

INFRAESTRUCTURA DE SALUD PÚBLICA

BIBLIOGRAFÍA ANOTADA



1. Alliance for Health Reform. "Chapter 11: Public Health". in: Alliance for Health Reform. "Covering health issues: sourcebook for journalists". Washington, DC: Alliance for Health Reform; 2004. 18p.

URL: <http://www.allhealth.org/sourcebook2004/pdfs/chapter11.pdf>

Notas: Citation: Alliance for Health Reform. Covering health issues: sourcebook for journalists. Alliance for Health Reform, Washington, D.C., 2004. 214p. Disponible también en español con el título: La cobertura de temas de salud: manual para periodistas: 2004. El acceso al documento completo se encuentra en: <http://www.allhealth.org/sourcebook2004/toc.asp> para el inglés y en <http://www.allhealth.org/spanishsourcebook2004/toc.asp>

Resumen: The nation's public health system is something that many Americans take for granted — until things go wrong. Following the attacks of September 11, 2001, and the anthrax mailings a month later, the workings and mechanisms of hundreds of public health agencies within federal, state, and local governments came under intense scrutiny by the media and Congress. That examination identified a multitude of problems: outdated laboratories, poor coordination, and serious workforce shortages. Congress responded by sharply increasing funding for bioterrorism preparedness. A portion of that funding is being used to rebuild a long-neglected public health infrastructure. Today's public health system is expected to have the capacity to analyze real-time data from emergency rooms, physician office visits, medication sales, and other scattered sources to detect aberrant patterns of disease outbreaks and other causes of illness and death.

2. Argentina. Leyes. "Acuerdos". *Boletín Oficial de la República Argentina*. 2004. 30.556

URL: <http://www.glin.gov>

Resumen: Decreto 1885 suscripto por el Presidente de la Nación con fecha 22 de diciembre de 2004. Ratifica el Convenio suscripto con fecha 22 de septiembre de 2004, entre la Municipalidad de Berazategui, la Subsecretaría de Recursos Hídricos de la Secretaría de Obras Públicas dependiente del Ministerio de Planificación Federal, Inversión Pública y Servicios y la empresa Aguas Argentinas Sociedad Anónima para la construcción y puesta en marcha de la Planta Depuradora de Líquidos Cloacales a ubicarse en la mencionada localidad. Incluye Anexos. (3 arts., p. 8-20).

3. Arias Sánchez, G. "El saneamiento de las ciudades en América Latina". *www: HidroRed*; 2002. [8]p.

URL: <http://tierra.rediris.es/hidrored/congresos/psevilla/gregorio.html>

Notas: III Congreso Ibérico sobre Gestión y Planificación del Agua. "La directiva marco del agua: Realidades y futuros" Última actualización dic. 2002

Resumen: — De acuerdo con las cifras de Banco Mundial, desde 1950 a 1995 la población de América latina aumentó de 179 a 481 millones de habitantes, lo cual supone una mayor carga sobre la infraestructura existente. La tasa de crecimiento poblacional para el año 2002 ha sido de 3% anual. La tendencia de crecimiento en la población no solo no se detendrá sino que continúa en aumento.

— El porcentaje de latinoamericanos que contaba con instalaciones de evacuación de aguas servidas supone una cobertura del 48 % de la población total (52% en área urbana y el 39 % en rural). Solo un 5% de las aguas de alcantarillado de las ciudades recibe algún tipo de tratamiento.

— Es difícil generalizar acerca de cualquier condición en Latinoamérica, debido a la diversidad económica, social y ambiental de cada región, tanto entre países como en una misma nación. Un factor sociológico a

destacar es la gente pobre que vive en áreas urbanas y habita en colonias y áreas no adecuadas para el desarrollo (laderas empinadas en cerros, zonas pantanosas, planicies inundables, cuencas de arroyos).

— En Latinoamérica existe una marcada diferencia entre la población de escasos recursos y la de altos ingresos lo que también se refleja en el acceso a infraestructuras de saneamiento y depuración de aguas residuales. El 80 % tiene cobertura de servicio de saneamiento en estratos superiores y solo el 18 % en estratos bajos.

— Así también cabe destacar las escasas condiciones de salubridad que aparecen en determinadas áreas urbanas. Las personas de escasos recursos se encuentran más susceptibles a las enfermedades y potencialmente debido también a la escasa alfabetización de estos núcleos, están menos conscientes de cómo mantener las condiciones salubres lo cual lleva a una mayor propagación de enfermedades en la población general.

4. "Assessment of epidemiologic capacity in state and territorial health departments-United States, 2004". MMWR Morb Mortal Wkly Rep. 2005. 54: 18: 457-9p.

URL: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5418a2.htm>

Notas: CORPORATE NAME: Centers for Disease Control and Prevention (CDC).

Resumen: In November 2001, the Council of State and Territorial Epidemiologists (CSTE) conducted a survey of state and territorial health departments to assess their core epidemiologic capacity. The survey was completed just before distribution of approximately \$1 billion in terrorism preparedness and emergency response funds in fiscal year 2002, intended to improve the U.S. public health infrastructure. Results of the 2001 survey, published in 2003, indicated inadequate capacity in six of eight key epidemiology program areas (all except infectious disease and chronic disease) to fully perform the essential public health services most dependent on epidemiology. In 2004, CSTE conducted a follow-up survey that assessed epidemiologic capacity in the United States and its territories in the same eight program areas, estimated the number of additional epidemiologists needed for full performance, and identified education and training needs. This report summarizes the results of that 2004 follow-up survey, which indicated a 26.9% increase from 2001 in the overall number of epidemiologists working in state and territorial health departments, increased capacity in two program areas (i.e., terrorism preparedness and emergency response; maternal and child health) and decreased capacity in six other program areas (i.e., infectious disease, chronic disease, environmental health, injury, occupational health, and oral health). Results also revealed that 28.5% of epidemiologists lacked any formal training or academic coursework in epidemiology. Creation of a strong public health infrastructure fully capable of performing essential services will require additional trained epidemiologists in state and territorial health departments.

5. Austin, E. "Bobbie Berkowitz: an interview". *Advances*. 2002. 1: 4p.

URL: http://www.rwjf.org/files/publications/newsletter/Advances1_2002.pdf

Resumen: This winter 2002 interview with Bobbie Berkowitz, Ph.D., appeared in The Robert Wood Johnson Foundation's quarterly online newsletter, *Advances*. The article highlights how a lack of money and funding towards public health infrastructure contributed to a lack of preparedness in the fall 2001 anthrax threats.

6. Baker, E. L., Blumenstock, J. S., Jensen, J., Morris, R. D., and Moulton, A. D. "Building the legal foundation for an effective public health system". *J Law Med*

Ethics. 2002. 30: 3 Suppl: 48-51p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed&cmd=Retrieve&list_uids=12508502&dopt=Citation

Resumen: Work has been underway nationally since the mid-1990s to equip state and community public health systems with the infrastructure needed to perform essential public health services. Key components of that infrastructure are a competent workforce, information and communication systems, health department and laboratory capacity, and legal authorities. As part of this transformative work, standards and assessment tools have been developed to measure the capacity and actual performance of public health systems. In addition, a number of states have examined the legal foundation for public health services and have revised and updated those authorities to improve their system's capacity in the context of evolving health challenges. Among those states are Nebraska, New Jersey, and Texas, all of which, beginning in 1999, have adopted dynamic new approaches to aligning public health's legal authorities with new missions and expectations for performance and accountability. This article describes the approaches that these three states have taken to strengthen their legal foundation for public health practice, to illuminate the perspectives legislators and health officials bring to the process, and to give decision makers in other states practical insight into the potential benefits of reviewing and restructuring public health's legal authorities. The underlying stimuli for the states' initiatives differed significantly, yet shared an important, common core. What they held in common was concern that outdated elements of the public health system and infrastructure hindered delivery of essential public health services at the community level. Where they differed was in the type of tools they found most suitable for the job of rejuvenating those structures. The approaches taken, and the policy tools selected, reflect the unique health needs of each state, establish relationships among state and community health authorities and agencies, and provide guidance by elected and appointed policy makers. Each state continues to refine its approach as it gains experience with the new authorities.

7. Baker, E. L., Potter, M. A., Jones, D. L., Mercer, S. L., Cioffi, J. P., Green, L. W., Halverson, P. K., Lichtveld, M. Y., and Fleming, D. W. "The public health infrastructure and our nation's health". *Annu Rev Public Health*. 2005. 26: 303-18p.

URL: 15760291

Resumen: Threats to Americans' health-including chronic disease, emerging infectious disease, and bioterrorism-are present and growing, and the public health system is responsible for addressing these challenges. Public health systems in the United States are built on an infrastructure of workforce, information systems, and organizational capacity; in each of these areas, however, serious deficits have been well documented. Here we draw on two 2003 Institute of Medicine reports and present evidence for current threats and the weakness of our public health infrastructure. We describe major initiatives to systematically assess, invest in, rebuild, and evaluate workforce competency, information systems, and organizational capacity through public policy making, practical initiatives, and practice-oriented research. These initiatives are based on applied science and a shared federal-state approach to public accountability. We conclude that a newly strengthened public health infrastructure must be sustained in the future through a balancing of the values inherent in the federal system.

8. Baker, E. L. Jr and Koplan, J. P. "Strengthening the nation's public health infrastructure: historic challenge, unprecedented opportunity". *Health Aff*

(Millwood). 2002. 21: 6: 15-27p.

URL: 12442836

Resumen: The nation's attention has been focused on the vital need for a strong public health infrastructure to protect community health. In this paper we provide an overview of progress during the past decade and point to immediate challenges and opportunities that resulted from recent events. Further, we highlight the need for continued vigilance and broad partnership development if we are to maintain public support for public health. Finally, we point to the need for better language, compelling case reports, and quantitative capacity assessment to guide policymakers and program leaders and to ensure long-term support.

9. Bellolio R., J. *"Hacia una gestión cada vez más eficiente en salud". Universidad Chile. Boletín de la Escuela de Medicina.* 94. 23: 1

URL: <http://escuela.med.puc.cl/publ/Boletin/SaludPublica/EficienteSalud.html>

Resumen: Hoy en día es cada vez más evidente en el país la presencia de administradores especializados en el sector salud. Esto se debe a que, desde el punto de vista económico, este es un sector atípico, cuyas características hacen que la gestión sea compleja y delicada, pues la vida humana está de por medio. Por lo tanto, la concepción valórica es distinta a la de cualquier otro servicio. La gestión en este sector es compleja, principalmente porque las características de oferta y de demanda del servicio de salud obligan a adoptar nuevos conceptos en la dirección de la organización, a crear nuevos sistemas y desarrollar nuevas estructuras, vale decir, cambiar el estilo tradicional de trabajo. Además, la heterogeneidad del personal que trabaja en el sector determina la existencia de actitudes contrarias a la modernización y al cambio, lo que implica un constante desafío para la capacitación como herramienta destinada a modificar actitudes. Hay que recordar que el principal activo de las empresas de servicios son sus recursos humanos...

10. Benjamin, G. C. *"Public health infrastructure: creating a solid foundation". Physician Exec.* 2001. 27: 2: 86-7p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=11291230&dopt=Abstract

Resumen: The nation's public health system remains in disarray, despite the 1988 warning by the Institute of Medicine in its landmark report, "The Future of Public Health." Recent concerns about antibiotic resistance, inadequate disease surveillance capabilities, bioterrorism, and an increasing need for training the public health workforce have brought this problem into the forefront of congressional concern. Recent legislation aimed at addressing this problem was passed last Fall and signed into law. This program will take a significant step towards ensuring a solid public health system when it is fully implemented.

11. Berkowitz, B. and Nicola, R. M. *"Public health infrastructure system change: outcomes from the turning point initiative". J Public Health Manag Pract.* 2003. 9: 3: 224-7p.

URL: 12747319

Resumen: The Robert Wood Johnson and W.K. Kellogg Foundations created the Turning Point initiative to transform and strengthen the public health infrastructure. This study examined 135 public health system changes for their links to multiple sector collaborative engagement, essential public health services, health outcomes, and infrastructure building strategies. An on-line documentation system developed by the University of Kansas was used to record and analyze these linkages. The results showed that each state accomplished notable system changes; the majority involved more

than one sector and primarily related to increasing local public health system capacity and organizational change.

12. Bolivia. Ministerio de Salud y Deportes. *"Análisis del sector salud. BOLIVIA: Resumen ejecutivo"*. Washington, DC: OPS; 2004. 61p.

URL: <http://www.lachsr.org/es/hsanalyses.cfm?view=countryAsDoc&viewid=5>

Resumen: El proceso de Análisis del Sector Salud en Bolivia fue iniciado a partir del mes de noviembre de 2003, luego de la realización de un taller en el que las autoridades del Ministerio de Salud y Deportes asumieron el reto de aplicar la Metodología de Análisis del Sector Salud propuesta por la oficina regional de la OPS Washington y con la asistencia y coordinación técnica de la representación de la Organización Panamericana de la Salud, en Bolivia (OPS/OMS). El presente documento rescata los aspectos relevantes desarrollados en el proceso de análisis del sector realizado hasta el momento en el país. Mediante un trabajo participativo y coordinado, se integra la información recolectada en las distintas etapas del proceso, en un resumen analítico para contribuir en una lectura crítica, analítica, reflexiva y con fines propositivos, y aporta a la formulación de políticas públicas del sector salud en el país. En el análisis de los aspectos más relevantes de exclusión social en salud, en cuanto a infraestructura destaca un alto número de servicios concentrados en el área urbana con Hospitales de I y III nivel de atención, Centros de Salud y Postas de Salud, que cuentan con todos los servicios. Sin embargo se notan, diversas falencias en la atención de los servicios de salud; tanto en la calidad, como en la calidez y en grupos excluidos como: adulto-mayor, niños trabajadores y/o de la calle, indigentes y otras poblaciones en riesgo. La existencia de servicios de salud en el área periurbana es deficiente, ya que no existen Hospitales ni Centros de Salud; solamente existe un número limitado de Postas que prestan atención primaria en salud. Los establecimientos de Salud enfrentan la insuficiencia de sistemas sanitarios completos (falta de alcantarillado y desagües), además de las pocas y difíciles vías de acceso. Aparentemente las ciudades intermedias cuentan únicamente con Hospitales de I nivel de atención y ocasionalmente de II nivel de atención bien equipados que fueron contruidos en su mayoría por la cooperación externa. En Comunidades cercanas y lejanas sólo se puede acceder a servicios de salud en Centros de Salud y Puestos de Salud, respectivamente. La dispersión de las comunidades rurales dificulta el acceso a los servicios de salud que además presentan carecen de servicios básicos.

13. Boroschek Krauskopf, R and Retamales Saavedra, R. *"Guías de reducción de vulnerabilidad en el diseño de nuevos establecimientos de salud"*. Santiago, CL: Centro Colaborador OPS/OMS Mitigación de Desastres en Establecimientos de Salud Universidad de Chile; 2003. 11p.

URL: http://www.disaster-info.net/hospital_disaster/assets/hosp-vulnerabilitysp_1.doc

Resumen: En la actualidad, y frente a la ocurrencia de fenómenos naturales severos, la infraestructura de salud suele sufrir la interrupción temporal o permanente de su operación, daños en su infraestructura y pérdidas de la inversión, situaciones que causan impactos negativos sobre el desarrollo social y económico de la población y del país. Esta situación se debe a que en su diseño solo se ha contemplado como objetivo la protección de la vida del personal y de los usuarios. Si bien esto es un objetivo mínimo indispensable que se ha logrado con algún éxito, las consecuencias propias de una visión limitada como esta ha generado en la práctica instalaciones con una baja o nula protección a la inversión o a su rol funcional dentro del sistema de salud. Esta situación se ve agravada debido a que históricamente la selección de la ubicación de los

establecimientos ha considerado solo parcialmente los peligros naturales presentes en la región y sus efectos sobre la comunidad y sus servicios, y por prácticas constructivas y de mantenimiento que disminuyen o eliminan la poca seguridad que se ha incorporado en el proceso de diseño del establecimiento. Esta situación se puede revertir. Si bien modificar la situación de la infraestructura existente es un trabajo difícil y de un costo relativamente alto, la incorporación de un objetivo de protección a la inversión y operación en el diseño y construcción de nuevas instalaciones es sencilla y de bajo costo. Los éxitos de su aplicación ya están a la vista en desastres como los terremotos de EEUU de 1994 y Japón 1995, donde hospitales y otras obras en la zona epicentral continuaron funcionando sin alteraciones. Sin embargo, este procedimiento requiere tomar conciencia del objetivo deseado para la instalación ante distintos escenarios de fenómenos naturales severos. Estos objetivos pueden ser: protección a la vida, protección a la inversión y protección a la operación. Para cumplirlos es necesario reorganizar la forma en que tradicionalmente se crean nuevos establecimientos de salud, utilizando diseños y construcciones que consideren en forma directa los peligros naturales en el sitio y en la región y los objetivos de protección deseada. De acuerdo a la experiencia internacional, el costo de un proyecto nuevo con esta filosofía se verá incrementado en menos de un 4%. Este porcentaje es relativamente menor si se compara con las pérdidas directas que tiene el sector anualmente y con el impacto social, político y económico que implica la paralización o pérdida total de un hospital, laboratorio o banco de sangre. Este documento está dirigido a administradores, profesionales y asesores técnicos del área de la salud que tienen por misión la gestión, diseño, construcción e inspección de proyectos de establecimientos de salud. En él se indican las actividades que deben ser desarrolladas durante las etapas de planificación, selección de equipos profesionales, selección de la ubicación, diseño y construcción del proyecto.

14. Bossert, TJ, Ruiz Mier, F, Escalante, S, Cárdenas, M, Guisani, B, Capra, K, Beauvais, J, and Bowser, D. "La descentralización de los servicios de salud en Bolivia". Washington, DC: OPS; 2000. 70p.

URL: <http://www.hsph.harvard.edu/ihsg/publications/pdf/lac/Bolivia-dec-espanol.PDF>

Notas: Serie LACHSR No. 35

Resumen: La provisión de los insumos médicos, medicamentos y otros gastos operativos es responsabilidad de los municipios. Los gastos de mantenimiento de los establecimientos de salud también deben ser solventados por la alcaldía. La infraestructura y equipamiento esta a cargo de los municipios. Sin embargo, en el caso de los municipios pequeños, los proyectos deben ser necesariamente cofinanciados con el FIS (para el caso de municipios tipo A), PROISS y PSF (para otro el resto). Estos proyectos y entidades están en función de los lineamientos y políticas del gobierno central. El presente estudio se basa tanto en un análisis de información a nivel macro como en estudios de caso en Municipios seleccionados. El periodo durante el cual se realizó el trabajo de campo fue agosto 1998 a marzo 1999. Esto representa aproximadamente 4.5 años después de adoptados los cambios que dieron inicio a la descentralización. Debido a que el proceso de descentralización en Bolivia es relativamente reciente, todavía se están realizando cambios que modifican las características del mismo. El estudio considera el marco legal que estuvo vigente hasta julio de 1999. Los cambios posteriores a esa fecha no son considerados por dos razones. Primero, que van más allá del periodo de realización del estudio. Segundo, que ha transcurrido muy poco tiempo como para que se pueda apreciar el impacto de los mismos

en el desempeño de los servicios de salud. El resto del presente informe está estructurado en seis secciones. La sección II presenta el marco conceptual adoptado mientras que la sección III describe la metodología. Las secciones IV-VI presentan los resultados. La sección IV caracteriza la descentralización en Bolivia en términos de los espacios de decisión. De esta manera se contesta la pregunta sobre el grado de decisión transferido por el nivel central a los municipios. La sección V presenta los resultados del análisis de la información macro mientras que la sección VI describe y presenta los resultados del trabajo de campo. Estas dos secciones contestan, desde dos perspectivas diferentes, las preguntas sobre las decisiones que están siendo tomadas a nivel local y los efectos las mismas tienen en el desempeño del sistema de salud. La última sección resume los resultados a manera de conclusión.

15. Campbell, P. and Conway, A. *"Developing a local public health infrastructure: the Maine Turning Point experience"*. *J Public Health Manag Pract.* 2005. 11: 2: 158-64p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed&cmd=Retrieve&list_uids=15711446&dopt=Citation

Resumen: This article describes the efforts of public health leaders to develop local public health capacity across Maine. More than 200 individuals representing both government and nongovernmental organizations became engaged in The Robert Wood Johnson Foundation-sponsored Turning Point project in 1999. In recent years, the state has had only two local (city) health departments, only one of substantial capacity covering an extremely small proportion of the total state population. This article describes Maine Turning Point organizational efforts, challenges, successes, and failures, from the perspective of 3 individuals involved in the process. Five years later, a new network of state-financed, community-based partnerships focused on chronic disease risk factors has been established, apparently strong enough politically to survive in an era of severe state budget cuts. Tobacco use has been reduced. Many other serious public health issues, however, from obesity to mental illness and substance abuse, remain to be successfully addressed. The development of a sustainable statewide network of local agencies providing the essential public health services remains an elusive goal.

16. Centers for Disease Control and Prevention. *"Public health's infrastructure: a status report"*. Washington, DC: CDC; 99. 34p.

URL: http://www.phppo.cdc.gov/documents/phireport2_16.pdf

Resumen: The Committee is concerned over the disparities of quality and capabilities of the American public health infrastructure. While biosecurity and bioterrorism threats should be confronted, there continues to be insufficient capital funding by private and public sources of hospitals, laboratories, clinics, information networks, and other necessary elements to the provision of public health services. The Committee intends that future funding for biosecurity purposes will incorporate a growing proportion dedicated to public health infrastructure needs. **Therefore, the Committee requests a report that assesses the current state of the Nation's public health infrastructure and makes recommendations on possible actions that could be taken to strengthen key components.** Such a report should include: an identification of the components of infrastructure, the operational capabilities of each component and their interrelationships, the desired goals and outcomes of the national infrastructure, and the suggested means to improve the system in ways that improve public health

efficiently and effectively. In addition, the report should also assess global health factors that might influence the domestic public health infrastructure. The department should consult broadly within the public health, medical and international health communities to receive a diversity of viewpoints."

17. Centers for Disease Control and Prevention. *"Rebuilding public health infrastructure. Governmental Public Health Implementation Team – Final Report and Recommendations"*. Washington, DC: CDC; 2004. 71p.

URL: <http://www.pfh.org/infrastructure/resources/rebuilding.pdf>

Resumen: The following recommendations were developed by GPHIT and presented to the leadership of CDC. Implementation of these recommendations is seen as an important step to address the overall goal of rebuilding our nation's public health infrastructure. **Preparedness:** For this topic, GPHIT sought to identify how CDC could help state and local agencies focus preparedness efforts in ways that also advance the public health infrastructure. Feedback received from state and local agencies quickly pointed to the need for expanded and more specific preparedness guidance and the sharing of best practices. The following two recommendations meet this need and serve as good mechanisms for promoting and disseminating strategies that simultaneously prepare and build public health infrastructure.

- *CDC's Office of Terrorism Preparedness and Emergency Response (OTPER) should develop a program operations manual to serve as a comprehensive guidance document for state and local public health agencies.*

- *OTPER should increase access to best practices through the collection, evaluation, and dissemination of best practices and other emergent programmatic information.* **Accreditation:** GPHIT identified a set of integrated actions and steps that CDC can take—as an agency or in collaboration with others—to advance efforts in developing a national accreditation system for state and local public health agencies. Through collaborative efforts, CDC and other national stakeholders must 1) develop a national set of peer-controlled state and local public health agency standards; 2) strengthen buy-in for accreditation; 3) explore implementation strategies and operational issues; 4) develop incentives for participation; and 5) develop the necessary partnerships. To address all strategies, the Office of the Chief of Public Health Practice (OCPHP) will collaborate with national partners and provide leadership on behalf of CDC. In addition, GPHIT recommends the following CDC-specific actions to catalyze progress in the five strategy areas:

- *The CDC Office of the Chief of Public Health Practice and the CDC Office of the Chief Operating Officer should explore incorporating incentive opportunities within cooperative agreements.*

- *CDC should fund key national partners to address the development of agency standards and participate in accreditation activities.*

18. Chow, JC. *"Diplomacy is central to building public health infrastructure"*. U.S. Department of State Global Issues: an electronic journal. 2001. 6: 3: 10-11p.

URL: <http://usinfo.state.gov/journals/itgic/1201/ijge/ijge1201.pdf>

Resumen: The Department of State works to advance U.S. objectives and interest in establishing a healthier world community through diplomacy. Resources are vital in building public health infrastructure and providing essential services to people living with HIV/AIDS. The State Department is now leading negotiations that would create a new Global Fund to Fight AIDS,

Tuberculosis, and Malaria. This new fund would attract, manage, and disburse additional resources through a new public-private partnership that would make a sustainable and significant contribution to the reduction of infections, illness, and death caused by these three diseases.

19. Committee on Assuring the Health of the Public in the 21st Century. "Strengthening the public health infrastructure". in: Committee on Assuring the Health of the Public in the 21st Century. "The Future of the Public's Health in the 21st Century". Washington, DC: National Academies Press; 2003. 563p.

URL: <http://www.iom.edu/report.asp?id=4304>

Resumen: Future public health efforts in the United States will require collective support by public and private organizations focusing on the improvement of population health by making strategic investments to address the multiple health needs of America. These investments have the capacity to broadly impact populations through "healthy" prevention policies that support education, adequate housing, a living wage, or clean air. Further, they may address some of the pervasive socio-economic inequities that appear to be associated with profound disparities in health status, access, and outcomes. The Future of the Public's Health in the 21st Century reviews the nation's health achievements in recent decades, examines hidden vulnerabilities that undercut current health potential, which, if not addressed, could produce a decline in the future health status of the American people. The report recommendations address a number of present and future challenges facing the nation's public health infrastructure, partnerships, and population health approaches.

20. Detmer, D. E. "Building the national health information infrastructure for personal health, health care services, public health, and research". BMC Med Inform Decis Mak. 2003. 3: 1p.

URL: <http://www.biomedcentral.com/1472-6947/3/1>

Resumen: BACKGROUND: Improving health in our nation requires strengthening four major domains of the health care system: personal health management, health care delivery, public health, and health-related research. Many avoidable shortcomings in the health sector that result in poor quality are due to inaccessible data, information, and knowledge. A national health information infrastructure (NHII) offers the connectivity and knowledge management essential to correct these shortcomings. Better health and a better health system are within our reach. DISCUSSION: A national health information infrastructure for the United States should address the needs of personal health management, health care delivery, public health, and research. It should also address relevant global dimensions (e.g., standards for sharing data and knowledge across national boundaries). The public and private sectors will need to collaborate to build a robust national health information infrastructure, essentially a 'paperless' health care system, for the United States. The federal government should assume leadership for assuring a national health information infrastructure as recommended by the National Committee on Vital and Health Statistics and the President's Information Technology Advisory Committee. Progress is needed in the areas of funding, incentives, standards, and continued refinement of a privacy (i.e., confidentiality and security) framework to facilitate personal identification for health purposes. Particular attention should be paid to NHII leadership and change management challenges. SUMMARY: A national health information infrastructure is a necessary step for improved health in the U.S. It will require a concerted, collaborative effort by both public and private sectors.

21. Fay, M and Morrison, M. "Infrastructure in Latin America & the Caribbean: recent developments and key challenges". Washington, DC: World Bank, IDB; 2005. 81p.
URL: <http://www.iadb.org/sds/conferences/infrastructure/WB-IDB%20Infrastructure%20in%20Latin%20America.pdf>
Resumen: The study presents new World Bank research that says improving the region's infrastructure to the level of Korea could result in annual per capita growth gains of 1.4 to 1.8 percent of GDP, as well as reducing inequality by 10 to 20 percent. The poor benefit from infrastructure expansion both because gaining safe water, electricity and other services improves health and quality of life, and also because it helps them advance economically. Better roads, for example, mean greater market access for small farmers and rural communities. In access to safe water, LAC surpasses the middle-income average, as well as China, having increased from 82 percent of the population in 1990 to 89 percent in 2002. In addition, the region has a higher cellular penetration than other middle income countries. Nevertheless, less than a third of national road networks are in good condition and the region has slipped behind middle-income countries in energy generation capacity.
22. Foster, V. "Impacto social de la crisis argentina en los sectores de infraestructura". Washington, DC: World Bank; 2003. 35p.
URL:
[http://wbIn0018.worldbank.org/lac/lacinfoclient.nsf/5996dfbf9847f67d85256736005dc67c/07f3eb142e4b089185256d5d00567b25/\\$FILE/ESW05-03_Infraestructura_spa.pdf](http://wbIn0018.worldbank.org/lac/lacinfoclient.nsf/5996dfbf9847f67d85256736005dc67c/07f3eb142e4b089185256d5d00567b25/$FILE/ESW05-03_Infraestructura_spa.pdf)
Resumen: La crisis económica argentina afectó de manera particular a los servicios de infraestructura bajo régimen de concesión con el sector privado. El presente informe presenta los resultados de la primera etapa de un estudio sobre la política social de los sectores de infraestructura en Argentina. El propósito de este trabajo es el de documentar el impacto social de la crisis en los sectores de infraestructura, y evaluar la medida en que los diversos sectores cuentan con los elementos de una política social.
23. García Casabal, MF, Castillo, LM, and Dassas, RM. "Situación de salud en Argentina: una propuesta para conocer". s.l: s.n; 2003. 17p.
URL: <http://www.16deabril.sld.cu/epic/xviforum/virtual/word/aps/cuatro.html>
Resumen: Este trabajo nos introduce y da a conocer la situación de salud que nos atañe a los argentinos. Damos a conocer como esta compuesto su sistema de salud: ¿Cómo es la infraestructura? ¿Con qué personal cuenta? ¿Cómo está distribuido? ¿De qué presupuesto dispone? ¿Cuál es la legislación nacional o municipal que se hace cargo? Como todo esto se encuentra sumergido, en un contexto macro social, también abarcamos la situación político social para dar a entender mejor esta problemática de salud.
24. "Gestión pública de salud: desafío prioritario". Libertad y Desarrollo. 2001. 548: 3p.
URL: http://www.lyd.com/biblioteca/pdf/548Gestion_publica.pdf
Notas: Sección Temas Públicos
Resumen: Los establecimientos públicos no compiten para atraer pacientes, no les interesa otorgar más prestaciones ya que sus ingresos no dependen de lo que realizan. En efecto, tienen clientes cautivos y sumisos, que no pueden exigir sus derechos. Es un imperativo ético, mejorar la eficiencia en el uso de los recursos públicos para salud. Para solucionar los problemas del

sector público es necesario reconocer que se originan en el inadecuado sistema de incentivos bajo el cual funciona. El financiamiento de los prestadores públicos no está orientado a la gestión. Los recursos estatales para financiar las instituciones de salud se traspasan fundamentalmente teniendo en cuenta elementos históricos como las remuneraciones, infraestructura, equipamientos, etc., sin considerar la adecuada utilización de éstos en la efectiva solución de los problemas de salud de las personas. Los establecimientos públicos no compiten para atraer pacientes, no les interesa otorgar más prestaciones, ya que sus ingresos no dependen de lo que realizan. En efecto, tienen clientes cautivos y sumisos, que no pueden exigir sus derechos. Con el fin de contener costos, los mecanismos utilizados han sido el racionamiento mediante rechazos, largas listas de espera y excesivas derivaciones, lo que provoca una reacción de inseguridad en la población usuaria y el descontento en los trabajadores de la salud y en toda la población que participa en el financiamiento del sector.

25. Goodridge, G and Weil, B. *"Family health international: a leader in the fight against HIV/AIDS"*. U.S. Department of State Global Issues: an electronic journal. 2001. 6: 3: 12-4p.

URL: <http://usinfo.state.gov/journals/itgic/1201/ijge/ijge1201.pdf>

Resumen: An international nongovernmental organization pursues a variety of strategies to help build health care infrastructure and preventive HIV/AIDS programs on the local level in the developing world. Virtually every organization striving to improve public health has had to come to grips with the HIV pandemic. International organizations working on HIV/AIDS issues face the triple challenge of dealing with the multiple causes and repercussions of the pandemic; strengthening the links among HIV/AIDS prevention, care, and support; and forging partnerships with governments and nongovernmental organizations (NGOs) to implement effective responses.

26. Healthy People 2010 Project. *"23. Public health infrastructure"*. in: Healthy People 2010 Project. *"Healthy People 2010: Volume II"*. Centers for Disease Control and Prevention; [2001]. 664p.

URL: <http://www.healthypeople.gov/Document/HTML/Volume2/23PHI.htm>

Resumen: Public health infrastructure is a complex web of practices and organizations that has been characterized as in "disarray." All public health services depend on the presence of basic infrastructure. Every categorical public health program—childhood immunizations, infectious disease monitoring, cancer and asthma prevention, drinking water quality, injury prevention, and many others—requires health professionals who are competent in cross-cutting and technical skills, public health agencies with the capacity to assess and respond to community health needs, and up-to-date information systems. Federal public health agencies rely on the presence of infrastructure systems at the local and State levels to support the implementation of their programs. In public health, a strong infrastructure provides the capacity to prepare for and respond to both acute and chronic threats to the Nation's health, whether they are bioterrorism attacks, emerging infections, disparities in health status, or increases in chronic disease and injury rates. Such an infrastructure serves as the foundation for planning, delivering, and evaluating public health. The public health infrastructure comprises the workforce, data and information systems, and public health organizations. Research also is a key activity of public health infrastructure in identifying opportunities to improve health, strengthen information systems and organizations, and make more

effective and efficient use of resources. Health data and surveillance systems provide information on illness, disability, and death from acute and chronic conditions; injuries; personal, environmental, and occupational risk factors; preventive and treatment services; and costs. To be most useful, public health data must be accessible, accurate, timely, and clearly stated and must adhere to strict confidentiality standards. The system must be linked with other data systems and must be linked with and integrated at the Federal, Tribal, State, and local levels. The systematic collection, analysis, interpretation, dissemination, and use of health data drive efforts to determine the health status of a population, plan prevention programs, and evaluate program effectiveness. Healthy People activities during the 1980s and 1990s have demonstrated the central role of data, focused attention on what is important to measure, and stimulated the development of new data systems. Although Federal agencies take the lead in collecting national public health data, these agencies are only some of the many necessary partners that collect, analyze, and use public health data. Surveillance often involves active cooperation among Federal, Tribal, State, and local agencies. For example, the Vital Statistics Cooperative Program obtains information on births, deaths, marriages, and divorces from all 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam. Programs in each area collect vital information from many sources in local communities, including funeral directors, medical examiners, coroners, hospitals, religious authorities, and justices of the peace. Other data collection systems, based on sample surveys rather than reports, depend on the participation of thousands of private citizens nationwide. And still other systems rely on the administrative records of public and private health care organizations.

27. Hofbauer, H, Lara, G, and Martínez, B. "La salud: un derecho social, no un privilegio". México, DF: FUNDAR; 2002. 34p.

URL: <http://www.internationalbudget.org/themes/ESC/salud.pdf>

Resumen: A pesar de los esfuerzos en la legislación por garantizar la universalidad en los servicios de salud, la falta de disponibilidad de un sistema funcional de salud pública, con infraestructura y recursos humanos suficientes para responder a las necesidades de la población, se mantiene como un hecho. La limitada disponibilidad de recursos públicos es, sin duda, un problema que enfrenta el país; sin embargo es urgente que se haga un análisis serio de las prioridades nacionales, con el objetivo de redimensionar y colocar el problema de la salud entre los problemas urgentes que exigen atención inmediata y sostenida. Una de las preocupaciones de la actual administración, al igual que de la pasada, es incrementar el acceso a los servicios de salud por medio de paquetes básicos de bajo costo y alto impacto. Si bien estas medidas básicas son indispensables, no son ni lejanamente las necesarias para sustentar una atención integral a la salud. Resulta preocupante este enfoque, porque sencillamente no resolverá los rezagos de atención ni mejorará las precarias condiciones de salud de la mayoría de la población. Dentro de este esquema, los programas focalizados que podrían contribuir a la equidad del sistema, al ofrecer atención especial a los grupos más vulnerables se caracterizan por asignaciones presupuestales mínimas, y a todas luces insuficientes.

28. IDRC/SEMA . "Nuevos modelos institucionales para la gestión ambiental urbana asociaciones multisectoriales para el uso sustentable del agua en áreas urbanas". IDRC/SEMA; 2003. 11p.

URL: http://www.ems-sema.org/convoca2003/call_esp.pdf

Resumen: La evaluación (2000) de la Organización Mundial de la Salud indica que se ha logrado un avance en la ampliación de redes de distribución de agua potable en los últimos treinta años en la región: de un 70% de los hogares en el período de los años 70 a aproximadamente un 85% en el 2000. Sin embargo, la cobertura en el suministro de agua para zonas urbanas ha disminuido en el transcurso de la última década debido al rápido crecimiento de la población urbana. Con respecto a los hogares que cuentan con sistemas de saneamiento, el informe de la OMS indica que la cobertura se ha ampliado de 36% en los años 70 al 78% en el 2000. A pesar de los avances en la cobertura de saneamiento, el hecho crucial es que la gran mayoría de estos sistemas descargan lo colectado en cuerpos hídricos sin que haya ningún tipo de tratamiento previo. De hecho, el informe de la OMS estima que tan sólo un porcentaje del 14% del agua residual es efectivamente tratado antes de su descarga. En la mayoría de los casos, la forma principal de tratamiento consiste únicamente en tratamiento primario, es decir, la remoción de sólidos en suspensión del agua que se coloca en tanques de depósito. La mayor parte de las experiencias y "mejores prácticas" destacadas en la literatura reciente sobre gestión de servicios ambientales urbanos señalan la necesidad de dotar a las autoridades locales de más autonomía y flexibilidad en la toma de decisiones, para permitirles liderar la institucionalización de las alianzas multi-sectoriales para la gestión sustentable de los servicios ambientales urbanos. La dimensión "institucional" emerge como un aspecto esencial en la promoción de un cambio cultural e institucional en la praxis de planificación y gestión de los gobiernos locales. Se deben institucionalizar espacios innovadores para la participación social y la toma de decisiones.

29. Kassler, W. J. and Goldsberry, Y. P. "The New Hampshire public health network: creating local public health infrastructure through community-driven partnerships". *J Public Health Manag Pract*. 2005. 11: 2: 150-7p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed&cmd=Retrieve&list_uids=15711445&dopt=Citation

Resumen: In 1997, under the auspices of the Turning Point program, New Hampshire's public health stakeholders convened a strategic planning process to transform the state public health system. What emerged was a fundamental vision that the public health system could only be improved by strengthening the capacity of local communities to address local health issues. A plan was developed to create regional public health structures, in areas with no local health departments, to deliver essential public health services at the local level. Seven years later, that plan has become the New Hampshire Public Health Network. The network now covers 67% of the New Hampshire population and includes 113 (48%) cities and towns. Pre- and post evaluations to assess local public health infrastructure at the inception of the program and following 2 years of funding and technical assistance showed significant improvement in local public health capacity and performance. This article describes the development of local public health structures in New Hampshire where none had previously existed.

30. Koplan, JP. "Building infrastructure to protect the public's health". CDC; 2001. 9p.

URL: <http://www.phppo.cdc.gov/documents/KoplanASTHO.pdf>

Notas: A Public health training network Broadcast sponsored by the Ass. of State and Territorial Health Officials in partnership with HHS, CDC, HRSA, and FDA

Resumen: My top priority as CDC's Director continues to be to build a solid public health infrastructure I am pleased to briefly share with you what we

collectively have decided are seven priority areas for capacity-building:

— Our first priority is the public health **workforce**. I can't over emphasize the need for a well trained, well staffed, fully prepared public health workforce. They are the basis for our public health system.

— Second, we need **laboratory** capacity to produce timely and accurate results for diagnosis and investigation.

— Third is **epidemiology and surveillance**, which will give you the ability to rapidly detect health threats.

— Fourth, secure, accessible **information systems** are essential for us to communicate rapidly, analyze and interpret health data, and provide public access to health information.

— Fifth, we need solid **communication** -- a swift, secure, two-way flow of information. This includes the ability to provide timely, accurate information to the public and advice to policy-makers in public health emergencies. We also need the ability to routinely translate scientific information and provide health information.

— Next, we need effective **policy and evaluation** capability we need to routinely evaluate and improve the effectiveness of public health programs. We also need a way to assess where we are in order to establish priorities for health improvement. Then we can develop logical plans to address these priorities. Finally, we need a **preparedness and response** capability. This includes response plans, as well as testing and maintaining a high-level of preparedness.

31. Lurie, N. *"The public health infrastructure: rebuild or redesign?". Health Aff (Millwood)*. 2002. 21: 6: 28-30p.

URL: <http://www.rand.org/health/centers/healthsecurity/new/lurie.html>

Resumen: The events of Sept. 11, 2001 have driven home the fact that our current public health system is fragmented and out of date, but the public still lacks an understanding of what a public health system is supposed to do. Moreover, since our public health system was developed, the major causes of life-threatening disease have largely shifted from epidemics of acute infectious disease (bioterrorism, HIV, West Nile Virus, and other emerging infections, to the contrary notwithstanding) to chronic diseases with significant lifestyle components. Similarly, the personal healthcare delivery system has grown, while the public health system has decayed. This essay addresses the question of whether rebuilding the current public health system is adequate or whether a complete redesign is needed to support the many functions a public health system needs to perform. These include surveillance and monitoring, disease prevention, health promotion, and ensuring appropriate health care services for those with limited access. The author outlines three issues that need to be considered in making this decision. First, the infrastructure must blend the personal health care delivery system with the public health system. Second, creating interdependent systems will require that the medical care system be held accountable for its part, particularly where "the market" has been permitted to drive prioritization and decision-making. Third, the infrastructure must support public health systems' accountability for results: The drive to improve quality must be brought to public health. This need for accountability may be exemplified by the current dilemma over how to spend the recent infusion of federal funds into state public health systems: will we allow the funds to be used simply to shore up weak systems or will we demand that the funds be used to build a new system that meets the public health needs of the 21st century?

32. Martínez, E. *"Forjando un futuro más justo". Perspectivas de Salud*. 2004. 9: 1: 5p.
URL: http://www.paho.org/Spanish/DD/PIN/Numero20_articulo01.htm
Resumen: Los Objetivos de Desarrollo del Milenio no son sólo retórica con buenas intenciones. Demandan avances concretos y cuantificables para mejorar la calidad de vida en el mundo en desarrollo. En América Latina y el Caribe, las metas plantean un desafío particular: cerrar las brechas que la hacen la región más desigual del mundo. Un estudio reciente realizado en Perú por la Universidad del Pacífico reveló que la mortalidad infantil está en estrecha relación con el número de consultas preventivas, el porcentaje de niños inmunizados contra el sarampión, los logros educativos de la madre, la calidad del agua potable y de los servicios de saneamiento, así como la calidad de la infraestructura de salud. Otras variables similares están relacionadas con la mortalidad infantil, es decir, el deceso de niños antes de cumplir el primer año de vida, y todas ellas están relacionadas con factores socioeconómicos, familiares y de conducta.
33. MEASURE Evaluation. *"Measuring capacity building in health and population programs"*. Washington, DC: MEASURE Evaluation; 2000. 37p.
URL: <http://www.cpc.unc.edu/measure/publications/pdf/ws-00-04.pdf>
Notas: Summary of a meeting held by MEASURE Evaluation, November 16-17, 1999 Arlington, VA
Resumen: In November 1999, the MEASURE Evaluation project hosted a two day meeting on Measuring Capacity Building in Health and Population Programs. The objective of the meeting was to present, analyze, and build consensus on a conceptual framework and indicators for measuring capacity building in the population, health and nutrition (PHN) sector. Participants included representatives from USAID, UNICEF, The World Bank, CIDA, Cooperating Agencies, and NGOs working in the PHN area (Annex A). The results of this meeting will contribute to the design and testing of Guidelines for Measuring and Evaluating Capacity Building in the PHN Sector. This report summarizes the presentations and main points of discussion at the meeting. The proposed MEASURE framework of capacity measurement analyzes capacity at four levels of society: health system, organizational, health professional, and client (Annex B). During the meeting, participants reviewed the basic structure of the framework and made a number of substantive recommendations about specific relationships between components, the definition of capacity levels, and the description of elements of capacity for each level. Five practitioners from cooperating agencies and private voluntary organizations (PVOs) reported on specific tools and experiences related to capacity measurement at different levels. There are few, if any specialized tools for measuring capacity at the system level. However, many well-developed tools exist for measuring organizational capacity. These instruments all approach the organization by breaking it into component parts and measuring each component based on self-identified goals or stages of development. Capacity measurement at the health professional level centers primarily on assessing the knowledge and performance of health professionals.
34. México. Gobierno de Guanajuato. *"Hospitales y Centros de Salud: Análisis de la infraestructura física"*. Web: México. Gobierno de Guanajuato; s.f.
URL: <http://www.guanajuato.gob.mx/ssg/infraestructura/Hospitales.htm>
Resumen: El Instituto de Salud Pública del Estado de Guanajuato es una dependencia del Ejecutivo estatal que emana de la reforma a la Ley Orgánica de la Administración Pública Estatal, publicada en el Diario Oficial del Gobierno del Estado de Guanajuato, el día 22 de noviembre de

1996. En el estado de Guanajuato se logra la certificación del Programa de Cobertura Universal, con un paquete básico de servicios de salud para población abierta, en junio de 2000. Existe en la entidad una infraestructura física de 474 Unidades Médicas de primero y segundo niveles que atienden a la población abierta bajo la responsabilidad del Instituto de Salud Pública del Estado de Guanajuato, distribuidas en ocho jurisdicciones sanitarias, con un total de 766 consultorios generales y 65 consultorios dentales, en unidades de primer nivel, con 148 camas censables y 884 camas censables y 132 consultorios (132 de especialidades). Con respecto a las unidades de primer nivel de atención, 60 se ubican en el área urbana y 387 en localidades rurales. Los 12 hospitales del Instituto de Salud Pública del Estado de Guanajuato, ofrecen sus servicios con 132 consultorios y 884 camas censables. Esta infraestructura está destinada a la atención de una población abierta registrada en el Estudio de Regionalización Operativa (ERO) 2000 del Instituto de Salud Pública del Estado de Guanajuato, de 2 millones 462 mil 838 habitantes, que respecto a 1995, representa una disminución del 14.93 del 100 por ciento significando 440, 243 habitantes menos.

35. México. Leyes. "Norma Oficial Mexicana NOM-233-SSA1-1993". *Diario Oficial de la República (DOR)*. 2004.

URL: <http://www.salud.gob.mx/unidades/cdi/nom/233ssa103.html>

Resumen: Establece los requisitos arquitectónicos para facilitar el acceso, tránsito, uso, permanencia de las personas con discapacidad en establecimientos de atención médica ambulatoria y hospitalaria del Sistema Nacional de Salud .

36. México. Secretaría de Salud. "4º Informe de labores". México, DF, MX: Secretaría de Salud; 2004. 333p.

URL:

http://www.salud.gob.mx/apps/htdocs/evaluacion/informe_labores/2004/4to_inflabores.pdf

Resumen: El Plan Maestro de Infraestructura en Salud (PMIFS) tiene como objetivo general ser el instrumento rector para la promoción, desarrollo y reordenamiento de la infraestructura de los servicios estatales de salud con el fin de racionalizar y priorizar los recursos para la inversión y la operación sustentable. Diseñado para cubrir las necesidades de información en infraestructura para periodos de 10 años, el PMIFS está caracterizado por orientar la toma de decisiones con relación al desarrollo de infraestructura física; definir la infraestructura necesaria para satisfacer la demanda de servicios de salud, mediante una red nacional de cobertura real y virtual para todo el territorio; aportar propuestas y recomendaciones para la optimización y fortalecimiento de la infraestructura institucional existente; identificar los criterios necesarios para priorizar los requerimientos de infraestructura física en función del perfil de salud de la población y el porcentaje de cobertura; y promover la coordinación y suma de recursos y esfuerzos evitando duplicidades e ineficiencias en una perspectiva de colaboración sectorial. Para la integración del PMIFS se realizaron cuatro talleres de trabajo con los estados. Como resultado se obtuvieron los cuadros de la infraestructura consensuada de las entidades federativas y del Distrito Federal, se establecieron los límites geográficos virtuales de las 18 redes resultantes y se elaboraron los mapas correspondientes.

37. Muñoz, F, López-Acuña, D, Halverson, P, Guerra de Macedo, C, Hanna, W, Larriew, M, Ubilla, S, and Zeballos, JL. "Las funciones esenciales de la salud pública:"

un tema emergente en las reformas del sector de la salud". Rev Panam Salud Publica/Pan Am J Public Health. 2000. 8: 1/2: 126-34p.

URL: <http://www.ucsd.edu.do/v3/pmgasalud/MED-910/DOCUMENTOS%20LECTURA/FUNCIONES%20ESENCIALES%20SALUD%20P%C3%9ABLICA%20Y%20REFORMAS.pdf>

Resumen: En las Américas, las reformas del sector de la salud se enfrentan al desafío de fortalecer la función rectora de las autoridades sanitarias y una parte importante de este papel consiste en dar cumplimiento a las funciones esenciales de la salud pública (FESP) que competen al Estado en sus niveles central, intermedio y local. Para ello es crucial mejorar la práctica de la salud pública y los instrumentos para valorar su estado actual y las áreas en las que debe ser fortalecida. En virtud de lo anterior, la Organización Panamericana de la Salud (OPS) ha puesto en marcha la iniciativa "La salud pública en las Américas", dirigida a la definición y medición de las FESP como base para mejorar la práctica de la salud pública y fortalecer el liderazgo de las autoridades sanitarias en todos los niveles del Estado. El presente artículo resume aspectos conceptuales y metodológicos relacionados con la definición y medición de las FESP y analiza las implicaciones de la medición del desempeño de las mismas en el mejoramiento de las prácticas de la salud pública en las Américas.

38. Nicaragua. Ministerio de Salud. "Documento conceptual del Plan Nacional De Salud". Managua, NI: Nicaragua. Ministerio de Salud; 2004. 11p.

URL: <http://bvs.org.ni/pns/documentos/conceptopns.htm>

Resumen: Para facilitar el proceso de formulación del Plan Nacional de Salud, el Ministerio de Salud considero necesario contar con un documento conceptual del plan, que permita a todos los actores uniformar criterios sobre los alcances, contenido, metodología y consulta en el proceso de formulación del plan, así como puntualizar conceptos básicos que contendrá el mismo. Además, esta conceptualización inicial dará al proceso de formulación del Plan la transparencia y seriedad del caso para que tanto el MINSA como las instituciones del sector, la sociedad civil, los Gobiernos Regionales y Municipales, las Organizaciones Comunitarias, la Comunidad Internacional Cooperante y todos los actores del sector, cuenten con un documento guía que facilite la pertinencia, involucramiento y adopción de los mismos en dicho proceso.

39. Organización Panamericana de la Salud. "El desempeño de las funciones esenciales de la salud pública en el Uruguay". Montevideo, UY: Uruguay. Ministerio de Salud Pública/ OPS; 2002. 57p.

URL: <http://www.ops.org.uy/pdf/saludpub.pdf>

Resumen: Las mayores fortalezas en el área de desarrollo de capacidades e infraestructura se encuentran en:

- el apoyo de expertos y recursos para el monitoreo y evaluación del estado de salud de las poblaciones en el Uruguay;
 - las capacidades y destrezas en epidemiología;
 - la capacidad de los laboratorios que hacen a la red de laboratorios de Salud Pública;
 - la gestión de la cooperación internacional en Salud Pública;
 - los conocimientos, habilidades y mecanismos para acercar los programas y servicios a la población; y,
 - el desarrollo de la capacidad institucional para la investigación.
- Las debilidades más relevantes se aprecian en:
- el desarrollo de la capacidad institucional para la gestión de la Salud Pública;
 - el mejoramiento de la calidad de la fuerza de trabajo; y,

— el sistema de gestión tecnológica y de evaluación de tecnologías en salud para apoyar la toma de decisiones en Salud Pública. En el marco de esa interinstitucionalidad que es la Salud Pública, creemos que dentro del rol que le compete al Ministerio de Salud Pública como autoridad sanitaria nacional, se deberían mejorar varios aspectos como son: la evaluación de la calidad de la información, la capacidad de hacer cumplir su rol normativo y regulatorio, la definición de estándares de calidad, el perfeccionamiento del laboratorio de salud pública en su función de referencia nacional, la descentralización operativa, la construcción de una red de vigilancia epidemiológica a nivel nacional, la investigación en salud, el diseño de un modelo holístico de atención médica, entre otras. Constituyen un hito la definición de las Funciones Esenciales de la Salud Pública y la construcción de una herramienta para la evaluación de su desempeño.

40. Organización Panamericana de la Salud. "Fortalecimiento de la capacidad nacional y subregional para la vigilancia, prevención y control de las enfermedades transmisibles emergentes y re-emergentes". Washington, DC: OPS; 2001. 7p.

URL: <http://www.paho.org/spanish/hcp/hct/eer/recacer-els-2001.pdf>

Notas: El presente documento fue presentado durante la Reunión Subregional sobre Enfermedades Emergentes y Re-emergentes, 7-9 de Mayo de 2001, San Salvador, El Salvador organizada por el Programa de Enfermedades Transmisibles de la División de Prevención y Control de Enfermedades de la OPS. La versión final incorpora las contribuciones de los países al documento de trabajo original.

Resumen: La RECACER podría ser definida como un ente operacional de los países Centroamericanos, que funcionará en el marco político del SICA y de acuerdo con las resoluciones del COMISCA y RESSCAD, y tiene como principales elementos de referencia la consistencia con las orientaciones y recomendaciones de los planes técnicos específicos elaborados desde 1992 por los países y por la subregión. Además, servirá como un foro permanente y dinámico, para la armonización de normas o protocolos de vigilancia y control, la elaboración de planes de acción, el intercambio de datos e información de forma ágil entre los países para la coordinación de actividades de prevención y control de epidemias. El objetivo principal es fortalecer y formalizar el trabajo cooperativo entre los países para vigilar, prevenir y controlar las enfermedades transmisibles que representan amenazas comunes a los países de la subregión.

41. Organización Panamericana de la Salud. "Lecciones aprendidas en América Latina de mitigación de desastres en instalaciones de la salud". OPS; 97. 116p.

URL: <http://cidbimena.desastres.hn/docum/ops/publicaciones/044/044.4.htm>

Resumen: En 1990 la Organización Panamericana de la Salud inició un programa para estimular el incremento de la resistencia a los desastres de las instalaciones de salud nuevas y existentes. Como parte de esta iniciativa ha desarrollado normas y proyectos-piloto, ha apoyado análisis de vulnerabilidad en hospitales de Chile, Colombia, Ecuador, Santa Lucía y Venezuela y ha cooperado en los esquemas de reconstrucción de hospitales en México. El Banco Mundial promueve asimismo la aplicación de medidas de mitigación. En un estudio realizado se concluye que para los países en desarrollo no sólo es más efectivo prevenir los desastres que recuperarse de ellos, sino que si el desarrollo sustentable es una meta, resulta imperativo que las consideraciones sobre mitigación sean incorporadas a los programas y planes de desarrollo. En la Conferencia

Internacional sobre Mitigación de Desastres Naturales en Instalaciones de Salud convocada por la Organización Panamericana de la Salud, bajo el auspicio del Gobierno de México y con el apoyo de la Secretaría del DIRDN, el Departamento de Asuntos Humanitarios de las Naciones Unidas (DHA), la Comisión Económica para América Latina y el Caribe (CEPAL), la Secretaría de la Organización de Estados Americanos (OEA) y el Banco Mundial, llevada a cabo en la ciudad de México entre el 26 y el 28 de febrero de 1996, se adoptaron una serie de recomendaciones concretas; la mayor parte de ellas tendientes a impulsar las acciones gubernamentales dirigidas a la mitigación de desastres naturales en instalaciones de salud. Entre las recomendaciones aprobadas durante la Conferencia antes citada destacan por su importancia las siguientes:

- la que exhorta a los países con riesgo de huracanes y terremotos a continuar o fortalecer o iniciar el proceso tendiente a la mitigación de desastres en instalaciones de salud durante el período comprendido entre 1996 y 2001, para lo cual es necesario formular metas basadas en un cronograma anual determinado por los países de acuerdo con la magnitud de la problemática;
- a que consideren las amenazas geológicas e hidrometeorológicas como un factor determinante en la toma de decisiones para la planificación de los servicios de salud;
- y que introduzcan medidas de mitigación en el diseño y construcción de establecimientos de salud, remodelaciones y ampliaciones de las instalaciones existentes.

42. Organización Panamericana de la Salud. *"OPS/OMS. La salud pública en las Américas."* *Rev Cubana Salud Pública* v. 2002. 28: 3

URL: http://scielo.sld.cu/scielo.php?pid=S0864-34662002000300011&script=sci_arttext&tlng=es

Notas: Comentario sobre el libro OPS/OMS. La Salud Pública en las Américas: nuevos conceptos, análisis del desempeño y bases para la acción. OPS. Washington, 2002, XVII + 400 páginas, aparecido en la *Rev Cubana Salud Pública* v.28 n.3 Ciudad de La Habana sep.-dic. 2002

Resumen: No encontramos mejor información para esta sección de nuestra revista que transcriben las páginas introductorias del libro, tituladas Carta de navegación. Por medio de estas notas iniciales se busca dar al lector algunas sugerencias de cómo "navegar" por este libro. Ello obedece a que hay distintas puertas de entrada a una construcción de varias partes modulares, concebidas en forma complementaria, pero que no necesariamente tienen que ser recorridas de manera lineal. De hecho, cada parte y cada capítulo se prestan para iniciar la lectura de unidades claramente diferenciadas que puedan permitir al interesado su análisis independiente cuya suma e interconexión contribuyen a la construcción espacial del planteamiento integral de la obra. Quienes provienen del campo de la salud pública, tanto del ámbito académico como de la práctica referida a la dirección, la gestión y la operación sanitaria, seguramente reconocerán múltiples señales que le permitirán entrar de inmediato a algunos apartados. En cambio, ello demandará recorridos más detenidos a los lectores que proceden de otros campos de actuación, o de otras disciplinas, cuyo vínculo con el quehacer de la salud pública es menos directo. En todo caso, el hilo conductor de esta obra, el leit motiv del libro, es la construcción de un eje que abarca: primero, una reflexión que nos permita concebir con la suficiente frescura y con el suficiente poder de resolución, tanto conceptualmente como desde la perspectiva analítica de las responsabilidades de lo público estatal y no estatal, la práctica actual en salud pública de la Región de las Américas

(Partes I y II); segundo, una posibilidad de traducir ese marco conceptual en definiciones operativas, con alto sentido pragmático, que han hecho posible medir el desempeño de las Funciones Esenciales de Salud Pública (FESP), propias de la autoridad sanitaria, en todos los países de América Latina y el Caribe (Parte III); y tercero, la formulación de la discusión de distintos procesos e instrumentos que hagan posible transitar de la medición hacia la acción, del diagnóstico de fortalezas y debilidades, al mejoramiento de la práctica de la salud pública, concentrando los esfuerzos en el desarrollo institucional y el fortalecimiento de la infraestructura en salud pública (Parte IV).

43. Ostlin, P., Sen, G., and George, A. *"Paying attention to gender and poverty in health research: content and process issues"*. *Bull World Health Organ.* 2004. 82: 10: 740-5p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed&cmd=Retrieve&list_uids=15643794&dopt=Citation

Resumen: Despite the magnitude of the problem of health inequity within and between countries, little systematic research has been done on the social causes of ill-health. Health researchers have overwhelmingly focused on biomedical research at the level of individuals. Investigations into the health of groups and the determinants of health inequities that lie outside the control of the individual have received a much smaller share of research resources. Ignoring factors such as socioeconomic class, race and gender leads to biases in both the content and process of research. We use two such factors--poverty and gender--to illustrate how this occurs. There is a systematic imbalance in medical journals: research into diseases that predominate in the poorest regions of the world is less likely to be published. In addition, the slow recognition of women's health problems, misdirected and partial approaches to understanding women's and men's health, and the dearth of information on how gender interacts with other social determinants continue to limit the content of health research. In the research community these imbalances in content are linked to biases against researchers from poorer regions and women. Researchers from high-income countries benefit from better funding and infrastructure. Their publications dominate journals and citations, and these researchers also dominate advisory boards. The way to move forward is to correct biases against poverty and gender in research content and processes and provide increased funding and better career incentives to support equity-linked research. Journals need to address equity concerns in their published content and in the publishing process. Efforts to broaden access to research information need to be well resourced, publicized and expanded.

44. Padgett, S. M., Bekemeier, B., and Berkowitz, B. *"Collaborative partnerships at the state level: promoting systems changes in public health infrastructure"*. *J Public Health Manag Pract.* 2004. 10: 3: 251-7p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed&cmd=Retrieve&list_uids=15253521&dopt=Citation

Resumen: Reforms in the public health infrastructure such as those called for in recent Institute of Medicine reports require stakeholder engagement on different levels than traditional grass-roots community work. The Turning Point Initiative, funded by The Robert Wood Johnson Foundation, involves 21 state-wide partnerships established for systems change and focused in specific areas of public health innovation and policy development. These partnerships represent a different model of strategic alliances and

relationship-building than has been previously described in the literature on community-level and health-promotion collaborations. This article utilizes qualitative data to illustrate the ways in which state-level partnerships for systems change both confirm and extend previous models. Findings indicate that state-level public health partnerships share many of the challenges and opportunities of locally-based and health-promotion-oriented partnerships. Collaboration at the state level, however, involves more attention to organizational alliances, coordination of institutional change, and strategic responses to political changes. These partnerships depend on a combination of interpersonal skills, material resources, and organizational savvy to manage complex planning and implementation processes. Influencing policy development and organizational redesign in public health systems requires nuanced understanding of the opportunities provided by various kinds of organizational partners.

45. Padgett, S. M., Bekemeier, B., and Berkowitz, B. *"Building sustainable public health systems change at the state level"*. *J Public Health Manag Pract.* 2005. 11: 2: 109-15p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed&cmd=Retrieve&list_uids=15711440&dopt=Citation

Resumen: Reforming the public health infrastructure requires substantial system changes at the state level, including the reorganization of state agencies' plans, roles, and relationships with other sectors and communities. Beyond the limited time period of pilot programs and grants, how are these public health system changes to be sustained? Turning Point is an initiative of The Robert Wood Johnson Foundation to transform and strengthen the public health system. The 21 states participating in this initiative developed multisector partnerships to produce public health improvement plans and from these, chose one or more priorities for implementation. Reform efforts to strengthen the public health system occur within complex fiscal and political environments, however, and must cope with both uncertainty and turbulence in the process of implementing change. Turning Point state partners have developed a variety of approaches to the challenge of incorporating effective community collaborations as a permanent strategy for transforming public health systems. A qualitative, descriptive study design was used to analyze the strategies used by Turning Point state partnerships to meet the challenges of sustaining their system improvements. These strategies included: institutionalization within government, establishing "third sector" institutions, cultivating relationships with significant allies, and enhancing communication and visibility among multiple communities.

46. Panamá. Ministerio de Salud. *"Dirección de Infraestructura de Salud"*. [www: Panamá Ministerio de Salud;](http://www.minsa.gob.pa/minsa2004/infraestructura.htm) 2004.

URL: <http://www.minsa.gob.pa/minsa2004/infraestructura.htm>

Resumen: La Dirección de Infraestructura de Salud está ubicada en el Nivel de Apoyo y depende jerárquicamente del Despacho Superior.

Objetivo:

1. Garantizar que la planta física de las infraestructuras de salud que comprende edificaciones, equipos industriales y biomédicos y obras sanitarias estén en condiciones adecuadas para la provisión de servicios de atención a la población y al ambiente y de salud pública.

Funciones:

1. Asesorar y presentar información oportuna y periódica al Despacho Superior en materia de su competencia.

2. Coordinar con la Dirección Nacional de Políticas de Salud en la definición de políticas sanitarias relativas a las condiciones que deben reunir la infraestructura y equipamiento de las instalaciones de salud.
3. Coordinar con la Dirección Nacional de Políticas de Salud en la formulación y evaluación del presupuesto de inversión.

47. Perú. Ministerio de Salud. *"Diagnóstico del sistema de mantenimiento"*. Lima, PE: Perú. Ministerio de Salud; 98. 126p.

URL: <http://www.minsa.gob.pe/publicaciones/pdf/mantenimiento.pdf>

Resumen: El Estudio denominado «Diagnóstico del Sistema de Mantenimiento», ha sido desarrollado por la Asociación Consultora CESEL S.A.- EMEX S.A. - INTERSALUS S.A. en base al Contrato de Consultoría firmado con la Unidad Coordinadora del Programa (UCP) de Fortalecimiento de los Servicios de Salud del Ministerio de Salud (MINSA) el 23 de noviembre de 1995 y que concluyó el 29 de febrero de 1996, dicho Contrato se realizó como resultado del Concurso N° 001/MINSA-BID, enmarcado dentro del Contrato de Préstamo N° 741/OC-PE suscrito entre el Gobierno del Perú y el Banco Interamericano de Desarrollo (BID) del 31.03.93. El Estudio está dirigido a determinar la situación actual de la infraestructura, instalaciones y equipamiento de los Establecimientos de Salud del MINSA, a determinar las acciones de Mantenimiento actuales, el entorno en el cual se realizan dichas acciones, así como las propuestas de solución a la problemática encontrada, que a su vez posibilitarán la contratación de la Firma Consultora encargada de implementar las recomendaciones del presente Estudio en el Concurso N° 002/MINSA-BID. La Metodología seguida en el presente Estudio ha consistido en la selección de una muestra de Establecimientos de Salud, concordada con la UCP, donde se han aplicado instrumentos para la recolección de la información. Los Hospitales seleccionados por su ubicación geográfica, densidad poblacional y demanda de atención. Por otro lado, se realizó la recolección de información sobre Mantenimiento en los diversos Organismos del MINSA, afines al Mantenimiento como son el Programa Nacional de Mantenimiento y Equipamiento (PRONAME), Oficina de Inversiones y Cooperación Externa (OFICE), entre otros; igualmente se tomó contacto con otros Establecimientos del Sector como son el Instituto Peruano de Seguridad Social (IPSS), Hospital de Aeronáutica y con instituciones relacionadas como Proveedores de Equipos, Proveedores de Servicios, Instituciones Universitarias y Tecnológicas, con la finalidad de disponer de la información confiable necesaria para obtener los resultados esperados.

48. Proyecto Esfera. *"Capítulo 5: Normas mínimas en materia de servicios de salud"*. in: Proyecto Esfera. *"Manual esfera: edición revisada 2004"*. Proyecto Esfera; 2004. 295-368 (408p)p.

URL: http://www.sphereproject.org/spanish/manual/hdbkpdf/hdbk_c5.pdf

Notas: En el URL:

http://www.sphereproject.org/spanish/manual/hdbkpdf/hdbk_full.pdf
puede bajar el Manual Esfera completo.

Resumen: Durante la respuesta a un caso de emergencia, en situaciones en que con frecuencia suben las tasas de mortalidad o podría pronto suceder así, las intervenciones prioritarias se deben concentrar principalmente en las necesidades urgentes de supervivencia, en las cuales se incluye la atención médica básica. Una vez que las necesidades de supervivencia han sido atendidas, se deberá desarrollar una cantidad mayor de servicios de salud. Durante todas las fases de la respuesta la adopción de un enfoque basado en sistemas de salud en el diseño, la implementación, el

seguimiento y la evaluación de los servicios contribuirá a garantizar que serán atendidas las necesidades más importantes, que la cobertura será apropiada, que se optimizará el acceso y que se fomentará la calidad. Las normas que siguen tienen aplicación en todos los contextos de desastres, pero son particularmente pertinentes en las situaciones en que los recursos escasean. Las normas han sido concebidas principalmente para que las comunidades afectadas por el desastre tengan acceso a servicios sanitarios de buena calidad durante la respuesta al desastre. Es de especial importancia fomentar la sostenibilidad de los servicios de salud tras el desastre si ha tenido lugar un trastorno considerable de la infraestructura y los servicios sanitarios. Sin embargo, para garantizar la sostenibilidad hace falta considerar factores muy diversos, entre ellos algunos de índole política, administrativa, institucional, financiera y técnica, los cuales quedan fuera del ámbito del presente escrito. Los organismos y el personal sanitario deben tener en cuenta que muchas veces las decisiones tomadas durante la respuesta a un desastre podrán llevar a resultados opuestos, sirviendo para estimular o para socavar la sostenibilidad a largo plazo de los servicios.

49. Rathe, M. *"Estimación del gasto y financiamiento de las Funciones Esenciales de Salud Pública (FESP): un marco de referencia. Informe final"*. Santo Domingo, DOR: Rathe, Magdalena; 2002. 73p.

URL: <http://www.dor.ops->

[oms.org/Bvs_rd/Homepage_rd_archivos/Documentos/Sistemas%20y%20servicios%20de%20salud/Informe%20Final%20OPS-FESP_Rathe_.pdf](http://www.dor.ops-oms.org/Bvs_rd/Homepage_rd_archivos/Documentos/Sistemas%20y%20servicios%20de%20salud/Informe%20Final%20OPS-FESP_Rathe_.pdf)

Resumen: Los resultados de la presente iniciativa tendrán importantes usos para fines del desarrollo de las políticas y la práctica de la salud pública a nivel regional, y contribuirán también a estos mismos fines en el resto del mundo. Algunos de sus posibles beneficios se resumen a continuación:

- Mejorar la capacidad de asignación de los recursos, tanto corrientes como de inversión, en las funciones esenciales de salud pública y, consecuentemente, hacer más eficiente el gasto público.
- Mejorar el conocimiento sobre la forma en que se lleva a cabo la ejecución de las FESP y sobre la manera en que los países pueden irse aproximando al estándar.
- Contribuir al mejoramiento de la infraestructura de salud pública y al desempeño en las FESP.
- Mejorar la calidad de los sistemas de salud en su conjunto, al elevar la capacidad normativa de la autoridad sanitaria y su desempeño.
- Transparentar la asignación de recursos en las FESP en las estadísticas presupuestarias y, consecuentemente, en las Cuentas Nacionales de Salud.

50. RESSCAD. *"Plan sub-regional de reducción de vulnerabilidad del sector salud"*. Managua, NI: RESSCAD; 2003. 17p.

URL: <http://www.disaster->

[info.net/saludca/desastresCR/Reunion%20Coordinadores/Plan%20Subregional%20del%20Sector%20Salud.doc](http://www.disaster-info.net/saludca/desastresCR/Reunion%20Coordinadores/Plan%20Subregional%20del%20Sector%20Salud.doc)

Resumen: Si bien es cierto que el sector salud se ha fortalecido en su capacidad de respuesta en todos los países, hay necesidad de identificar algunos puntos críticos que requieren de apoyo y desarrollo urgente:

- Todos los Ministerios de Salud de los países, cuentan con oficinas de desastres, sin embargo, se identifica la necesidad de que sean fortalecidas a través de presupuestos y recursos, elementos esenciales para asumir el liderazgo en el sector. Ninguno de los países en la actualidad cuenta con un presupuesto institucional, que le permita cumplir con las acciones

planificadas en sus planes de emergencia a los diferentes niveles.

- La planificación para situaciones de desastres, se ha visto limitada a planes institucionales y no sectoriales.
- La descentralización reciente y las responsabilidades dadas a los municipios o regiones sanitarias no han sido precedidas por la formación de una capacidad local de manejo de emergencias.
- La mayoría de los países tiene análisis del sector salud, sin embargo es evidente la ausencia de un diagnóstico situacional, que identifique elementos necesarios para enfrentar situaciones de desastres.
- Los procesos de capacitación en los países han sido generados de manera muy puntual y no con un carácter de programa.
- En emergencias anteriores se evidencio la ausencia de mecanismos de coordinación Sub Regional, entre los Ministerios de Salud de los países miembros de la RESSCAD.
- En todos los países existen instrumentos jurídicos que dan las bases legales para el desarrollo de actividades frente a los desastres, sin embargo es necesaria la integración de estas acciones bajo un marco de sistema que integre a todas las instituciones y sectores y defina responsabilidades descentralizadas. El enfoque de sistema hace más fuerte al sector salud. Bajo este enfoque el único país que funciona bajo un sistema es Nicaragua. Es importante recalcar los esfuerzos realizados por las Unidades de Desastres de los Ministerios de Salud, para lograr un mayor fortalecimiento institucional, mejorar sus capacidades locales, disminuir o mitigar la vulnerabilidad de la infraestructura hospitalaria, y de los sistemas de agua y saneamiento. Sin embargo, se hace necesario dar sostenibilidad a estos esfuerzos y lograr reforzar la capacidad operacional de las instituciones del sector salud.

51. Rodrigues, R. J. and Risk, A. *"eHealth in Latin America and the Caribbean: development and policy issues"*. *J Med Internet Res.* 2003. 5: 1: e4p.

URL: <http://www.jmir.org/2003/1/e4/>

Resumen: This paper reviews trends and issues in health and in the information and communication technologies (ICT) market as they relate to the deployment of eHealth solutions in Latin America and the Caribbean. Heretofore designed for industrialized countries and large organizations, eHealth solutions are being proposed as an answer to a variety of health-system management problems and health care demands faced by all health organizations including those in developing societies. Particularly, eHealth is seen as especially useful in the operational support of the new health care models being implemented in many countries. The authors examine those developments vis-à-vis the characteristics of the Latin American and the Caribbean health-sector organizational preparedness and technological infrastructure, and propose policy and organizational actions to foster the development of eHealth solutions in the region.

52. Saiag, E. *"The israeli virtual national health record: a robust national health information infrastructure based on a firm foundation of trust"*. *Stud Health Technol Inform.* 2005. 116: 427-32p.

URL:

[http://iospress.metapress.com/\(dkjcv55vtqxs145e3whoibo\)/app/home/contribution.asp?referrer=parent&backto=issue,76,182;journal,1,11;linkingpublicationresults,1:300379,1](http://iospress.metapress.com/(dkjcv55vtqxs145e3whoibo)/app/home/contribution.asp?referrer=parent&backto=issue,76,182;journal,1,11;linkingpublicationresults,1:300379,1)

Resumen: In many developed countries, a coordinated effort is underway to build national and regional Health Information Infrastructures (HII) for the linking of disparate sites of care, so that an access to a comprehensive Health Record will be feasible when critical medical decisions are made [1].

However, widespread adoption of such national projects is hindered by a series of barriers- regulatory, technical, financial and cultural. Above all, a robust national HII requires a firm foundation of trust: patients must be assured that their confidential health information will not be misused and that there are adequate legal remedies in the event of inappropriate behavior on the part of either authorized or unauthorized parties[2]. The Israeli evolving National HII is an innovative state of the art implementation of a wide-range clinical inter-organizational data exchange, based on a unique concept of virtually temporary sharing of information. A logically connection of multiple caregivers and medical organizations creates a patient-centric virtual repository, without centralization. All information remains in its original format, location, system and ownership. On demand, relevant information is instantly integrated and delivered to the point of care. This system, successfully covering more than half of Israel's population, is currently evolving from a voluntary private-public partnership (dbMOTION and CLALIT HMO) to a formal national reality. The governmental leadership, now taking over the process, is essential to achieve a full potential of the health information technology. All partners of the Israeli health system are coordinated in concert with each other, driven with a shared vision - realizing that a secured, private, confidential health information exchange is assured.

53. Shoaf, Kimberly I. *"Activity Update: CDC designation and funding". UCLA Center for Public Health and Disasters.* 2002. 5: 2p.

URL: <http://www.cphd.ucla.edu/pdfs/Summer2002Newsletter.pdf>

Resumen: Recently, the Center for Public Health and Disasters was designated as one of fifteen Academic Centers for Public Health Preparedness. The Center, which has long promoted collaborative activities and interdisciplinary dialogue, was a logical choice for designation as a preparedness center. "The funding of these centers comes at a crucial period as the nation moves forward to improve its public health infrastructure to respond swiftly and effectively to threats and emergencies," said HHS Secretary Tommy Thompson. "This new funding will help centers identify, assess, and improve critical gaps in preparedness for the state and the localities that they serve."

54. Soares, S. R., Bernardes, R. S., and Netto Ode, M. *"Relações entre saneamento, saúde pública e meio ambiente: elementos para formulação de um modelo de planejamento em saneamento". Cad Saude Publica.* 2002. 18: 6: 1713-24p.

URL: <http://www.scielo.br/pdf/csp/v18n6/13268.pdf>

Resumen: The understanding of sanitation infrastructure, public health, and environmental relations is a fundamental assumption for planning sanitation infrastructure in urban areas. This article thus suggests elements for developing a planning model for sanitation infrastructure. The authors performed a historical survey of environmental and public health issues related to the sector, an analysis of the conceptual frameworks involving public health and sanitation systems, and a systematization of the various effects that water supply and sanitation have on public health and the environment. Evaluation of these effects should guarantee the correct analysis of possible alternatives, deal with environmental and public health objectives (the main purpose of sanitation infrastructure), and provide the most reasonable indication of actions. The suggested systematization of the sanitation systems effects in each step of their implementation is an advance considering the association between the fundamental elements for formulating a planning model for sanitation infrastructure.

55. Thomas, P, McDonnell, J, McCulloch, J, While, A, Bosanquet, N, and Ferlie, E. "Increasing capacity for innovation in bureaucratic primary care organizations: a whole system participatory action research project". *Ann Fam Med*. 2005. 3: 4: 312-17p.

URL: <http://www.annfammed.org/cgi/reprint/3/4/312>

Resumen: Data included 70 key informant interviews, observations of clinical governance interventions and committee meetings, analysis of written materials, surveys and telephone interviews of London Primary Care Organizations, interviews with 20 nurses, and interviews with 6 finance directors. A broad range of stakeholders reviewed data at annual conferences and formed conclusions about trustworthy principles. Sequential research phases were refocused in the light of these conclusions and in response to the changing political context. **RESULTS** Five features were associated with increased organizational capacity for innovation: (1) clear structures and a vision for corporate and clinical governance; (2) multiple opportunities for people to reflect and learn at all levels of the organization, and connections between these "learning spaces"; (3) both clinicians and managers in leadership roles that encourage participation; (4) the right timing for an initiative and its adaptation to the local context; and (5) external facilitation that provides opportunities for people to make sense of their experiences. Low morale was commonly attributed to 3 features: (1) overwhelming pace of reform, (2) inadequate staff experience and supportive infrastructure, and (3) financial deficits.

56. Thompson, Tommy G. "Public health knows no borders". *Electronic Journal of the Department of State*. 2003. 8: 1: 31-34p.

URL: <http://usinfo.state.gov/journals/itps/0803/ijps/thompson.htm>

Resumen: La salud pública mundial, por su naturaleza misma, es un esfuerzo multilateral", dice Tommy Thompson, secretario de Salud y Servicios Sociales de Estados Unidos. Thompson, quien fuera gobernador del estado de Wisconsin durante 14 años, dice que Estados Unidos "puede liderar y contribuir a la causa de la salud mundial, pero no puede cumplir su misión solo. Por ello las naciones del mundo, en colaboración con las organizaciones no gubernamentales y los grupos comunitarios locales, se han unido para establecer el Fondo Mundial para Combatir el SIDA, la tuberculosis y el paludismo. Las demandas extraordinarias de esta crisis exigen este esfuerzo extraordinario. El Fondo es un componente indispensable de la lucha mundial contra el SIDA. Es una verdadera asociación pública y privada, que suministra ayuda financiera de suma urgencia a los países y las comunidades que se hallan en situaciones desesperadamente difíciles. Esta ayuda apuntala las infraestructuras de salud y médica, ofrece a las familias una buena probabilidad de éxito en su lucha y, lo que es más importante, salva vidas.

57. UNDP. "The wealth of the poor: Managing ecosystems to fight poverty. World resources 2005". Washington, DC: UNDP; 2005. 268p.

URL: http://pdf.wri.org/wrr05_lores.pdf

Resumen: In the spring of this year, the Millennium Ecosystem Assessment (MA), an international appraisal of the health of the world's ecosystems, published the first of its series of reports after five years of intensive study. The MA findings sound an alarm bell for the future, but they also contain within them a framework to address the challenges we have created for ourselves. The MA has shown beyond any question the degradation we have caused to the ecosystems of the earth. At the same time, the MA has demonstrated unequivocally that we can better manage these assets, and, by so doing, secure their benefits for the future. *World Resources 2005*

is about simple propositions: Economic growth is the only realistic means to lift the poor out of extreme poverty in the developing world; but the capacity of the poor to participate in economic growth must be enhanced if they are to share in its benefits. The building blocks of a pro-poor growth strategy begin with natural resources. These provide the base upon which the vast majority of the poor now depend for their fragile existence, but over which they exercise little control, and therefore can't exercise full stewardship. The role of governance transparent and accountable governance is critical to fostering pro-poor growth and essential to ensuring that the engine of that growth, natural resource wealth, is managed wisely. Making governance friendlier to the poor means tackling issues of property rights, access to information and decision-making, adequate representation, institutional transparency, and fairness in sharing the costs and benefits of resource management. These are all aspects of *democratic governance* decision-making that respects the rights and needs of those who depend on resources. For the poor, democratic governance is the door to equity and one of the building blocks of sustainability. This fusion of ecosystem management and good governance is also necessary to achieve the Millennium Development Goals, the set of eight goals adopted by the international community in 2000 to address world poverty. As the foundation of rural livelihoods, ecosystems are central to real progress toward the health, nutrition, sanitation, and environmental targets embedded in the Millennium Development Goals. Indeed, without empowering the poor to responsibly manage their environment for economic gain, we cannot effectively attend to rural poverty in its many dimensions. (See Box 1.1.) The goal of this report is to highlight the vital role of ecosystems and their governance of nature and powering poverty reduction. The report's central question is: Who controls ecosystems, and how can this control be reconfigured to allow the poor to use their natural assets as sustainable sources of wealth creation, vehicles of political empowerment, and avenues of integration into the national and global economies?

58. United Nations Framework Convention on Climate Change. *"General bases for the application of the Bolivian national implementation strategy of the United Nations Framework Convention on Climate Change"*. La Paz, BO: UNFCCC; 2002. 137p.

URL: <http://unfccc.int/resource/docs/natc/boladd6.pdf>

Resumen: Since the 1980s there has been evidence of more intense and frequent manifestations of the phenomena of "El Niño" and La Niña. These bring heavy 16 rains in some regions and drought in others. Both rains and drought damage the road networks in rural and urban areas. Whereas flooding directly damages the infrastructure, drought also has its levels of impact mainly due to the desolation of the regions. It is also known that "El Niño" is striking more frequently and intensely because of climate change. On the other hand climate change is accompanied by changes in high and low pressure levels bringing strong winds, cyclones, tornadoes and hurricanes throughout the continent. Damage is seen through all sectors, however it is more evident and could have serious consequences if the sanitary infrastructure is compromised due to the fact that health centers are reference points for the sick and injured and are mainly their only chance of survival. The climatic models developed by the PNCC 1997 and SENAHMI 1999 show a clear tendency in an increase in rains in the rainy season in humid areas, and a decrease or irregularity in the rain patterns in the dry season. It is very probable that the rains will be more intense in some regions even without the presence of an event of climatic variability. This will mean an additional burden on the rural and urban infrastructure,

especially on the country's communications and transport systems.

59. US. Department of Health and Human Services. *"Federal funds for public health infrastructure begins to flow to states"*. Washington, DC: US. Department of Health and Human Services; s.f. 2p.

URL: <http://www.hhs.gov/news/press/2002pres/20020125a.html>

Resumen: HHS Secretary Tommy G. Thompson announced today plans for the release of the first installment of more than \$200 million in funds from the more than \$1 billion in bioterrorism money designated for states to help prepare their public health infrastructures to respond in the event of a bioterrorism attack.

60. US. Department of Health and Human Services. *"The public health workforce: an agenda for the 21st Century"*. Washington, DC: US. Department of Health and Human Services; [1999]. 69p.

URL: <http://www.health.gov/phfunctions/pubhlth.pdf>

Notas: A Report of the Public Health Functions Project

Resumen: Current changes in the public health system necessitate planning for organizational change (Nelson et al., 1994, 1995). This process emphasizes the importance of knowing the composition of the present workforce and being able to describe the workforce providing essential public health services to community members. Knowing which professionals are currently performing specific public health functions is integral to projecting what types of public health professionals will be required in the future. Effectively and efficiently providing training and education for an evolving public health workforce requires a clear understanding of the composition of that workforce. The landmark IOM study (1988) on public health noted that although public health workers had adequate technical preparation in specific fields, many may lack training in management, political skills, and community organization and diagnosis, all of which are essential for leadership in complex multifaceted public health activities. The IOM study further emphasized the challenge facing public health personnel to update their knowledge and skills in light of the continuous evolution of the public health field. Based on a review of previously published reports, barriers to strengthening the public health workforce can be summarized as:

- Inadequate knowledge about the competencies the workforce will need to meet future challenges and about new training and education resources that will be needed to develop those competencies;
- Lack of formal training in public health and in the application of broad public health competencies to emerging new functions, e.g., constituency building, leadership, and use of electronic information systems;
- Limited public health professional certification requirements that can serve as incentives for participation in training and education;
- Indecision about workforce development across multiple public health and health financing agencies;
- Absence of stable funding for public health and the fragmentation imposed by categorical funding streams; and
- Failure to use advanced technology to its full potential, e.g., to provide training.

61. Valdivia, M. *"Public health infrastructure and equity in the utilization of outpatient health care services in Peru"*. *Health Policy Plan.* 2002. 17 Suppl: 12-9p.

URL: http://heapol.oxfordjournals.org/cgi/reprint/17/suppl_1/12

Resumen: This article analyzes the magnitude and nature of socioeconomic

differences in the utilization of outpatient health care services in Peru. In particular, it explores the potential equity-enhancing effect of the expansion and improvements in the network of health centres during the 1990s. The Peruvian health reform made relatively little progress in terms of the reform agenda promoted internationally during the 1990s. Nevertheless, the expansion of the public network of health centres and the improvements in their equipment has been noteworthy during the same period. Using the 1997 survey of the Peruvian Living Standards Measurement Study (PLSMS), we find large differences in the utilization of outpatient health care services. The richest to poorest quintile ratio is 1.9, and even larger in rural areas. Estimating a probit model with random effects at the district level to control for the systematic geographic bias associated with the optimal public allocation of such infrastructure, we find the income effect to be very large, even after controlling for other socioeconomic characteristics. Finally, we also find that the expansion of the public network of health centres has indeed an equity-enhancing effect, but this is rather small. These results indicate that although the expansion of the public network of health facilities may be necessary, it is not sufficient to promote equity in the utilization of health care services by Peruvian adults, especially in rural areas. It is important to look deeper into the costs of consultations and drugs as economic barriers to the utilization of health services by the poor. In particular, the expansion of health insurance mechanisms for the poor should be carefully monitored and evaluated.

62. Venezuela. Leyes. *"Ley Especial que crea el Distrito del Alto Apure."*. *Gaceta Oficial*. 2001. CXXIX: 37,326

URL: www.glin.gov

Resumen: Law 56 of 16 November 2001 is known as the Special Law that Creates the District of Alto Apure, consisting of the municipalities of Jose Antonio Paez and Romulo Gallegos both located in the state of Apure. The District of Alto Apure will have the following powers: participation in zoning plans; environmental planning; and promotion and coordination of the municipal powers granted under article 178 of the Constitution of the Bolivarian Republic of Venezuela (urban zoning; civil architecture and public works; historical property; public ornamentation; low-cost housing; local tourism; protection of the environment and cooperation in environmental sanitation; urban and residential tidiness; treatment of wastes; protection and civil defense; citizen safety; attention to health; social protection; preschool education; culture and sports; and municipal public services). The District will also have jurisdiction over roadways and will promote intercity public transportation services. Provides that an Organizing Board of the District will prepare the way for popular election of authorities. (41 provisions; pp. 321.268-321.271).

63. Waring, S. C. and Brown, B. J. *"The threat of communicable diseases following natural disasters: a public health response"*. *Disaster Manag Response*. 2005. 3: 2: 41-7p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed&cmd=Retrieve&list_uids=15829908&dopt=Citation

Resumen: Natural disasters, such as the recent Indian Ocean tsunami, can have a rapid onset, broad impact, and produce many factors that work synergistically to increase the risk of morbidity and mortality caused by communicable diseases. The primary goal of emergency health interventions is to prevent epidemics and improve deteriorating health

conditions among the population affected. Morbidity and mortality due to infectious diseases can be minimized providing these intervention efforts are implemented in a timely and coordinated fashion. This article presents a review of some of the major issues relevant to preparedness and response for natural disasters.

64. World Bank. *"Belize - Country Brief water and sanitation), and helping to promote private sector participation in the provision of services and maintenance of infrastructure"*. Washington, DC: World Bank; 2002.

URL:

<http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/LACEXT/BELIZEEXT/N/0,,menuPK:322044~pagePK:141132~piPK:141107~theSitePK:322034,00.html>

Resumen: Belize in many ways is unique from its Central American neighbors, Mexico and Guatemala. The overwhelming majority of Belize's nearly 250,000 citizens speak English, with smaller groups speaking Creole, Spanish and several indigenous dialects. Additionally, Belize maintains strong ties to both the United Kingdom, as a member of the Commonwealth, and to the English-speaking Caribbean, as a signatory member of CARICOM. Since gaining independence in 1981, Belize has enjoyed a stable, three-branch system of government. The current Prime Minister, Said Musa, was elected in 1998 and will serve a five-year term. His party, the People's United Party (PUP), currently maintains strong majorities in both the 29-member House of Representatives and the eight-member Senate. The economy of Belize depends primarily on agriculture, (in particular bananas, sugar and citrus) which accounted for 13 per cent of GDP and 68 per cent of exports in 2000. More recently, the economy has been diversified towards tourism, other service industries and shrimp farming. Continuing along the path of increasing diversity and improving international competitiveness in traditional exports will help Belize consolidate its economic and social progress.

65. World Bank. *"Chapter 3. The structure and trends in deprivation"*. in: World Bank. *"Poverty in Mexico : an assessment of conditions, trends and government strategy"*. Washington, DC: World Bank; 2002. 41-105p.

URL:

<http://www.bancomundial.org.mx/pdf/estudiosporsector/povertyinmexico/5.pdf>

Resumen: With respect to human investment—in education and health—and access to physical assets, there has been significant progress in Mexico, both over the past decade and in the period since 2000. It is particularly noteworthy that the progress occurred despite the major adverse effects on the economy of the 1994-95 crises, which constituted a massive setback to income poverty, as will be seen in next section. Despite this progress in human and physical assets, major problems remain. These revolve in particular around questions of inequality and quality. Both education and health status, and access to social services, remain highly unequal. However, there has been a substantial improvement in the participation of the poorest income groups in lower-secondary education and health services for the uninsured, particularly in the 1998-2002 period. In terms of quality, there are still major problems that apply with particular force to poorer groups in the society, exacerbating differences in access. These are most clearly documented for education, but also appear to apply to health. Comparable considerations of unequal access, and low and variable quality apply to access to physical assets, including housing, electricity, water, and sanitation. Problems of low and unequal quality of

services appear to have as much to do with institutional functioning and patterns of accountability as with resources.

1. Dato, VM//Potte, MA//Fertman, CI//Pistella, CL: A capacity mapping approach to public health training resources. *Public Health Rep.* 2002. 117: 1: 20-7.p.

URL: http://www.publichealthreports.org/userfiles/117_1/117020.pdf

Resumen: The capacity mapping approach can be used to identify existing community resources. As part of this approach, inventories are used to provide information for a capacity map. The authors describe the development of two inventories and a capacity map for public health workforce development. For the first inventory, the authors contacted 754 institutions to determine available public health training resources; 191 institutions reported resources, including 126 directly providing distance learning technologies and courses or modules addressing important competency domains. Distance learning technologies included video conferencing facilities (61%) and satellite download facilities (50%). For the second inventory, the authors obtained information on 129 distance-accessible public health training modules. The workforce development capacity map produced from these two inventories revealed substantial resources available for use by individuals or agencies wishing to improve training in public health competencies.

2. Amodeo, AR. "Commentary: developing and retaining a public health workforce for the 21st century: readiness for a paradigm shift to community-based public health". *J Public Health Manag Pract.* 2003. 9: 6: 500-3p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=14606189&dopt=Abstract

Resumen: The Partnership for the Public's Health work in supporting partnerships between local health departments and community-based organizations has offered important insights into the difficulties of changing public health practice to a more community-based model. Keys to these difficulties are workforce issues: availability, appropriateness of initial training, recruitment, retention, and issues of continuing education. These challenges and some positive examples are discussed.

3. ASTHO. "State public health employee worker shortage report: a civil recruitment and retention crisis". Washington, DC: ASTHO; 2004. 20p.

URL: <http://www.astho.org/pubs/WorkforceShortageReportFinal.pdf>

Resumen: The most difficult challenge state and local public health agencies face in developing the capacity to respond to terrorist events, emerging infectious diseases, and other public health threats and emergencies is assuring a qualified workforce is available to carry out these functions. If current workforce demographic trends are left unchecked, they will have an adverse effect on the capacity of state health agencies to carry out their mission; including responsibilities that have continued to expand since the events of September 11, 2001, and the ensuing anthrax attacks. In October 2002 the Council of State Governments (CSG) and the National Association of State Personnel Executives (NASPE) conducted a workforce survey of all state agencies. The resulting report, "State Employee Worker Shortages: The Impending Crisis," noted that state governments could lose more than 30 percent of their workforce to retirement, private-sector employers, and alternative careers by 2006, and that health agencies would be the hardest hit. The findings from the CSG/NASPE workforce survey appeared to confirm the anecdotal evidence and other information that was emerging about the pending

crisis in the state public health workforce. The combination of that evidence and the CSG/NASPE findings were so compelling that ASTHO concluded a broader inquiry and analysis of state public health workforce trends were warranted. Consequently, in November and December of 2003, ASTHO surveyed its members, the senior health officials of the 57 states and territories (and the District of Columbia), on a wide spectrum of workforce trends and indicators. ASTHO received responses from 37 states. This report contains the results of the survey.

4. Beaglehole, R and Dal Poz, MR. *"Public health workforce: challenges and policy issues"*. *Human Resources for Health*. 2003. 1: 7p.

URL: <http://www.human-resources-health.com/content/pdf/1478-4491-1-4.pdf>

Resumen: This paper reviews the challenges facing the public health workforce in developing countries and the main policy issues that must be addressed in order to strengthen the public health workforce. The public health workforce is diverse and includes all those whose prime responsibility is the provision of core public health activities, irrespective of their organizational base. Although the public health workforce is central to the performance of health systems, very little is known about its composition, training or performance. The key policy question is: Should governments invest more in building and supporting the public health workforce and infrastructure to ensure the more effective functioning of health systems? Other questions concern: the nature of the public health workforce, including its size, composition, skills, training needs, current functions and performance; the appropriate roles of the workforce; and how the workforce can be strengthened to support new approaches to priority health problems. The available evidence to shed light on these policy issues is limited. The World Health Organization is supporting the development of evidence to inform discussion on the best approaches to strengthening public health capacity in developing countries. WHO's priorities are to build an evidence base on the size and structure of the public health workforce, beginning with ongoing data collection activities, and to map the current public health training programmes in developing countries and in Central and Eastern Europe. Other steps will include developing a consensus on the desired functions and activities of the public health workforce and developing a framework and methods for assisting countries to assess and enhance the performance of public health training institutions and of the public health workforce.

5. Buj Buj, A. *"El reto de las epidemias en Iberoamérica ante el nuevo milenio"*. *Scripta Nova - Revista Electrónica de Geografía y Ciencias Sociales*. 99. 29: 45

URL: <http://www.ub.es/geocrit/sn-45-29.htm>

Resumen: En casos concretos, la transformación del entorno puede contribuir a la multiplicación y propagación de nuevos agentes patógenos. Algunos expertos consideran que la deforestación y también determinadas explotaciones agrícolas o mineras están en el origen del retorno de la malaria en algunos países de Iberoamérica. En este mismo sentido se han apuntado otros factores como influyentes en el retorno de las plagas, en especial los cambios ambientales y ecológicos así como las sequías o las lluvias torrenciales, entre otros desastres naturales. De especial significación, al haber sido comprobado repetidamente, han tenido históricamente y siguen teniendo las calamidades naturales de cara a la aparición de las epidemias. A finales de octubre de 1998 el huracán Mitch asoló varios países centroamericanos, dejando decenas de miles de muertes y provocando una fuerte crisis sanitaria en sus territorios al

repuntar el cólera, el dengue y la leptospirosis. Otras causas de naturaleza social más concretas para explicar el retorno de las plagas son en primer lugar la pobreza en sí misma, tal como han denunciado los expertos al hablar de la precariedad de la vivienda como promotora de epidemias como la malaria o la enfermedad de Chagas. Hay que hablar también de las dificultades presupuestarias en las últimas décadas, tanto de los organismos internacionales como de los estados nacionales, causantes por ejemplo del abandono de los programas de lucha contra el *Aedes aegypti* lo que ha provocado que casi todo el continente americano se haya reinfestado otra vez de dengue. ¿Cuál fue el legado de la campaña contra el cólera en Perú? Desde el punto de vista de la curación, la salvación de vidas y la educación sanitaria, señala Marcos Cueto, la campaña tuvo logros humanitarios admirables, especialmente si se considera la escasez de los recursos. Esto se debió en parte al esfuerzo, la solidaridad y el ingenio de médicos, enfermeras y personal sanitario. Otros avances importantes fueron que la cloración del agua se hizo más frecuente en las ciudades, algo que casi no ocurría antes de la epidemia, y que se mejoraron la recogida de basuras y los hábitos higiénicos. Pero, escribe este experto en temas de salud, con el cólera se desperdició una oportunidad para mejorar la infraestructura sanitaria peruana. La responsabilidad de todo ello debe buscarse en la persistencia de un discurso sanitario que culpó al individuo de la enfermedad y priorizó las soluciones técnicas y curativas. Como consecuencia, en 1992 se registraron 212.642 casos de cólera y en 1993, 71.448. En 1996 sólo se registraron 4.518 casos, pero los casos acumulados desde los inicios de la plaga hasta ese último año ascendieron a 655.548. Sea como fuere, lo cierto es que a pesar de que la enfermedad se haya quedado como endémica en buena parte de los países afectados, el cólera ya no ha vuelto a tener la incidencia de 1991. Con toda certeza contribuyó a ello, en el caso peruano, la existencia de 1.020 centros de salud y de 3.162 puestos sanitarios en todo el país en el año del cólera, según nos apunta Cueto. La explicación que dio la OMS, posteriormente, puso énfasis en el relativo buen nivel sanitario de los países afectados.

6. Cioffi, J. P., Lichtveld, M. Y., and Tilson, H. *"A research agenda for public health workforce development"*. *J Public Health Manag Pract*. 2004. 10: 3: 186-92p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed&cmd=Retrieve&list_uids=15253514&dopt=Citation

Resumen: In the past decades, public health research has focused on categorical rather than cross-cutting or systems issues. Little research has been carried out on the infrastructure required to support public health programs. This article describes the results of an interactive process to develop a research agenda for public health workforce development to inform all those with stakes in the public health system. This research is defined as a multidisciplinary field of inquiry, both basic and applied, that examines the workforce in terms of costs, quality, accessibility, delivery, organization, financing, and outcomes of public health services to increase knowledge and understanding of the relationships among workforce and structure, processes, and effects of public health services. A logic model and five priority research areas resulted from meetings of expert panels during 2000 to 2003. Innovative public and private partnerships will be required to advance cross-cutting and systems-focused research.

7. *"Commentary: developing and retaining a public health workforce for the 21st*

century: readiness for a paradigm shift to community-based public health." *J Public Health Manag Pract.* 2003. 9: 6: 500-3p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=14606189&query_hl=12

Resumen: The Partnership for the Public's Health work in supporting partnerships between local health departments and community-based organizations has offered important insights into the difficulties of changing public health practice to a more community-based model. Keys to these difficulties are workforce issues: availability, appropriateness of initial training, recruitment, retention, and issues of continuing education. These challenges and some positive examples are discussed.

8. Córdova Piscocoy, JR. "Comunicación educativa en salud : oficina de comunicaciones del Ministerio de Salud". Lima, PE: Córdova Piscocoy, Jenny Rocío; 2003. 43p.

URL:

http://sisbib.unmsm.edu.pe/bibvirtual/tesis/Human/cordova_pj/contenido.htm

Resumen: El informe que se presenta a continuación, recoge la experiencia de la labor realizada en la Oficina de Comunicaciones del Ministerio de Salud, los procedimientos y métodos utilizados en la ejecución de diversas actividades, así como las limitaciones y obstáculos que se presentan durante el desarrollo de las mismas. Del mismo modo, se describen las políticas de comunicación del Ministerio de Salud, las cuales son la base para el desarrollo de todas las actividades de información y educación dirigidas a la población. Finalmente se realiza un análisis de la problemática comunicacional, se compara, del mismo modo, lo teórico y lo experimentado, y se brindan algunas recomendaciones para lograr un cambio que contribuya con el logro de resultados positivos, mejorando así la salud y la calidad de vida de nuestra población.

9. Cuccia, M, Dunlap, J, Litchveld, M, and Morse, S. "Centering" the Workforce Around Public Health". 1p.

URL: http://apha.confex.com/apha/129am/techprogram/paper_28699.htm

Notas: http://apha.confex.com/apha/129am/techprogram/paper_28699.htm

Resumen: Both HRSA and CDC are supporting national centers at schools of public health to ready public health workers to meet the many challenges facing them on the front lines. These collaborative federal-academic efforts are cutting-edge in their primary focus towards training working professionals in public health while addressing scholarship and excellence in practice-based curricula and research. The CDC program seeks to ensure that frontline public health workers have the skills and competencies required to effectively respond to current and emerging health threats. Grantees are working with state and local public health agencies and other practice organizations to: assess the learning needs of public health workers; develop effective curricula; train, certify, and credential workers; use appropriate technology in course delivery; translate applied research into improving worker competency and the health of the public; and, evaluate the impact of these efforts. The HRSA centers aim to improve the nation's public health system by strengthening the technical, scientific, managerial, and leadership competence and capacity of the current and future workforce. HRSA grantees have aligned with multiple academic and practice partners to: meet the training needs of public health workers providing service to medically underserved populations; establish and/or strengthen field placements for

students; and, involve faculty members and students to enhance services to improve the public's health. The scientific session will consist of 2 grantees each from the pool of HRSA and CDC centers reporting on progress over the first year of the project, with a moderator from a practice organization serving as facilitator. Learning Objectives: Articulate how various federally-funded centers at schools of public health are working to prepare and train the public health workforce; describe specific linkages between academic institutions, federal agencies, and practice partners and show how this collaboration is vital to building the public health infrastructure; and, discuss methods to translate scientifically-rigorous practice-based research and teaching into professional training for improving the health of the public.

10. Danielson, J., Zahniser, S. C., and Jarvis, D. "Identifying training needs in the public health workforce: the public health prevention service as a case study". J Public Health Manag Pract. 2003. 9: 2: 157-64p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=12629915&query_hl=2

Resumen: The Public Health Prevention Service is a three-year training program committed to developing a workforce that is skilled in planning, managing, and evaluating prevention programs. In 2000, a questionnaire was administered to participants to assess their training needs. According to the resultant data, training is preferred in traditional formats (e.g., case studies and group discussion) and in short installments (one to three hours). Topics identified for future training included software application, prevention effectiveness (i.e., economic analysis), program evaluation, budgeting, and consensus building.

11. Dato, V. M., Potter, M. A., Fertman, C. I., and Pistella, C. L. "A capacity mapping approach to public health training resources". Public Health Rep. 2002. 117: 1: 20-7p.

URL: http://www.publichealthreports.org/userfiles/117_1/117020.pdf

Resumen: The capacity mapping approach can be used to identify existing community resources. As part of this approach, inventories are used to provide information for a capacity map. The authors describe the development of two inventories and a capacity map for public health workforce development. For the first inventory, the authors contacted 754 institutions to determine available public health training resources; 191 institutions reported resources, including 126 directly providing distance learning technologies and courses or modules addressing important competency domains. Distance learning technologies included video conferencing facilities (61%) and satellite download facilities (50%). For the second inventory, the authors obtained information on 129 distance-accessible public health training modules. The workforce development capacity map produced from these two inventories revealed substantial resources available for use by individuals or agencies wishing to improve training in public health competencies.

12. Dayan, G. H., Ortega-Sanchez, I. R., LeBaron, C. W., and Quinlisk, M. P. "The cost of containing one case of measles: the economic impact on the public health infrastructure--Iowa, 2004". Pediatrics. 2005. 116: 1: e1-4p.

URL: <http://pediatrics.aappublications.org/cgi/reprint/116/1/e1>

Notas: CORPORATE NAME: Iowa Measles Response Team.

Resumen: BACKGROUND: In February 2004, students from a college in Iowa, with a

high proportion of non medical exemptions to vaccination, traveled to India; one fourth of the students contracted measles while there. One exposed, susceptible student returned home during his infectious period, necessitating 2 months of containment efforts in Iowa. OBJECTIVE: The objective of this study was to measure the direct costs of measles containment from a public health system perspective. METHODS: We evaluated activities performed, personnel time/materials allocated, and direct costs incurred in 2004 US dollars by the Iowa public health infrastructure. The study period was defined as March 5, 2004 (when the Iowa Department of Public Health was first contacted about the case), through May 12, 2004 (when a final meeting was held on the containment effort). RESULTS: A total of 2525 hours of personnel time were expended to review flight manifests, contact exposed passengers, set up vaccination clinics, trace >1000 potentially exposed contacts, and institute and enforce quarantine orders for vaccination refusers. Two thousand twenty-five phone calls were received from the public, and 2243 miles were driven by staff. The temporal distribution of personnel time was characterized by marked peaks at the report of potential secondary cases. The total estimated cost was 142452 dollars. CONCLUSIONS: The direct cost to the public health infrastructure of containing 1 case of measles was far greater than the estimated cost of uncomplicated individual illness (less than 100 dollars). Economic analyses of vaccine-preventable diseases may need to go beyond the costs of individual illness to account for the costs of protecting society.

13. Fox, CE. *"Remarks to the American Public Health Association"*. Boston, MA: U.S. Department of Health & Human Services. Health Resources and Services Administration (HRSA); 2000. 4p.

URL: <http://newsroom.hrsa.gov/speeches/APHAInfrastructure.htm>

Resumen: In public health, a strong infrastructure ensures our ability to prepare for and respond to both acute and chronic threats to the Nation's health, whether they are bioterrorism attacks, emerging infections, or disparities in health status. As the Access Agency, HRSA plays a critical role in the improvement of the nation's public health infrastructure. We do this by:

- Monitoring and surveillance activities to determine unmet needs of the underserved;
- developing a data and information system to track health status objectives; and
- improving the supply and competency of the public health workforce.

14. Gebbie, K. M. *"The public health workforce: key to public health infrastructure"*. *Am J Public Health*. 99. 89: 5: 660-1p.

URL: <http://www.astdhphe.org/PlanforSuccess/files/002.htm>

Resumen: This issue of how we develop our workforce, how we think about our workforce and the public health practice field and development them is in fact, one that's very exciting, full of a lot of activities these days, and worth spending a little bit of time thinking about. Our rationale for doing workforce development is very, very simple. If you have competent workers, essential public health services are delivered, which means programs are effective and people and communities get healthier. If that chain of logic doesn't hold for some reason, then there's probably no reason to worry about the workers in the first place, but I think it is an accurate statement. It isn't sufficient to just assume that our initial professional education is adequate. Almost all of us who practice in the public health field came into it with some professional education in an area beyond public health and then have honed our public health skills,

but that beginning isn't enough. It is definitely not enough in this day and age to identify with or learn a single programmatic area. The world will change too much over the course of our professional lifetime and we have to be able to move across programmatic lines. And it is definitely not enough to just sit there and passively wait for education to arrive somehow on our desk, in our doorway, wherever we happen to be. We have to assume some professional accountability for reaching out for educational opportunities, for expecting our workplaces to accommodate the need for them and find new and better ways to continue our own growth. A reminder that all of this is grounded in our understanding of what are essential public health services comes from this particular wheel. It's available in a lot of different forms from various places. The outer circle uses the 1988 Institute of Medicine triad of assessment, policy development and assurance. The inner wedges of the wheel are the services that are necessary to deliver on those essential functions that we have. Management holds the wheel together and research sits at the center feeding into all of the component parts. It isn't specific to any program area or any population. You pick up a program area of interest, whether it's cancer control or injury prevention or infectious disease monitoring and control or environmental services. And you have to walk your way all the way around the wheel for services in that programmatic area to happen. We hope it is developmental over time, that is, it is an upwardly moving spiral and not simply a static wheel that goes around and around in a rut or, something driving itself downward into the ground (which I had an awful image of one time). The public health infrastructure is another language that we have evolved to describe what has to be there for those essential services to happen. If those are the essential services that feed all programs, what do you have to have before you launch into them? This trilogy is the most common way of describing that infrastructure, which consists of:

- A prepared workforce, people who know what they are doing and are continually learning
- Data and information, what are the facts about the population you serve, your condition you're worried about, the resources availability to the community?
- And finally, the systems and relationships, the organizational charts, the laws, the inner-agency agreements, the informal commitments that we make to work together.

15. Gebbie, K. M. and Merrill, J. "Enumeration of the public health workforce: developing a system". J Public Health Manag Pract. 2001. 7: 4: 8-16p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=11434045&dopt=Abstract

Resumen: Although it has been of interest to public health leaders, advocates, and policy planners for many years, decades have passed since the last organized count of public health workers. This article reports on methods used by the Columbia University School of Nursing, Center for Health Policy, to enumerate the public health workforce in 57 states and territories based on existing reports, summaries, and surveys. The complexity of public health workforce data is described and the scheme utilized to characterize the workforce using public agency categories is illustrated. The resulting "best current estimate" provokes many questions regarding future policy about a public health workforce database.

16. Grant Makers in Health. "Training the health workforce of tomorrow: based on a

grant makers in health issue dialogue". Washington, DC: GIH; *Issue brief*, 2001. 12: 44p.

URL: http://www.gih.org/usr_doc/healthworkforce.pdf

Notas: CORPORATE NAME: Grant makers In Health, Washington, D.C., USA.
GENERAL NOTE: HSR: "Based on a Grant makers In Health Issue Dialogue, Washington, D.C."

Resumen: As part of its continuing mission to serve trustees and staff of health foundations and corporate giving programs, Grant makers In Health (GIH) convened a small group of grant makers and national experts concerned about health workforce issues. This roundtable - held on October 31, 2001, in Washington, DC - explored various issues related to the supply, composition, and competency of the health workforce, and the role that these factors play in maintaining and improving the health status of individual patients and broader populations. The session also highlighted the current activities of and future opportunities for foundations. This Issue Brief synthesizes key points from the day's discussion with a background paper prepared for roundtable participants. It includes quantitative and qualitative information on workforce issues and profiles public sector and grant maker strategies for addressing workforce problems.

17. Guevara, EB and Mendias, EP. "A comparative analysis of the changes in nursing practice related to health sector reform in five countries of the Americas". *Rev Panam Salud Publica/Pan Am J Public Health*. 2002. 15: 2: 347-53p.

URL: <http://www.scielo.org/pdf/rpsp/v12n5/14093.pdf>

Resumen: Objective: To identify changes in nursing practice and the nursing-practice environment that has occurred with implementation of health sector reform in five countries in the Americas. Methods: An exploratory study of selected settings in Argentina, Brazil, Colombia, Mexico, and the United States of America was conducted between 1997 and 1999 to collect narrative data from 125 professional nurses about their perceptions of nursing practice and changes in work environments. Descriptions of characteristics and trends in nursing practice in the study sites were also obtained. Results: Reorganization of health services has occurred in all five of the countries, responding to health sector reform initiatives and affecting nursing practice in each country. Respondents from all five countries mentioned an emphasis on private enterprise, changes in payment systems for patients and providers, redistributions in the nursing workforce, changes in the personnel mix and nursing-practice functions, work shifting from the hospital to the community, and greater emphasis on cost control and prevention in practice settings. Conclusions: The study provides initial information about current nursing issues that have arisen as a result of health care reform initiatives. Regardless of differences in service models or phases of health sector reform implementation, in all the countries the participating nurses identified many common themes, trends, and changes in nursing practice. The driving forces for change and their intensity have been different in the five countries. Nurses maintain their core values despite increased work stress and greater patient care needs in all the countries as well as economic crises in the Latin American countries.

18. Hajat, A., Stewart, K., and Hayes, K. L. "The local public health workforce in rural communities". *J Public Health Manag Pract*. 2003. 9: 6: 481-8p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed&cmd=Retrieve&list_uids=14606186&dopt=Citation

Resumen: This work describes the public health workforce and training needs of

rural local public health agencies (LPHAs) in comparison with suburban and metropolitan LPHA jurisdictions. A survey was sent to 1,100 LPHAs nationwide. The rural urban commuting area codes (RUCAs) defined LPHAs as rural or urban, and the Standard Occupational Classification system enumerated the workforce. Most occupational classifications had significantly fewer staff in rural LPHAs. Public health nurses ranked as the most needed staff and serve in various important capacities in rural LPHAs. In terms of training, job-specific or programmatic continuing education was identified as the most important training need. Developing leadership and public health workforce capacity within rural public health is an essential agenda item for rural America. Decision makers may need to consider different organizational structures while balancing the need for local input and control. Regionalization and collaborative approaches to difficult workforce issues may present potential solutions to workforce challenges.

19. "Hurricane Katrina response and guidance for health-care providers, relief workers, and shelter operators". MMWR Morb Mortal Wkly Rep. 2005. 54: 35: 877p.

URL: <http://www.cdc.gov/mmwr/PDF/wk/mm5435.pdf>

Notas: CORPORATE NAME: Centers for Disease Control and Prevention (CDC).

Resumen: Hurricane Katrina struck the coastal areas of Alabama, Florida, Louisiana, and Mississippi on August 29, 2005, causing substantial numbers of deaths among humans and animals, infrastructure damage, and flooding. Affected areas continue to experience shortages of essential services, including electricity, potable water, food, and fuel; damage to health-care and public health systems; and disrupted communications. CDC/ATSDR, local and state health departments, other federal agencies, and other partners are supporting public health and medical-care functions for persons in affected areas and those displaced as a result of the hurricane.

20. "Information needs and uses of the public health workforce--Washington, 1997-1998". MMWR Morb Mortal Wkly Rep. 2000. 49: 6: 118-20p.

URL: <http://www.cdc.gov/mmwr/PDF/wk/mm4906.pdf>

Notas: CORPORATE NAME: Centers for Disease Control and Prevention (CDC).

Resumen: Substantial efforts have been made to ensure that state and local public health agencies have the information technology and training needed for public health communications, information access, and data exchange. Numerous public health-related data and information resources are available on the World-Wide Web (e.g., MEDLINE, MMWR, CDC Prevention Guidelines Database, and Emerging Infectious Diseases); however, little systematic work has been done to understand the information needs of the public health workforce. To identify these needs and patterns of use and to set priorities for developing new online public health information resources, the University of Washington School of Public Health and Community Medicine (UW SPHCM) and the Washington State Department of Health (WSDoH) held structured and facilitated discussions with segments of the local public health workforce in Washington during 1997-1998. This report summarizes the results of those discussions, which indicate that different segments of the public health workforce have different information needs.

21. Lichtveld, M. Y. and Cioffi, J. P. "Public health workforce development: progress, challenges, and opportunities". J Public Health Manag Pract. 2003. 9: 6:

443-50p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed&cmd=Retrieve&list_uids=14606182&dopt=Citation

Resumen: The public health workforce is key to strengthening public health infrastructure. National partners have articulated a vision of a sustainable and competent workforce prepared to deliver essential public health services. Six strategic elements provide a framework for action: monitoring workforce composition; identifying competencies and developing related curriculum; designing an integrated life-long learning delivery system; providing individual and organizational incentives to ensure competency development; conducting evaluation and research and assuring financial support. Partners convened in January 2003 to review progress and to re-evaluate strategies in light of the recently released Institute of Medicine reports on infrastructure and workforce issues. Although significant challenges remain, there is convergence on priorities for competency development, research questions to be addressed and next steps in the national dialogue on certification and credentialing in public health.

22. Lichtveld, M. Y., Cioffi, J. P., Baker, E. L. Jr, Bailey, S. B., Gebbie, K., Henderson, J. V., Jones, D. L., Kurz, R. S., Margolis, S., Miner, K., Thielen, L., and Tilson, H. "Partnership for front-line success: a call for a national action agenda on workforce development". *J Public Health Manag Pract.* 2001. 7: 4: 1-7p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed&cmd=Retrieve&list_uids=11434035&dopt=Citation

Resumen: Despite more than a decade of dialogue on the critical needs and challenges in public health workforce development, progress remains slow in implementing recommended actions. A life-long learning system for public health remains elusive. The Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry in collaboration with other partners in federal, state, local agencies, associations and academia is preparing a national action agenda to address front-line preparedness. Four areas of convergence have emerged regarding: (1) the use of basic and crosscutting public health competencies to develop practice-focused curricula; (2) a framework for certification and credentialing; (3) the need to establish a strong science base for workforce issues; and (4) the acceleration of the use of technology-supported learning in public health.

23. Morse, SS and Merrill, JA. "First steps: a pilot preparedness program for public health nurses". New York, NY: Columbia University. Maiman School of Public Health; [2003]. 4p.

URL: <http://cpmcnet.columbia.edu/dept/sph/CPHP/pdf/web-promo-article.pdf>

Resumen: Public health will face major challenges in the coming decades. The 1999 West Nile outbreak in New York City and other recent incidents demonstrate how important public health is as a frontline defense against emerging infections, bioterrorism, and other unexpected emergencies. A well prepared public health workforce is more critical than ever. The challenges are particularly great in urban areas, which traditionally serve as ports of entry, may be appealing targets to terrorists, and have large and diverse populations with complex health risk factors. To better prepare the public health workforce to carry out routine functions effectively and fulfill the additional roles required in emergencies, a national network of "Centers for Public Health Preparedness" has been established by the Centers for Disease Control and Prevention (CDC). The

network currently includes seven academic Centers funded through a cooperative agreement with the Association of Schools of Public Health (ASPH). Goals include the development of competency-based public health practice courses primarily designed to utilize distance-learning technology (such as World Wide Web-based instruction) that can be implemented locally and replicated nationally. The Center for Public Health Preparedness at the Mailman School of Public Health, Columbia University, is working toward these goals in partnership with the New York City Department of Health (NYC DOH).

24. Mowat, D. L. and Moloughney, B. W. "Developing the public health workforce in Canada: a summary of regional workshops on workforce education and training". *Can J Public Health*. 2004. 95: 3: 186-7p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15191120&query_hl=4

Resumen: The report of the National Advisory Committee on SARS and Public Health recommended the need for a national public health human resource strategy and the need to identify opportunities for improving training. The recent regional workshops reinforced both these recommendations, and the excellent suggestions made by the participants will be utilized by the many work groups that will endeavor to improve public health system infrastructure in this country.

25. Organización Internacional del Trabajo. "Informe sobre las condiciones de empleo y de trabajo en el marco de las reformas del sector de la salud: Informe para el debate de la Reunión tripartita las condiciones de empleo y de trabajo en el marco de las reformas del sector de la salud". Ginebra: OIT; 98. [110]p.

URL:

<http://www.ilo.org/public/spanish/dialogue/sector/techmeet/jmhsr98/jmhsr.htm>

Resumen: En todos los países, las capacidades humanas e institucionales resultan fundamentales para el buen éxito de las inversiones y políticas de reforma. Por lo tanto, se desplegarán esfuerzos especiales para examinar y ajustar los procesos de contratación y las posibilidades de formación y readaptación profesional que se ofrecen a los trabajadores del sector, a fin de tener en cuenta las orientaciones políticas más precisas que se han impartido al respecto. Uno de los aspectos prioritarios es el perfeccionamiento de diversas calificaciones profesionales en las esferas de la salud y la nutrición. Al mismo tiempo, se prestará una atención prioritaria a cuestiones de gestión de carácter más amplio, como la financiación de la atención sanitaria. Una forma de impulsar las mejoras en el rendimiento de los sistemas de salud consiste en impartir formación a un número conveniente de trabajadores ocupados en las esferas de la formulación de políticas y de gestión, sobre todo a especialistas en salubridad pública, analistas de políticas empresariales, administradores de hospitales y expertos en gestión de medicamentos. En el curso de los últimos 30 años, en los servicios de salud de los países desarrollados se ha reforzado la función de los administradores, economistas y planificadores, que han contado incluso con el respaldo de los servicios de asesoramiento empresarial. En muchos de estos países, es corriente que los hospitales estén dirigidos por unos administradores cuya profesión no esté vinculada a la medicina, mientras que en los países en desarrollo la administración de los hospitales sigue estando a cargo de los médicos. Ni que decir tiene que, al preparar los nuevos programas de estudio para

los profesionales de la atención sanitaria, habrá que tener debidamente en cuenta el contexto general de aplicación de las reformas del sector. Por ejemplo, una orientación más centrada de las políticas a seguir requiere capacitar al personal de los servicios de salud para el control de los costos. Para orientar debidamente las decisiones que se adopten en materia de inversiones, será necesario disponer de datos económicos, demográficos y epidemiológicos fiables, a distintos niveles.

26. Potter, M. A., Ley, C. E., Fertman, C. I., Eggleston, M. M., and Duman, S. *"Evaluating workforce development: perspectives, processes, and lessons learned"*. *J Public Health Manag Pract*. 2003. 9: 6: 489-95p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=14606187&dopt=Abstract

Resumen: Evaluating workforce development for public health is a high priority for federal funders, public health agencies, trainees, trainers, and academic researchers. But each of these stakeholders has a different set of interests. Thus, the evolving science of training evaluation in the public health sector is being pulled simultaneously in a number of different directions, each emphasizing different methods, indicators, data-collection instruments, and reporting priorities. We pilot-tested the evaluation of a 30-hour, competency-based training course in a large urban health department. The evaluation processes included strategic, baseline assessment of organizational capacity by the agency; demographic data on trainees as required by the funder; a pre- and post training inventory of beliefs and attitudes followed by a post training trainee satisfaction survey as required by the trainers and the agency; and a 9-month post training follow-up survey and discussion of learning usefulness and organizational impact as desired by the academic researchers and the trainers. Routinely requiring all of these processes in training programs would be overly burdensome, time-consuming, and expensive. This pilot experience offers some important practical lessons for training evaluations in the future.

27. Rigoli, F. *"Desarrollo de la fuerza de trabajo en salud pública: modelos de formación y desarrollo curricular"*. *Revista Facultad Nacional de Salud Pública*. 2004. Vol. 22, número especial: 41-9p.

URL: <http://guajiros.udea.edu.co/revista/vol%20esp/03a.pdf>

Notas: Memorias del III Congreso Internacional de Salud Pública. Colombia, Medellín, Facultad Nacional de Salud Pública

Resumen: El centro de la exposición de hoy reside en discutir cuál es el papel de las instituciones de educación en salud pública, que hay muchas: Facultades de Ciencias de la Salud, Escuelas de Salud Pública, Institutos privados, hay muchas instituciones que trabajan en la educación en salud pública. Pero bueno, lo típico, digamos, son las Escuelas de salud pública o las Facultades de salud pública que hay en muchos países. El autor señala que el principal punto es el desarrollo del liderazgo para la salud de la población. En realidad más que formar buenos Especialistas en áreas técnicas, deben formar líderes que estén preocupados por la salud de la población. Esto reafirma la importancia de las competencias más genéricas. ¿Cuál es la principal misión de una institución de educación en salud pública? Es formar líderes que estén preocupados y que puedan liderar procesos para la salud de la población.' Los proyectos ALFA por ejemplo, son proyectos financiados por la comunidad europea con algunas características especiales en cuanto a que es lo que tienen que intentar y quienes son los posibles socios, sobre

todo para asociar Escuelas de América Latina con algunas Escuelas europeas, y también se han formado en este momento algunas redes subregionales. En el caso concreto en Argentina se hizo una red de programas de salud pública que está además uniendo a otras Escuelas de Salud Pública en países del cono sur. La iniciativa trata de unir los esfuerzos y los recursos y sobre todo las experiencias de un conjunto muy grande de instituciones de formación en salud pública en América Latina para lograr estos objetivos. . El hecho de aparecer los casos de SARS en Toronto motivó una discusión de los problemas de salud pública en Canadá, y la discusión de los problemas de salud pública en Canadá mostró que un porcentaje muy pequeño de los profesionales que el país había formado en salud pública, estaban realmente trabajando en salud pública. La mayoría estaban trabajando en muchas otras cosas, desde la gerencia de servicios, o directamente habían abandonado la práctica de salud pública, etc. En el caso de Estados Unidos lo que motivó el fuerte impulso al estudio de los problemas de salud pública, al estudio de las fuerzas de trabajo en salud pública, fue el bio terrorismo. Cuando aparecieron los primeros problemas en el año 2001, se hizo relevamiento. Si hay una amenaza quiénes son los que están capacitados para responder a esa amenaza. Y se encontró también que había en todo Estados Unidos unas 450.000 personas trabajando en servicios de salud pública y la estimación que se hizo fue que eso prácticamente no iba a poder ser capaz de atender demandas y realmente los problemas eran verdaderos. También se descubrió que aún en los países desarrollados, un factor común con los países de América Latina es la escasez de datos. En realidad, la aparición de estos nuevos problemas de salud, no nuevos, porque la mayoría son viejos, pero la re-emergencia de los problemas de salud pública como primera plana en los diarios, mostró la poca capacidad, el poco conocimiento que teníamos sobre estos problemas, y el poco conocimiento que teníamos sobre las instituciones y la capacidad de respuesta de las instituciones para responder. Y empezó a motivar esfuerzos para desarrollar a la gente que trabaja dando respuesta a estos problemas.

28. Tilson, H. and Gebbie, K. M. *"The public health workforce". Annu Rev Public Health*, 2004. 25: 341-56p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed&cmd=Retrieve&list_uids=15015924&dopt=Citation

Resumen: The development of a fully-competent public health workforce as a key component of the nation's public health infrastructure has become the focus of increasing attention. The subject is included in one, and is the major topic of a second, report from the Institute of Medicine published late in 2002. Workforce issues have stimulated the convening of the majority of public health-related associations in a range of collaborations on the subjects of defining, enumerating, credentialing, educating, and studying the workforce. The authors review the major questions confronting the field and introduce key components of current thinking about approaches to improvement.

29. Yeatman, H. R. and Nove, T. *"Reorienting health services with capacity building: a case study of the Core Skills in Health Promotion Project". Health Promot Int*, 2002. 17: 4: 341-50p.

URL: <http://heapro.oxfordjournals.org/cgi/reprint/17/4/341>

Resumen: This paper presents a case study of the application of a framework for capacity building [Hawe, P., King, L., Noort, M., Jordens, C. and Lloyd, B.

(2000) Indicators to Help with Capacity Building in Health Promotion. NSW Health, Sydney] to describe actions aimed at building organizational support for health promotion within an area health service in New South Wales, Australia. The Core Skills in Health Promotion Project (CSHPP) arose from an investigation which reported that participants of a health promotion training course had increased health promotion skills but that they lacked the support to apply their skills in the workplace. The project was action-research based. It investigated and facilitated the implementation of a range of initiatives to support community health staff to apply a more preventive approach in their practice and it contributed to the establishment of new organizational structures for health promotion. An evaluation was undertaken 4 years after the CSHPP was established, and 2 years after it had submitted its final report. Interviews with senior managers, document analysis of written reports, and focus groups with middle managers and service delivery staff were undertaken. Change was achieved in the three dimensions of health infrastructure, program maintenance and problem solving capacity of the organization. It was identified that the critically important elements in achieving the aims of the project-partnership, leadership and commitment-were also key elements of the capacity building framework. This case study provides a practical example of the usefulness of the capacity building framework in orienting health services to be supportive of health promotion.

1. Brailer, D. "David Brailer on a private-public health information technology infrastructure. Interview by Susan V. White". *J Healthc Qual.* 2004. 26: 6: 20-4p.

URL: 15603091

Resumen: David Brailer, MD PhD, was appointed the first National Health Information Technology Coordinator by the U.S. Department of Health and Human Services Secretary Tommy Thompson on May 6, 2004. As National Coordinator he is to execute President Bush's Executive Order of April 27, 2004, calling for widespread deployment of health information technology (HIT) within 10 years. Dr. Brailer is an authority on clinical data sharing, local health information exchanges, and the use of peer-to-peer technologies in healthcare. He is a leader in the strategy and financing of quality and efficiency in healthcare, with a particular emphasis on HIT and health systems management. Previously, Dr. Brailer was a Senior Fellow at the Health Technology Center in San Francisco, advising a variety of regional and national data-sharing projects and several major corporations about the role of IT in improving the quality of healthcare. Dr. Brailer recently completed 10 years as Chairman and CEO of CareScience, Inc., a provider of care management services and Internet-based solutions that help reduce medical errors and improve physician and hospital-based performance. Dr. Brailer holds doctoral degrees in both medicine and economics. While in medical school, he was a Charles A. Dana Scholar at the University of Pennsylvania School of Medicine and the first recipient of the National Library of Medicine Martin Epstein Award for his work in expert systems. Dr. Brailer was among the first medical students to serve on the Board of Trustees of the American Medical Association.

2. Chute, C. G. and Koo, D. "Public health, data standards, and vocabulary: crucial infrastructure for reliable public health surveillance". *J Public Health Manag Pract.* 2002. 8: 3: 11-7p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed&cmd=Retrieve&list_uids=15156620&dopt=Citation

Resumen: The present, rapid adoption of electronic records in clinical care is likely to shift public health surveillance from passive, human-mediated abstraction to active, computer-generated reports. However, the accuracy and efficiency of this process depends upon the adoption of consistent information standards from bedside to population and the relevance of these data to public health. This article outlines the current status of data standards of relevance to public health and expands upon the ideal goal state in which health information would be collected once and then reused for multiple health-related purposes, including public health surveillance.

3. Colombia. Instituto Nacional de Salud. "Subdirección de Red Nacional de Laboratorios - Laboratorio Nacional de Referencia". Bogotá, CO: INS; 2004. [2]p.

URL: <http://www.ins.gov.co/laboratorios/nivel2.php?seccion=28>

Resumen: El Instituto Nacional de Salud (INS) dentro de las funciones esenciales de salud pública, debe dirigir y coordinar las labores técnicas, científicas y administrativas de vigilancia en salud pública en las áreas de su competencia, con la Red Nacional de Laboratorios, apoyando a los entes territoriales en el desarrollo de sus capacidades de vigilancia

epidemiológica, investigación y control de las amenazas a la salud de su población. Por consiguiente, el INS para cumplir con su tarea de vigilancia, prevención y el control de los problemas de salud pública requiere para desarrollar sus actividades de vigilancia por el laboratorio, cumpliendo con los estándares aceptados y exigidos internacionalmente, contar con un recurso científico capacitado, que permita estar a la vanguardia de los desarrollos científicos y tecnológicos para hacer frente a los eventos de salud pública. Por otra parte en su papel de autoridad nacional de referencia técnica, debe transferir a los entes territoriales conocimientos y nuevos desarrollos tecnológicos en red de laboratorios y realizar el monitoreo de sus acciones en esta área. Adicionalmente, el INS por medio de la Subdirección de la Red Nacional de Laboratorios debe contribuir al logro de uno de los propósitos del Plan de Desarrollo del Gobierno 2002-2006 como es el mejoramiento de la vigilancia y control en salud pública e impulsar el desarrollo de la Red de Laboratorios de Salud Pública. La red busca fortalecer la capacidad científica y técnica en vigilancia y diagnóstico, tanto a nivel nacional como territorial, en las diferentes áreas de la Red Nacional de Laboratorios. Adicionalmente, estimular la formación de los profesionales de la salud pública en las áreas de gestión, prevención, diagnóstico, vigilancia, investigación investigaciones y análisis y monitoreo de los resultados de las actividades de prevención y control por laboratorio y fortalecimiento de los laboratorios de salud pública, con el fin de que los entes territoriales tengan la capacidad de asumir las responsabilidades que les corresponden en la solución de los problemas en salud pública.

4. Colombia. Universidad de Antioquia. Facultad Nacional de Salud Pública. *"Infraestructura tecnológica"*. Universidad de Antioquia; 2001. 10p.

URL: <http://guajiros.udea.edu.co/fnsp/Documentos/Direccion/SII/PL-IT-G-02.pdf>

Resumen: Proyecto Plesap Asistencia de Planeación Facultad Nacional de Salud Pública Universidad de Antioquia.

5. Dykes, P. and Bakken, S. *"National and regional health information infrastructures: making use of information technology to promote access to evidence"*. *Medinfo*. 2004. 11: Pt 2: 1187-91p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed&cmd=Retrieve&list_uids=15361000&dopt=Citation

Resumen: The vision for national and regional health information infrastructures (HII) includes provision of a framework that is supportive of access and integration of health information with the goal of improving the health and safety of individuals, public health systems, and nations. Internationally, prominent examples of national and regional HIIs exist that provide a means for achievement of this goal. However, to fully realize benefits, an explicit mechanism is needed for linking national and regional HIIs with existing knowledge, automated processes and evaluation of the ability of HIIs to meet the information needs of primary recipients. Using the United States' Nation Health Information Infrastructure (NHII) as an example, the authors describe expansion of the conceptual framework to explicitly acknowledge the role of access to evidence at the overlap between the three dimensions of the NHII to create an "evidence-based" link between interrelated components. The role of national measures in setting e-communication goals and evaluating the evolving infrastructure in meeting informational needs of users is discussed. Additionally, automated knowledge management tools such as practice guidelines are presented as a means by which access to critical information is

delivered to users, in a format that is appropriate for their health literacy level and that provides adequate support for informed decision making.

6. English, K. C., Wallerstein, N., Chino, M., Finster, C. E., Rafelito, A., Adeky, S., and Kennedy, M. "Intermediate outcomes of a tribal community public health infrastructure assessment". *Ethn Dis.* 2004. 14: 3 Suppl 1: S61-9p.

URL: 15682773

Resumen: The purpose of this collaborative participatory project was to assess the strengths and needs of a tribal community as part of a larger public health capacity building program. Key project partners included: the Ramah Band of Navajo Indians, the Albuquerque Area Indian Health Board, the University of New Mexico Masters in Public Health Program, and the University of Nevada, Las Vegas, American Indian Research and Education Center. Principal intervention steps entailed: 1) relationship-building activities among tribal programs and between the Tribe and the scientific community; 2) an orientation to public health; 3) a comprehensive public health infrastructure assessment, utilizing a standardized CDC instrument; and 4) a prioritization of identified needs. The direct outcome was the development and beginning implementation of a community specific public health strategic action plan. Broader results included: 1) increased comprehension of public health within the Tribe; 2) the creation of a community public health task force; 3) the design of a tribally applicable assessment instrument; and 4) improved collaboration between the Tribe and the scientific community. This project demonstrated that public health assessment in tribal communities is feasible and valuable. Further, the development of a tribally applicable instrument highlights a significant tribal contribution to research and assessment.

7. Green, L. A., White, L. L., Barry, H. C., Nease, D. E. Jr, and Hudson, B. L. "Infrastructure requirements for practice-based research networks". *Ann Fam Med.* 2005. 3 Suppl 1: S5-11p.

URL: http://www.annfammed.org/cgi/reprint/3/suppl_1/s5

Resumen: BACKGROUND: The practice-based research network (PBRN) is the basic laboratory for primary care research. Although most PBRNs include some common elements, their infrastructures vary widely. We offer suggestions for developing and supporting infrastructures to enhance PBRN research success. METHODS: Information was compiled based on published articles, the PBRN Resource Center survey of 2003, our PBRN experiences, and discussions with directors and coordinators from other PBRNs. RESULTS: PBRN research ranges from observational studies, through intervention studies, clinical trials, and quality of care research, to large-scale practice change interventions. Basic infrastructure elements such as a membership roster, a board, a director, a coordinator, a news-sharing function, a means of addressing requirements of institutional review boards and the Health Insurance Portability and Accountability Act, and a network meeting must exist to support these initiatives. Desirable elements such as support staff, electronic medical records, multiuser databases, mentoring and development programs, mock study sections, and research training are costly and difficult to sustain through project grant funds. These infrastructure elements must be selected, configured, and sized according to the PBRN's self-defined research mission. Annual infrastructure costs are estimated to range from \$69,700 for a basic network to \$287,600 for a moderately complex network. CONCLUSIONS: Well-designed and properly supported PBRN infrastructures can support a wide range of research of great direct value to patients and society.

Increased and more consistent infrastructure support could generate an explosion of pragmatic, generalizable knowledge about currently understudied populations, settings, and health care problems.

8. Hinman, A. R., Saarlal, K. N., and Ross, D. A. "A vision for child health information systems: developing child health information systems to meet medical care and public health needs". *J Public Health Manag Pract*. 2004. Suppl: S91-8p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed&cmd=Retrieve&list_uids=15643366&dopt=Citation

Resumen: In both the medical care and public health arenas, a variety of information systems have been developed to serve providers and program managers. In general, these systems have not been designed to share information with other information systems and provide comprehensive information about a child's health status to the information user. A number of initiatives are underway to develop integrated information systems. In December 2003, All Kids Count hosted an invitational conference "Developing Child Health Information Systems to Meet Medical Care and Public Health Needs." Through a series of plenary presentations and breakout discussion groups, participants developed a series of recommendations about governance, economic issues, information infrastructure, and uses of information from integrated child health information systems (CHIS). Common threads in the recommendations were: (1) development of a national coalition of stakeholders to promote integration of separate child health information systems within the context of ongoing national initiatives such as the National Health Information Infrastructure and the Public Health Information Network, (2) the need to develop the business and policy cases for integrated CHIS, (3) the need to develop agreement on standards for collecting and transferring information, and (4) the need to get the word out about the importance of integrating separate CHIS to improve health and health services.

9. "IOM: overhaul of government public health infrastructure, new partners needed". *Public Health Rep*. 2003. 118: 1: 74-5p.

URL: <http://www.acpm.org/112702headlines.htm>

Resumen: The Institute of Medicine in its much-anticipated follow-up report to the 1988 landmark report, *The Future of Public Health*, has called for a major overhaul of the government public health infrastructure to meet the health needs of Americans in the 21st century. *The Future of the Public's Health in the 21st Century* points to the recent spread of the West Nile virus and the anthrax scare of 2001 as dramatic examples of the challenges the country faces and the importance of governmental agencies and public and private sector partners working together in a unified public health system. The report notes many of the tremendous achievements made in the 20th century to improve the health and quality of life of the American people—such as the reduction and prevention of life-threatening ailments and the improved safety of homes, workplaces, roads, and automobiles. Yet, despite leading the world in health expenditures, the U.S. is not fully meeting its potential in health status and lags behind many of its peers, said the committee that wrote the report. This conundrum, according to the report, can in part be explained by the fact that as little as one to two percent of all U.S. health expenditures is directed toward prevention, while 70 percent of avoidable mortality can be attributed to behavior and environment.

10. Kaushal, R., Blumenthal, D., Poon, E. G., Jha, A. K., Franz, C., Middleton, B., Glaser, J., Kuperman, G., Christino, M., Fernandopulle, R., Newhouse, J. P., and Bates, D. W. *"The costs of a national health information network"*. *Ann Intern Med.* 2005. 143: 3: 165-73p.

URL: <http://www.annals.org/cgi/content/full/143/3/165>

Notas: CORPORATE NAME: Cost of National Health Information Network Working Group.

Resumen: BACKGROUND: The use of information technology may result in a safer and more efficient health care system. However, consensus does not exist about the structure or costs of a national health information network (NHIN). OBJECTIVES: To describe the potential structure and estimate the costs of an NHIN. DESIGN: Cost estimates of an NHIN model developed by an expert panel. SETTING: U.S. health care system. MEASUREMENTS: An expert panel estimated the existing and the expected prevalence in 5 years of critical information technology functionalities. They then developed a model of an achievable NHIN by defining key providers, functionalities, and interoperability functions. By using these data and published cost estimates, the authors determined the cost of achieving this model NHIN in 5 years given the current state of information technology infrastructure. RESULTS: To achieve an NHIN would cost 156 billion dollars in capital investment over 5 years and 48 billion dollars in annual operating costs. Approximately two thirds of the capital costs would be required for acquiring functionalities and one third for interoperability. Ongoing costs would be more evenly divided between functionality and interoperability. If the current trajectory continues, the health care system will spend 24 billion dollars on functionalities over the next 5 years or about one quarter of the cost for functionalities of a model NHIN. LIMITATIONS: Because of a lack of primary data, the authors relied on expert estimates. CONCLUSIONS: While an NHIN will be expensive, 156 billion dollars is equivalent to 2% of annual health care spending for 5 years. Assessments such as this one may assist policymakers in determining the level of investment that the United States should make in an NHIN.

11. Luck, J. and Peabody, J. W. *"When do developing countries adopt managed care policies and technologies? Part II: Infrastructure, techniques, and reform strategies"*. *Am J Manag Care.* 2002. 8: 12: 1093-103p.

URL: <http://www.ajmc.com/files/articlefiles/AJMC2002decLuck1093-1103.pdf>

Resumen: OBJECTIVES: To specify the essential infrastructure elements required to implement managed care techniques successfully in a developing country, once the necessary macroeconomic preconditions for managed care have been met. Also, to describe how managed care techniques can be integrated into health system reform strategies. STUDY DESIGN AND METHODS: Analysis of available developing country health system and healthcare spending data, review of the available literature, and authors' experience evaluating healthcare reform in developing countries. RESULTS: Successful managed care relationships among payers, providers, and patients rely on several essential infrastructure elements: enabling legislation; regulatory mechanisms to administratively correct health and insurance market failures; enforceable contracts; and formal groups or associations of providers. Once these infrastructure elements are in place, a developing country government can consider implementing 1 or more managed care techniques, including payment strategies, demand-side techniques, and utilization management. CONCLUSIONS: Governments in many developing countries can take deliberate steps to accelerate the evolution of certain macroeconomic preconditions--human capital and information systems--and essential infrastructure elements necessary to support managed care techniques.

They may then choose to experiment carefully with implementing specific managed care techniques, with consideration given to how the managed care techniques can promote primary care.

12. Lumpkin, J. R. and Richards, M. S. "Transforming the public health information infrastructure". *Health Aff (Millwood)*. 2002. 21: 6: 45-56p.

URL: <http://content.healthaffairs.org/cgi/content/abstract/21/6/45>

Resumen: The public health information infrastructure is undergoing a transformation that is enabled by changes in health care informatics. The implementation of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the patient medical record information standards, and National Health Information Infrastructure (NHII) recommendations by the National Committee on Vital and Health Statistics provide the basis for improved data reporting to public health agencies. The U.S. Department of Health and Human Services should provide leadership and resources for this transformation. Newly available federal resources will have the greatest effect on improving the information infrastructure if there is a strong commitment to developing and implementing public health data standards that build upon the National Electronic Disease Surveillance System.

13. Martinez, A., Villarroel, V., Seoane, J., and del Pozo, F. "Analysis of information and communication needs in rural primary health care in developing countries". *IEEE Trans Inf Technol Biomed*. 2005. 9: 1: 66-72p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed&cmd=Retrieve&list_uids=15787009&dopt=Citation

Resumen: This article presents three studies dealing with information and communication needs in rural primary health care from Peru and Nicaragua. Results show that primary health-care systems in rural areas of developing countries are very inefficient. Among the main reasons we found factors related to communication infrastructure, information sharing, and continuous training of health professionals. We conclude that telemedicine systems can improve this situation, but the lack of infrastructures, low income levels, and other conditions, impose strong limits to the introduction of new technologies. The main conclusion is that differences in needs and conditions between developing countries and industrialized ones force to use different solutions and approaches. This article presents some proposals on technology requirements and how to deal with the use of telemedicine in rural areas of developing countries. These proposals can be useful to all kind of actors (national public administrations, multilateral institutions, industry, academy, civil society, etc.) in order to promote really relevant and sustainable proposals in telemedicine for rural regions of developing countries.

14. McConnell, H. "International efforts in implementing national health information infrastructure and electronic health records". *World Hosp Health Serv*. 2004. 40: 1: 33-7, 39-40, 50-2p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed&cmd=Retrieve&list_uids=15114922&dopt=Citation

Resumen: Many countries are developing national strategies using information and communication technologies (ICTs) to implement health information infrastructure and electronic health records (EHR), into their medical systems. Efficiency, quality of care and medical error along with new

opportunities presented by the technologies themselves have driven this process internationally. Many countries have had spectacular failures costing billions of dollars alongside some amazing successes. There has been very little dialogue internationally about what works and what doesn't work despite the fact that many government and international agencies have placed this key priority on their agendas. The nature of the technologies used promotes cooperation and these innovations in healthcare lend themselves particularly to working together for collaboration and for communication in order to learn best practice from each other. In this paper, I look at some of the national initiatives for developing an information infrastructure for healthcare as well as some of the challenges presented by these very different approaches around the world. We also review briefly the many organizations looking at international standards relating to eHealth and to implementation of electronic health records.

15. Milio, N. *"Beyond informatics: an electronic community infrastructure for public health"*. *J Public Health Manag Pract*. 95. 1: 4: 84-94p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=10186647&dopt=Abstract

Resumen: Public health agencies are in the early stages of building an electronic infrastructure that will link them to each other and eventually to the "information superhighway." Emphasis in planning and development is on data systems and the information and training services that can enhance essential public health services. This article argues for a larger vision of the potential of electronic networks for public health. It discusses the health and other challenges facing public health, the limitations of conventional efforts, and the emerging consensus on public health core functions. Finally, it examines current and potential uses of information technology. The article concludes by proposing that the public health community should develop a collaborative and inclusive vision of public health in an electronic world and provide guidance and support for agency implementation to ensure a stronger system that can meet the health and health equity challenges ahead.

16. Morey, S. and Madden, L. *"Building the infrastructure for public health"*. *N S W Public Health Bull*. 2003. 14: 3: 50-1p.

URL: [http://www.health.nsw.gov.au/public-](http://www.health.nsw.gov.au/public-health/phb/HTML2003/march03html/article5p50.html)

[health/phb/HTML2003/march03html/article5p50.html](http://www.health.nsw.gov.au/public-health/phb/HTML2003/march03html/article5p50.html)

Resumen: The PHUs, the NSW Public Health Officer Training Program, and the NSW Public Health Bulletin are today integral parts of the health system. With the creation of rural area health services in 1996,[4] PHUs became part of each area health service in NSW. In 1998, when the Corrections Health Service was formed, the number of PHUs reached 17. This network of PHUs permits coordination of many essential public health functions across the state. The NSW Public Health Officer Training Program has provided a skilled workforce able to fill a wide variety of public health functions including those encompassed by the PHUs. It has also served as a model for training programs in other states, such as Western Australia, and for other disciplines in public health, such as the NSW Bio-statistical Officer Training Program. The Bulletin is now indexed on Medline and Index Medicus. The need for a strong public health capacity remains as great today as it was in 1988. However if continued gains are to be made in public health, public health training and infrastructure must remain relevant and capable of adapting to changing environments.

17. Perú. Ministerio de Salud. "Tecnologías de tratamiento de residuos sólidos de establecimientos de salud". Lima, PE: Perú. Ministerio de Salud; 98. 64p.

URL: <http://www.minsa.gob.pe/publicaciones/pdf/tecno.pdf>

Resumen: El presente documento resume el Enfoque de las Tecnologías de Tratamiento de Residuos Sólidos de Establecimientos de Salud, estudio elaborado por el Programa de Fortalecimiento de Servicios de Salud de Ministerio de Salud en el marco del Proyecto de Manejo de Residuos Sólidos Hospitalarios, ejecutado a través de DIGESA, que será de gran utilidad para los directivos de los establecimientos de salud y del MINSA, el cual les permitirá identificar, seleccionar y organizar sistemas de tratamiento de desechos sólidos generados en los establecimientos de salud del país. Existe un desconocimiento de las técnicas de tratamiento actuales, sus ventajas técnicas, económicas y ambientales, sus costos por parte de los funcionarios de salud, quienes toman la decisión final en la selección, adquisición y puesta en operación de los sistemas de tratamiento. El estudio se plantea en la necesidad de determinar cuál es la tecnología de tratamiento más adecuada para los establecimientos de salud del país, dada la situación económica, de salud y ambiente actual. Este cuenta con varios productos, el primero identifica las tecnologías de tratamiento más empleadas en el ámbito mundial, el segundo producto consiste en determinar la viabilidad técnica y operativa de poder ser implementadas en el país y el tercero y más importante es el estudio de viabilidad económica, donde se toman en cuenta los costos de inversión, operación y mantenimiento.

18. Powles, J and Comim, F. "Chapter 6: Public health infrastructure and knowledge". in: Smith, R, Beaglehole, R, Woodward, D, and Drager, N. "Global Public Goods for Health: health economics and public health perspectives". Oxford, Oxford University Press; 2003. 320p.

URL: http://www.who.int/trade/distance_learning/gpgh/gpgh6/en/index.html

Resumen: The purpose of this session is to examine the extent to which these infrastructures may usefully be seen as either global public goods for health (GPGH) in themselves, or, more indirectly, as 'access goods', which serve to support other GPGH. The session considers the concept of public health infrastructures and notes, in particular, the extent to which such infrastructures tend to be embedded in other social structures, public health infrastructures through the lens of economics, and considers the extent to which they may appropriately and usefully be viewed as (global) public goods, as intermediate goods or as access goods, the action that might be taken to consolidate and build public health infrastructures, and notes the fundamental role played in such endeavors by the creation and transmission of knowledge, and concludes with an assessment of the usefulness of the GPGH concept.

19. Rendon, A., Martinez, A., Dulcey, M. F., Seoane, J., Shoemaker, R. G., Villarroel, V., Lopez, D. M., and Simo, J. "Rural telemedicine infrastructure and services in the department of cauca, Colombia". Telemed J E Health. 2005. 11: 4: 451-9p.

URL: <http://www.liebertonline.com/doi/abs/10.1089/tmj.2005.11.451>

Resumen: The development of telemedicine programs for the public health network of the Department of Cauca, Colombia, (Department is the major political and territorial division of the country. The Department of Cauca is located on the Pacific coast in the southwest of the country.) would make it possible to satisfy many identified needs such as medical coordination, continuing education, epidemiologic surveillance, patient referral and counter referral, and an end to the feeling of isolation among

professionals who work in rural health centers. Nevertheless, geographic, economic, and social difficulties, and the lack of a telecommunication infrastructure in areas with these characteristics present a challenge of such magnitude that the majority of existing telemedicine projects in Colombia have been centered in urban or other areas which present fewer difficulties. In the municipality of Silvia, the University of Cauca has established a prototype network using the "Hispano-American Health Link" (EHAS in Spanish) program technologies, which uses very high frequency (VHF) and wireless fidelity, (WiFi, a set of standards for wireless local area networks) radio systems for the deployment of low-cost voice and data networks. Over this network information access and exchange services have been developed, in order to meet the needs identified above. The objectives were to obtain information about the development of the project's activities and their possible impact. Project telecommunication network and information services are described, and the results and conclusions of the first evaluation are presented.

20. Santillana Macedo and MA. "Páginas de salud pública". *Salud Pública de México*, 2004. 46: 5: 493-4p.

URL: <http://www.scielosp.org/pdf/spm/v46n5/a15v46n5.pdf>

Notas: Cita de la publicación mencionada: *Consejo Nacional para la Cultura y las Artes. Atlas de la infraestructura cultural de México. México, DF: Conaculta; 2004. 342p.*

Resumen: La aparición del Atlas de la infraestructura cultural de México permite apreciar varios acercamientos a la extraña y rara relación entre cultura y salud. Además, resulta relevante que los resultados entre las Encuestas Nacionales de Salud (ENSA) y la mostrada en este texto que comento son presentadas de forma muy similar, lo que nos permite inferir que el nivel de bienestar "o malestar" de la población mexicana se encuentra íntimamente vinculado. Un ejemplo de estas similitudes en cuanto a salud y cultura es que los autores señalan explícitamente que la información sirve para construir conocimiento; éste no se da por sí mismo en una encuesta o Atlas, por mejor diseñados que estén. O sea que la ENSA y este Atlas nos proporcionan datos que se construyeron con base en una metodología, y a nosotros nos toca generar el conocimiento derivado de esto. De forma similar aportan los autores que decir y saber cuántos recursos hay, no quiere decir que se utilicen, cuánto y cómo. Lo mismo que en salud, decir que en un municipio hay una biblioteca o un centro de salud, no quiere decir que se utilice, o siquiera que se cuente con el personal mínimo en alguno de estos centros. Es decir, en una analogía a lo propuesto en salud en lo que pueden ser hospitales o clínicas de primer nivel de atención, una cosa es la infraestructura que en este caso se refiere a lo cultural (radios, bibliotecas, librerías, casa de cultura, teatros, cines, etc.) y otra la difusión, el uso adecuado, la utilización y sostenimiento por la comunidad o la administración pública o privada de estos centros culturales. Otro elemento en el que se puede observar cierto paralelismo con salud, por lo menos en cuanto a planes nacionales de índole sexenal, fue el explícito interés de hacer este Atlas como un elemento metodológico para apuntar, a través de acciones posteriores, hacia una disminución de las inequidades en todo el país. Lo que nos lleva a una interesante hipótesis, que si bien no se explicita por parte de los autores de este Atlas, es fácil deducir: es decir, ¿donde hay menos recursos culturales hay, por tanto, menor bienestar de la población? Y su complemento lógico: ¿donde hay más recursos culturales hay, por tanto, mayor bienestar de la población?

21. Sottile, P. A. "Approaches in European health information systems architectures". *Stud Health Technol Inform.* 2003. 96: 29-37p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed&cmd=Retrieve&list_uids=15061522&dopt=Citation

Resumen: Information and Communication Technology (ICT) in healthcare represents a fundamental and highly qualifying pre-requisite for enabling the interoperability of information systems, the continuity of the caring process to the patient over the territory, the creation of an integrated electronic healthcare record, as well as the monitoring and optimization of the organizational and economical aspects of healthcare enterprises. This paper presents a European architectural strategy for healthcare information systems, capable of facilitating the evolution of the existing procedures and their smooth integration into a homogeneous information and functional infrastructure, without requiring major modifications in already existing modules and protecting, therefore, previous investments.

22. Spreeuwenberg, C. "Knowledge Infrastructure for Public Health: an advisory report from the Advisory Council on Health Research". *Ned Tijdschr Geneesk.* 2003. 147: 50: 2459-62p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed&cmd=Retrieve&list_uids=14708209&dopt=Citation

Resumen: Social, scientific and technological developments are forcing health care systems to shift the focus from disease to health and from cure to prevention. The Advisory Council on Health Research (RGO) has published an advisory report about the knowledge infrastructure serving the needs of public health in the Netherlands. The Council's concept of public health also includes aspects such as policy and health management. The Council concludes that more research is needed on the following determinants of health: environmental issues, social factors, unhealthy behavior and genetic factors. Intervention research must focus on health protection, health promotion and disease prevention. The public health infrastructure can be improved by amalgamating research groups, establishing departments of public health at every academic medical centre, and linking service, education and research.

23. Stead, W. W., Kelly, B. J., and Kolodner, R. M. "Achievable steps toward building a National Health Information infrastructure in the United States". *J Am Med Inform Assoc.* 2005. 12: 2: 113-20p.

URL: <http://www.jamia.org/cgi/reprint/12/2/113>

Resumen: Consensus is growing that a health care information and communication infrastructure is one key to fixing the crisis in the United States in health care quality, cost, and access. The National Health Information Infrastructure (NHII) is an initiative of the Department of Health and Human Services receiving bipartisan support. There are many possible courses toward its objective. Decision makers need to reflect carefully on which approaches are likely to work on a large enough scale to have the intended beneficial national impacts and which are better left to smaller projects within the boundaries of health care organizations. This report provides a primer for use by informatics professionals as they explain aspects of that dividing line to policy makers and to health care leaders and front-line providers. It then identifies short-term, intermediate, and long-term steps that might be taken by the NHII initiative.

24. Yáñez, MR, and Villatoro S., P. "Las nuevas tecnologías de la información y de la comunicación (TIC) y la institucionalidad social. Hacia una gestión basada en el conocimiento". Santiago de Chile, CL: CEPAL; 2005. 83p.

URL: http://www.eclac.cl/publicaciones/DesarrolloSocial/8/LCL2298PE/sps_108.pdf

Notas: Serie Políticas Sociales N° 108

Resumen: En este documento se dan a conocer las ponencias presentadas en el módulo "El rol de las tecnologías de la información y comunicación (TIC) en las experiencias de institucionalización de la política social", realizado en el marco del Seminario Regional "Mejoramiento de la institucionalidad de la política social y constitución de una autoridad social", organizado conjuntamente por la CEPAL y BIREME, OPS-OHG (10 al 12 de agosto del 2004). En las presentaciones se entregan elementos del contexto socio-institucional que fundamentan la implementación de redes y comunidades virtuales para el fortalecimiento de la institucionalidad social en América Latina y el Caribe. Asimismo, se presentan experiencias de instalación de dispositivos virtuales -en particular los casos de la Red en línea de instituciones sociales de América Latina y el Caribe (RISALC) y la Biblioteca Virtual en Salud (BVS)- para el mejoramiento de la gestión de la información y conocimiento; el intercambio de experiencias, y la difusión de buenas prácticas entre los actores de la institucionalidad social de la región. En este documento también se esbozan lineamientos y propuestas de acción para la constitución de una agenda digital social en la región.

25. Yasnoff, W. A., Overhage, J. M., Humphreys, B. L., LaVenture, M., Goodman, K. W., Gatewood, L., Ross, D. A., Reid, J., Hammond, W. E., Dwyer, D., Huff, S. M., Gotham, I., Kukafka, R., Loonsk, J. W., and Wagner, M. M. "A national agenda for public health informatics". *J Public Health Manag Pract*. 2001. 7: 6: 1-21p.

URL:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed&cmd=Retrieve&list_uids=11713752&dopt=Citation

Resumen: The American Medical Informatics Association 2001 Spring Congress brought together the public health and informatics communities to develop a national agenda for public health informatics. Discussions on funding and governance; architecture and infrastructure; standards and vocabulary; research, evaluation, and best practices; privacy, confidentiality, and security; and training and workforce resulted in 74 recommendations with two key themes: (1) all stakeholders need to be engaged in coordinated activities related to public health information architecture, standards, confidentiality, best practices, and research and (2) informatics training is needed throughout the public health workforce. Implementation of this consensus agenda will help promote progress in the application of information technology to improve public health.

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URL: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5418a2.htm>
Keywords: INFRAESTRUCTURA/CAPACIDAD ORGANIZACIONAL
7. ASTHO. "State public health employee worker shortage report: a civil recruitment and retention crisis". Washington, DC: ASTHO; 2004. 20p.
URL: <http://www.astho.org/pubs/WorkforceShortageReportFinal.pdf>
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8. Austin, E. "Bobbie Berkowitz: an interview". *Advances.* 2002. 1: 4p.
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