 World leaders will soon gather again here in Rio de Janeiro to consider how to meet the challenge of sustainable development laid down twenty years ago. This Political Declaration recognizes the important policies needed to achieve both sustainable development and health equity through acting on social determinants.

16.5 We recommend that the social determinants approach is duly considered in the ongoing reform process of the World Health Organization. We also recommend that the 65th World Health Assembly adopts a resolution endorsing this Political Declaration. ■

ESTeSL: VI National Meeting of Science and Technology in Health gathers students, teachers and professionals from Portugal

The Higher School of Health Technology of Lisbon (ESTeSL) held on October 20, 21 and 22 the VI National Meeting of Science and Technology in Health, which had over 400 registered participants.

During the event, in several Panels, Conferences, Concurrent sessions, Symposia and Workshops, students, teachers and professionals in science and technology in health from around the country pondered on the five topics of the meeting: Research, Innovation, Practice, Citizenship and Internationalization.

João Lobato, president of ESTeSL, David Tavares, president of the Meeting's Scientific Committee, and Pedro Rebelo, President of the VI Meeting were present at the Opening Session of the Meeting held at the end of the first day of activities. Luis Costa, from the Faculty of Medicine of the University of Lisbon and the Institute of Nuclear Medicine, delivered the Inaugural Conference of the event, entitled "From research to clinical practice".

With great clarity and simplicity, the speaker stressed the importance of rapprochement between research projects and therapeutic innovations in oncology, as well as the need for a multidisciplinary and global work in this research area.

Invited by the organizers of the meeting, RETS' coordinator Anamaria Corbo participated in the panel "The international outlook of science and technology in health", held on the 22nd. At the closing session of the event, prizes were awarded for best free oral communication and the best poster, and homage was paid to the 30 Years of ESTeSL.

The VII Meeting is already scheduled for October 2014.



This article is a summary of the material published on the website of ESTeSL. Learn more about the VI National Meeting of Science and Technology in Health and see the pictures of the event at: <http://www.estesl.ipl.pt/default.aspx?Page=2560>.

INS launches the Magazine of Public Health of Paraguay

The Magazine of Public Health of Paraguay (Revista de Salud Pública del Paraguay), the official mouthpiece of the Institute, was officially launched on October 31st under the presence of Esperanza Martinez, Health Minister, Rubén Figueroa, PAHO-Paraguay's Representative, José Marín Massolo, the person responsible for the National Strategic Directorate for Human Resource in Health (DNERHS), Raúl Gulino Canese, director of the National Institute of Health (INS), and other authorities.

The publication was created in order to disseminate information related to Public Health, and is open to all scientific papers produced in the different disciplines related to the area, such as medicine, health sciences, social sciences, education, economy and management.

The idea is that the Journal becomes a good reading choice



for researchers working in Public Health and relying on the theoretical and methodological quality of the published works. The quadrimestral Magazine will publish original articles, review articles, fast communications, short communications and case reports. It will also have a section of letters to the editor and editorials related to Public Health. The publication's quality is ensured by an independent Editorial Committee which oversees the excellence of the material sent through a thorough and rigorous peer review. The articles published are indexed or summarized by the Database of the Latin American and Caribbean Health Sciences Literature (LILACS) and Scielo.

The electronic version of the first issue of the magazine is available at INS' website. The PDF document can be downloaded at the URL: <http://migre.me/65VIu>

Education of Health Professionals for the 21st Century: Report in Portuguese and Spanish and deepen reflections on the topic

In its ninth edition (March/2011), RETS Magazine published a large article about a report on the training of health professionals published in the Lancet magazine, Volume 376. The idea was to disseminate the proposals presented in the article “Health Professional for a new century: transforming education to strengthen health systems in an interdependent world” produced by the Independent Commission of the study in order to foster discussions about them. With the same goal, RETS proposed to cooperate in translating into Portuguese the original text in English.



Since early November, although the process of finalizing the Portuguese edition is still in progress, a preliminary version of the document is now available under the “Translations” section of the Commission’s website (<http://www.healthprofessionals21.org>).

With this initiative, the text in Portuguese prepared under the RETS with the support of the Commission and the collaboration of Marcia Castro, Associate Professor, Department of Global Health, Harvard School of Public Health, joins in the Chinese, German and Spanish versions, which were already ready.

Health workforce: IHMT is designated WHO Collaborating Centre



On November 1st, the Institute of Hygiene and Tropical Medicine, New University of Lisbon (IHMT/UNL), headed by Professor Gilles Dussault, was designated WHO Collaborating Centre for “Health workforce policy and planning” by WHO Director-General Margaret Chan.

The designation is the result of intense cooperation work between the Institute and WHO Human Resources for Health Department that has been developed for over five years now in research projects, consultancy, HRH training and publications in the field.

As a Collaborating Center, the IHMT will contribute to the WHO with the analysis and assessment of the econo-

mic effectiveness and efficiency of health workforce policies and practices in the African Countries of Portuguese Official Language (PALOP), East Timor and the European Union, with emphasis on supporting the agenda of Primary Health Care. In addition, the Institute will collaborate with countries in their efforts to strengthen the capacity and performance of their health workforce and with WHO in the development and implementation of regional and national human resources for health development policies.

Currently two IHMT members are part of the Editorial Board of the electronic magazine “Journal Human Resources for Health”. Professionals from the Institute also accumulate a great experience of technical cooperation with PALOP, Brazil and other developing countries in Africa and Latin America.

RETS New Member: the Pan-American Association of Medical Technologists (APTAM)

Currently chaired by Chilean Juan Carlos Araya, the Pan-American Association of Medical Technologists (APTAM) is a nonprofit organization gathering Medical Technologies professionals and representative institutions from the Pan-American countries in order to create, establish and further compliance with common goals on issues related to the full and free exercise of competencies acquired during their academic training.

APTAM was created in Arica (Chile) in 1992 during the I Pan-American Meeting convened by the Chilean Board of Medical Technologists in order to increase communication and exchange of experiences among participating countries, also favoring the professional exchange to strengthen the dissemination of knowledge in



various specialties. In the V Pan-American Meeting held in 2010 in Santiago (Chile), APTAM was revitalized after some years of inactivity.

On that occasion, the “Santiago Declaration” was also prepared, a document in which important agreements on the identity and autonomy of Medical Technologists and their equivalent professional designations are recorded. The “Santiago Declaration” was published in full in the Chilean Medical Technology Journal 30 (2), 2010.

In September this year, the VI Meeting was organized by the Colégio de Licenciados en Producción de Bioimágenes y Afines and held in Buenos Aires (Argentina). Read more about APTAM in RETS’ website (<http://www.rets.epsjv.fiocruz.br>), under “Members”.

Workshop discusses Human Resources for Health Information Systems

There are no more doubts that the workforce is a key element to the organization of a health system that meets the needs of the population. It is also consensus that the planning and management of human resources for health is a complex task and depends largely on the availability of reliable information on these workers. The big problem is that there is still much difficulty in almost every country to create and operate human resource for health information systems that can effectively support decision-making in the field, making them increasingly more effective and efficient.

In order to improve this situation in the Americas, from October 4 to 6, the Pan American Health Organization (PAHO/WHO) and the Ministry of Health of Brazil held a workshop in Brasilia, Brazil which gathered experts from Argentina, Brazil, Chile, Costa Rica and Peru, as well as PAHO/WHO HRH consultants. Experiences were shared and regional cooperation strategies were discussed in the event. A cooperation agenda for the strengthening of national HRH information systems was also drawn up.

Fragmentation and lack of standard indicators

On the first day of the workshop, Mario Roberto Dal Poz, from the World Health Organization (WHO) Department of Human Resources for Health, presented the challenges for the strengthening of HRH information systems. He said all recognize the importance of timely and updated information, but few are willing to bear the financial and political costs for the establishment and operation of quality information systems.

Another major problem identified by Dal Poz is the fragmentation of data sources and the lack of standard indicators that enable comparison and complementary use of these data. Thus, according to the speaker, WHO proposes some basic agreements to address the issue, including: reach a consensus on what to measure, based on a common conceptual map and recommended basic indicators; promote the use of multiple sources of information and better systematic sources; improve the comparability of information, advancing in the integrated use of international classifiers; promote and strengthen strategies and mechanisms of production, analysis, use and dissemination of information, such as HRH Observatories; and establish a comprehensive strategy for the strengthening of systems that considers from

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the identification of the necessary information up to its use in decision-making.

Diversity of national experiences fosters debates

In the second and third days of the event, an overview of HRH information in the five participating countries was presented, especially some experiences and initiatives that have been successfully implemented or strengthened in each country, such as the HRH Situation Room in Brazil, the Public Registry of Individual Health Providers in Chile and the HRH Observatory in Peru.

The presentations showed that the information production context tends to increase collaborative work, openness and integration between institutions, as well as to increase the presence of the State, whose role is to ensure the establishment of information systems that meet the daily needs and can be progressively developed and are constantly evolving. It also became clear that the public user of this information is quite diverse, including managers, health workers themselves and the general population, which reaffirms the need to democratize access to this information and make it increasingly more transparent.

However, despite visible progress in several aspects, there is still much work to be done so that national policy makers and HRH managers have at their disposal timely, updated and reliable information on the health workforce.

At the end of the event, among other things, the publication of a regional document with a summary of the main discussions and the systematic and detailed account of national experiences was proposed. It was also decided that the workshop participants invited to join the WHO Information Systems Discussion Group give rise to a reference group on the subject, as well as that workshop's conclusions and recommendations are adopted by PAHO's HRH department in its technical cooperation activities with Latin American and Caribbean countries.

At country level, the idea is to set up teams working on defining a set of indicators by size and monitoring type. It was also suggested that all from the group sought to review the document "Nueva gobernanza global como insumo", which contextualizes the definition and direction of information systems. ■

Esta matéria foi elaborada a partir das mensagens enviada por Mónica Padilla para a lista da Rede ProRHUS (<http://www.observarh.org/prorhush>). Todas as apresentações do evento e algumas leituras recomendadas estão disponíveis no site do Observatório Andino (<http://devserver.paho.org/obsertoriorh/drupal/index.php?q=node/235>) ou no site da RETS (<http://rets.epsjv.fiocruz.br>), em: 'Biblioteca' > 'Eventos' > 'Taller de Sistemas de Información de Recursos Humanos en Salud, Brasília 2011'.

AFRICA**Angola**

Escola Técnica Profissional de Saúde de Luanda
(+244) 222 357204

Escola Técnica Profissional de Saúde de Lubango
(+244) 537406

Instituto Médio de Saúde de Benguela
cfs-b@nexo.ao

Direção Nacional de Recursos Humanos - Ministério da Saúde
(+244) 924 215 344 / (244) 923 489 923

Cabo Verde

Universidade de Cabo Verde
(+238) 261 9904 / (+238) 261 2660

Gabinete de Estudos, Planeamento e Cooperação - Ministério da Saúde
(+238) 261 0900 / (+238) 261 3620

Guinea Bissau

Escola Nacional de Saúde
(+245) 663 9880 / (+245) 587 8864

Direção de Recursos Humanos - Ministério da Saúde Pública
(+245) 722 3402 / (+245) 20 1188

Mozambique

Centro Regional de Desenvolvimento Sanitário de Maputo - Ministério da Saúde
(+258) 21 247 0543

Direção Nacional de Recursos Humanos - Ministério da Saúde
(+258) 21 310429

São Tomé and Príncipe

Instituto de Ciências de Saúde Dr. Victor Sá Machado
(+239) 910536

AMERICAS**Argentina**

Escuela Superior de Salud Publica de la Provincia del Chaco
(+54) 3722 431951 - <http://portal1.chaco.gov.ar/pagina?id=371>

Instituto Superior de Tecnicaturas para la Salud - Ministerio de Salud de la Ciudad Autónoma de Buenos Aires
(+54) 11 4807 3341 / (+54) 11 4807 0428

Dirección de Capacitación Profesional y Técnica e Investigación - Gobierno de la Ciudad de Buenos Aires
(+54) 11 4807 3341

Dirección Nacional de Capital Humano y Salud Ocupacional - Ministerio de Salud de la Nación
(+54) 11 4379 9184 - <http://observatorio.msal.gov.ar>

Dirección de Capacitación de Técnicos para la Salud - Ministerio de Salud de la Provincia de Buenos Aires
(+54) 221 4838 858

Asociación Instrumentadores Bonaerenses
(+54) 221 421 6640 - <http://www.instrumentadores.org.ar>

Asociación Argentina de Técnicos en Medicina Nuclear (AATMN)
(+54) 11 4863 4449 - <http://www.aatmn.org.ar>

Revista TecnoSalud
(+54) 011 4794 8216 - <http://www.revistatecnosalud.com.ar>

PAHO - Argentina
(+54) 11 4319 4242 - <http://new.paho.org/arg>

Bolivia

Escuela Nacional de Salud - La Paz
(+591) 2 244 4225

Escuela Técnica de Salud Boliviano Japonesa de Cooperación Andina
(+591) 4 425 7501 - <http://www.etsbjca.com.bo>

Escuela Técnica de Salud del Chaco Boliviano 'Tekove Katu'
(+591) 3 952 2147

Unidad de Recursos Humanos - Ministerio de Salud y Deportes
(+591) 2 248 6654

PAHO - Bolivia

(+591) 2 241 2465 - <http://new.paho.org/bol>

Brazil

Rede de Escolas Técnicas do SUS (RET-SUS)
(+55) 61 3315 3394 - <http://www.retsus.epsjv.fiocruz.br>

Escola Politécnica de Saúde Joaquim Venâncio (EPSJV)
(+55) 21 3865 9797 - <http://www.epsjv.fiocruz.br>

Coordenação Geral de Ações Técnicas em Educação na Saúde - Secretaria de Gestão do Trabalho e da Educação na Saúde - Ministério da Saúde
(+55) 61 3315 2303

PAHO - Brazil

(+55) 61 3426 9595 - <http://new.paho.org/bra>

Chile

Asociación Panamericana de Tecnólogos Médicos (ATPM)
(562) 6384752 - pantecmed@gmail.com

División de Gestión y Desarrollo de las Personas - Ministerio de Salud
(+56) 2 574 0345

PAHO - Chile

(+56) 2 437 4600 - <http://new.paho.org/ch>

Colombia

Asociación para la Enseñanza de Técnicas Dentales
(+57) 1 310 2971

Facultad de Odontología - Universidad de Antioquia
(+57) 4 219 6718 - <http://odontologia.udea.edu.co>

Fundación Universitaria de San Gil (UniSanGil)
(+57) 7 724 5757 - <http://www.unisangil.edu.co>

Fundación Universitaria del Área Andina
(+57) 1 249 7249 - <http://www.areandina.edu.co>

Medised - Institución de Educación para el Trabajo y Desarrollo Humano
(+57) 1 684 5054 (Sede Norte) / (+57) 1 267 8610 (Sede Occidente)

Servicio Nacional de Aprendizaje (Sena)
(+57) 1 285 2448 - <http://www.sena.edu.co>

Dirección General de Análisis y Política de Recursos Humanos - Ministerio de la Protección Social
(+57) 1 330 5000 / (+57) 1 330 5050

PAHO - Colombia

(+57) 1 314 4141 - <http://www.paho.org/col>

Costa Rica

Escuela de Tecnologías en Salud - Facultad de Medicina/UCR
(+506) 2511 4493 - <http://ets.ucr.ac.cr>

Cuba

Facultad de Tecnologías de Salud (Fatesa/ISCM-H)
(+53) 5 286 0389 / (+53) 7 640 0192

El Salvador

Opas - El Salvador
(+503) 2298 3491 - <http://www.paho.org/els>

Equador

PAHO - Equador
(+593) 2 246 0330 - <http://www.paho.org/ecu>

United States

Global Community Health Training Center of Jackson State University
(+1) 601979 8848

Honduras

Universidad Nacional Autónoma de Honduras (UNAH)
(+504) 232 2110 - <http://www.unah.edu.hn>

México

Departamento de Enfermería Clínica Integral Aplicada/Cucs - Universidad de Guadalajara
(+52) 33 1058 5200 - <http://www.cucs.udg.mx/enfermeriaclinica>

Escuela de Enfermería - Universidad Autónoma del Estado de Morelos
(+52) 777 322 9632 - <http://www.uaem.mx/>

Facultad de Enfermería - Universidad Autónoma de Tamaulipas - Campus Tampico
(+52) 834 318 1700 - <http://www.enfermeria-tampico.uat.edu.mx>

PAHO - México

(+52) 55 5980 0880 - <http://www.paho.org/mex>

Panama

Opas - Panamá
(+507) 262 0030 - <http://www.paho.org/pan>

Paraguay

Centro Educativo Superior en Salud - Ypacaraí - Facultad en Ciencias de la Salud
(+595) 513 432 029 / (+595) 513 432009

Instituto Nacional de Salud (INS)
(+595) 21 294 482 - <http://www.ins.gov.py>

Instituto Técnico Superior Del Saber
(+595) 21 583 647

Dirección de Institutos Técnicos Superiores - Ministerio de Educación y Cultura (+595) 21 498 716

Dirección Nacional de Recursos Humanos en Salud - Ministerio de Salud Pública y Bienestar Social
(+595) 21 204 601

PAHO - Paraguay

(+595) 21 450 495 - <http://www.paho.org/par>

Peru

Dirección General de Gestión del Desarrollo de Recursos Humanos - Ministerio de Salud
(+51) 1 333-2899 - <http://www.minsa.gob.pe/dggdrh>

PAHO - Peru

(+51) 1 319 5700 - <http://www.paho.org/per>

Uruguay

Escuela Universitaria de Tecnologías Médicas - Universidad de la República (+598) 2 487 1323 - <http://www.eutm.fmed.edu.uy>

Dirección General de la Salud - Ministerio de Salud Pública
(+598) 2 400 1002 / (598-2) 4097800

PAHO - Uruguay

(+598) 2 707 3590 - <http://www.paho.org/uru>

EUROPA**Portugal**

Associação Portuguesa de Técnicos de Anatomia Patológica (APTAP)
<http://www.aptap.pt/index.htm>

Escola Superior de Tecnologia da Saúde de Lisboa
(+351) 218 980 400 - <http://www.estes.ipl.pt>

Instituto de Higiene e Medicina Tropical (IHMT)
(+351) 213 652 600 - <http://www.ihmt.unl.pt>

Escola Superior de Saúde - Cruz Vermelha Portuguesa
(+351) 213 616 790 - <http://www.esscvp.eu/>

Direção Geral da Saúde - Ministério da Saúde
(+351) 218 430-500 - <http://www.dgs.pt/>

WORLD HEALTH ORGANIZATION (WHO)

Human Resources for Health (HRH)
(+41) 22 791 2542 - <http://www.who.int>

PAN AMERICAN HEALTH ORGANIZATION (PAHO - WDC)

Human Resources for Health (HRH)
(+1) 202 974 3000 - <http://new.paho.org>

WHO AFRICAN REGION (AFRO)

Health Systems & Services Cluster
(+47) 241 39 388 - <http://www.afro.who.int/>

The International Network for Health Technicians Education (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.

