

# Human Resources Plans and Primary Health Care: Challenges for Intersectoral and Social Participation



**Pan American  
Health  
Organization**

Regional Office of the  
World Health Organization



global health  
workforce  
alliance

With the collaboration of the Ministries of Health of  
Brazil and El Salvador



# Human Resources Plans and Primary Health Care: Challenges for Intersectoral and Social Coordination

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PAN AMERICAN HEALTH ORGANIZATION/  
WORLD HEALTH ORGANIZATION (PAHO/WHO)



GLOBAL HEALTH WORKFORCE ALLIANCE (GHWA)



HEALTH MINISTRY OF BRAZIL



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# Introduction

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This publication contains the papers presented at the workshop on Human Resource Planning and Primary Health Care: Challenges for Social and Intersectoral Coordination, held in San Salvador, May 4-6, 2010, organized by the Global Health Workforce Alliance (GHWA) and the Pan American Health Organization (PAHO) in collaboration with the Ministers of Health of El Salvador and Brazil.<sup>1</sup>

The workshop is part of an effort to make priority changes in the status of health workers in Latin American countries within the framework of agreements adopted at the 2007 Pan American Sanitary Conference. It defined the Regional Goals for Human Resources for Health (HRH) for 2007-2015, in the process of transforming health systems towards the renewal of Primary Health Care and the integration of services.

The material collected includes an analysis of the progress in the development of Human Resources Plans in selected countries that have experienced difficulties in meeting the Regional Goals for Human Resources for Health. Likewise, it raises discussions and agreements on how to improve coordination among ministries of Health and their counterparts—Finance, Labor and Education—to make viable plans for human resources for health and to consider some projects funded by international cooperation that were designed to improve the HRH situation in three countries of the Region.

This issue of improving the health workforce situation falls within the work of the Global Health Workforce Alliance (GHWA). The Alliance was founded in 2006 within the context of the World Health Report, “Working Together for Health,” as a global platform for action to face the crisis of human resources for health, with particular focus on the 57 countries identified by WHO as those suffering from a critical workforce shortage. In March 2008, GHWA held the first Global Forum on Human Resources for Health in Kampala, Uganda, giving rise to the Kampala Declaration and its Global Action Program. GHWA also promotes good practices for countries to develop Human Resources Plans, focusing on coordination processes among interested parties. In preparation for the 2nd Global Forum on Human Resources

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1. See San Salvador Agreement: Development of Human Resources Plans in the Framework of Primary Health Care, signed in San Salvador on May 6, 2010. Available at: [http://new.paho.org/hq/index.php?option=com\\_content&task=view&id=2798&Itemid=2054&lang=es#Propositodeltaller](http://new.paho.org/hq/index.php?option=com_content&task=view&id=2798&Itemid=2054&lang=es#Propositodeltaller).

for Health to be held in Bangkok in January 2011, a series of meetings on this issue took place in Africa and Asia.

The process of Country Collaboration and Facilitation (CCF) developed by the Alliance originated in the Kampala Declaration, Global Program of Action, and the Alliance's strategic document Moving Forward from Kampala. The CCF identifies opportunities for partners, members, regional entities and other country stakeholders to work together in a coordinated, collaborative and participatory manner under the GHWA's principles to develop specific actions to respond to the human resources crisis in the countries.

As part of this process, the health ministers of Latin America adopted the Health Agenda for the Americas 2008-2017 on June 3, 2007, in Panama City. This is a collective commitment to achieve the best possible health and well-being levels for people in the Region. Of the eight areas of the identified actions, the seventh refers to the increase of social protection and access to quality health services, and the eighth refers to developing and strengthening management of health workers.

Both action areas are strongly related. The political will to achieve universal and equitable access to health services and the strategy of Primary Health Care are facing historical problems with health workforce shortages--a health workforce without the necessary profiles and competencies, concentration of existing workers in urban and higher-income areas, and productivity and performance problems due to low motivation. This situation reaches crisis dimensions in countries with higher levels of poverty and social inequities.

The Regional Goals for Human Resources for Health 2007-2015, adopted by the Pan American Sanitary Conference in 2007, identified priority changes in the status of health workers in order to develop health systems based on primary health care and universal coverage. Currently, many countries in the Region are involved in measuring and monitoring indicators of the 20 proposed goals. The indicator measurements will provide useful inputs to review ongoing Human Resources Plans or to design new ones. This practice promotes cooperation among countries to search for innovative strategies to solve common problems.

An indispensable strategy for designing Human Resources Plans is the coordination of stakeholders, a concept promoted by the Regional Initiative of Observatories of Human Resources for Health since 1999. From the perspective of the health authority's management role, a critical part of its responsibility is coordination with other government sectors in setting-up policies and strong Human Resources Plans. However, it seems that the coordination of the Health Sector with

other key sectors such as Education, Finance, and Labor is limited and, in many cases, lacks institutional mechanisms to ensure its effectiveness.

To manage this coordination, representatives of the ministries of Health, Education, Labor, and Finance; civil service; congress members; professional institutions; and civil society from Brazil, Bolivia, Ecuador, El Salvador, Honduras, Guatemala, Paraguay and Peru stepped forward. They signed the “Compromise of San Salvador for the Development of Human Resources Plans in the Context of Primary Health Care” on May 6, 2010, at the workshop held in San Salvador.

The commitment is based on the ‘right to health’ and strengthening social protection systems; it indicates the willingness to cooperate in building government capacity, promoting a culture of dialogue, strengthening institutional mechanisms of exchange and analysis, improving institutional development, designing integrated information management systems on human resources, exchanging expertise and resources, and jointly exploiting the possibilities of support and co-operation among countries and international organizations. This has the purpose of promoting the development of policies and Human Resources Plans to push health systems towards equity, universality and the right to health and access to health services within the Primary Care Strategy Health.<sup>2</sup>

The purpose of the workshop held in San Salvador was to help strengthen the stewardship of the national health authority in developing Human Resources Plans for primary health care through the adoption of strategies and mechanisms of liaison and coordination with key sectors of government and other interested entities.

The workshop focused on those Latin American countries with the greatest difficulty in meeting the 20 Regional Goals of Human Resources for Health and the universal health care coverage.

The objectives were to:

Analyze the development of human resources plan for the transformation of health systems towards primary care renewal and service integration.

- Analyze the development of Human Resources Plans for the transformation of health systems towards primary care renewal and service integration.
- Identify priority issues for a working agenda among the health sector and Finance, Labor and Education sectors to develop Human Resources Plans.

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2. See San Salvador Agreement: Development of Human Resources Plans in the Frame of Health Primary Care, signed in San Salvador on May 6, 2010. Available at: [http://new.paho.org/hq/index.php?option=com\\_content&task=view&id=2798&Itemid=2054&lang=es#Propositodeltaller](http://new.paho.org/hq/index.php?option=com_content&task=view&id=2798&Itemid=2054&lang=es#Propositodeltaller).

- Characterize the practices of the relationship among health ministries and their counterparts in finance, labor and education for building the viability of Human Resources Plans.
- Identify the main successes and problems, evaluate good practices, and make recommendations for strengthening intersectoral work when developing plans.

The countries invited to the workshop were Bolivia, Brazil, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Paraguay and Peru. Each country had a delegation of four to six participants who were senior management within the ministries of Health, Education, Finance, and Labor, and involved in human resources for health planning. Additional participants were selected, depending on each context, such as associations or academic institutions, social security institutions or private institutions employing health personnel. As a partner country organizing the event, Brazil had its own delegation.

Identification of members of each country delegation was undertaken by consultation with the Ministry of Health's authorities. It was proposed that the Minister of Health, in coordination with the PAHO country representative, call his counterparts from the ministries of Education, Finance, and Labor, to inform them about the analysis workshop and communicate interest in strengthening intersectoral coordination to make viable Human Resources Plans and identify the suitable participants from each ministry. GHWA and PAHO technically and financially supported case studies in the participating countries, which were presented and discussed at the workshop. To carry out the studies, a common methodology was designed and applied with flexibility, given particular interests of the specific country.

The workshop was designed to give participating countries' ministries of health the opportunity to strengthen their relationships and define an agenda with the invited government sectors. It was expected that the exchange of experiences among different countries would contribute to improving the coordination mechanisms to address critical problems of human resources and to enable the development of Primary Health Care.

PAHO and WHO provided a regional situation analysis on the agenda and the mechanisms and problems of intersectoral cooperation in human resources. This analysis was an important component for the formulation and validation of technical cooperation strategies.

The workshop was the first major activity of the GHWA in the Region of the Americas. Its conclusions will contribute to the 2nd Global Forum on Human Resources for Health to be held in Bangkok, Thailand in January 2011.

PART ONE

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# CHAPTER 1

## THE IMPORTANCE OF INTERSECTORAL AND SOCIAL COORDINATION PLANNING

Building Hope: Transforming Health Systems  
and Human Resources Policies in El Salvador

*Dr. María Isabel Rodríguez*  
*Minister of Health of El Salvador*

Intersectoral Cooperation and Development of Sustainable Plans

*Dr. Charles Godue*  
*Human Resources for Health Project Coordinator,*  
*Area of Health Systems Based on Primary Health Care, PAHO*

Cooperation and Coordination between Sectors and Actors:  
The Role of the Global Health Workforce Alliance

*Dr. Hirotsugu Aiga*  
*GHWA*

Reflections on Main Findings from the Country Studies

*Dr. Carlos Rosales*  
*PAHO*

Lessons on Intersectoral Case Studies

*Dr. Hugo Mercer*

Government Capacity and Governance for  
Management of Human Resources Public Policies

*Dr. Pedro Brito*

# Building Hope: Transforming Health Systems and Human Resource Policies in El Salvador

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DR. MARÍA ISABEL RODRÍGUEZ  
*Minister of Health of El Salvador*

This presentation is the result of the efforts undertaken since June 1, 2009. The political situation created when the democratic forces took office—which had been ignored for decades—opened the doors for the transformation of the public health system in El Salvador. This public opening of the health field was preceded by intense debate. Social forces did not remain quiet during difficult periods; on the contrary, our proposal was enriched by the contribution of new experiences that could develop in this country and also by public health and international health thinkers who contributed by developing proposals under adverse and complex circumstances in the country. In El Salvador, those complex circumstances led to the hegemony of forces determined to put economic benefit over the social interest, which negatively impacted the health system.

Current authorities have had the national and international solidarity to lead this reform with the commitment of the President of the Republic who said—during the campaign and also as elected president—that health was a public good, a fundamental human right and an inherent component of the country's development strategy. The President stated, "My first commitment to the Salvadorian people and the international community is to make health a priority area of my administration."

I would like us to think together. In facing a reform, and acting on a commitment of this kind is not simple, especially in a country like ours where the health situation is extremely deteriorated. The main characteristics that we find in our health system are:

- Low social investment;
- Social inequities in general and in health in particular (El Salvador is one of the most inequitable countries in the world);
- Continued and deliberate dismantling of health services to stimulate private sector growth;
- Existence of a precarious population and, therefore, social tension and conflict;
- Diseases due to poverty, new and re-emerging epidemics;
- Chronic degenerative diseases and injuries due to external causes;

- Shortage and high-cost of medicines;
- Problems associated with sexual and reproductive health, teenage pregnancy, and STDs;
- Problems associated with mental health: depression, suicide, and addictions;
- Low coverage from the Salvadorian Social Security Institute, with low levels of solidarity with the rest of the population, which increases inequalities;
- Weak mechanisms for community participation;
- Poor focus on health promotion, disease prevention and rehabilitation, and
- A highly segmented and fragmented national health system.

This situation, which was known but had not been confronted, forced us to disclose this reality publicly.

The process of change we are promoting in El Salvador means speaking about a reform process that will respond to the dramatic health conditions in a context of injustice and inequity.

Consequently, the main challenge will be to define what is new in our proposal, which cannot be one more recipe and will not be a system make-over like other reforms that remained mere declarations. This forces us to think about what guarantees that a reform process like this will succeed.

It is important to remember the major conventions and declarations on human resources for health in which El Salvador is a signatory member.

The first attempt at human resource planning in the hemisphere was the meeting held in Punta del Este, Uruguay in 1961, which intended to give a response to the crisis at the time, marked among other factors, by the Cuban revolution. Building economic and social development for the Americas was discussed. In human resources, there was an essentially quantitative response, in addition to initiatives to expand medical coverage. Nevertheless, little was done.

Then, in Chile in 1972, during the presidency of Salvador Allende, the 10-Year Health Plan for the Americas was formulated, which recommended developing a process for human resources planning in each country. In El Salvador, these recommendations were considered based on the political, economic and social leanings of the leaders in office at that time.

The aforementioned was confirmed by the Declaration of Alma Ata in 1978, with the goal of health for all. This statement was misinterpreted by many; it was

seen not as comprehensive care, but as a way to serve the poor with poor services, which Mario Testa called “primitive care.”

Then, we all witnessed the reforms of the 1990s, driven by structural adjustment programs from international financial organizations, which resulted in selective primary health care conceived only as an first-level care and with severe restrictions on health budget and a dismantling of the health system. Our public hospitals became beggars of the private systems.

In this context, the situation of the Salvadorian health system in July 2009 was the following:

- Low investment in health, use of former budgets, and public- system paid services (“voluntary quotas”);
- Increase of out-of-pocket health spending of low-income population;
- Deficient service coverage (less than 40 percent of the population was covered by the public system which should cover about 80 percent of the population);
- Segmented, fragmented, uncoordinated, and inequitable system;
- Low problem-solving capacity at all levels;
- Lack of regulation for the private sector and low social participation;
- Proliferation of vertical programs;
- Human Resources: little team spirit and staff motivation, lack of commitment to changes, disintegration of education/health/labor/science and technology areas, lack of continuous education, and inadequate and chaotic distribution of health workers;
- Inadequate and deteriorated infrastructure without coherent planning;
- Medicines: inadequate supply and storage, shared stewardship and high prices in the private sector;
- Information systems: fragmented, unable to use for decision making;
- Lack of a system for medical emergencies and disasters, and
- In international cooperation: weak management, high fragmentation and initiative overlapping.

Given this situation, a first task of the new government was to make clear that health is a collective task. Therefore, there was an effort to conduct a consultative forum that allowed us to glimpse at the main challenges. Health is a task to which

everyone can contribute. The public should play an active and ongoing role in the development and implementation of new health policy.

To meet these objectives, our response is based on the following points:

- Reject health as a commodity. Health is a public good and a human right.
- Reorient the national health system based on a comprehensive primary health care strategy.
- Strengthen community organization, social participation and intersectoral work.
- Provide efficient health care service performance.
- Health care reform as a strategic response of the Government of El Salvador.

Ensuring health for all is a public duty. Perhaps what best expresses this idea is Dr. Florentino Garcia's statement, which describes the Unified Health System as "the realization of joint efforts by intellectuals, researchers, teachers and health workers, and society as a whole." So, our strategy, which seeks to ensure the right to health of all Salvadorians, proposes the following processes:

- Reorganize the public health services network for broader responsiveness and universal coverage.
- Public participation to build the new system and its social control.
- Setting up a National Emergency Medical System.
- Unified information systems
- Consolidated list of essential drugs ensuring acquisition, distribution, prescription, dispensing and rational use.
- Unified operation for laboratory quality control, blood banks, clinical laboratories, and others.
- Accreditation at all levels of health care institutions.
- Effective regulation of the private sector.
- Joint strategies for financing shared resources.
- Extensive scientific and technological development.
- Support for strengthening the National Health Forum.

The construction of the health network emerges as a national effort to end the system chaos generated by hospitals and units built without a unified vision and without an adequate relationship among them. Thus, it is essential to define what we mean by an integrated network of health services. Perhaps the best way

of putting it into words is by saying that each brick, bed, and piece of equipment added to the system is part of a harmonious development of an integrated system to serve the society.

This new design is a comprehensive and integrated strategy based on a primary care strategy and on an integrated network model of health care, with institutional strengthening to improve the responsiveness of primary care level and other levels.

The attributes of the care model are: (1) universal care focused on family and social determinants, with defined intersectoral actions to address local problems, functioning with integrated networks to ensure appropriate care throughout the system, and (2) an adequate reference-return system with the democratic participatory approach of local councils, with an integrated local program and continuous education for all technical and professional categories of the network.

We all agree that the cornerstone of a reform and, in general, in the health system are the human resources, or staff, or work force. The bottom line is that those people who have assumed responsibility for health care must have a clear sense of how and why this knowledge is important and how it should be applied. Therefore, an ongoing staff development program is essential. If we fail to raise awareness among health workers and do not maintain a continuing education program in health, all our efforts will be fruitless.

When facing these challenges, it is very important to understand what remains—a profound deterioration of health workers over many decades that has left them insensitive to human pain and unable to react in situations.

In El Salvador we are experiencing a problem of nursing migration because of the cruel pressure, or rather, the private purchase of nurses. There is a private university whose main objective is to train professionals for export. Our duty is to measure the extent of the problem and look for solutions, where university, science and technology sectors must play a key role to confront the migration problem and to solve the workforce distribution problem in remote areas with greater need for professional care. The solution to these problems must match the stimuli created by the central level.

We must stress the importance of proper and solid training and redeployment of health personnel, development of clear rules to ensure equal opportunities and more presence of not only services but also of universities. Our public policies must also consider that the workforce consists of people who have decided, individually and collectively, to devote their lives to providing health services. For that reason, they also need significant personal and family development.

One of the main challenges to maintain a good public health network is to manage the existing resources of the system and those to be added. The financial resources needed to reduce the huge gap that we currently have in the workforce-population ratio are important to the country. Therefore, obtaining those resources for the 5-year period will be the result of a national effort focused on health.

Health workers already in the system must be involved in a new work ethic. These efforts are not only related to financing or finding new jobs. The challenge is to call the health workers to share in this new commitment and a new way to respond to the demands of these new responsibilities. Success will depend on the health workers's full commitment and identification with the demands posed by the system, from the health promotion worker to the specialized physician.

I think we are about to move forward with the organization that our communities have demanded for many years. We believe we are near the desired goal of responding to the population, particularly the most vulnerable and historically neglected ones, and to give the community a technical, human and supportive response so that it can finally have the long awaited health care that the Constitution grants.

Therefore, this meeting invites us to join efforts to coordinate health, education, finance, and labor on the same path, united in pursuit of that response.

# Intersectoral Cooperation and Development of Sustainable Plans

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DR. CHARLES GODUE

*Human Resources for Health Project Coordinator, Area of Health Systems Based on Primary Health Care, PAHO*

To begin this meeting, it is important to highlight the increasing interest that the human resources issue has acquired on the public agenda of countries. This phenomenon was necessary to strengthen cooperation activities in the Region and has resulted in the establishment of two important alliances that have helped mobilize technical resources in support of country initiatives: one with Brazil and the other with Canada. In this context, the support of Canadian cooperation was essential to hold this meeting.

In addressing the main challenges that bring us together for this event, we must ask what has been the path taken in this decade on Human Resources for Health and at what stage are we in the discussion about plans and developments. The Toronto meeting in 2005 marked a qualitative leap in the progress on this issue, where the countries of the Region identified five common challenges that constituted a 10-year action platform for human resources. The end of the decade, 2015, coincides with the millennium goals and provides a glimpse into the relationship between human resources, health status and service coverage, which also are reinforced by the World Health Report of 2006.

Between 2005 and 2007, a regional consultation on the renewal of Primary Health Care in the Americas was undertaken. The document defining PAHO's policy on primary health care became essential for the strategic renewal of human resources. Recently, a proposal for primary health care operational aspects has been developed, which incorporates the concept of integrated health networks for the strategic direction of the plans.

The Pan American Health Conference of 2007 states 20 goals for 2015, defined by the five challenges of the "Toronto Call to Action." These goals feed the discussion on building Human Resources Plans and seek consistency with the proposal on primary health care, considering the context of each country. For Human Resources Plans, the 20 goals meet the same guidance objectives as the Toronto challenges meet policy guidance. Each country has to identify specific monitoring indicators to know the level of development against each of the proposed goals, and to be able to respond to where we are going, what we want to achieve and how we can learn from what we are doing. In this regard, a measurement manual for the 20 goals for 2015 exists. It is expected that in 2011 the entire region of the

Americas will have a baseline to measure the 20 human resource goals defined at the Conference of 2007. The countries should set goals (for example, the Andean states for Goal One that all countries of the region will have achieved a density of at least 25 health workers per 10,000 inhabitants) and compare them with the current situation to identify the gap to be covered.

In our opinion, there are three levels of relationships that are essential to discuss. The first has to do with the level of convergence between Human Resources Plans and health policies, more precisely, the care model and primary health care and universal coverage policies. This has repercussions between actors who develop human resource policies and those who develop health policies. While policies are not summarized in the care model, they are related to the feasibility of the care model being developed in the country.

The second level is the existing relationship between the guidance on human resource policies and Human Resources Plans, which ultimately is in the operational component of the strategies with objectives, indicators, etc. This is a core topic for discussion at this event.

The third level is related to the institutional structure of the health authority to successfully carry out these responsibilities or, in other words, it is related to the leadership capacity of health ministries on matters of health policies and Human Resources Plans. Studies have been undertaken on the situation of human resource units to evaluate them and understand their guidelines. It was found that many human resource units still have to deal with the administration of public sector staff, the Ministry of Health. However, there is a shift towards strategic functions of human resources. These two levels are essential, reciprocally related but different, and require different expertise.

A first overview of these units looks at the institutional structure. In some cases, we found several human resource units: one in charge of personnel management; another in charge of training and, sometimes, social services; and another in charge of medical residencies. In other cases, plans show limitations, for example, by focusing too much on the educational conditions and neglecting other aspects: attracting and keeping the staff gaps, working conditions, contractual arrangements, and performance among others. From this reality, two initiatives, already known, arise: one is to develop and offer an online course on policies on human resources for health, as a working strategy in learning units under the concept of "learning by doing." The other strategy is CIRHUS, a training project in the Andean countries with Brazilian cooperation, which has allowed management to train leaders in their respective health systems, and then to be institutionalized in academic institutions in each country with curriculum adjustments based on the local reality. Both initiatives are aimed at strengthening the capabilities of management teams.

In the context of this meeting, we want to highlight a core idea. Governing capacity for plan formulations requires building the feasibility of such plans within the government. In order for plans to be feasible, they must have a solid financial basis, agreed decisions on staff training (which has to do with higher education institutions, academic institutions and others) and have adequate working conditions. The core element of thought on this event is this complex relationship between the Ministry of Health, as responsible for plan formulations, and feasibility achievement within different sectors of government. It has been noted that the action of the Ministry of Health has been addressed to external actors, such as universities and professional associations. The challenge today is to work within the government structure.

This is the first meeting gathering health sector representatives with other government players who are essential for plan formulation. This leads to the need to determine a set of key elements for intersectoral coordination. This is what we want to do at this event. We want to ask ourselves about priority issues and challenges for the dialogue between the Ministry of Health and other government sectors in order to know best practices in terms of consultation mechanisms and successful strategies for cooperation among countries. We are confident that by the end of this meeting, we will have made progress in finding the answers.

# Cooperation and Coordination between Sectors and Players: The Role of the Global Health Workforce Alliance

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DR. HIROTSUGU AIGA  
GHWA

The first thing that should be noted is the amazing progress shown by the countries of this region in human resources for health. Now, the challenge is to define what the GHWA can do for these countries and also the contribution the countries can make to the GHWA.

A key point to remember is that five of the 57 countries with crises in human resources are from Latin America; therefore, it is also necessary to focus on collaborative efforts in this region. The parties involved in the Global Health Workforce Alliance are 258 registered members and 29 active partners. Leader agencies, such as PAHO and WHO, and professional associations and a network of 158 members and 20 secretaries also make up the Alliance. The activities of our organization can be summarized as follows: (a) advocacy, (b) mediation, and (c) calculation.

In March 2008 the First Global Forum on Human Resources for Health was held in Uganda, Kampala. This meeting adopted the Kampala Declaration, its twelve calls for action, and the Agenda for Global Action. To achieve what was stated in the declaration and agenda, the following aspects are very important:

- **Workforce recruitment:** In almost all countries, recruitment is undertaken by the Ministry of Health. It is very important to consider the number of health workers: more health staff is needed.
- **Education and training:** In many countries, it is not the Ministry of Health's responsibility, it is the Ministry of Education's. This situation calls for coordination between both institutions, which is, in fact, one of the purposes of this meeting. On the other hand, a higher investment by the Ministry of Health is needed for staff training and continuing education. Improving quality by continuing education is also a function of the Ministry of Education.
- **Health personnel migration:** This involves the Ministry of Labor and, sometimes, the Ministry of Foreign Affairs.
- **Accreditation:** This involves health professional associations and the private sector.

- **Social recognition:** It is very important that the health worker be recognized and respected as a member of society. This also should involve NGOs and civil society.

Besides the issues involved, many stakeholders are involved: ministries of Health, Education, Labor, and Finance; health associations; private sector; civil society; and even some development partners like the Canadian International Development Agency and others. The coordination and involvement of all these actors, in addition to the simultaneous measures taken by other stakeholders, is essential. Through the Alliance, a comprehensive human resources plan was developed, taking into account all parties involved. This represents a philosophy and underlying principle of the GHWA.

The process must be transparent (this can be reached by bringing in different stakeholders) In order to gain public support. The involvement of many encourages the stakeholders to be part of not only the decision-making but also implementation. For example, the Ministry of Education should produce new employees and the Ministry of Health should ensure their continuing education.

It is important to clarify that a model is not intended for all the parties, and all the parties do not necessarily have to have the same model. A formula or recipe indicating how to do things step by step does not exist. Good foundations towards progress exist in Latin America and what matters is to maximize the existing mechanism. Progress in open dialogue with other sectors has been made.

The GHWA support is intended to accelerate the process already started and not to create a new organization. The unity of all the aforementioned actors makes the team operate as a national human resources committee. The GHWA seeks for exchange of views, experiences and awareness among everyone.

The proposed design model is based on the joint work of three regions; one of the 29 GHWA partners, the most proactive and leading in human resource issues in the country, will help accelerate the process; the human resources committee will monitor via the Internet. Latin America has made considerable progress; therefore, something different could be done and discussed.

Another model is one in which the National Committee of Human Resources sometimes has problems in finalizing agreements and seeks consultation with the GHWA, whereby a process of ongoing monitoring and consultation develops; but your Region may not want to follow this model.

What is expected from each country? The answer: to define their health-care provider's profile and their human resources. Some countries have already defined these but, in general, information on workers in the private sector is lacking. Based

on the country profile, each country from the list of critical countries is expected to develop this global plan in human resources. The next step is implementation of the plan. The process must be undertaken by the national committees working as a team to carry out, implement, evaluate, and monitor; in other words, to do everything.

Based on experiences in other countries such as Ghana and Vietnam, it has been understood that there must be a dialogue among all stakeholders at these meetings. When this didn't happen, the information between the actors was not sufficient. For example, one ministry did not know what the other knew. Workers' associations were also isolated. They were called involved parties, but they were not; so now is the time to involve them. The Ministry of Health should prepare a well-documented plan; it should be done by consensus so that those involved can feel ownership.

How to begin? First, it starts by opening a dialogue among key stakeholders. This has already been done in this Region, so the second stage comes, which is to organize a national committee on human resources for health with all stakeholders. Where it has already been done, it must be strengthened; for example, by inviting the missing actors. Then, the discussion about human resource issues in a more global manner should begin.

Finally, it has to be noted that if some countries have their own model, they do not need to implement this one. If this model is useful for them, they can use it. If those countries need to receive support from the GHWA, we will be happy to support them.

## Reflections on Main Findings from the Country Studies

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DR. CARLOS ROSALES  
PAHO

From the studies presented, the analysis indicates little coordination and coherence between the general health policy plans and human resource policies. This characteristic is very relevant, given the interactive nature of the relationship.

On the other hand, establishing links among government priorities, health care model determinants, financing and management of services with human resource issues, priority areas, development strategies and involved sectors can produce synergies for a consistent and sustainable policy on human resources.

The development of Human Resources Plans that define the required capabilities, increase in staff, working conditions and new competencies is a key process to generate and implement national health policies.

Studies and working groups seem to agree that the reinforcement of governance can be made through a human resources committee under the leadership of ministries of health by using the consultation mechanisms that each country has created and by addressing the subjects of interest from different perspectives.

A second element for reflection in the analysis and related to the aforementioned is the need to strengthen the capacity (staff, skills, structure, and financing) of the entity responsible for formulating the policy framework and human resource work plan.

Most of the studies state that Ministries of Health are responsible for formulating policies and plans for human resources; they also state that the involvement of other actors in these processes is necessary. The main differences that arise are related to how to participate and the type of participation of other stakeholders, whether it is for validation and negotiation of documents prepared by ministries or if it is a joint formulation process.

In addition, all countries stress the importance of health sector preconditions, such as:

- Political and technical strengthening of the governance structure for the development of Human Resources Plans
- Capacity development of staff in charge of this execution
- Modernization of reporting processes (work management) and calculation methodologies

- Generating opportunities for consultation from a structural perspective that legitimates intersectoral participation.

Unfortunately, the studies and work groups do not progress in explaining the issues related to responsibility (shared or not) for the execution of activities. Regarding work plan financing, they make reference to it as final activities of the plan: how to increase the workforce and undertake the training, etc., but not to the funding itself.

Some interaction and intersectoral issues highlighted from the studies and working groups are below.

#### Health and Finance:

- Developing mechanisms and methods of financial analysis to obtain adequate personnel according to service requirements and the possibilities of sustainable financing
- Funding linked to institutional development and the new problem-solving capabilities and profiles according to the population needs.
- Creation of strategies for analysis and joint budget negotiations between Finance and Health, based on the current social policy and the existing tax ceiling.

#### Health and Education:

- Renovation of the Primary Health Care vision based on the need for health teams and not only some professions.
- Development of competency profiles required for:
  - ▶ Staff training.
  - ▶ New staff training profiles (primary health care, family health, health policies and management).

#### Health and Labor:

- Elimination of precarious working conditions and, in some cases, precarious contracts (external and internal ones).
- Strengthening the coordination and implementation of a decent work strategy as a mechanism to monitor staff working conditions.
- Establishment of integrated information systems, including decent-work monitoring indicators.
- Development and strengthening of health careers.

# Lessons Learned from Intersectoral Case Studies

DR. HUGO MERCER  
GHWA

It is important to arrive at this meeting on Planning on Human Resource for Health and Primary Health Care, with the endorsement of country studies describing the existing situation on this matter. Case studies on the human resources situation in each country, although made in a very short time, responded to a similar guideline which allows noting some general observations.

The studies focused on “Challenges for social and inter-sector coordination.” They deeply analyzed the existence of management competence at a national level in human resources for health by verifying whether a unit responsible for human resources management policies existed, and whether an explicit public policy on this matter existed.

The studies reviewed documentary sources and obtained vivid descriptions through interviews with officials from Ministries of Education, Health, Labor, Economy and Finances, government agencies, congressmen, professional associations, universities, international agencies and civil society representatives.

TABLE 1: CASE STUDIES ON INTERSECTORAL ACTIVITIES  
IN POLICIES ON HUMAN RESOURCES FOR HEALTH

Country	Human Resources for Health Plans	Intersectoral Agenda	Coordination Practices	Challenges to Implement Intersectoral Activities
Bolivia	No	X		Funding with congressional approval
Brazil	Yes	Defined	Conference Committees	National coverage
Ecuador	Yes	Defined		Implementation mechanisms
El Salvador	No	X	Committee (CISALUD)	Funding
Honduras				
Guatemala	No	X		
Paraguay	No	X		Agreements and laws
Peru	Yes	X	Committees	

Case studies showed that a kind of temporal continuum among the analyzed Latin American countries exists. Some of them, like Brazil, began to discuss and create public policies to strengthen the health workforce more than three decades ago. Since then, the State’s responsibility for human resource policies has been defined and established; a unit within the Ministry of Health has been charged with the education and management of human resources for health; and workforce

training centers and accreditation agencies have improved. This structure implies a slowly ripening process and strong investment by all stakeholders, especially in the public sector.

The continuum goes from this successful and steady public policy to others issues that have recently begun a similar process. In the most advanced cases and in the incipient ones, it is noticeable how certain conditions facilitate the implementation of public policies in this area. A democratic system exists, which is responsive to the population's interests and demands. This, along with the trustworthy management of public funds, makes health workforce education an aspect valued by the society.

The ability to negotiate, develop and efficiently settle agreements among stakeholders is also a contributing factor to the best implementation of public policies on human resources for health. Everyone knows that having properly distributed qualified staff who are satisfied with their working conditions, facilitates the coordination of policies from different sectors. By definition, achieving such a coveted situation is a process; it is a chain of actions with contributions from the educational system, families, the employment rate, working conditions, access to communications, and physical accessibility in all areas of the country. Therefore, it is a complex coordination among sectors, actors, and interests that care for the quantity and quality of health workers needed to improve and maintain the health of the entire population.

All countries are interested in strengthening their ability in health workforce management. Creating units within the ministries with a legal framework to establish and apply long-term policies is a widespread need of all countries. This leadership capacity includes the public and private sectors, plus the ability to generate and use scientific research, to evaluate and monitor to ensure sound evidence-based decisions.

In summary, the case studies show a consistent will of the countries to strengthen national health systems oriented towards primary health care with universal and equitable coverage. To achieve this policy objective, securing personnel is essential; and for that, the willingness to work together and accomplish the task exists.

# Government Capacity and Governance for Management of Human Resources Public Policies

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DR. PEDRO BRITO  
*Advisor, PAHO*

In this presentation, we will point out some issues that have been highlighted at this meeting, which was initially perceived as very complex; however, we have to admit that the meeting has had excellent results.

In these three days, we have been lucky enough to listen and share experiences, problems, progress, know-how, and problem-solving methods, with great depth around an important question and one of great responsibility: How are policies, plans and programs related to Human Resources for Health being implemented to transform health systems based on the Primary Health Care strategy and to ensure universal health access to citizens?

Significant progress has been made in understanding matters regarding human resources for health and the management of policies, plans and programs in the countries of the Region. We recognize that this is a complex and heterogeneous field with different actors and processes and also different influence politically within different institutional cultures.

For this reason, interdisciplinary and intersectoral action are needed. It is from this perspective that the challenge was raised to invite representatives not only from the health sector but also from others, such as education, labor, planning and finance. It takes a great level of maturity to recognize that health is not an autonomous field; it is a politically subordinate field; it belongs to a system, and also to a project of the government and society.

Another point to highlight is the importance given to the larger context within which we work. The economic and political situations of the countries have remained in the background which explains why we are working to transform health systems with a very different perspective from that of the 1990s. In all cases observed, we are witnessing the strengthening of democracy and a greater maturity of institutions. In many countries, public policies are more stable, which shows a depth of experience. Mandatory changes are no longer implemented with the arrival of each new government. Fortunately, we are not experiencing the economic crisis that some countries in the North are experiencing. This time, developing countries have had some advantages and favorable conditions to weather the storm.

The importance of the political dimension of management has also been noted. We are talking about public policy management as a political function, which is part of a larger project: the transformation of the health system. It is the application of a government proposal aimed at a different society project. So talking about policy management implies the transformation of the Human Resources for Health Policy. When public policy was discussed at this meeting, the discussion was on a project to redistribute the power. Public policies are made to favor some over others or to favor some that should have been rewarded but were abandoned. Redistribution of authority is the backdrop present in any project to transform a health system. That is, a government project that determines the health workforce field is a project to redistribute authority in the society.

To illustrate this fact, a triangle can be used as a framework to locate the government's project at the apex and, at the two bottom corners, the ability of government (or governance) and governability. Some teachings related to government capacity (what must be done to achieve this transformation) and governance (how and with whom to do so) have been given. The triangle eloquently shows the predicament of sector leaders and managers from health and other sectors: functions, daily responsibilities, the moment at which they have the responsibility for managing legal and regulatory mechanisms and resources to fulfill the mandate given to government.

Regarding the ability of government, we can resume a recent past reflection about how the ability of government was destroyed by the processes of the 1980s and 1990s. With the idea that the State was not necessary because the market had the capacity to generate and distribute resources appropriately, it was argued that there was no need to have capacity to govern. Therefore, with the neoliberal reform of the State, among other things, reductions in personnel and human resource units in the Ministry of Health were undertaken. Some units disappeared. These reduction processes were resisted by very few countries. Colombia was probably the most orthodox country in applying the health system transformation from a market perspective. However, we must remember that for a long time before this, Colombia have had one of the best human resources ministries across the Region with a perspective with which we disagreed; however, it had the technical capacity to maintain a given system that we recognized. All this was destroyed. In other countries the process was not so extreme, but it was the trend. Human resource policies were replaced by investment projects or institutional development financed by banks, and the intervention mechanisms were raised in terms of bids, public bids, for tasks that had to be performed by the reform. Planning, regulation and management mechanisms were canceled. Some countries managed to weather the storm, but other bodies disappeared; the technical capacity of these units were drained because the projects required coordination or executing units

that paid better; and national human resources were taken away to work on the projects. Capacity not only vanished, but also disaggregated. So, when reviewing the country studies for this meeting, the reorganization of their units was posed as well as the reconstruction of the capacity that had been destroyed.

We also learned that public policy building is a slow process. Brazil, for example, has been working on it for 22 years. The experience of almost all countries that have succeeded in rebuilding their institutions shows that it is a long process; however, it needs to be done, not only in human resource units, but in all instances and elements that are necessary for health governance and human resources policies.

In this regard, three elements are necessary for government capacity on health:

- **Institutionalism:** Institutions, rules of play, norms, the ability for political action, social dialogue committees, participation, meeting places, etc., are generated by the initiative of the governing entity, but they involve the participation of other sectors from the government and society, including social movements and social actors. All this is institutionalism, the basis on which governance is performed. This goes far beyond government charts. This is democracy for participation, social dialogue, effective mechanisms of participation, flexibility in mechanisms and resources, and long-term and medium-term strategic visions so that everyone is moving in the same direction. It is about conditions for sustainability, durability, technical competence, knowledge, technologies, and appropriate use of scientific and technological development in order to govern.

It is also important to build essential functions or core competencies for human resource units, which consist of the ability to promote policies and planning. All societies in the region, perhaps with the exception of Cuba, are market economies; therefore, it is necessary to plan, regulate and build management capacity. Economists often say that some markets, such as health or labor, are imperfect and, if they are not regulated, the distortions and inequities may be worse. The negative effect of these “imperfections” is precisely what has been experienced in the last 15 years. Therefore, government capacity to plan, regulate and manage is essential. These capabilities are not mutually exclusive. Regulation does not mean stop planning; in contrast, planning cannot be done without regulation, or regulation without management.

- **Availability, access and ability to execute financial resources:** The Ministry of Finance in almost all countries responds uniformly in a negative manner to requests for financial resources for social policy in govern-

ments that are not homogeneous. Within the same government, ministers compete for resources and ministries of Economy has to juggle to make the electoral commitments compatible with the requirements of shortage, emergencies, and pressures from those with power. I remember that a governor of an Argentine province called the financial resources “leading feasibilities.” Dr. Rodriguez made reference to Sergio Arouca, who spoke of and upheld the right to health as a State’s responsibility, and the need to fund it by referring to the creation of Unified Health System (SUS) in Brazil.

There is no reform that does not involve an additional investment. The financing panel of this event made a good description of dilemmas and some approaches to those dilemmas. It is not possible to negotiate with Finance only with a staffing plan because it is part of a larger body that is more important and transcendent, which is the transformation of the system, and ultimately a public policy towards universality and right to health. Discussion must be addressed politically and not only financially. Regarding the funding, we learned that government is not homogeneous. Can political will exist without a correlate budget? A huge responsibility to fulfill the commitments exists. We talk about a project that is more than a policy on human resources. It is a project to transform the system, in which the workforce is a fundamental element.

This leads us to emphasize the importance of the political-economic context for the changes that are occurring in many countries and that are creating conditions for a substantive transformation. There is no fundamental change in a health system that has not attracted citizen support. That’s why there are health systems defended by citizens. For example, Chile resisted the complete transformation of the health system into private market, even in the most difficult moments of the dictatorship, the National Health Service of Chile continued, and covered over 70 percent of the population. The British, Cubans, Costa Ricans, and Brazilians, support them because they were processes of change with new social pacts generated by citizen support. These days we have learned that strategic alliances are necessary and social movements are the main guarantors of the transformation. It’s about doing what we have to do in order not to go back. This requires ensuring conducting feasibilities.

- **Need for knowledge and information for management, policies, plans and programs.** Important progress has been made. Some countries have a critical mass of information and knowledge as a firm basis to make decisions. But in most countries adequate information systems remain as unfinished business. They do not have timely, appropriate, sustainable, high

quality information systems. Questions have to be asked and answers have to be given through research.

In terms of governance, what do we do? How do we put plans and policies into practice? What ability do we need to implement and comply with policies? It is a matter of political process. There is a process of political leadership, not just to fill squares with people, but to mark established roads, definitions and signs that shows the path. Many countries walk towards solidarity and universal systems based on primary health care; however, it is difficult to put Human Resources Plans into practice without a definition of a care model and management model.

The care model emerges from the national reality. The example of Bolivia is clear. A care model cannot exist if the plurinational, multi ethnic and intercultural nature of the country is not taken into account. All our countries have curative models. We need to strengthen prevention and health promotion in a context of social participation. But definitions are missing such as those related to the economic reform project of the health system and system financing. A health system financed with tax and fiscal resources is not the same as a strategy of universal insurance, although the two projects would grant the right to health. The most common system is a mixed one, where the state's role is crucial when there is not sufficient ability to pay. This should not mean that, as State policy, the fragmentation of systems according to fund-raising capacity has to be preferred.

The other major process that has been learned in these days is democratic participation, which is the core element of political feasibility. Positive examples of dialogue and negotiation exist. The process is complex, difficult, and the challenge is how to sustain it, make it effective, and open it to the players who will support the change.

Another aspect to be considered is setting a political agenda in order to negotiate, agree to work on what is primordial based on what unites rather than what separates. The question is where to start. Strategy is crucial. In some cases we define a gradual agenda, which begins to explain what works, allowing the actors to participate effectively. Other possibilities exist in other contexts where a more direct and profound transformation can be made.

Management skills for human resource policies can be acquired in training courses for directors, executives, and managers. Some countries are giving those courses. PAHO seeks the continuity of the observatories and I think we should continue with that line. The Global Alliance of Human Resources for Health offers resources to see if this that has been done in

a few countries can be done in each country with all stakeholders at national level, and to explore the potential of sub-regional integration bodies. Other bodies are being created for working, learning, and moving forward together. The important thing is to maintain and deepen these initiatives to strengthen the steering role of the ministries of health in our Region.

PART ONE

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## CHAPTER 2

### BUILDING AN AGENDA FOR INTERSECTORAL COORDINATION

Health and Finances

Health and Labor

Health and Education

## Health and Finances

*((Ministries of Finance and Economics,  
Treasury, Planning and Development, and Health))*

### *Human resource strategy within a national strategy framework of health, economic and social development*

The first Committee's finding is that all countries in the Region have limited resources in a context of unlimited needs, in the social area in general, and in the health sector in particular.

It is necessary for governments to build a national project to facilitate the definition of resources for the health sector. The nation's highest authorities are responsible for defining a financial framework for social spending. In this scenario, the dialogue between Health and Treasury, rather than an intersectoral negotiation, should be a joint effort aimed at organizing financial resources to implement public health policies based on the country model that has been defined.

The following topics were addressed:

- Identifying, at a country level, the increase of available human resources for health and the number of human resources considered as optimal from the point of view of a strategy for the country's economic and social development. Identifying these gaps will allow for the definition of investment plans to train human resources for health as part of an economic and social development strategy for the countries.
- Differentiating the human resource gaps in the public sector and nationally. The emphasis on investment strategies should be put on the public sector. Differentiating between public sector and national gaps allows the countries to identify the possible role that wage policies play in the public sector to close the gaps with existing human resources at the national level. Determining the cost of incentives to close the HRH gaps will help determine the fiscal needs to achieve optimum quality and quantity of human resources in public health systems.
- The intersectoral dialogue needed to go forward in the national agenda for human resource development requires that the society and health system be defined within a national development strategy framework. It is not enough to present the issue of human resources as a management problem. A social pact is necessary to move forward tax reforms that would allow progress on policies oriented toward public health systems with universal coverage.

### *Financial management and human resources for health management*

For the health sector, resources should focus on employment instability by generating stable labor systems (health career); yet, at the same time be flexible enough to offer incentives for specific functions, e.g., jobs in remote areas. Given this, it is necessary to:

- Identify position (the quantity) and wages (rate) gaps that exist among different states (provinces and/or counties) that may cause inequities and uneven distribution of human resources in public sector institutions in the countries.
- Assess the impact on the level and composition of human resources in public sector health institutions, policies on unstable employment and/or hiring restrictions, and salary ceilings for public institutions.

### *Improving knowledge of planning, budgeting and financial management tools in the Public Sector*

Health managers believe that it is necessary to know the amount of public-sector financial resources available in order to implement their processes. Planning is not possible without knowing the budget framework. In this regard, it is necessary to:

- Identify and use financial and budgetary management instruments to ensure the allocation of human resources for health in public institutions and identify legal and labor issues that prevent effective management of human resources in public health institutions in the country.
- Exchange experiences with other countries on issues related to the definition or redefinition of roles and functions; standardization of contract types; control mechanisms for human resource management (contracted-hours versus actual work hours); distortions in labor markets and health services resulting from private practice of professionals from public institutions; and the impact from the variety of existing contracts and positions in public institutions.

From the finance sector perspective, the health sector is responsible for financial calculations of any plan or initiative it wants to undertake, which should be framed in a defined management model. For their part, health managers need frameworks to guide their spending budget. The finance sector requires that the health sector spend what was actually allocated.

Committee members agree that each sector lacks knowledge of the other's functions and modalities—the concept of “collective ignorance.” It is imperative to have joint work planning based on a defined policy, rather than a budget negotiation without further clarification from the parties involved.

# Health and Labor

*(Ministries of Labor, Civil Service and Health)*

The Committee believes that labor management is not an end in itself but a goal towards improving services for the users. This means the analysis should include the themes of ethical practice, and commitment to services and the public.

In this context, the changes in labor management policies occurring in the Region are noticeable; they originated from the need to make changes in the health systems, with a more inclusive view towards the population, as opposed to the reforms of the 1990s, which were characterized by unstable employment that negatively impacted the quality of services provided.

This new scenario opens up new challenges for health worker management. The following are some of the most important challenges:

- Adequate information, both the quality and quantity, for decision making on labor management (according to the requirements of public functions, organization and supply of services).
- Development of mechanisms for negotiation and consultation with workers as a strategy to provide sustainable actions.
- Promotion of health careers and their coordination and harmonization with the civil service career.
- Institutional capacity development: new staff skills (profile redefinition) and professionalization of the management function.
- Implementation of comprehensive health policies for health workers.

Along with the challenges outlined, several critical issues exist that may hinder their approach and these should be addressed across sectors:

- Unequal compensation (salaries vary greatly).
- Migration of health workers.
- Critically-needed professions.
- Labor unrest and lack of negotiation mechanisms.

In order to address the aforementioned, the Committee proposes the following lines of intersectoral work:

- Define mechanisms for integration of information from the involved institutions

- Establish a relationship between the Health and Labor parties beyond emergency communications caused by conflicts.
- Set a decent intersectoral work policy that includes worker health and union agreements, among other priority issues.
- Strengthen information exchange and documentation on good and bad practice.

## Priority Issues

The group identified some priority issues the current national contexts:

- **Reorientation of undergraduate education towards Primary Health Care.** The programs have to clarify the meaning of Primary Health Care and define the new competencies that professionals will need under this approach; teachers will have to be involved in managing this paradigm shift to ensure change. Changing curriculum or study plans is not enough. Making a paradigm shift is not possible without changing the structure of thinking of those responsible for medical education. Contributions to this new educational focus is a theme that causes concern. Also, the concept of an interdisciplinary model remains, in most cases, merely a conversation.

Universities require further definition from the government, the health systems, and actual headway in building networks based on Primary Health Care. It is necessary to redefine the stages of practice or clinical fields; they cannot remain exclusively in hospitals. Similarly, salary schemes ensuring health workers continuity at different levels of the health system are needed. In these aspects of health action, it is important to move from institutional policies to public policies and to adopt Primary Health Care, not as a label, but as a strategy that links values of equity and justice as a bridge linking health services to people.

- **Education of health specialists through medical residencies.** Training programs have proliferated and the issue of medical residency is a major problem in almost all countries: the type of profiles, the number of programs, the ability of hospitals to supervise the learning process, the lack of educational programs and lack of coordination between academia and services, mistreatment of residents, and the use of residents in hospitals are considered. Notwithstanding the above, the experiences of integrating teaching assistants are valuable; The need to redirect this practice is recognized; it was considered a good experience in the past but has been lost over time.
- **Regulation**
  - ▶ **Quality regulation through the accreditation process.** Many countries in Latin America have begun accreditation processes for medical training programs. These processes seek to improve quality. They are

seen as positive partnerships established among countries that are evaluating the standards proposed by the Ibero-American Accreditation Agency of Physicians, which places Primary Health Care at the core of training. This is a clear example of intersectoral action because the ministries of Education, in most cases, established the mandatory accreditation of educational programs.

Some countries have addressed the need for curriculum homogenization with the minimum requirements for Primary Health Care according to the public's needs.

- ▶ **Professional certification:** Some countries have started the accreditation processes and others are making progress. Several diverse proposals have come from medical schools and professional associations and have been considered by the State. Some proposals are from the Ministry of Health and are associated with continuous training processes related to the approach of health prevention and promotion.
- ▶ **Regulation of educational institutions (opening of new universities).** The market deregulation brought the deregulation of educational institutions; as a result, medicine and nursing schools were founded. The former develop traditional training programs that focus on illness, healing and hospitals. Many countries train physicians and nurses for export to other countries.
- ▶ **Regulation and accreditation of physicians trained in other countries.** Some countries raise the issue of professional qualifications of graduates who return home from foreign schools and then their colleagues create barriers to prevent them from entering the labor market.
- ▶ **Diversity of educational laws and conflicting perspectives.** Numerous laws and regulations for each of the ministries exist, which makes it difficult to establish necessary controls and supervision mechanisms.
- **Lack of national development plans and work agendas on human resources for health.** Most countries have or have had in the past national intersectoral committees; some were created by law. Some have made progress in identifying common problems but not much in building public policy; others have disappeared at some historical moment and then re-emerged at another time adopting new sizes and functions.

The plans for development of human resources always remain as proposals for intersectoral work; their implementation is hampered by various conflicts of interests beyond the ministries and universities.

- **Coordination between working groups working from both sectors.**  
In some countries, in addition to national plans, it is important to set up working groups between Health and Education in order to address specific issues.

### *Major Obstacles*

- Lack of definition of health sector reforms and health systems based on Primary Health Care.
- Interinstitutional intolerance and that of interest groups.
- Lack of policies and plans of human resources.
- Deregulation of education and the problem of misunderstood “university autonomy.”
- Current paradigm of health seen as a commodity.
- Unclear new curricular guidelines.
- Resistance to change.
- Lack of social commitment from health workers.
- Health workers’ and teachers’ lack of knowledge of continental and world mandates.

### *Mechanisms and Factors that Can Facilitate Change*

- New information technologies, communication, and network learning.
- Role of science and technology.
- South American integration.
- Economic recovery in many countries of the sub-region that could overcome the same crisis of the core countries.
- Democracy in the region.
- Growing awareness of the need for intersectoral dialogue.
- The current situation, which allows for a better institutional order.
- People’s growing claim of citizen rights.
- Recent UNESCO recognition of education as a public asset.
- Possibilities of sharing experiences and belonging to learning networks.
- Increasing need to make short-term and long-term projections of the situation of human resources, and the possibility of engaging both sectors in broadened discussion forums.

PART ONE

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## CHAPTER 3

SAN SALVADOR'S  
COMMITMENT: DEVELOPMENT  
OF HUMAN RESOURCES PLANS  
WITHIN THE PRIMARY  
HEALTH CARE CONTEXT

## San Salvador's Commitment: Development of Plans on Human Resources in the Primary Health Care Context

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Representatives of the Ministries of Health, Education, Civil Service, Labor, Treasury, congressmen, representatives of professional institutions and the civil society from Brazil, Bolivia, Ecuador, El Salvador, Honduras, Guatemala, Paraguay and Peru, gathered in San Salvador city, on 4th, 5th and 6th of May 2010, at the Workshop on Human Resources Plans and Primary Health Care: Challenges and Social Inter-sector Coordination, organized by the Alliance Global Health Workforce and the Pan American Health Organization with the collaboration of the Ministries of Health of El Salvador and Brazil, after having analyzed the situation of political and Human Resources Plans of our countries, we state the following:

- Serious social and economic inequities continue in our countries, with a direct expression at health levels of the population and in the access to services and appropriate health personnel for families and communities they serve, with the required quality, both human, cultural and technical.
- In this historical situation, we are witnessing processes of transformation in our societies and processes to deepen the democratic scenario in which social movements and health claims, including those of indigenous people, give a fundamental contribution.
- In many countries, the social transformation processes are reinforced by political will at the highest level and state policies aimed at reducing poverty and social exclusion, asserting the right to health and the extent of social protection and health care coverage, forming a new social pact.
- State Policies are a challenge for governments and public agencies in achieving permanent redistribution effects. They require innovative strategies in the development and building of feasible policies, plans and programs.
- The commitment to the right to health and primary health care involves that our government search strategies, practices and mechanisms for inter-sector coordination in building quality, viability and sustainability of policies and Human Resources Plans aimed at closing gaps between health personnel and needs.

In view of the aforementioned, we restate our commitment to the right to health and the strengthening of social protection systems, and express our will, under the principles of solidarity, mutual support and cooperation to the following:

1. **Government Capacity Building** for the promotion, development, implementation and sustainability of policies and Human Resources Plans for the transformation of health systems towards equity, universality and the right to health in the frame of a health primary care strategy.
2. **Promoting a culture of dialogue**, exchange and mutual learning among key sectors of government to develop policies and human-resource-for-health plans, in a frame of shared responsibility for government policies.
3. **Build, strengthen and sustain institutional areas and mechanisms** to exchange information, analysis, planning, coordination and consultation with key government sectors, particularly the sectors of Finance, Planning, Education, Civil Service and Labor, at the different levels of health system management and relevant social actors.
4. **Deepening the process of change, management and institutional development** of planning, regulation, management of education and health work and personnel management of ministries of health.
5. **Development of integrated management information systems** on health human resources, and collaborative reporting networks.
6. **Exchange of experiences**, expertise, models, methods, studies and other relevant resources to solve the problems about health workforce management policies.
7. **Jointly take advantage of the possibilities of support** and cooperation among countries with international organizations, with the instances of integration and the actual capabilities of each country.

San Salvador, May 6, 2010

## PART TWO

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# COUNTRY STUDIES ON HUMAN RESOURCES PLANS AND PRIMARY HEALTH CARE: CHALLENGES FOR INTERSECTORAL AND SOCIAL COORDINATION

Study Methodology

Bolivia Study

El Salvador Study

Guatemala Study

Honduras Study

Paraguay Study

Peru Study

The following guidelines were used for preparing country study papers.

The papers were to constitute the main component of the presentations given by the participating country delegations. Preparation had to involve the country delegation members; the information had to be relevant for developing national plans for human resources in the participating countries.

To promote the commitment of national health authorities, the professionals responsible for the papers' preparation were appointed by those authorities, in consultation with PAHO's country office. They would be, preferentially, national professionals working closely with a group created for this purpose in the Ministry of Health (Directorate of Human Resources), which could also work jointly with experts from the sectors of economy, finance, labor and education.

The methodology proposed for the preparation of documents included the following steps: (a) identification and review of existing documentation, such as policy statements, strategies, plans, legal frameworks, and evaluation of plans; (b) implementation and analysis of data obtained from semi-structured interviews with key officers of the ministries; and (c) discussion and validation of findings by the members of each delegation. The countries could add other aspects.

Suggestions were to have at least two Elluminate web conferences with the staff responsible for the country's papers; the first one at the beginning of the process to communicate the objectives and methodology and to answer questions, and the second one at the middle of the process to ensure that common criteria were being followed in the preparation of documents.

The paper should have the following contents:

- Development of human resource for health policies and transformation of health care models. This should include:
  - ▶ Policy frameworks for health system transformation. The purpose of this section is to describe the vision, strategic directions and policy framework for the transformation of the health system, with special focus on the renewal of primary health care.
  - ▶ Policy frameworks for human resources. The objective of this section is to describe the vision, strategic directions and framework for human resource policies to support health systems based on Primary Health Care.

- ▶ The participatory process in the development of human resources policies. This section analyzes the country's experience in mobilizing the relevant stakeholders for the formulation of policies and determining the feasibility of Human Resources Plans.
- Development of Human Resources Plans and coordination with key government sectors.
  - ▶ Progress in the development of the human resources for health plan.. The framework of the human resources policy has an impact on the Human Resources Plans of. This section examines the progress made in the formulation and implementation of plans, their main components, constraints or problems
  - ▶ Coordination process with key government sectors. This section analyzes the relationship among the Ministry of Health and the ministries of Finance, Labor and Education in building the feasibility of the human resource plan of.
- Analyses, reflections and recommendations. This section presents comments and core ideas from the discussion among members of the country's delegation and the highest authority on health regarding country study findings and the authors' reflections and recommendations to improve the quality and viability of Human Resources Plans through consultation with key stakeholders.

At this workshop, studies of the following six countries were presented: Bolivia, El Salvador, Guatemala, Honduras, Paraguay and Peru.

### Introduction

This document—Analysis of the first approach of sectoral coordination with the ministries of Education, Labor, Employment & Welfare, Economy & Finance on the implementation and execution of the Policy on Development of Human Resources for Health in Bolivia—shows the culture of coordination among state sectors in our country. It also shows the values of government and the Ministry of Health materialized in the National Economic and Social Development Plan: An honorable, sovereign, productive and democratic Bolivia for “Living Well,” and the Sectoral Plan of Health.

On January 22, 2006, Bolivia began a new stage in its history filled with hope and great challenges. The government posed the need for building a “Democratic and Cultural Revolution.”

*“The proposals and orientations of the National Plan of Development constitute the basis and beginning for dismantling colonialism and neo-liberalism in our country. They also represent the current secular claims of people to build a Multicultural and Communal State; which will permit the empowerment of social movements and emergent indigenous people. The main goal of this plan is to provide good living to Bolivians.”<sup>3</sup>*

The Sectoral Plan of Health, and therefore, health policies, is part of the National Plan of Economic and Social Development of the government. The Policy on Development of Human Resources for Health was based on the directives and guidelines formulated in the Sectoral Plan of Health.

### 1. Background

December 18, 2005 is the greatest turning point in Bolivia’s history because of the overwhelming victory of an indigenous candidate—Evo Morales Ayma—in the Presidential election held that year.

The National Development Plan falls within the context of “the socioeconomic, political and cultural changes promoted by social movements.” The plan is based on those proposals. The first version was presented to the social movements and the President of the Plurinational State in June 2006. The document was publi-

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3. Government of Bolivia 2007. National Plan for Development. “Bolivia Digna Soberana, Productiva y Democrática para “Vivir Bien” D. S. N° 29272, del 2007. Official Gazette of Bolivia.

cized nationwide to be reviewed and adjusted as needed. The final revised version was approved in September 2007 by Supreme Decree No. 29272.

The development of health policies and, thus, the Sectoral Plan, followed the same procedure of consultation, analysis, reflection and proposal to the organized civil society. In 2006, the Ministry of Health and Sports called nine pre-constituent departmental workshops and one national workshop to systematize the proposals presented at the departmental workshops. These conclusions contributed to a Sectoral Plan of Health, which was approved along with the National Development Plan.

The Policy on Human Resources for Health Development of supports the proposals and orientations of the National Development Plan and the Sectoral Plan, and therefore, the health policies. This policy and previous ones were developed with participation of organized civil society.

The development of the Policy on Human Resources for Health Development began by mid- 2007 and approved by a ministerial resolution in December 2009.

## **2. Political Framework for the Transformation of the National System of Health**

### **2.1. General Political Framework (Constitution of the Plurinational State of Bolivia)**

#### *Constitution of the Plurinational State*

It is the rule of law guiding the transformation of society and the State in general, and sectoral policies in particular.

Chapters/ Sections	Articles	Content
<b>Second</b>	<b>Fundamental rights</b>	
	Art. 18. I.	"All people have the right to health."
	II.	"The State shall guarantee the inclusion and access to health to all people without exclusion or discrimination."
	III.	"The Unified Health Systems shall be universal, free, equitable, intercultural and participative. It shall offer high quality services, warmth care and social control. The Systems shall be based on principles of solidarity, effectiveness and responsibility. It shall be developed through public policies at all government levels."
<b>Fifth</b>	<b>Social and economic rights</b>	
Section II	Right to health and social security	
	Art. 35. I	"The State shall grant the right to health at all its levels by promoting public policies oriented to improving the quality of life, collective welfare and free access to health care services."
	II.	"There is a Unified Health Care System; it includes the tradition of nations and indigenous people."
	Art. 36. I.	"The State shall guarantee access to universal health coverage."
	Art. 37.	"The State has the ineludible obligation to guarantee and support the right to health, which is a higher function and a primary financial responsibility. It shall prioritize health promotion and disease prevention."
	Art. 40	"The State shall guarantee the participation of organized people in the decision making and management of the Public Systems of Health."

### *National Development Plan - "An Honorable, Sovereign, Productive and Democratic Bolivia for Living Well"*

The National Development Plan seeks to build a new society based on the energy and capacity derived from the multicultural backgrounds of the people and the diversity of practices in urban and rural communities to build a new way of national organization. This new way is supported by the new institutionalization reaffirmed by a new socio-communal State, decolonized and founded on rural and urban sociocultural diversity, which is the expression of the diversity of interests and aspirations of change for "Living Well."

According to the strategic guidelines of the Development Plan, all territory and sector plans must incorporate the objectives related to the four pillars of the plan:

- **Pillar I. Honorable Bolivia.** Its objective is: *"To eradicate poverty and inequity in order to achieve an equitable pattern of distribution and/or re-distribution of income, wealth and opportunities..."*

- **Pillar II. Sovereign Bolivia.** Its objective is: *“To contribute to building the State as an international, sovereign, and self-determined player, with its own identity, through a foreign policy aimed at political and diplomatic interactions with people and by protecting natural resources and biodiversity...”*
- **Pillar III. Productive Bolivia.** Its objective is: *“To transform the productive model through a diversified and integrated change by achieving the development of productive and integrative complexes, and generating surplus, income and employment to change the primary exclusive exporter pattern.”*
- **Pillar IV. Democratic Bolivia.** Its objective is: *“To build a society and a Plurinational and socio-communal State, where people exert political, social and communal power and are co-responsible for the decisions about their own development and that of the country. People not only choose but also repeal mandates by exerting social control...”*

The National Development Plan constitutes the tool *“addressed to eradicate the deep social inequality and inhumane exclusion that oppresses the majority of Bolivian people and particularly the indigenous people and peasants. This requires a change in the pattern of development from the primary exporter, which starts by transforming the productive model. It requires the dismantling of neoliberal colonialism, decolonization of the State and building of a new Bolivian identity based on a plurinational institutionalism with intercultural and communal approach.”* At the same time, the development proposal is founded on the idea of *“living well,”* a claim for humanization where cultural diversity assures social responsibility and obligation in public management. Thus, development becomes a collective process of action and decision making by the society, which is seen as an active participant rather than a passive recipient of top-down directives.

*“Living Well”* corresponds to *“...a pattern of development and a comprehensive, plurinational, and diversified democratization where development and democracy have equal importance. No development exists without democracy, without welcoming the participation of society in economic, political and cultural activities and decisions.”*<sup>4</sup>

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4. Government of Bolivia 2007. National Plan for Development. “Bolivia Digna Soberana, Productiva y Democrática para “Vivir Bien” D. S N° 29272, del 2007. Gaceta Oficial de Bolivia.

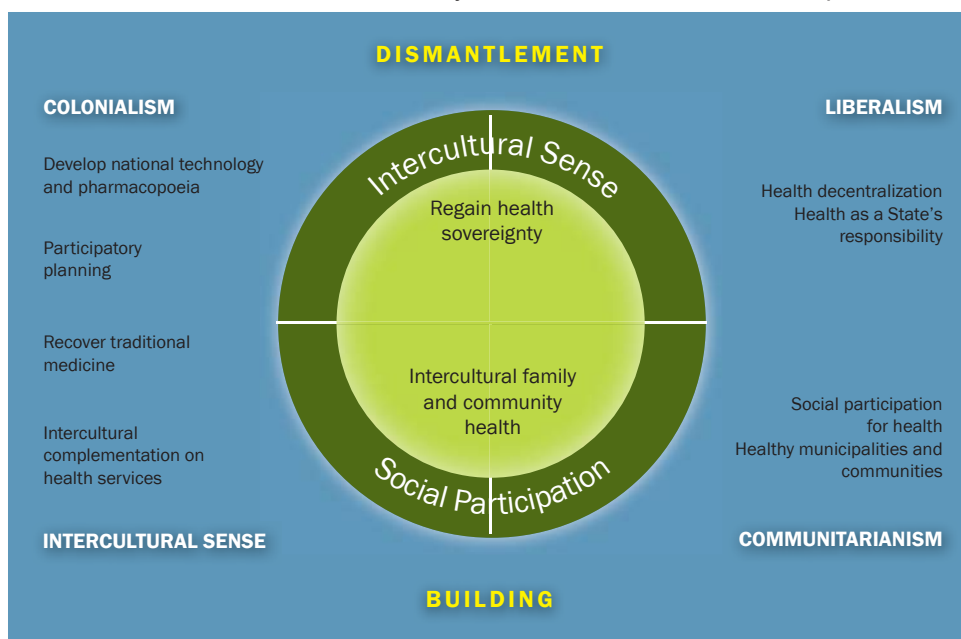
## 2.2. Sectoral Political Framework

### *Sectoral Health Plan*

The Sectoral Health Plan, approved by the Supreme Decree No. 29272, highlighted the exclusive and inequitable characteristics of the health system and services. This situation worsened during twenty years of neoliberal government policies, with logic of universality and homogeneity corresponding to a paradigm of a State/Nation in crisis and a highly economic reductionist view and, therefore, dehumanizing. In those decades, the health sector experienced budget cuts as a result of the State downsizing. There was a proliferation of private health care centers and services, salary crisis and job losses caused by the displacement of workers from one strategic sector of production and services to another. These factors increased inequality, decreased access to health care, and weakened the public sector institutions. As a result, the so-called diseases of poverty increased.

To reverse the precarious health condition of the population, the national government has defined a new social policy focused on promoting health and social security. Within this framework, the Ministry of Health and Sports, with a sectoral and comprehensive vision, proposed to eradicate social exclusion by recognizing social issues as a whole for measuring the current health condition and formulating coordinated proposals to solve health problems and achieve socioeconomic change.

The Sectoral Health Plan is closely related to the National Development Plan.



## Health Policies

### ■ Unified, Communal and Intercultural Family Health Care System

This policy seeks to overcome any form of exclusion and discrimination on health for economic, social and cultural reasons through the universal health care access and by serving the most remote locations. **This policy is a mandate established in the Political Constitution of the State (C.P.E is its acronym in Spanish), Art. 18, Section I, II y III and Art. 35. Section II.**

### ■ Sectoral Leadership

This policy seeks to regain and consolidate the sovereignty and stewardship of the Ministry of Health and Sports over the health system by leading sectors with a greater capability of management to guarantee the financial sustainability of the sector and protect the health, living conditions (housing and access to basic services, etc.,) and work of all Bolivians and their relationship with the environment. **It is established by the C.P.E., Section III. Ministries of the State; Subsections 1 through 8, Chapter VIII: Distribution of Competencies. Art. 298, Clause II Exclusive Competencies of the State's Central Level. Clause 17.**

### ■ Social Mobility

*"This policy seeks to promote the active and responsible participation of citizens by guaranteeing the development of the human capacity to act in liberty, to empower health committees at a local, municipal, departmental and national level in order to achieve good management and social control."* **This Mandate is established in the C.P.E. Title VI: Participation and Social Control. Art. 241, Clauses I to IV, Art. 242. Subsection 1 and 2.**

### ■ Health Promotion

*"It seeks to regain the responsibility of the State for promoting a culture of comprehensive health for quality of life by establishing sectoral alliances to influence in socioeconomic, political and cultural determinants affecting directly or indirectly affecting the health and lives of the first indigenous peasants, Afro-Bolivians and the middle class."* **This policy is a mandate established in the C.P.E, especially in Art. 37 and 16, 17, 19 and 20, of the Second Chapter of the Fundamental Rights related to the determinants.**

- **Solidarity**

*“This policy seeks to carry out a National Alliance focused on eradicating violence and malnutrition, on rehabilitation and prevention programs, equal opportunities for disabled people, and the inclusion of vulnerable groups living in extreme poverty.”* **This is established in the C.P.E., Section VIII: Rights of Disabled People. Art. 70. Subsection 2 and Art. 72.**

- **Traditional Medicine and Multiplicity of Cultures**

*“This policy seeks to resume the herbal pharmacopoeia utilized by our ancestors, which makes up the active ingredients of any medicine. It is also focused on generating mechanisms of reciprocity and complementarity in health care processes, and old former experiences such as the care given before, during and after childbirth by communal midwives and ethnic native physicians.”* **This policy constitutes a mandate established by the C.P.E. Art. 42, Clauses I, II and III.**

- **Human Resources for Health Development**

No policy, whether it is economic, social or cultural, will have a long-lasting effect if the human resource factor is not taken into account; it is the means to achieve the objectives. This policy, therefore, constitutes the central axis of changes and transformations proposed by the health sector.

### 2.3. Family, Communal and Intercultural Health Care Model (Sectoral Plan of Health)

The Family, Communal and Intercultural Health Care Model, has been approved by Supreme Decree No. 29601 of 2008 and, therefore, constitutes a fundamental component of the official policy of the Ministry of Health and Sports.

The Family, Communal and Intercultural Health Care Model constitutes the **new way of thinking, understanding, feeling, and doing** health in diverse and multicultural scenarios (Ayllu, Tentas, Markas, captaincies territories, neighborhoods, native community lands.) It involves, links and coordinates physicians, traditional midwives and certified physicians with individuals, families, community and its organizations in terms of health care and management.”<sup>5</sup>

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5. Ministry of Health and Sports. Unit of Public Health and Social Mobilization 2009. Salud Familiar Comunitaria Intercultural. Technic-strategical document. N° 171. La Paz – Bolivia.

## *Objectives of the Family, Communal, and Intercultural Health Model*

*“To assure that health is exerted as a fundamental right so that families and community can receive the type of health care that not only addresses illness itself, but also its harmony with the integrity of the person, the community and Nature by accepting and valuing what they feel, know and practice”<sup>6</sup>.*

## *Principles of Family, Communal, and Intercultural Health*

- Social and communal participation.
- Intersectoral communication.
- Comprehensiveness.
- Cultural interaction

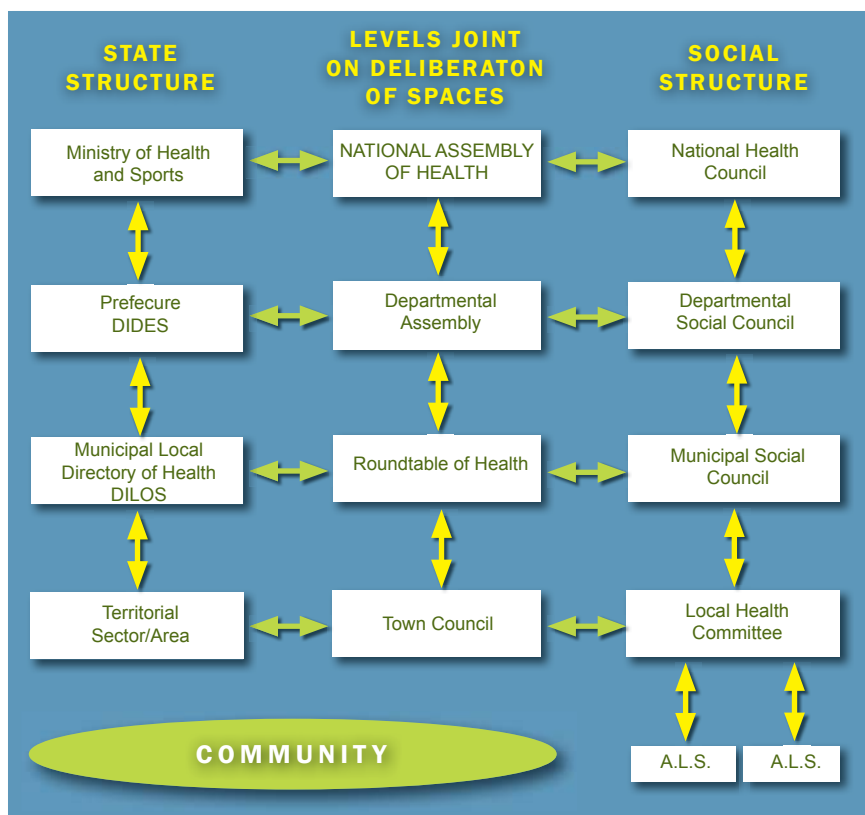
## *Components of Family, Communal and Intercultural Health*

- Model of participative management. This is one of the mechanisms to open spaces of participation where urban and rural communities (Ayllus, Tentas, Markas, and Jatas among others), through their legitimate health representatives, make joint decisions at the municipal and departmental government levels. Health teams and the community are represented in health committees and social, municipal, departmental and national councils. They are the spaces in which actions are taken upon consensus: **identification and examination** of problems, limitations, potentialities, demands, strategies, formulation of plans, programs, and projects, budget, and evaluation of results. **The latter is the main instrument of participative planning.**

The model of participative management comprises deliberate and decision-making levels, as shown on the following chart:

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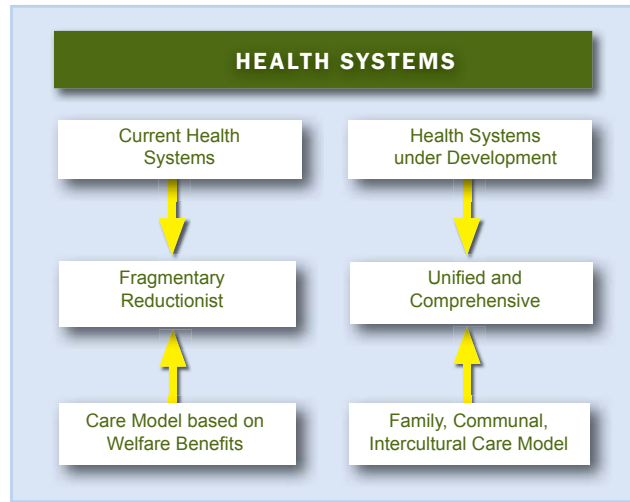
6. Ministry of Health and Sports. Unit of Public Health and Social Mobilization 2009. Salud Familiar Comunitaria Intercultural. Technico-strategic document N° 171. La Paz – Bolivia.



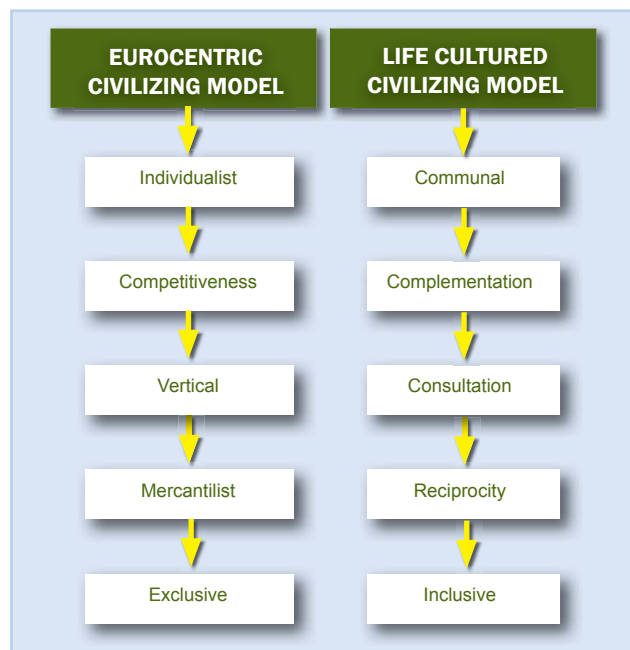
- **Family, Communal and Intercultural Health Care Model.** This model is based on an ideology, philosophy and political view that is qualitatively different from the health model focusing on welfare benefits.

With this model, the government works jointly with individuals and community social players (Ayllus, Tentas, Jatas, and Markas, among others) TO PROMOTE LIFE and not death. Health workers leave the health care center to interact with healthy or sick families of the community. When doing this, they try to identify different pathologies, and potential diseases. They will also put into practice processes of participative research and action; they take care of the detected pathologies by taking prevention actions, and promoting health when discussing and making decisions about the illness.

The Model of Community Health Care is based on in the following principles and values.



Prepared by Dr. Franz Trujillo. Internal Coordinator RM SAFCI. La Paz, Bolivia, 2008.



Prepared by Dr. Franz Trujillo. Internal Coordinator RM SAFCI. La Paz, Bolivia, 2008.

- **Experiences of Family, Communal and Intercultural Health Care.**

- ▶ **Medical Residency in Family Communal and Intercultural Health Care.**

The Ministry of Health and Sports has put into practice the Model of Family, Communal, and Intercultural Health Care through the Medical Residency of Family, Communal, and Intercultural Health (FCIHC; its acronym in Spanish is SAFCI.) This experience has put into practice the policies of the health sector and the philosophical-theoretical, technical and methodological guidelines of the Model of Family Communal and Intercultural Health Care.

The Medical Residency in Family, Communal, and Intercultural Health Care was created in 2007 at the Ordinary Convention of 2006 of the National Committee of Teaching, Health Care and Research Integration. This committee is formed by representatives of the Ministry of Health and Sports, the Executive Committee of the Bolivian University [Universidad Boliviana; CEUB is its acronym in Spanish] and the Ministry of Education.

NUMBER OF FCIHC MEDICAL RESIDENCIES (MR)  
BASED ON ACADEMIC PROCEDURES

Nº	Academic Management	Nº of M.R. SAFCI	Observations
1	2007-	131	The first group graduated in March 2010
2	2008-	31	The second group will graduate in March 2011
3	2009-	50	The third group will graduate in March 2012
4	2010-	46	The fourth group will graduate in March 2013
	<b>Total</b>	<b>260</b>	

- **Mobile Units of Family, Communal, and Intercultural Health Care.**

The Ministry of Health and Sports formed ambulatory teams comprising a physician, a nurse, a dentist, a social worker (sociologist), and a driver.

There are 50 working teams located in the nine departments, which are implementing the Family, Communal, and Intercultural Health Care Model; they undertake health care, prevention and promotion activities.

## 2.4. Main Challenges for Implementing Sectoral Policies

- One of the main challenges is to build a Unified Health Care System with an intercultural approach. This is a challenge that requires going beyond infrastructure, equipment, and health care norms which are necessary but insufficient for transforming the sector.

- A cultural interaction requires leaving behind old ways of thinking, feeling, and health care management; breaking old practices of a health system corresponding to a Nation deeply tainted with characteristics of only one culture intended to homogenize and segregate, and that is exclusive and inequitable. Therefore, it is mandatory to reverse this situation. We are those who think, analyze, reflect, comprehend, feel and do; we are involved in the field of health care. Therefore, we should start changes from within in order to contribute to a change at the governmental level. These changes are fundamental for the implementation of a Unified System with an approach of cultural interaction of private and public institutions responsible for the education of human resources, international organizations, NGO's, and people.
- Providing the personnel of the National System of Health with continuous training within the framework of Family, Communal and Intercultural Health Care.
- Negotiating, with the Ministry of Economy and Finance the availability of funds in order to hire qualified professionals and implement and carry out a universal and free Unified Health Care System with an approach of cultural diversity.
- Setting basis and generating mechanisms with traditional physicians and midwives to involve them in the health system.
- Reorganizing infrastructure and equipment, and categorizing medical health care centers by redefining prototypes according to cultural regions and networks, among other aspects.

## 2.5. Perspective of the Expansion of the Family, Communal and Intercultural Health Care System

With the implementation of a Unified Health Care System focused on Family, Communal and Intercultural Health, the occurrence of primary illnesses will decline in the short and medium term. In addition, coordination, agreements and strategic alliances with municipalities, provincial governments, ministries and other institutions that contribute to the health area will be carried out more efficiently.

The Ministry of Health follows national norms on quality of network services such as the Family, Communal and Intercultural, Municipal Network, the Network of Health Care Services, the Ministerial Resolution No. 1036, Referral and Return, Characterization of Health Care Centers and Second Level Hospitals. These norms will be modified according to the Unified Family, Communal, and Intercultural Health Care System Law.

## 2.6. Process of Developing Health Sector Policies

The health care policies are the result of the analysis, reflection and proposals posed by representatives of the indigenous peasant Bolivian nations, intercultural communities, universities, international organisms, and the National System of Health, who gathered in the nine departments of Bolivia. Subsequently, they participated in meetings held nationally with the objective of systematizing all the proposals presented at the workshops held in the nine departments.

## 2.7. Problems Identified in Implementing and Executing Sector's Policies

- Perspective and logic anchored to a fragmented work focused on biology and medicine, which corresponds to a State-Nation logic rooted in a single culture.
- Frequent changes of authorities and, consequently, the interruption of transformation processes that started with political will.

# 3. Framework of Human Resources for Health Policies

## 3.1. Vision of the Policy on Development of Human Resources for Health

It is addressed to:

*"Consolidate an essential workforce committed to the changes that have been occurring in the country, and particularly to the policies of the health sector; who are capable of building health working teams with a comprehensive, holistic and intercultural approach, based on the principles of solidarity, equity, and reciprocity at all levels of the networks within and among sectors. They shall promote the full exercise of the right to health by providing health care services equally to all cultures and world visions, complementing knowledge, thinking, feelings and practices addressed to 'Living Well,' families and communities."*

## 3.2. Approval of the Policy on Development of Human Resources for Health

The Ministry of Health and Sports has a Policy on Development of Human Resources for Health approved by Ministerial Resolution No. 1233.

### 3.3. Coordination of the Policy on Development of Human Resources for Health with National and Sectoral Policies

The Policy on Development of Human Resources for Health is completely coordinated with the National Plan of Economic Development: an Honorable, Sovereign, Productive and Democratic Bolivia for the "Living Well" of its people, and consequently for the health sector.

### 3.4. Main Lines of Action of the Policy on Development of Human Resources for Health

The following six lines have been determined:

- **Line 1:** Dissemination of national policies, policies on health and the Policy on Development of Human Resources.
- **Line 2:** Management of Human Resources for Health.
- **Line 3:** Training of human resources for health to coordinate undergraduate and postgraduate programs, and continuous education with an intercultural vision and with sensitivity to the socio-sanitary public health reality of the country.
- **Line 4:** Information systems on human resources for health coordinated with the Health Information Systems (SNIS is its acronym in Spanish.)
- **Line 5:** Research systems on health.
- **Line 6:** Creation of a Training Center of Family, Communal, and Intercultural Health Care.

### 3.5. Formulation of the Policy on Development of Human Resources for Health

During the term of 2007, when Dr. Nila Heredia was Minister of Health and Sports, the need for creating a Policy on Development of Human Resources for Health was evident. It was a response to the demands originated in the changes taking place throughout the country and particularly in the health sector.

The Policy on Development of Human Resources for Health was prepared at three national workshops carried out with the participation of representatives of the schools of medicine of the ten public universities, the Bolivian Catholic University (Universidad Católica Boliviana) departmental health services (SEDES is the Spanish acronym), social organizations such as the Bolivian Worker's Federation (COB is the Spanish acronym), the National Council of Ayllus and Markas of Qullasuyu (CONAMAQ is the Spanish acronym), the Single United Confederation of

Peasant Workers of Bolivia (CSUTCB is the Spanish acronym), the Confederation of Indigenous Peoples of Bolivia (CIDOB is the Spanish acronym), the Assembly of Guaraní Peoples (APG is the Spanish acronym), the Bartolina Sisa Movement, the Women's Movement "Juana Azurduy de Padilla", intercultural communities, associations of health professionals, general directorates (Planning, Services, and Promotion of Health), representatives of different units such as Community Health and Social Mobilization, RMSAFCI (Medical Residency on Family, Communal, and Intercultural Health, after its acronym in Spanish), health care workers' associations, schools of Public Health of the Ministry of Health and Sports, and representatives of PAHO and WHO.

The call for the three nationwide workshops was made by the ministers. A phone follow-up was undertaken from the office of Highest Executive Authority of the Ministry of Health and Sports.

### 3.6. Dissemination Strategy of the Policy on Development of Human Resources for Health

- The policy was approved by Ministerial Resolution No. 1233.
- The Policy on Development of Human Resources for Health was presented at an official meeting hosting agencies of international cooperation, schools of health sciences of the Major University of San Andrés [(Universidad Mayor de San Andrés (UMSA)) and the Autonomous & Public University [Universidad Pública y Autónoma (UPEA)], as well as health professional associations, social organizations and staff of the National System of Health.
- The policy was presented to directors and managers from the eight Social Security's agencies at a workshop.
- A strategy for the Policy on Development of Human Resources for Health exists; however, due to the change of government it was not applied.

### 3.7. Participation in Institutions of Subregional Integration

- One of the meetings of vital importance was the one held in Toronto, Canada. Five challenges and twenty goals related to Human Resources for Health were set. That event was the starting point for the formulation of actions by PAHO and WHO and member states.
- At the Meeting of Ministers of the Andean Region held in the city of Santa Cruz de la Sierra, in Bolivia, on March 30, 2007 the challenges and goals set in Toronto were ratified.

- In November 2007, a meeting of the Andean Subregion took place in La Paz, Bolivia, where the 10-Year Plan for Human Resources of the Andean Region and MERCOSUR was reviewed, analyzed and completed. This plan includes five lines of action: (a) Development of national capacities for exerting leadership function, defining and implementing policies, planning, and management; (b) Monitoring and evaluating the 20 Goals of Toronto; (c) Development of collective intelligence for management and utilization of information on human resources for health; (d) Training of specialists in management of Human Resources for Health-CIRRUS; and (e) Research and management of migration; this plan was approved at the 38th Meeting of Ministers of Health of the Andean Region (REMSAA is the Spanish acronym) held in Quito, Ecuador in 2008.
- Significant progresses have been made in the five lines of action.

### 3.8. Lessons Learned

- Building the Policy on Development of Human Resources for Health enabled us to know each other, the image we have about ourselves, and the basic mechanism employed by the participants related to Human Resources for Health. As a result, dissimilar and similar opinions on various aspects became evident.
- Working on epistemological, theoretical, methodological and technical discrepancies.
- How to enter into cooperation and generate consensus.
- We learned very much from the knowledge and practices from the representatives of social organizations.

## 4. Coordination with Key Government Sectors in Relation to the Strategic Policy on Development of Human Resources for Health

### 4.1. The 10-Year Strategic Plan for the Policy on Development of Human Resources for Health

- To implement and execute the Policy on Development of Human Resources for the Health, the 10-year strategic plan was formulated utilizing the method of Strategic Planning. The six lines have already been put into operation in projects corresponding to prioritized problems. For each project, a general objective, indicators, expected results, to-do activities, fundamental resources, and an evaluator have been determined.

- Some projects have been created to check, follow up and evaluate the activities of each project. Moreover, a budget plan was also made for each of the projects. The projects will be handled by consultant contractors.
- Of the 36 projects included in the 10-Year Strategic Plan of the Development of the Policy on Human Resources for Health, the following 12 projects are priorities for the 2010 administration:

## 4.2. Priority Projects by Field of Action

Projects	
<b>Field 1: Administration and Management of Human Resources for Health</b>	
Project 1.1.	Redefinition of the skills/abilities, aptitudes and responsibilities of the personnel of the National System of Health.
Project 1.2.	Making compatible laws, decrees and guidelines related to the health.
Project 1.3.	Redesign the Unified Health Care career, taking into account new skills, abilities and responsibilities.
<b>Field 2: Health Education</b>	
Project 2.1.	Training Human Resources for Health at the undergraduate and graduate levels (assistants, technicians, associate's degrees, specialization, master's and doctorate's degrees.
Project 2.2.	Systems to monitor follow up and evaluate the processes corresponding to Project 2.1.
Project 2.3.	Continuous Education in Health in every geographical region and health work performance.
Project 2.4.	Systems to monitor follow up and evaluate the processes corresponding to Project 2.3.
Project 2.5.	Training of agents for the implementation of the Policy on Development of Human Resources for Health.
Project 2.6.	Systems to monitor, follow up and evaluate the processes corresponding to Project 2.5
<b>Field 3: Anthropology and Social and Clinical Research</b>	
Project 3.1.	A general diagnosis of postgraduate curriculum offered by public, private, and international institutions in charge of the education of Human Resources for Health.
Project 3.2.	Systems to monitor follow up and evaluate the processes corresponding to Project 3.1.
Project 3.3.	Strengthening the National Information System of Human Resources for Health coordinated with the National Systems of Information on Health.

## 4.3. Management of Human Resources for Health

Preliminary negotiations before PAHO, WHO, and the Spanish Agency for International Development Cooperation (AECID is the Spanish acronym) were completed. The Maximum Executive Authority of the Ministry of Health and Sports will call for an Interagency Meeting of International Cooperation to explain the 10-Year Strategic Plan of the Policy on Development of Human Resources for Health and look for financial and economic support to carry out these projects.

#### 4.4. The Policy on Development of Human Resources for Health as an Agenda Item of the Ministry of Health and Sports

Dr. Nila Heredia, Deputy Minister of Health and Promotion of the Ministry of Health and Sports, is leading the elaboration of the Bill on the Unified System of Family, Communal and Intercultural Health Care. The need for two or three additional articles on Human Resources for Health has been posed.

#### 4.5. Difficulties in the elaboration of the 10-Year Strategic Plan

No difficulties in the elaboration bill process have arisen. Nevertheless, it was not approved because of the change of government.

#### 4.6. Functions of the Ministry of Education, Ministry of Labor, Employment and Welfare, and Ministry of Economy and Finance

The Supreme Decree No. 29.894 establishes the structure and functions of the Executive Power of the Plurinational State. The following table shows the common functions of the four ministries subjected to intersectoral coordination.

STRUCTURE AND FUNCTIONS OF THE EXECUTIVE POWER  
OF THE PLURINATIONAL STATE - D. S. 29.894

No.	Ministries	Functions	Ministry of Health
1.	Ministry of Labor, Employment and Welfare	c. "To guarantee employability and employment stability by taking into consideration gender equality, disabled people equality and unjustified termination prohibition."	b. "To regulate, plan, control and handle—in the short term—the National System of Health Care comprised of social security sectors, public and non-profit and for-profit private organizations, and traditional medicine."
			q. "To promote policies and programs of prevention, rehabilitation, training and re-employability of disabled people."
		k. "To formulate salary policies."	
		q. "To generate welfare policies from the perspective of building universal, supportive and equitable social security for Bolivian people."	Deputy Minister of Health and Promotion c. "To formulate norms and regulations to implement universal health care."
1.1.	Deputy Minister of Labor and Welfare	d. "To promote prevention policies on occupational injuries and illnesses and report on compliance with regulations on safety and health at work."	
Continues on the next page...			

No.	Ministries	Functions	Ministry of Health
2.	Ministry of Education		j. "To regulate the functioning of training institutions of Human Resources for Health in coordination with the Ministry of Education."
2.1.	Vice ministry of Higher Education in Professional Training	g. "To regulate the functioning of Public Schools on Specialized Training"	Office of the Deputy Minister of Health and Promotion. k. "To coordinate and promote the creation of norms and regulations for the adequate functioning of institutions of training of Human Resources for Health within the policy framework and agreements on Teaching and Health Care Integration."
		i) "Coordinate actions for the Bolivian participation in regional and subregional training for higher education."	
		j. "To regulate the functioning of higher-education institutions: private, public non-autonomous, indigenous, and charter schools."	
3.	Ministry of Economy and Finance	j. "To establish the public sector wages policy."	The minister coordinates with the respective ministry the activities related to wage policy formulation and growth in the sector.
3.1.	Office of Deputy Minister of Budget and National Accounting	f. "To regulated and approve wage scale of institutions and agencies of the Public Sector within the frame of legal provisions."	
3.2.	Office of the Deputy Minister of Pensions and Financial Services	e. "To formulate policies to extend financial services in rural and suburban areas."	

#### 4.7. Coordination with Key Sectors of the National Government of Bolivia

##### *Instruments for Interviews (Interview Guide)*

An interview guidebook was prepared based on the questions proposed by the Regional Meeting of Human Resources for Health.

# INTERVIEW OUTCOMES

Nº	Questions	Ministries		University System of Bolivia
		Labor, Employment and Welfare	Education	Bolivian University's Executive Committee
1.	Identification of the procedures of the Plan of Human Resources for Health	Line of Action 2: Management of Human Resources for Health		
		Project 2.1.: Redefinition of abilities, skills, aptitudes and responsibilities of the Human Resources for Health. Private universities and institutes of technical formation in health care.	Project 2.1.: Redefinition of abilities, skills, aptitudes and responsibilities of the Human Resources for Health. Public universities.	
Project 2.2.: Compatibility of laws, decrees and regulations of the health sector based on the New Political Constitution of the State.		Project 2.2.: Compatibility of laws, decrees and regulations of the health sector based on the New Political Constitution of the State.	Project 2.2.: Compatibility of laws, decrees and regulations of the health sector based on the New Political Constitution of the State.	
Project 2.3.: Design and management of the UNIFIED health care career.		Project 2.3.: Design and management of the UNIFIED health care career.	Project 2.3.: Design and management of the UNIFIED health care career.	
Line of Action 3: Health Care Education				
		Project 3.1.: Strategic general plan of continuous education of Human Resources for Health at the graduate and postgraduate levels. Private universities and institutes of health care technical training.	Project 3.1.: Strategic general plan of continuous education of Human Resources for Health at the graduate and postgraduate levels. Private universities.	
Continues on the next page...				

Nº	Questions	Ministries		University System of Bolivia
		Labor, Employment and Welfare	Education	Bolivian University's Executive Committee
1.	Identification of the procedures of the Plan of Human Resources for Health		Project 3.2.: Standardization of training programs at the graduate and postgraduate levels in private universities and institutes of technical training of Human Resources for Health.	Project 3.2.: Standardization of training programs at the graduate and postgraduate levels in public universities.
			Project 3.3.: The training of agents specialized in development of Human Resources for Health. Private universities.	Project 3.3.: The training of agents specialized in development of Human Resources for Health. Public Universities.
			Project 3.4.: Plan of postgraduate programs offered in Human Resources for Health. Private universities.	Project 3.4.: Plan of postgraduate programs offered in Human Resources for Health. Public universities.
		<b>Line of Action 4: A Qualitative and Quantitative Information Systems of Human Resources for Health</b>		
		Project 4.1.: Creation of National Information Systems of Human Resources for Health coordinated with the National Integrated Health Care Systems.	Project 4.1.: Creation of National Information Systems of Human Resources for Health coordinated with the National Integrated Health Care Systems.	Project 4.1.: Creation of National Information Systems of Human Resources for Health coordinated with the National Integrated Health Care Systems.
		Project 4.2.: Creation of the National Council of Human Resources for Health.	Project 4.2.: Creation of the National Council of Human Resources for Health.	
		<b>Line of Action 5: Health Research Systems (Clinical, Social, Anthropological, and Cultural Research)</b>		
			Project 5.1.: Strategic general systems of research on health with an intercultural perspective for development.	Project 5.1.: Strategic general systems of research on health with an intercultural perspective for development.
			Project 5.3.: Formulation of policies on health research.	Project 5.3.: Formulation of policies on health research.
			Project 5.4.: Training of health research agents on health.	Project 5.4.: Training of health research agents on health.
Continues on the next page...				

Nº	Questions	Ministries		University System of Bolivia
		Labor, Employment and Welfare	Education	Bolivian University's Executive Committee
2.	Rationality or logic of argumentation	Supreme Decree No. 2894 sets forth the functions of the Offices of Deputy Ministers to coordinate activities pertaining to the Human Resources for Health plan of the Ministry of Health.	The Ministry of Education considers the projects marked as priority corresponding to the six lines of actions of the Policy on Development of Human Resources for Health will allow us, first, to have norms coherent with the mandates established in the Political Constitution of the Plurinational State.	The Organic Law of the Universidad Boliviana establishes in Chapter. I. Mission. Section. 4. <i>"The training of proper professionals with personal attributes, scientific excellence..., to promote scientific research, studies in humanities, resuming ancient knowledge...to contribute to the defense of the country's sovereignty and the commitment to national and social liberation."</i>
			Secondly, it will allow us to continue and deepen the work already started on curricular design changes in general, and those of schools of medicine of private universities in particular.	Chapter II. Principles. Section. 5. Subsection m) <i>"The relationship with our environment demands that we are open to cultural manifestations in a continuous dialogue..."</i>
3.	Levels of Coordination and Interaction in the Development of the Plan	No relation or direct participation existed. The Ministry of Health and Sports wants to develop this intersectoral relationship and participation with the plan of Human Resources for Health, which should be permanent.	The Ministry of Education makes specific arrangements about medical residencies through the National Committee of Teaching, Research and Health Care Integration.	The coordination with the Ministry of Health and Sports is carried out through the National Committee of Teaching, Research and Health Care Integration. This is limited to the issue of medical residencies.
			The coordination with the Ministry of Health and Sport should be continuous in order to incorporate the Family, Communal and Intercultural Health Care component in the curriculum of schools of medicine in private universities.	We consider the Policy on Development of Human Resources for Health to be a fundamental mechanism to analyze, reflect upon, participate and coordinate in a continuous manner. Even more if the Policy on Development of Human Resources for Health were formulated by representatives of the schools of health sciences of the Universidad Boliviana.
4.	Established Mechanisms, Rules and Procedures for Coordination.	The Supreme Decree No. 29894 establishes the functions for both ministries in relation to the Human Resources for Health; however, there are further matters to coordinate (...the creation of a supportive, universal and equitable coverage. To promote prevention policies on professional illnesses and occupational injuries...) Health and Safety at Work.	Those established by the Supreme Decree No. 29894 and the Political Constitution of the Plurinational State.  To coordinate the setting-up of the postgraduate program in Communal Medicine, which will be developed within the framework of the ALBA (The Bolivian Alliance for the Peoples of our Americas.)	The Universidad Boliviana abides for what is stipulated in the Political Constitution of the State in Section II., Art. 91, Clauses I and II; Art 93, Clauses II; Art 97, and for what is established by the Organic Law of Universidad Boliviana.
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Nº	Questions	Ministries		University System of Bolivia
		Labor, Employment and Welfare	Education	Bolivian University's Executive Committee
5.	Regularity in Relationships and Coordination.	<p>No relationship exists between both ministries regarding the Human Resources for Health plan.</p> <p>The functions of the General Directorate of Social Security, especially in making the Coverage Extension Plan of the Short- Term Social Security Systems, assuring public health, undertaking labor and medical inspections in entities of Social Security management, setting policies and programs of health and safety at work.</p>	<p>The relationship between both ministries is not permanent. However, we consider the Human Resources for Health policy to be a good means to analyze, reflect upon and develop activities conjointly.</p>	<p>Coordination in training specialist physicians exists; that means medical residencies; these relationship and coordination are not permanent.</p>
6.	Experience in Arrangements, Major Problems and Lessons Learned	<p>No prior experience exists about the policy or plans of Human Resources for Health.</p> <p>Joint work is done with the National Institute of Social Security (INASES is its acronym in Spanish) to coordinate the Coverage Extension Plan of the Social Security System in the short term.</p> <p>In other areas such as safety and health at work, the relationships and arrangements are not very stable yet. The purpose is to strengthen these relationships and arrangements.</p>	<p>The Ministry of Education is a member of the National Committee of Teaching and Health Care Integration.</p> <p>The Universidad Boliviana participates through its Executive Committee. However, a distancing exists with this educational institution due to its autonomy.</p> <p>Positive experiences will be gained after identifying common projects about the Policy on Development of Human Resources for Health, with the Executive Committee of the Universidad Boliviana and the Ministry of Labor, Employment and Welfare.</p>	<p>The Executive Committee of the Universidad Boliviana is a member of National Committee of Teaching, Research, and Health Care Integration. The experience in training human resources for health is limited to medical residencies.</p> <p>This distancing between the government and the university is historic.</p> <p>After creating conjointly the policy on Human Resources for Health, its implementation and execution should be a common responsibility because the projects pose challenges that call for a coordinated work, without impositions from any either party.</p>
7.	Main participants with a positive influence in the negotiations for the development of the Human Resources for Health plan.	<p>Technical and administrative requirements of both ministries.</p> <p>Supreme Decree 29894.</p>	<p>The Universidad Boliviana, the Ministry of Health and Sports, and the Ministry of Education have specific mandates for training given by the Political Constitution of the State.</p>	<p>The Ministry of Health and Sports, the Universidad Boliviana and the Ministry of Education are involved in the training of the Human Resources for Health and have specific mandates given by the Political Constitution of the State.</p>
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Nº	Questions	Ministries		University System of Bolivia
		Labor, Employment and Welfare	Education	Bolivian University's Executive Committee
8.	Mechanisms to make the Plan of Human Resources for Health viable and to improve the way the coordination is carried out.	To create a technical, inter-institutional committee in order to coordinate, discuss and include the proposals related to the Plan and Policy on Development of Human Resources for Health.	To strengthen the National Committee of Teaching and Health Care Integration, upon evaluation of its performance and results. To make a complete readjustment of it. This change will be a mechanism to make the Policy on Development of Human Resources for Health viable by keeping sight of its perspective, meaning and scope.	However, the National Committee of Teaching and Health Care Integration, needs to be completely readjusted to become a true mechanism to make the Policy on Development of Human Resources for Health viable under the comprehensive and holistic framework it was formulated.
9.	Describe an actual case of "negotiation" to make a component of the Human Resources for Health viable (Health Care degree, performance incentives...)	To solve administrative issues posed by health care employees related to the labor and disciplinary regimes, the UNIFIED health care career and create the registry of Human Resources for Health.	The admission of the 800 Cuban students of 4th and 5th levels in the medical school was not a negotiation; it was coordination.  With the Ministry of Health to making Health Care Centers and second-level hospitals available. An agreement was concluded with the Executive Committee of the Universidad Boliviana, which states that the universities of the University Educational Systems are responsible for giving the academic certificate to graduates.	All projects related to the lines of actions of the Policy on Development of Human Resources for Health require factual coordination and consultation.  Each school of medicine can create a space for coordination at the sectoral meetings periodically hosted by the University Educational System of Bolivia.

## 5. Conclusions and Recommendations

Nº	Conclusions	Recommendations
1.	The Ministry of Health and Sports has the Development Policy on Human Resources for Health approved by Ministerial Resolution No. 1233.	The plan should be disseminated at the national level to all social players involved in the training of Human Resources for Health, social organizations, personnel of the National Health Care System, ministries, congress members and international organizations.
2.	The Ministry of Health and Sports has the 10-Year Strategic Plan of Development Policy on Human Resources for Health.	<p>The current authorities of the Ministry of Health and Sports should analyze the plan, which should be publicized at the national level to all social players involved in the training of Human Resources for Health, social organizations, municipalities, and personnel of the National Health Care Systems, ministries, and others. It should be approved by ministerial resolution. The Ministry should start the preparation, implementation and execution of the projects related to the six lines of actions of the Policy on Development of Human Resources for Health.</p> <p>To call for an interagency meeting in order to gain technical and economic support.</p> <p>It should be included in the Sectoral Strategic Plan of Health.</p>
3.	It is necessary to form a professional team for the implementation and execution of the 10-Year Strategic Plan of the Policy on Development of Human Resources for Health.	To Include the professional team in the reformulation of Annual Operational Plan. At the beginning, they could be line consultants and subsequently plant consultants.
	It is necessary to form a professional team for the implementation and execution of the 10-Year Strategic Plan of the Policy on Development of Human Resources for Health.	To Include the professional team in the reformulation of Annual Operational Plan. At the beginning, they could be line consultants and subsequently plant consultants.
4.	Even though there are norms established by the National Government and the Organic Law of the Universidad Boliviana, coordination and consultation with the ministries and the institutions in charge of the training of Human Resources for Health are sporadic.	The ministries and the Executive Committee of the Universidad Boliviana should jointly establish a consultation strategy based on the projects related to the six lines of action.

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- \_\_\_ Health Sectoral Plan.
- \_\_\_ Policy on Human Resources for Health Development.
- \_\_\_ Strategic Plan of Socialization of Human Resources for Health Policy.
- \_\_\_ Strategic Decennial Plan of Human Resources for Health Policy.
- \_\_\_ Main laws, decrees, and regulations in relation to human resources for health.

## Introduction

This report<sup>8</sup> synthesizes the findings of the case study “Situation of Human Resources for Health in El Salvador.” This study was undertaken in order to analyze—based on the information available—the current situation of Human Resources for Health in El Salvador and its relationship with the Ministry of Labor, Ministry of Finance, and Ministry of Education and with the purpose of preparing a document for the Human Resource Planning and Primary Health Care: Challenges for Social and Intersectoral Coordination workshop. In preparing this document, we gathered information from primary sources at the ministries (focal points) as well as secondary sources to develop Human Resources for Health policies and the transformation of health care models, the framework of Human Resources policies, the participation process in the development of these policies, and the process of coordination with key government sectors.

## 1. Background

The Republic of El Salvador is the smallest country in the continent of the Americas; it is located in Central America. The total land area of El Salvador is 21,040.79 square kilometers. Its population is about 5,745,000 inhabitants. It is geographically divided into 14 departments, which comprise 262 municipalities. According to its Political Constitution, El Salvador is a sovereign state with a republican, democratic and representative government. The three fundamental government branches are: the legislature formed of 84 representatives; the Executive, headed by the President of the Republic; and the judiciary, formed of the Supreme Court of Justice that comprises 15 judges; one of which is its president.

In order to respond to the right to health granted by the Constitution, the health system comprises the public sector, the Ministry of Public Health and Welfare (MSPAS is its acronym in Spanish)—which is responsible for the health care of 73.6 percent of the population; Social Security (ISSS is its acronym in Spanish)

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7. Revised version of DDRHH, MSPAS, 27 April 2010.

8. The preparation of the study was done with the support of a consultant team from PAHO, which worked with the Department of Human Resources for Health Development (DDRHS) of the Ministry of Public Health and Social Assistance (MOH), conducting interviews with key informants in the Ministry of Health and Ministries of Education, Finance and Labour, reviewing of documentation regarding the new guidelines and proposals made by the current health administration, analyzing of information with MOH counterpart team and in the development of a country document version from the information collected and analyzed.

in charge of 23.9% (it serves only employed people), Military Sanitation Health (1.1%) and the Institute of Teachers' Welfare (1.4%) according to the law of the National Health System approved by Decree No. 442, published in the Official Gazette No. 214, volume 377, on November 16, 2007; the governing body is the Ministry of Health.

To respond to the health care demands of the people it serves, the Ministry of Health has a network of 619 health centers, out of which 588 provide primary health care—377 health units, three emergency centers, 160 health “houses,” 46 rural nutrition centers, two clinics, and one Center of Maternity, Childcare and Nutrition (CIAMIN). The second level has 27 hospitals and the third level has three specialized hospitals.

To manage and provide health care, the Ministry has a workforce of 24, 007 people who work under two types of contracts: 75 percent under the Salary Law and the other 25 percent are paid with budgetary funds from the Government of El Salvador. The administrative personnel numbers 5,816 employees, and 18,191 employees are technicians or professionals. The number of physicians is 4,318 (17.97% residents, 33.21% general practitioners, 37.21% specialized physicians, 5.46% administrative personnel, and 6.13% social workers, which corresponds to 23.73% of the total); 5,639 nursing workers (60% nurse assistants and 40% nurses, which made up 31% of the general total —2,157 are health promoters, representing 9.1% of the human resources, and the rest are professionals and technicians in chemistry, pharmacy, physiotherapy, nutrition, anesthesia and clinical laboratory, among others.

In order to strengthen the MSPAS, the Solidarity Fund for Health (FOSALUD) provides human resources to 91 health care units and 3 emergency care centers (they work on night shifts, weekends, and holidays; with a plan of extended coverage, some NGO's have been hired to develop strategies for disadvantaged areas) In a first analysis of the need for human resources for implementation of the first health care level comprising 1,533 community health care teams with a family approach, a total number of 9,304 employees is required for the 14 departments; this workforce includes physicians, nurses and health promoters. Currently, 57% of this workforce exists; the gap is 43%.

Based on preliminary data of the national reports on health, the preliminary investment in human resources in fiscal year 2009 was US\$252,862,039, which represents 57% of the total MSPAS spending.

In the past, no political will existed in the management and development of Human Resources for Health. Nevertheless, the National Committee for Monitoring of the Comprehensive Health Care Reform, which was approved by Executive

Decree No. 51 on June 24, 2003, attempted to design a “Political Proposal on the Development of Human Resources,” which was later dismissed.

There is an uneven relationship between the supply and demand for Human Resources for Health. The supply of physicians, nurses and other health professionals is not regulated. A growing number of professionals graduate each year from private and public institutions without existing new job opportunities. This generates unemployment, emigration and unstable employment.

## **2. Political Framework for the Transformation of the Health System**

The elected President of El Salvador, Mr. Mauricio Funes, presidential candidate for the Frente Farabundó Martí para la Liberación Nacional (FMLN) took office on June 1, 2009. His agenda included the political will to create a national health system oriented to improving the health condition of all Salvadorians as a response to the quality decline and dismantling of the public health system. At the same time, the increasing participation of the private sector and its drive for profit left a significant number of people without access to health care, especially for children and poor women. Moreover, the chronic problems of segmentation, fragmentation, budget cuts and concentration of health care has increased in the last decades. All of this caused a decrease in health promotion and illness prevention through social participation.

Considering that health is a fundamental right, the new administration has adopted guidelines that will allow the country to go forward towards a unified health care system with universal coverage based on a model of Primary Health Care.

The vision for the health system is expressed in the President’s Government Plan (2009) and in the strategies stated in the document “Building Hope” (Rodríguez, 2009.) Such a vision places equity and universal coverage as core points of the health policy, along with the strengthening of intersectoral relations and civic participation in the management and application of the system.

The creation of this health system is a difficult task because in addition to the historic difficulties inherent to a poor country there are those resulting from a long internal conflict where the democratic institutions are not yet in full force. At this point, every area of government can be either an instrument for cooperation or confrontation. The MSPAS’s policy is to strengthen and create opportunities for dialogue and cooperation. The Ministry makes this reform with a comprehensive approach that includes structural aspects (organization and functions), cultural aspects (respect for the rights of citizens, safety of health workers,) and regulatory aspects (recruitment standards).

## 2.1. Vision of the Health System for the 5-Year Period 2010-2014

The MSPAS intends to improve considerably the health of Salvadorians in the next five years through the development of a health system that has comprehensive and universal access (at the prevention level) and is integrative (by means of care levels coordinated through networks;) and that is complemented by actions among sectors that will have an impact on the social determinants of health.

In addition, the management reform model will have been accomplished with a committed, trained and specialized workforce produced by an interinstitutional policy on human resource development and technologic innovation. Additionally, the role of MSPAS will have been strengthened; this is necessary to guarantee the people's human right to health; this will have been done through interagency and intersectoral organization, functional integration of the social security system, and effective regulation of the private sector; these actions are aimed at developing a more equitable and efficient health system.

To make progress in the transformation of the health system and care model, the goal for 2014 set by MSPAS is the strengthening of the action framework of the Health National System created by Law No. 442 of November 2007.

## 2.2. Axis of the Policy on Health System Transformation

The general objective of the new policy on health is to *“Guarantee the right to health to all Salvadorian people through a National Health System that steadily strengthens public matters (including social security) and effectively regulates private matters, access to promotion, prevention, attention and rehabilitation of health; a healthy and safe environment including, but not limited to, the creation and maintenance of an efficient and highly responsive health care system that offers equitable access to high-quality services for all people.”* (Rodríguez, 2009: 13.)

In order to accomplish this general objective, the following six lines of transformation are proposed, which contains 25 strategies:

- Structure, organization and functioning of the National Health System. This is to be achieved through primary and comprehensive health care; strengthening of the MSPAS stewardship; regulation of the national health system; and development of social and community participation.
- Health care and illnesses. Creating a network of health care, by strengthening hospitals, social security, worker safety, reproductive and sexual health, care for the disabled, and by reducing the impact of emergencies and disasters.

- Human resource development of the national health system. The main strategies are the development of human resources, coordination with training institutions, and the reinforcement of health promotion workers.
- Drug Policy. To guarantee availability, high quality, and rational use of medicines.
- Water and sanitation. To prioritize the application of a policy on potable water and basic sanitation.
- Management and financing. Efficient use of public health spending, the reinforcement of financing mechanisms and sources, and the development of supervision, control and monitoring instruments to guarantee the accomplishment of objectives, goals and activities included in the National Plan of Health

### 2.3. Approach and Strategy for Organizing Health Care

In the framework of the health policy, Strategy No. 8 stipulates that *“The National Health System will provide all the population, through a public network, with benefits whose quantity and quality will increasingly lead towards comprehensive coverage.”* In this sense, the MSPAS has been working on the design of a proposal for a Comprehensive Public Health Network (February 2010) aimed at guaranteeing universal health access with a comprehensive and integrative approach. The proposal includes the categorization of seven types of health care, grouped into four levels of increasing complexity. The objective of the first health care level is to act as a gate to enter into the system; it will be formed of health promoters and family health communal units. The second level will comprise hospitals currently called peripheral or departmental hospitals; they will be called basic hospitals (basic clinics), and general hospitals (basic and specialized clinics). The current general out-patient care provided by peripheral and departmental hospitals will turn into health care units with a coordination system and health care team. The third health care level will be comprised of specialized hospitals. The fourth health care level will consist of specialty hospitals.

As indicated in the proposal of the health care network mentioned in the MSPAS study (February 2010:10)<sup>9</sup>, one of the indispensable operational aspects for health networks will be to define the population and territory they will serve and their service levels by taking into account a broad knowledge of their health needs and preferences to determine the characteristics of the services to be provided.

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9. This proposed Comprehensive Public Health Network is still being defined.

According to the Directorate of Planning, a system that includes planning, monitoring and evaluation of the quality of the health services is being developed based on the policy strategies of MSPAS. This planning system starts from a local diagnosis of the needs health care units have in order to do the corresponding budget allocation. This plan is monitored and evaluated periodically to control the use of budget items and the quality of services provided; on this point, the role of human resources is fundamental.

## 2.4. Challenges of the New National Health Policy

Given the commitments established in the framework of the social reform of the government of El Salvador, the goal of the Comprehensive Reform of the Health System is a Unified Public System that has to be efficient, sustainable, and provides high-quality universal coverage. This system will give priority to the public sector; at the same time, it will normalize, regulate and supervise the private sector in all its forms. Its actions will be based on the strategy of a comprehensive primary health care by focusing on its basic pillars of intersectoral participation and equity to guarantee the coverage in the most vulnerable, distant and inaccessible locations; this is to guarantee the right to health for all people.

Some steps will be followed to gradually integrate all service networks of the public sector to eradicate the current segmentation and fragmentation. In this sense, the strengthening of Human Resources for Health is proposed. This requires joint planning among training institutions and employers of Human Resources for Health, profile definitions, a code of ethics, and current and future needs of the reformed system under a Primary Health Care approach.

Moreover, this development must also give response to the critical problems in Human Resources for Health already identified in the Latin American health systems, including that of El Salvador, and according to the consultation submitted by PAHO in 2005, which identifies the main challenges in human resources faced by the countries of the Region.

The five fundamental challenges identified became the common platform of the Call to Action for a Decade of Human Resources for Health at the 7<sup>th</sup> Regional Meeting of Observatories of Human Resources for Health, held in Toronto in October 2005. These challenges are coherent with the policy guidelines of the MSPAS (MSPAS, October 2009: 37 and 38):

- To define the long-term policies and plans to adapt to the changing workforce
- To place the right people in the right places, and achieve an equitable distribution based on the health needs of the population.

- To promote employment stability of health care workers.
- To create work environments facilitating the commitment to the institutional mission of guaranteeing high-quality health care for all people.
- To coordinate, with the educational and professional sectors, the training, accreditation and approval of human resources at the graduate and postgraduate levels, according to the policy and the National Health Plan (MSPAS, October 2009: 37 and 38.)

Thanks to the Call to Action, many countries have either started or intensified the process of formulating national and sub-regional action plans with a 10-year perspective. These plans focus on the need for development of human resources of all institutions. They also call for rethinking the way the plans are approached and the commitment in each country.

In this sense, some of the challenges that the health policy has to face are the following:

- To eliminate the weakened, segmented, fragmented, exclusive and improperly financed health system that emphasizes curative actions. To move forward in building a national public health system, that is strengthened by an integrated network of services, and based on a comprehensive primary health care with universal coverage.
- To effectively regulate the for-profit private sector in order to eliminate the health commercial approach seen throughout the health care system.
- To guarantee a long-lasting transformations of the health system; this should be taken as the State's policy whether it be for the current or future governments.
- To develop through training seminars human resources with a new vision and abilities to play their corresponding role in creating the new National Health System.

To face these challenges, it will be necessary to develop a strategy of national participation and coordination to develop the new proposed national policy on health. It is important to mention the initiative of the Interagency Committee of Health (CISALUD, by its acronym in Spanish) that before was limited to the prevention of the avian influenza committee (CONAPREVIAR is the acronym in Spanish) and whose functions and structure have been modified. Other players, such as the ministries of Finance and Education, pointed out that "this experience is a space for technical and political discussions on health sector determinants that could contribute to rethinking an interagency policy on human resources" (Interviews held at the ministries).

### 3. The Human Resources Policy Framework

The objective of this section is to point out the strategic orientations and the policy framework for human resources to strengthen the Health Care System based on Primary Health Care (APS is its acronym in Spanish.)

The vision of the Ministry is to reorient the National Health System based on the strategy of a comprehensive primary health care. In the document, “Building Hope, Strategies and Recommendations on Health for 2009-2014,” the MSPAS resumes the position on health expressed by President Funes, which aims at forming a national alliance for health issues, capable of bringing sustained changes that will allow all people access to high-quality, comprehensive, and universal health care. In this view, four main strategies related to the development of human resources are proposed:

- **Strategy 11:** Safety and health at work—designing a program to improve the safety and health of workers.
- **Strategy 18:** Development of human resources—developing and implementing a policy in this area.
- **Strategy 19:** Coordination with the educational sector—creating cooperation mechanisms between educational institutions and health care providers to adapt health care education and provide high-quality health care that meet’s the population’s health needs.
- **Strategy 20:** Communal health workers—strengthening the health promotion role as a fundamental element of the National Health System based on Primary Health Care.

Implementation of these four strategies will allow us to have a strong workforce, trained and empowered in their duties with a vision, objectives and institutional goals. With the aim of developing these strategies, the Directorate of Human Resources Development has been created. It is responsible for strategic management of the development of human resources for health; it consists of two units: the Labor Management Unit and the Human Resources Education and Training Unit. One of the main challenges is the design and implementation of the Policy on Human Resources for Health Development.

With this coordination body, the MSPAS will be able to contribute to the education of leaders of Human Resources for Health.

### 3.1. Main Problems in Establishing the Framework of Human Resources for Health Policies

The Directorate of Human Resources Development is dealing with the following fundamental problems in Human Resources:

- The lack of a policy on development for human resources for health. Two attempts were made; one in 2006 and the other in May 2009.
- Unemployment and underemployment generated by several factors such as an excessive number of graduates in some professions, the financial incapability of the health sector to hire personnel due to economic limitations, and the presence of significant salary inequities in different services.
- A paradoxical shortage in human resources<sup>10</sup> (43% at the first care level, 2010), and inequitable distribution of resources in geographical areas and populations.
- Overlapping of diverse criteria to estimate the needs for health personnel in different areas (A study on Human Resources for Health /USAID, Sep, 2009).
- Even though 75% of MSPAS's personnel are hired under the Salary Law system, 25% are hired by the government of El Salvador; this causes employment instability even though both types of employment offer the same legal rights (promotion opportunity, uniforms, and in some cases, food benefits.)
- Disparity in work conditions between Social Security (ISSS) and MSPAS. The gap between welfare benefits and economic and non-economic incentives is significant for a large group of the workforce, especially MSPAS employees.
- Staff who do not have the skills required for implementation of the comprehensive health care model based on the primary health care strategy because continuing health education programs have traditionally had a clinical approach. Great efforts should be made to provide the workforce with the necessary institutional skills.
- Weak or deficient mechanisms for coordination and cooperation among health care institutions and the human resources for health training centers
- The lack of a health care career program.

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10. Based on the report: PAHO 2009: "Datos básicos de El Salvador 2000-2008." San Salvador.

- The lack of a planning system for human resources that allocates human resources according to position profiles and the comprehensive primary health care model to meet the population's need for health.
- The absence of human resource information systems that would allow timely decision-making to solve problems and generate actions towards the development and quality of health care.

This vision and the strategies proposed, include actions in the sphere of human resources, policies, and plans proposed by MSPAS for transforming the Health National System. In this sense, total coherence and coordination exist between both areas, as shown in the following chart. Each party develops separately without losing communication/coordination with the other party.

### 3.2. Work Axis of the New National Policy on Health and Human Resources

National Policy on Health Care	Policy on Development of Human Resources for Health
1. Strategic building of the institutional transformation.	1. Management of Human Resources for Health with the new health care policy.
2. Information to define health care policies.	2. Information to define the policy on Human Resources for Health.
3. Definition of axis for transforming the National Health Care System.	3. Definition of axis for transforming Human Resources for Health.
4. Definition of the health care model and financing of the new system.	4. Definition of the new approach and competencies of Human Resources for Health for their development according to the new health care model.
5. Development of health care regional managers.	5. Eliminate the precariousness of the health care career.
6. Management of policies on research on public health.	6. Definition of salary scales and positions.
7. Establishment of sectoral and intersectoral coordination mechanisms of the health care policy.	7. Registry of professions and control verification (validation of professional diplomas.).
8. Design and implementation of the new planning system. Monitoring and evaluation of the health care policy.	8. Definition of evaluation and performance systems of Human Resources for Health and incentive systems.
9. Regulation of private health care entities (service providers and medicine providers.)	9. Plan of strengthening the training of Human Resources for Health according to the new health care approach.
	10. Coordination of training and regulation of Human Resources for Health with academic institutions.

Note: This is a personal creation based on the information provided by the DDRHS/MSPAS.

To solve the aforementioned problems, the Directorate of Development of Human Resources for Health (DDRHS is its acronym in Spanish) has posed a

conceptual and operational implementation plan for Strategies 11, 18, 19 and 20, which will be applied through a work plan.

### 3.3. Four Strategic Areas of Human Resources for Health Development or Priority Work Lines Established by MSPAS

First area. Development of management abilities and the policy on human resources related to the creation of a team by training leaders and formulating a policy based on analysis and agreement between the main players.

Second area. Planning and regulation on Human Resources for Health. This includes the search for information for strategic management of human resources for health, assuring the monitoring of policies and the identification of critical problems.

Third area. Change in human resources for health matters; actions aimed at improving working conditions, worker health, abilities of communal health agents, and providing nursing personnel.

Fourth area. This comprises education and training of health workers, training regulation, support of training programs, and coordination of MSPAS with health training institutions. The creation of a school for strategic human resources for health has been proposed which will be linked to the National Institute of Health.

For each of these work areas, expected outcomes have been identified. Also, the processes to be developed are defined as well as the activities to be carried out, the period of completion, process requirements, and the necessary technical cooperation. In order to meet this, a strategic work plan and a calendar of operational work have been designed. They take into account the actions that respond to Strategies 11, 18, 19 and 20 (Document Building Hope. Strategies and Recommendations on Health 2009-2014.).

A planning matrix with goals and activities for the short, medium and long term has been created which includes a listing of results, activities, execution period and technical requirements.<sup>11</sup> The main expected results of this planning are shown in the following table:

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11. The matrix does not include an indicator system; however, it allows monitoring the fulfillment of the activities and results throughout time. (See MSPAS, "Propuesta de Desarrollo de Recursos Humanos para la Salud").

Main Expected Results	Short Term	Intermediate Term	Long Term
Creation of a leading team to conduct the process.			
Building, approval and implementation of the National Health Policy by authorities. Consultation with the main players.			
Information for strategic management of the development of Human Resources or Health.			
Planning on Human Resources or Health.			
Policies on improving working conditions, especially health at work.			
Work management to support the transformation of health care.			
Improvement community agents' abilities.			
Increase in the number of nursing professionals and specialized physicians.			
Strengthening the Directorate of Human Resources for Health by encouraging its commitment to the change and its management capacity.			
Implementation of a training program for general practitioners to work at the primary care level.			
Incorporation of professionals who graduated abroad into the health workforce.			
Hiring and training human resources for health included in the system with funds of the government of El Salvador to extend the coverage.			
Strengthening the training of specialized physicians.			

## 4. Process of Sectoral Coordination with Other Key Government Sectors

### 4.1. Plan of Intersectoral Coordination: Intersectoral Committee for the Implementation of the Health Care Policy: CISALUD

At the beginning of Dr. Rodriguez's administration, the Inter ministerial Committee (CONAPREVIAR is its acronym in Spanish) was responsible for coordinating the actions to deal with the threats of the avian flu. This committee, which had been appointed by the President, fulfilled its duty. The Ministry decided to add more members and include other issues on the Committee's agenda. That decision was based on the need for promoting intersectoral relationships in order to gain consensus in a highly polarized political scenario where government was constantly being questioned.

The procedure was materialized through the following steps: maintaining the MSPAS as a convener, increasing the number of participating agencies from a dozen to more than thirty, and strengthening leadership through the presence and continuous commitment of the Minister. CONAPREVIAR became "CISALUD," where the new acronym refers to the Intersectoral Committee of Health. The level

of representation of the ministries of Labor, Education, Finance, and various government offices was from ministerial given that the Minister presided over the two monthly sessions. The invited ministers used to participate in these meetings. This was called the Political Committee.

The operational and monitoring decisions were made by the Technical Committee, which was lead by the Deputy Minister of Health. Representatives of other organizations used to attend. The Committee has weekly meetings.

It is noteworthy that this dialogue, consultation and negotiation, apart from enabling intersectoral structure for addressing the social determinants of health, offers an opportunity to negotiate the policies on human resources for health. This body could, at some point, be an advisory committee of the National Health Council.

Its dynamics and strategic direction are shared by the participating institutions; it is comparable to the interactions that the Health Action Framework specifies. CISALUD complies with the cycle of case analysis, planning, implementation, monitoring and evaluation. It has moved from the starting point of critical conditions of governance to a progressive generation of alliances, recognition of leadership, selection and commitment to the adopted policies and the allocation of financial resources.

Some examples show how this consensus process has developed as a large table for consensus. The control of the dengue epidemic and the H1N1 pandemic virus along with the response to Hurricane Ida, are critical milestones through which each of the other partners has shown trust in the management by the Ministry of Health.

More than bilateral results, with the ministries of Labor, Finance and Education, CISALUD shows a collective, interagency, intersectoral commitment that sets the conditions for specific achievements of great importance.

#### EXAMPLE OF GOOD PRACTICE BETWEEN MSPAS AND THE MINISTRY OF EDUCATION

##### H1N1: an opportunity for cooperation

The MSPAS called, through CISALUD, to a cooperation with all member agencies that were involved in the field of education. In order to have presence throughout the national territory, all staff of the health sector and the whole educational community (teachers, students, and family members) were called to become part of the health workforce. To this end, four filter points of contact were identified to intervene in relation to H1N1: homes, school buses, school entrances and school facilities. In each of these areas a person was appointed and an evaluation and monitoring system set up to follow up on prevention activities

## 4.2. Social Participation: Social Forum on Health

One of the strategies of the National Health Policy “Building Hope” is the social and communal participation (Strategy 4), which is consistent with the sections of Political Reform and Citizen Participation Policy of the Government Program 2009-2014. In the government program, several guidelines were set related to strengthening citizen participation and their role in decision-making.

In line with the commitments of the first hundred days in office, the National Health Forum was created by means of a ministerial decree. Its mission is “to contribute to the generation of consensus for making strategic decisions that allow transforming the health system towards universality, equity, quality and inclusion and that allow a cross-sectoral approach based on social determinants ... “ (Project Citizen Forum, April 2010: 3 and 4). The Forum is not a cross-state area, but it is an open space of civil society organizations for social auditing.

Additionally, this Forum aims at developing a Citizen Auditing mechanism whose objective is “... local leadership to exercise constant monitoring on health services in order to ensure that the citizen’s right to timely and quality health care be effective.”

Each of the work areas has a schedule of activities with their respective responsibilities and time lines. For example, in the months of April and May, five regional forums and a national forum meeting of synthesis and formulation of proposals will be held. Working roundtables, at this first phase, will finish their function when the First National Health Conference is held.

The communication strategies of the forum include the publication of a newsletter aimed at keeping the population informed about the activities conducted.

In short, CISALUD (intersectoral coordination space) and Citizen Forum (space for civil society participation) are the two main areas from which the transformation of the health system in El Salvador is conducted, and where the possibility of building plans for human resources for health with institutional commitment exists.

## 5. Development of Human Resources Plans and Coordination with Key Government Sectors

At this time (early April of 2010), the formulation of the National Human Resource Plan is at the initial development stage; the DDRHS / MSPAS are in charge of the plan’s elaboration. Some of the main activities for preparation of the plan are the following:

The information for formulating the plan is not enough; therefore, one of the planned activities is hiring experts with the support of PAHO in order to have the baseline information required. For the same reason, the creation of a body responsible for generating information has been suggested. To date, there is no proposal or communication strategy to be adopted within the Ministry and the government apparatus nor a communication strategy because the plan is not yet complete. It is important to mention that the plan is based on the four strategies addressing Human Resources for Health in the Ministry's policy document.

### 5.1. Relationship between Sectors: Finance, Education and Labor

The Ministry of Finance (2009) faces a difficult situation because it has to distribute scarce resources in a society that has a huge social debt. This claim is relevant to a government whose pledge for greater social justice is one of its major commitments. For that, the first strategic guideline of the Ministry of Finance is that of "ensuring resources for social needs," consisting of prioritizing resources for education, health, potable water, sanitation, public safety and the fight against poverty.

The government aims at boosting public investment policy that is primarily oriented to social areas; improving investment conditions, security and public investment to stimulate growth. It plans to finance new investments through three sources: government revenue, international loans and public-private partnerships that do not endanger the sovereignty, and by ensuring state control over natural resources and strategic assets while ensuring competition and protecting the living conditions of population.

In health and education, public investment priorities for the short term are: to maintain and improve the network of hospitals and health centers, (particularly the construction and equipping of a new maternity hospital), and including those hospitals and health centers that have international funding and are needed to improve access to health. The education sector intends to invest in educational infrastructure in order to locate educational centers closer to communities by improving and giving maintenance to those existing ones; it intends to improve the control of training at different levels and support efforts to strengthen universities of the State.

The link with the Ministry of Labor is still weak, with no mechanism for coordination with the MSPAS to facilitate the development of a human resources plan. Indeed, it is noticeable the importance of Ministry of Labor as a player in the protection of the health worker rights. In this case, we found that among health institutions there are diverse competencies and mechanisms of regulation of industrial relations (worker-employer) among health institutions.

The Ministry of Labor does not have jurisdictional competence in some modalities or systems of health worker recruitment, except for its participation as support of social dialogue. Some systems lack worker protection measures, such as severance compensation for termination for State employees. (The compensation for termination does not exist for fired employees.) A significant inequality exists in hiring systems amongst institutions for equivalent positions at the same level. In the ministries, as opposed to autonomous institutions, workers can form unions to collectively negotiate work conditions. Therefore, collective right norms are applied in the Civil Service. This was not possible before; it was made possible in 2009 when the ILO conventions 87 and 98 became effective.

A detail of the labor system of each institution follows:

- **Ministry of Public Health and Welfare (MSPAS.)** MSPAS's officials are protected by the Civil Service Law and the Salary Law. This body regulates the state's relations with its officials and employees to ensure their security and efficiency of public administration.
- **Salvadorian Social Security Institute (ISSS).** It is an autonomous institution. Therefore, its staff joins the ISSS and pay for the general plan for sickness, maternity and occupational risks. Because of their nature, labor relationships are governed by the Labor Code and the collective rights plan. In fact, it ISSS is an institution that has one of the most generous collective agreements in the sector. This explains the existence of differences with other institutions such as the MSPAS.
- **Salvadorian Institute of Teachers' Welfare (ISBM).** This institute is aimed at managing the contributions of civil service teachers to funding a special program that provides medical and hospital care and permanent coverage, as well as hired staff that does not belong to the professional or technical services plan. Due to their nature, labor relationships with the personnel under contract are governed by the provisions of the Labor Code; the relationships with the staff appointed according to the salary are governed by Civil Service Law.
- **Social Security Institute of the Salvadorian Armed Forces (IPSFA).** It ensures the welfare and social security for personnel of the Armed Forces (any person belonging to the Army regardless of the system of hiring and payment). The benefits granted by this institute are: disability pension, retirement pensions, survivor pensions, retirement fund, joint life insurance solidarity, and burial assistance. Due to the nature of labor relationship, in this case the Ministry of Labor has no jurisdiction.

Finally, some of the issues of concern of the Ministry of Labor regarding the employment status of a health sector staff are late wage payments; increase of

fixed-term hiring (under contract or professional services) by which the recognition of some rights and worker benefits are avoided; the existence of different labor systems, which makes it difficult for the Ministry to intervene, or let alone workers under unequal status or defenselessness with regard to other workers.

## 5.2. Main Challenges for the Development of the National Health Plan and Development of Human Resources

Since the plans of development of the Directorate of Development Human Resources for Health are incipient, it is hard to specify difficulties or problems. It is more appropriate to speak of challenges of the great task before us.

- To develop a plan for human resources with a gender approach and the system's user rights, as well as the rights of health care workers.
- To improve the working conditions of health care workers in terms of employment stability, wages, benefits, and training.
- To ask for the technical support and consultancy necessary to prepare some inputs of the plan, such as analysis of the situation of human resources for health; structure, organization and functioning of the Directorate of Human Resources for Health; to train staff under the new model of care and management of health services; develop new competencies of human resources; and set up information systems on human resources for health, for example.
- To achieve consensus and conclude the sectoral and intersectoral agreements necessary for formulating and implementing the plan.
- Adequate allocation of human resources for health according to the reorganization of health care networks.
- To develop the competencies abilities at strategic levels in order to respond to health work approach.
- Increase the workforce indicators of human resources for health in order to reduce gaps.
- Build opportunities for consensus among the social players involved in the institutions of the sector, professional associations, and unions.

## 6. Recommendations

In this section we present some comments and ideas that emerged in discussions with MSPAS staff, as well as some recommendations to improve the quality and viability of Human Resources Plans.

- Promoting the new approach that focuses on gender, human rights and citizenship in each of the strategies proposed in the Health and Human Resources Policy to contribute to empowerment and greater citizen participation in this field by following the strategic guidelines of the Policy on Citizen Participation of the Government Program for 2009-2014.
- Promoting the development of new competencies of Human Resources for Health so that they fit the requirements of the new health care model. This effort means to change the culture of staff and users regarding the vision of the health-disease process.
- Strengthen DDRHS with personnel and equipment, and the development of new skills, so that workers will be able to successfully take on the challenges posed in the area of development of human resources for health.

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### Introduction

Continuing technological developments, changes in demand caused by globalization, and complex changes that occur constantly show that the success of organizations of any type lies on the capacity and quality of its human resources. This is a reality forcing us to think and create ways of managing human resources not only for contributing to the achievement of corporate goals, but also human ways in order that workers be pleased in a career that gives them confidence in their future.

Mistakes have been made in management theory when the concept of an organization is seen as an abstraction that is different from people. Organizations are groups of people associated with a specific purpose, so that when discussing the development of organizations, we are talking in an indirect way of human resource development. However, on many occasions this valuable resource was seen as something external to the process of strengthening and developing organizations and not as a priority. Therefore, its consideration was delayed to the point that any economic outlay used for strengthening was seen more as an expense with no return rather than an investment. In fact, its importance was always underestimated compared to other management elements, without realizing that those tangible elements could not function without the decisive intervention of human resources.

In the past, in the Ministry of Health, the issue of human resources was not considered an important element in the development of health. The actions taken by the Ministry in terms of human resources were located in a personnel office, which was responsible for control, benefit calculation, and payroll, among other responsibilities.

Even for organizations such as PAHO, the issue of human resources was not relevant, especially when compared with health care issues and emerging problems related to mitigation of diseases, epidemics and other disasters that have occurred in the Region. At least, from 1980 to 2001, PAHO's governing bodies have not passed any resolution in this regard, making the above evident.<sup>12</sup>

In the health sector in Guatemala, the importance of health human resource development was highlighted in 1997, when certain articles of the Health Code

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12. Source: Pan American Health Organization (PAHO) 2007: Health in the Americas 2007, Scientific and Technical Publication. VOLUME I.

were reformed, specifically Article 25. It mentions “The priority of human resources,” stating that the Ministry of Health was to give priority to human resources as a key factor in modernizing the health sector.

In 1999, a significant move took place when creating the Human Resources Department, which marked the importance given to the human resource concept in the Ministry of Health; this gave a significant shift in approach, treatment and management of human resources.

At the international level some events that highlighted the importance of human resources took place. It is particularly noteworthy to mention that in 2006 the World Health Organization dedicated World Health Day to acknowledge the work of health professionals under the motto “Working Together for Health,” defining this as a priority area in the work plans of 2006-2015.<sup>13</sup> In addition to this decision, the Millennium Development Goals (MDGs) highlighted the importance of having a sufficient number of qualified human resources in order to meet the objectives.<sup>14</sup>

In 2006, 28 countries met in Toronto at the 7th Regional Meeting of the Observatories of Human Resources for Health, sponsored by the Pan American Health Organization, in conjunction with the Ministry of Health of Canada. This event originated “The Toronto Call to Action 2006-2015 for a Decade of Human Resources for Health.” This meeting sought to mobilize national and international players from the health sector and other relevant sectors of civil society to collectively set policies and actions for the development of human resources for health, and to assist in achieving the Millennium Development Goals, national health priorities, and access to quality health services for all people in the Americas by 2015.

In the preparation of this study, some valuable documents were consulted, which had been provided by the PAHO country office. Some of them were considered key to undertaking a brief analysis of the real situation of the health workforce in Guatemala. These include: (a) The Toronto Call to Action; (b) The 10-Year Development Plan on Human Resources for Health, 2006-2015, (c) Indicators of Regional Goals for Human Resources for Health 2007-2015; d) a study: Reports on Human Resources for Health in Guatemala; (e) Characterization of the Nursing Workforce in Guatemala; (f) Draft: Human Resources for Health in Guatemala: Availability and Training (Dr. América Mazariegos de Fernández) and other documents such as laws, ministerial agreements, etc.

At the same time, interviews were undertaken with key staff from institutions related to the Ministry of Health about the administration, financing and workforce

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13. PAHO 2007: 348.

14. PAHO 2007.

allocation, such as the National Civil Service Office (ONSEC, is the Spanish acronym) and the Technical Budget Directorate of the Ministry of Finance and University Academic System, which is now integrated into the Interagency Committee of Joint Actions of the Academic and the Health Sectors chaired by the Deputy Minister of Health.

## 1. Policy Framework for Health System Transformation

The Ministry of Health and Welfare has set a policy framework named Strategic Guidelines for 2008-2012, based on a vision and mission seeking to illustrate the status of health care in the country by 2020.

The vision states: *“In Guatemala, in 2020, every Guatemalan, at different stages of life, will have equal access to comprehensive and integrated health services with a human approach of quality and cultural relevance through effective inter-agency and intersectoral coordination.”*

*Its mission is expressed in terms of: Ensuring the right to health of the country’s population, by exercising the stewardship of the health sector through the leadership, coordination, and regulation of health services offered, and by controlling resource funding and administration directed towards humane treatment in order to guarantee health promotion, disease prevention, recovery and rehabilitation of people with quality, cultural relevance and equitable conditions.”*<sup>15</sup>

The health policy framework proposed by the Ministry of Public Health and Welfare for processing and handling the health system in Guatemala includes the following policies:<sup>16</sup>

- Strengthening the leadership of the Ministry of Public Health in order to strengthen the State of Guatemala;
- Improving and expanding health care coverage and providing comprehensive integrated health services;
- Promoting and strengthening measures to ensure access to medicine;
- Recognition of the use and practice of alternative and traditional medicine;
- Promoting research and technological development in health;
- Strengthening research and health workforce development;

15. Ministry of Public Health and Welfare: Vision, Mission & Challenges. Available at: [http://portal.mspas.gob.gt/vision\\_y\\_mision\\_general.html](http://portal.mspas.gob.gt/vision_y_mision_general.html).

16. Ministry of Public Health and Welfare: Vision, Mission & Challenges. Available at: [http://portal.mspas.gob.gt/vision\\_y\\_mision\\_general.html](http://portal.mspas.gob.gt/vision_y_mision_general.html).

- Developing environmental primary care through regulation, monitoring and enforcement of the existing legislation of water, sanitation and hygiene in order to improve the population's quality of life;
- Responding to health service demand generated by the implementation of programs for social equity and solidarity;
- Improving funding and quality of health spending; and
- Harmonizing and aligning international cooperation with national interests and sector priorities.

In addition to the aforementioned policies, the Health Ministry's authorities considered that it was important to define some challenges and institutional commitments in order to make the implementation of the Ministry's policies more viable. In its commitments, the Ministry of Health has included the development of human resources. Among the major challenges outlined by the health authorities are the following:

- Rethinking and redesigning the care model to ensure a health system in the Guatemalan nation that is more inclusive, democratic and caring; this would imply that the Health Ministry resume health stewardship;
- Having a health workforce prepared for changes;
- Promoting the design and implementation of a differentiated care service by encouraging respect for other cultures and diversity;
- Ensuring the decentralization of resources where societal participation is essential; and
- As a sine qua non condition: achieving the territorial management of health.

The challenges at the institutional level include actions regarding human resource development. They are the following:

- Ensuring quality, free and universal health care for low-income populations;
- Strengthening programs of health promotion and disease and external damage prevention;
- Ensuring access to safe, effective, and good-quality medicines;
- Expanding and strengthening the infrastructure, basic equipment and supplies to the health service network;
- Increasing health spending in the Republic's general budget;
- Developing human resources for health;

- Modernization of institutions;
- Regional health management;
- Reducing maternal and infant mortality rates;
- Contributing to the reduction of child malnutrition; and
- Reducing the incidence of infectious diseases (emerging and reemerging prevalent diseases) vector-borne zootoxic diseases, and chronic and degenerative diseases.

### 1.1. Problems Faced by the Ministry of Health in Implementing the Guidelines

The Ministry of Health, as responsible for health care in the country, faces many different problems. Some impact directly or indirectly on the issue of human resources; they are the following:

- Economic, political, legal and social exclusion in Guatemala; difficult to obtain resources; social vulnerability, and little recognition of special group identities. This phenomenon is extended to the provision of services, creating health services that are exclusive, segmented and fragmented due to the same patterns of behavior.
- Poverty levels in the country ranging from 56% to 60% of a population of nearly 15 million inhabitants (14,361,666 according to the INE [National Institute of Statistics]). This percentage of poverty includes about 16 percent of extreme poverty, which creates a complex situation of demands for a health system with insufficient financial resources. Guatemala's health spending is considered one of the lowest in the Region.
- The aforementioned issues generate little chance of development at the rural level, which is steeped in poverty and has increasing deterioration of environmental and social conditions that do not provide quality living conditions, especially for health staff who move to work in those areas.
- For the reasons stated above, a clear and inequitable distribution of health workforce exists in the country; it occurs in all professions that are concentrated in the metropolitan area and surrounding cities, or in those with training institutions, like Quetzaltenango and Sacatepequez. In the capital of Guatemala, for example, it is estimated that 71% of the physicians, or 9,185 out of 12,940 registered in 2009 live there, which means an approximate distribution of 30.1 physicians per 10,000 inhabitants; or 1 physician per 332 people, while in other places of the country, such as the Altiplano, there are less than 2 physicians, and others like the Quiche, in 2009, had a density of 1,07. In other words, in Quiche 1 physician must cover 9,064

people, and in Alta Verapaz 1 physician must cover 6,451. Those figures show an unequal total distribution.<sup>17</sup>

- The table below shows the disparity regarding the concentration of human resources in the regions in the country.
- This distribution of human resources significantly hinders the achievement of the institutional purposes to improve morbidity and mortality rates in the country and bring health care to the neediest areas.

GEOGRAPHIC DISTRIBUTION OF HUMAN RESOURCES FOR HEALTH - MSPAS – 2007<sup>a</sup>

Region	Population Percentage	Medical Staff Percentage	Paramedic Personnel Percentage
Metropolitan	22	47	33
North	9	4	6
Northwest	8	7	8
Southeast	8	7	8
Central	11	9	10
Southwest	24	19	21
Northwest	14	5	9
Peten	4	2	4
Total	100	100	100

Note:

<sup>a</sup> The classification of the staff at the Ministry of Health and the Human Resources Department is included in PAHO 2007. Information on Human Resources for Health. Universidad Rafael Landívar. P. 46.

Source: Characterization of the staff of the Ministry of Public Health, General Directorate of Human Resources, 2007.

## 2. Framework of the Policy on Human Resources for Health

When analyzing the documentation received, no guideline or official document was found stating a national policy on human resources for health. This was corroborated by key informants at the meeting. This shows that the Ministry of Public Health, at the time, had not defined a policy on development of Human Resources for Health. However, the documentation does include provisions of institutional policy on health, which show the intention to work on strengthening human resources for health. The provisions are the following:

- Strengthening of research, development and management of the health workforce is policy number five.
- Having a health workforce prepared for changes is the second challenge.

17. PAHO. 2009: Information on Human Resources for Health in Guatemala. University Rafael Landívar. P. 7.

- Developing human resources for health is the institutional challenge number six.

In October 2006, as an initiative and contribution from the Joint Action Committee of the Academic and Health Sectors, formed by the University of San Carlos de Guatemala, Mariano Galvez University, Rafael Landivar University, the Guatemalan Social Security Agency and the Ministry of Health as committee coordinator, developed the 10-Year Development Plan on Human Resources for Health in Guatemala for 2006-2015.

It is important to mention this plan, though it is not considered by the current government, as the only means to verify what has been achieved, and what was defined against the commitments made after the “Toronto Call to Action,” at the meeting in Ontario, Canada from October 4 -7, 2005<sup>18</sup> as challenges and goals for human resource development.

Excerpts of the plan stating the challenges, the vision for 2015, and the expected progress by 2010 follow.

### *For Challenge I:*

*“Define policies and long-term plans for adapting the workforce to the health care needs and foreseen changes in health systems, and develop institutional capacity to implement and periodically review them.”*

The Ministry stated the following:

- The vision for 2015 described in the Plan states:

*“A policy on health workforce exists; it responds to the current health system and operates in national and institutional plans.”*

- The expected developments for 2010 were described as follows:
  - ▶ Permanent information is available on personal health needs, expressed in quantity, profiles and competencies, demographic and epidemiological changes and the characteristics and trends of new resource training, which underpins the national policy on human resources.
  - ▶ A National Policy on Human Resources for Health exists.

18. Ministry of Public Health and Welfare. Interagency Commission of Joint Actions on Education and Health Sectors. Subcommission on Health Task Force Development, with support of PAHO/WHO 2006: Decennial Plan on Human Resources for Health Development. Guatemala 2006-2015.

- ▶ The necessary technical, labor, budgetary and educational changes have been made to implement the policy.
- ▶ Institutions of services and training are in a continuous process of adaptation to the policy.<sup>19</sup>

### *For Challenge II:*

*“Placing the right people in the right places to get a fair distribution of health professionals in different regions according to different health needs of the population.”*

#### ■ Vision for 2015:

*“Health availability that allows people from all regions of the country and from different social strata and ethnic groups access to health services in an equitable manner.”*

#### ■ Progress made in 2010.

- ▶ Timely information exists on resource availability in terms of number, skills and cultural characteristics in all regions and departments in the country.
- ▶ A political decision has been taken; legal support and a budget exist to mobilize and motivate health personnel in areas of greatest need

### *For Challenge III:*

*“Regulation of migration and displacement of health workers to ensure access to health care for all the population.”*

#### ■ Vision for 2015:

*“Ongoing monitoring of national and international migration of health workers is performed, and actions to regulate have been taken in the face of incremental and negative effects on availability and distribution of human resources.”*

#### ■ Progress made in 2010:

- ▶ A system is functioning to detect and record internal and external migrations of health workers in the country, which is discussed in the Observatory of Human Resources for Health.

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19. Ministry of Public Health and Welfare and others 2006: Pages 4 and 5.

### For Challenge IV:

*“Building work relationships between workers and health organizations that promote healthy work environments and foster commitment to the institutional mission in order to guarantee quality health services for the population.”*

- Vision for 2015:

*“There exist mechanisms, rules, regulations and agreements concluded by consensus allowing workers, unions and managers to harmoniously pursue the objectives of the institutions.”*

- Progress made in 2010:

- ▶ There are systems of hiring, monitoring, and evaluation that are approved by workers and managers who maintain a healthy work environment.
- ▶ There is a system of performance evaluation based on a work incentive program.
- ▶ There is a system of continuing education linked to the administrative career.

### For Challenge V:

*“To develop mechanisms of interaction between educational institutions (universities and schools) and health services to adapt the workforce training to a model of universal, equitable and quality care service according to the health needs of the population.”*

- Vision for 2015:

*“Universities and training schools provide training of adequate quality and quantity in geographic regions and disciplines as needed. Graduation profiles have been defined based on the skills required by the institutions that provide employment.”*

- Progress made in 2010:

- ▶ Mechanisms of interaction between health care institutions, universities and other schools have been strengthened through legislation of national coordinating bodies, and by working together to search for information, analyses and decision making.
- ▶ Universities have established priority health degrees in technical and professional areas where specific needs have been identified.

- ▶ Approaches and a minimal health training program have been identified in response to the characteristics of the health system, models of care, and expertise provided by employing institutions.
- ▶ The training of health technicians in the Ministry of Health and the IGSS [Guatemalan Institute of Social Security] has been transferred to certified educational institutions, and mechanisms for regulation have been developed by the Ministry of Health.
- ▶ The Interagency Committee of Joint Actions of the Academic and Health Sector is the analytical and advisory body to regulate training of human resources for health training and to guide new programs.

A logic matrix was made for each challenge in the 10-year plan; it consists of important headers to follow, such as initiative for two years, expected changes for each project, progress marks, main course of action, and feasibility and viability. This matrix allowed the Interagency Committee to verify the scope of each of the initiatives undertaken and planned in order to meet the challenges.

In July 2009, the “Study: Information on Human Resources for Health in Guatemala”<sup>20</sup> was published, which was prepared by the Rafael Landivar University and the Pan American Health Organization (PAHO). Its design took into account four expected outcomes:

- **Outcome 1:** Analysis of the status of the main components of the health workforce in the country
- **Outcome 2:** Identifying trends in production, distribution, human resource allocation, problems, challenges and obstacles to its improvement and development
- **Outcome 3:** Proposing goals and strategies in human resources for health for 2009-2015 based on the “Regional Goals for Human Resources” and the Toronto Call to Action
- **Outcome 4:** Definition of an ongoing process of data collection / management of human resources able to be sustainable and applicable in an observatory of human resources.

This document describes the actions and strategies for the Development of Human Resources for Health and a SWOT analysis for the development of human resources for health in the country over the next six years. It also makes a first attempt to assess the progress in challenges and goals of Resolution # CSP27/10 PAHO “Regional Goals of Human Resources for Health 2007-2015.

20. Pan American Health Organization 2009: Information on Human Resources for Health in Guatemala. University Rafael Landivar.

It is unclear whether such an assessment used the indicators published in the paper: “Indicators of Regional Goals for Human Resources for Health for 2007-2015 Manual for baseline measurement.”<sup>21</sup> They were included in that document to be taken into account in the evaluation by the authorities of the Ministries of Health. It is included in this document as one of the valuable contributions to the situation analysis of human resources (shown in Annex 1). The same document includes actions and strategies for the period 2009-2015 as a suggestion to be considered for national goals. Unfortunately, no evidence exists whether they have been included by the authorities of the Ministry of Health (See Annex 2).

### **3. Development of Human Resources Plans and Coordination with Key Government Sectors and the Health Sector**

In order to clarify the relationship of the Ministry of Health with key organizations that comprise the non-governmental sector and with governmental entities, a diagram is included below.

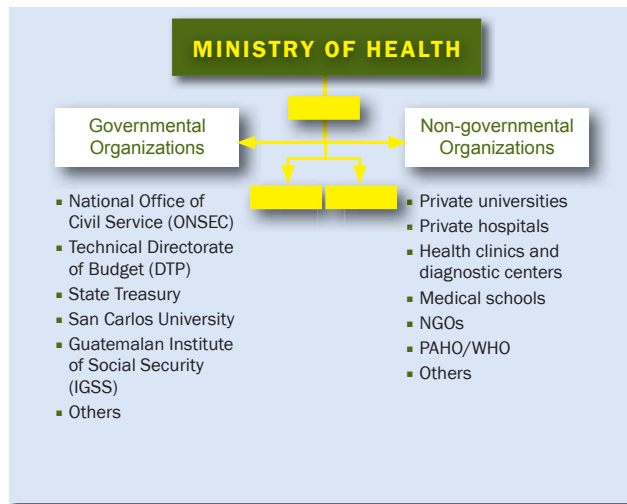
Each of the entities included in this diagram has a link with the Ministry of Health, which acts as a technical-administrative support or as entities receiving the leadership of the Ministry of Health to ensure population health care. All these organizations have, to a greater or lesser extent, a relationship with the Ministry of Health regarding the development of human resource for health.

The following chart describes the relationship of three of these institutional bodies of the central government: The National Civil Service Office (ONSEC), the Ministry of Finance (represented by the Technical Budget Directorate [DTP]), and the educational sector (represented by the national academic and private sectors of the country).

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21. PAHO (undated): Indicators of the Regional Goals for Human Resources for Health 2007-2015. Handbook for Measurement and Monitoring.

## MINISTRY OF HEALTH MAIN CONTEXT OF INTERACTION



### 3.1. National Office of Civil Service (ONSEC)

ONSEC is the governing body responsible for regulating implementation of the Civil Service Law, rules and other supplementary laws that govern all public servants. This was approved by Congress on May 10, 1968 by Decree 1748, and became effective on January 1, 1969. Its highest authority is the President of the Republic.

Its functions within the legal framework established by the constitution of the Republic of Guatemala, the Civil Service Law, and State Civil Pensioners Law and its regulations, and other supplementary provisions, which state that the National Civil Service Office (ONSEC) is responsible for regulating the relationship between the public administration and its servants, which are all administrative bodies under the authority of the executive organism and its decentralized and autonomous entities ruled by that legislation, and all matters concerning the administration of the different pensions that are granted to former employees and beneficiaries of the State Civil Pensioner System.<sup>22</sup>

Regarding the management of human resources, Article 13 of Government Agreement N° 355-2009, assigned ONSEC the decentralization of functions and staff positions. An excerpt from Article 13 indicating the decentralized orientation to be assumed by this government office follows.

*"The National Office of Civil Service will provide the necessary technical and legal advice and approve the profile of those responsible for man-*

22. CD of ONSEC 2007: "Lineamientos generales para la reestructuración de las coordinaciones de recursos humanos (oficinas tipo)." Guatemala. Available at: <http://www.onsec.gob.gt/#>.

*aging Human Resources Type Units; this commitment is assumed by the appointees in authority to validate the modernization process of the Public Administration.”*

The Government Agreement No. 185-2008 of July 7, 2008 establishes the rules governing the application of the human resources policy that should be implemented in the Public Administration and, therefore, in the Ministry of Health.

Article No. 3 of the Agreement on administrative policies establishes some policies worthy of mention that are based on the concept of a decentralized public administration of human resources. The subsections of the article are the following:

- **Subsection c.** Attract competent human resources for an adequate performance by public servants by observing and evaluating issues of multiculturalism and gender.
- **Subsection d.** Evaluate the performance of public servants once a year in order to develop training programs and incentives to improve their work efficiency.
- **Subsection e.** Train public servants continuously and provide them with basic knowledge, skills, and abilities for current and future work; and encourage their professional and personal growth, according to their potential and the needs of the Public Administration.
- **Subsection h.** Collaborate with the ministries at the Executive level, especially the ministries of Education, Public Health and Welfare, and Government to continuously review their organizational structures and redesign their procedures in order to respond with greater speed to matters within their jurisdiction and in order to grant an immediate response to the demands of the population by giving priority to the areas of education, health and safety.
- **Subsection j.** Give authority to the National Office of Civil Service to ensure strict compliance with provisions adopted for human resources through the tools, techniques and instruments in the way it may consider appropriate.

Article No. 7 of the aforementioned Government Agreement assigns ONSEC the responsibility for designing rules, procedures and tools that allow the implementation of the policies defined in the Agreement. The appointed authorities are required to comply with and enforce the provisions issued

Finally, Agreement 185 supports the decentralization of functions explained in Article No. 8, which obliges ONSEC to begin the decentralization of certain func-

tions in ministries, departments and agencies of the Executive by assuming the new regulatory and control role of such actions. For this reason, in the central government institutions, the human resources “type” units should be working with the techniques and criteria previously established.

In order to carry out its functions, ONSEC, through Resolution D-2007-128 of February 28, 2007, defined the basic structure that the administrative units and their corresponding functions, institutions, will have, depending on their institutional size. They are the following:

- A Directorate or Chief Office
- Unit of Personnel Applications
- Staff Recruitment Unit
- Personnel Management Unit
- Staff Development Unit

The responsibilities and roles of these units are the following:

- Directorate or Chief Office Unit will be responsible for overseeing the establishment and maintenance of an integrated and transparent Human Resource Management system (Article 4.)
- Staff Application Unit is responsible for analysis and evaluation of the organizational structure. It has to provide the institutions with position profiles enabling the selection and recruitment of the right people for the performance of their duties and assigned responsibilities (Article 5.)
- Personnel Recruitment Unit is responsible for selection and recruitment by using tools and techniques that will facilitate those functions, assuring a selection process in compliance with the principles of merit, ability and transparency. This unit will be formed by other units of Recruitment and Selection (Article 6).
- Personnel Management Unit is responsible for keeping track of the public officers who work in each unit, and establishing and implementing the tools allowing to monitor their behavior. This unit will be formed of other units: Personnel Actions, Monitoring and Payroll Management (Article 7.)
- Personnel Development Unit is responsible for ensuring the development of people. For that, it will design and implement training and continuing education programs; it will ensure compliance with measures to maintain the environmental and psychological conditions of workers, and perform other activities related to its function. It will be made up of the Training and Development Unit and Health and Safety Unit.

Currently, in compliance with these mandates, the Directorate of Human Resources in the Ministry of Health has already made these structural changes. It designated the required “Type Units” based on the aforementioned characteristics.

### 3.2. Ministry of Finance (Technical Directorate of Budget, DTP)

The relationship between the Ministry of Health and the Ministry of Finance, specifically in human resources issues, focuses on budgetary aspects. The Technical Directorate of Budget (DTP is acronym in Spanish) reports to the Ministry of Finance, which is responsible for the Public Sector Budget System and for regulating, managing and coordinating budget processes; it has to analyze, monitor and evaluate the budget execution, focusing on the control of public management performance to promote the development of the country according to its needs.

This unit is limited to controlling the proper utilization of resources through the implementation of budget items classifications: institutional, geographical, purpose and functions, expenditure type, funding sources, headings, economic resources, expenditure object, and expenditure economy.

In November of each year, the Ministry of Health and all the other institutions governed by the DTP’s guidelines are to submit their budgets by following established guidelines and requirements, unless there are changes authorized by the Congress.

The DTP also takes care of requests for changing the use of funds allocated to certain budget items, ensuring that sufficient funds exist. The DTP controls the expending used under headings covering positions with permanent salaries such as the 011, and 022. It also keeps track of the amounts allocated to temporary positions. The latter option is used especially by the Ministry of Health for the constant rotation of medical personnel in hospitals. It facilitates the immediate recruitment of health personnel and does not generate labor liabilities. Other items under the symbol 029 and 182 are used for personnel under contract, which is handled independently by the Ministry of Health without the control of the DTP.

An interaction between the Ministry of Finance and the Ministry of Health takes place when the latter requests a bonus for health personnel once a year. Once the DTP verifies fund availability for the budget item, the Ministry of Health handles the delivery in the manner it deems appropriate.

Another interaction between the Ministry of Finance and the Ministry of Health takes place when the creation of additional positions is needed. The Ministry of Health submits the request to the National Office of Civil Service (ONSEC), which sends the request to the Technical Directorate of Budget for checking the availability of funds needed for the positions to be created. The DPT sends back the

technical opinion to the ONSEC, communicating whether funds are available or not and the budget items that would be affected. Finally, ONSEC issues an opinion approving or denying the request.

### 3.3. Higher Education

In Guatemala, the education sector has a direct relationship with the Ministry of Health; it is represented by the public and private university academic systems, which are responsible for the training of human resources in health sciences.

On March 5, 2004 a significant event occurred in the management of human resources for health in Guatemala. The Ministry of Health, in conjunction with public and private universities in the country, decided to form an interagency committee to deal with the proper coordination of human resources development. Taking advantage of the visit of Dr. Mirta Roses Periago, Director of the Pan American Health Organization, the Declaration of Joint Intention of Schools of Medicine and Health Sciences was signed by three universities and the Ministry of Public Health and Welfare of Guatemala. The participating universities were the University of San Carlos of Guatemala, Rafael Landívar University and Mariano Gálvez University.

The rationale for reaching national integration was the specific situation of the nation's health, highlighting the prevalence of chronic and acute malnutrition in children, high infant and maternal mortality, and high frequency of infectious diseases. These are signs of poverty, deteriorated living conditions and environment, especially in rural and marginal urban areas, and limitations in coverage and quality of health services of the health system prevailing in the country.

Along with the above conditions, the Peace Agreements and the Millennium Development Goals were cited as cornerstones for building sustainable human development where joint participation of social sectors and institutions were necessary.

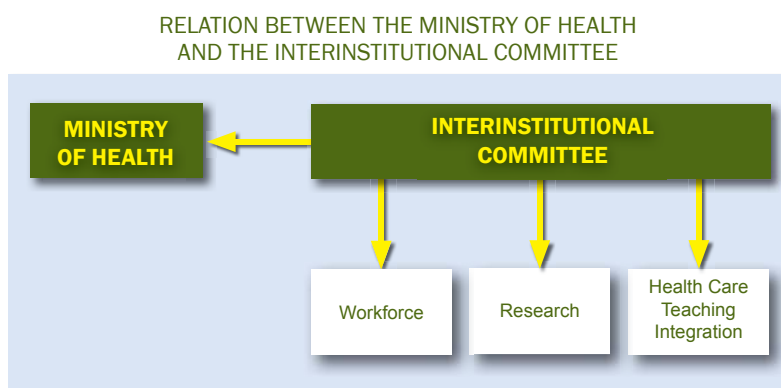
It was pointed out the importance of the participation of universities in social functions promoting the wellbeing of the population and sustainable human development; full enjoyment of human rights and dignity, and promoting the values of equity, peace, justice, respect, freedom, and solidarity.

The Ministry of Health highlighted the need for a national education and training effort to develop human resources for health in the country to face the priority issues based on primary health care and the care model of universal coverage, reliable food and nutrition, reduction of child and maternal mortality in order to have a healthy country.

It is necessary that universities in health sciences, in terms of quality human resources development, undertake research in response to national needs, extend the public service activities and strengthen human values, give technical harmony for the development of the health system, the coordination and integration of activities between schools of medicine and the Ministry of Health, and think of health advantages and the Guatemalan population.

The Interagency Committee was subsequently validated with the Ministerial Decree N° SP-M-1814-2005. It consists of an Executive Council composed of the Minister of Health and Welfare (who may be represented by the deputy minister), Dean of the Schools of Medical Sciences and Health from the University of San Carlos de Guatemala, the Dean of the School of Medicine of the Mariano Gálvez University, and Dean of the School of Medicine of the Rafael Landívar University. Each representative has a deputy, who may participate in the discussions of the Committee, representing the full member without the right to vote. The technical secretary reports to the Pan American Health Organization, which also has the right to speak without vote.

The Executive Council may form work subcommittees. Currently, three subcommittees exist: the Subcommittee on Workforce, the Subcommittee on Research, and the Subcommittee on Teaching and Health Care Integration.



The subcommittee of Health Promotion and Prevention has to be formed.

Article No. 3 of the aforementioned ministerial decree assigns the Committee the following functions:

- Strengthen teaching and health care integration.
- Promote activities that integrate and complement the efforts of each institution in order to meet the health needs of the country by optimizing existing resources.

- Harness joint work by means of agreements, specific plans and regulations that facilitate feasibility, monitoring and performance evaluation.
- Promote strategies and modalities of support from universities in order to train human resources for health.
- Invite other units and academic, research, and services institutions to join and participate in this effort.
- Consolidate and expand mechanisms for strengthening the human and ethical values of students and professionals involved in the health care of the Guatemalan population.
- Perform other duties the Committee deems necessary.

The Ministry of Health, in addition to the functioning and role in the Interagency Committee, undertakes other negotiations related to human resources with the present universities. At the individual level, it is important to highlight the specific negotiations with the University of San Carlos, with which it concluded an agreement to accept professionals for medical residencies several decades ago.

Regularly, direct negotiations are undertaken with private universities, which are formalized through Letters of Understanding. These negotiations are carried out according to the specific requirements of the Ministry of Health and under the Framework Convention between the Ministry of Health and the Interagency Committee.

Another specific case of negotiation and interaction of the Ministry with the academic and education sectors occurs when assigning students to hospitals for their respective practices. These negotiations result from the guidelines and requirements of each hospital.

## 4. Observatory of Human Resources for Health

The observatory of human resources, in general, is aimed at generating and cooperatively accessing information and knowledge required to identify situations, problems and personnel development trends in health systems in order to define policies and strategies of personnel management. Its main objective is to support policies to strengthen human resource development in the context of the processes of change in health systems in which the countries in the Region are involved.<sup>23</sup>

In Guatemala, the Observatory is an initiative of the Interagency Committee on Joint Actions of the Academic and Health sectors. One of the work lines of the

23. In Pan American Health Organization 2000: Observatory on Human Resources for Health. Interinstitutional proposal PAHO-CEPAL-ILO. Quito. Available at: [http://www.opas.org.br/rh/publicacoes/textos/pub01ind\\_int.pdf](http://www.opas.org.br/rh/publicacoes/textos/pub01ind_int.pdf).

Committee is strengthening the health workforce; for that, it needs updated information on human resource training.

The Committee is responsible for the development and operation of the Observatory, although this is coordinated by the Human Resources Directorate of the Ministry of Health. It is formed of representatives by institutions related to the health workforce who express interest in actively participating.

- The objectives pursued by the Observatory are the following:
- Provide information on the health workforce situation and trends.
- Maintain dialogue and consensus among stakeholders in order to produce recommendations and address the interactions for development of the health workforce.
- Identify and promote research on national and international institutional processes related to the health workforce, with special emphasis on sector reform and regional integration.
- Use and promote the use of information, and formulate recommendations for planning, training, regulation and allocation of human resources contributing to the provision of health services.
- Respond to requests for advice on issues and situations through technical opinion, participatory discussion and mediation.
- Ensure the coordination and cooperation for the development of the health workforce.
- Strengthen the oversight role of the Ministry of Public Health and Welfare.<sup>24</sup>

## 5. Lessons Learned

The lessons learned have been identified by the Interagency Committee on Joint Actions and educational institutions. They are the following:

### 5.1. Interagency Committee

- The fact of having integrated the academic sector, represented at the three universities with the Ministry of Health in an interagency committee, is a clear sign of awareness of the health problem, and particularly the human resources development; health is a concern all of and not just the State. In this sense, the country has a vision for solution of its health problems.

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24. These notes were taken from Dr. Annette Morales de Fortín, Dean of the School of Medicine of the University Mariano Gálvez.

- Regarding the performance of the Interagency Committee, although some believe that it is not working ideally, just the fact of deciding to form the Committee is a real strength of the system; it has allowed them to listen to each other as representatives of their institutions. Integration into the Association has allowed everyone to learn from the experience of others in problematic situations. Hospital problems are handled as a team.
- The factors that positively influence the Association are present, for example, when allocating human resources in hospitals. This negotiation has been concluded according to the needs of hospitals and not the needs of universities.
- The formation of the Committee has allowed, in addition to the above, the awareness that if universities are isolated, they are displaced from reality. The Committee allowed the different bodies of the health sector to unite in terms of human resources, which would otherwise not have been achieved.
- All members of the Interagency Committee believe it is important that the Ministry of Health takes the stewardship role in planning and managing human resources, which should be stated in a human resources plan. This would allow having clear parameters for negotiation with a country vision, rather than a segmented view on the issue of human resources.

In general, members of the Interagency Committee think that this committee would work better under certain conditions, which, broadly, are the following:

- The members of the Committee must undertake their responsibilities as part of the System of Human Resource Development.
- The Committee could be more useful to the Ministry if the latter had a guideline of human resource management in order to focus on the actions of educational institutions. This would be achieved with a long-term and steady Plan of Human Resource Development, which would make universities better plan the development of programs to meet what the Ministry of Health has defined as priority.
- The major weakness of the Committee is often caused by changes of government and political interests. For that reason, there was no continuation because when a new government takes office, everything has to start from zero once again.

## 5.2. Other Institutional Bodies

- On the positive side we have found that there is a great possibility for graduates to practice their professional expertise in the national hospital system. The University of San Carlos qualifies the professionals before graduation and subsequently certifies them as specialists.
- Regionalization conducted by the universities, like the University of San Carlos with the residency program, has been an extraordinary step in alleviating the health problems in the country. There are other examples of projects, such as those of Rafael Landívar University and Mariano Gálvez University, which also carry out regionalized programs.
- The National School of Nursing in Alta Verapaz has developed some low-cost electronic technology that can be used for many purposes and is currently being used for training, especially of nursing assistants. This is a successful lesson learned and a creative help in the provision of human resources in the country.

## 6. Analysis, Reflections and Recommendations

Detailed below are some findings from the documents consulted (described in the Introduction of this document) as well as some comments and important information provided by key informants at the time of the interview.

### 6.1. Analysis

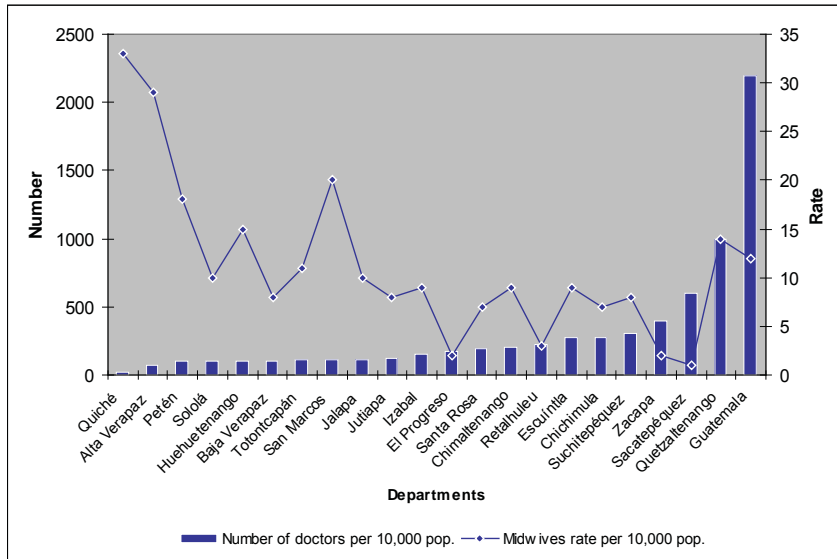
This part is basically oriented to the realities the Ministry of Health faces as head of health in the country along with the Interagency Committee. These realities constitute the most important challenges in the work of human resource development with the purpose of improving the health situation in the country.

- According to the paper Health Human Resources in Guatemala by Dr. Mazariegos América, “the ratios of the number of professionals and technicians per capita are a reflection of the health system that each country adopts.”<sup>25</sup> According to data collected in this document, there is an inverse relationship between the number of physicians per 10,000 inhabitants and the number of midwives integrated in health services. This relationship is described in the following figure, which makes evident the importance of incorporating these human resources into the health team.

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25. Mazariegos de Fernández, América. Human Resources for Health in Guatemala: availability and training. Draft document. P. 180.

### AVAILABILITY OF DOCTORS AND MIDWIVES INTEGRATED IN HEALTH SERVICES IN THE COUNTRY DEPARTMENTS



Source: The figure has been taken from the draft document of Fernández Mazariegos, p.181.

- In the case of nursing, according to the paper Characterization of the Nursing Workforce in Guatemala<sup>26</sup> there are 3.6 nurses per 10,000 inhabitants in the metropolitan area, while in the counties the ratio is much lower.
- In addition, most county hospitals have only one registered nurse on night shifts, who has to supervise the entire hospital and leave the patient in the hands of nursing assistants.<sup>27</sup> Ideally, patients should always be seen by a physician and not by a nurse; however, due to the lack of professionals these problems exist. In some cases the situation is even worse because patients are treated by nursing assistants.
- There is no National Human Resources Plan to be used as a benchmark for long-term planning by the Interagency Committee on Joint Actions of the Academic Sector and Health Sector. There are only approaches that respond unilaterally to some requirements defined by the Ministry of Health as priority areas. On the other hand, sometimes, the Ministry of Health when making these requests did not realize in advance that there was no funding to meet those needs.

26. Ministry of Public Health, University of San Carlos de Guatemala, Guatemalan Institute of Social Security (IGSS), Guatemalan Association of Registered Nurses, University Rafael Landívar, University Mariano Gálvez, Pan American Health Organization 2009: Characterization of Nursing Task Force in Guatemala. April 2009.

27. Ministry of Public Health and others 2009: p. 3.

- Because no plan exists, universities are offering degree programs based on student demand and not on the needs of the Ministry of Health to achieve its health goals.
- While prevalent economic conditions in areas defined as high poverty have no substantial improvement, the health problems the Ministry of Health must solve will not have a real solution, even when budget problems are solved, or the standards of human resource development are raised. On the other hand, it is very difficult for the Ministry of Health, as well as for national and private training institutions that are taking care of their human resources (physicians and nurses) to think about moving to areas where there is a shortage of staff, and where morbidity and mortality indices are high. People seeing little chance to develop as professionals—to have their private clinic and decent incomes—and who have to sustain their families will try to stay away from those environments that are not able to meet their expectations.
- Although the Ministry of Health and the Social Security Institute (IGSS), the two largest employers of human resources for health in the country, are governed by the Civil Service Law and the Budget Classification Manual for the Public Sector of Guatemala, no salary uniformity exists between both institutions. The IGSS pays better salaries than the Ministry. Hence, upon graduation, certain professionals intend to move to the IGSS. The Ministry of Health does not attract workers; most professionals who graduate from the University of San Carlos go to the IGSS or the private sector.
- Regarding postgraduate courses in Medicine, it is now very easy to go abroad. This puts national programs at a disadvantage, which decreases the possibility of hiring people with good abilities and high educational levels because professionals prefer to live abroad rather than specialize in Guatemala.
- It is known that some nursing homes use staff with little academic preparation for nursing tasks. Over time, these staff members are considered by those nursing homes as nursing assistants without proper accreditation from the Ministry of Health. This forces these people to work only in those places. They are subject to low wages because it is the only place where they can work.

## 6.2. Reflections

No national accreditation system of human resources produced locally in Guatemala exists; mechanisms for continuing education as a requirement for practice

in the health professions are emerging but without guarantee for maintaining the necessary skills.

- In Guatemala, for health professionals or other professions there is no policy of regular salary increases related to the cost of living or inflation, which regularly increases about 10 percentage points per year. It is true that the Ministry has improved wages, but these increases were not sufficient.
- In recent years, private universities have contributed to increase the training and professionalization of nursing assistants in the capital and in some departments. However, the large deficit facing the country is not yet covered, which increases the potential risk of migration to developed countries.
- Given that human resources is the most important human element for change, its development should be a continuous function of management, given the need for constant evaluation of their knowledge and skills for providing high quality services.
- Planning and regulation of human resources in Guatemala is a state duty, namely of the Ministry of Health; however, it is not always possible to perform this regulatory function because there are no technical tools, human resource capacity, or political will.
- Some notable weaknesses are the lack of policy and planning of human resources for health, the transition in the labor market and the production of knowledge, the imbalances and inequities in the workforce distribution, and, especially, the problems of scarcity and internal and external migration.
- The education at the universities Rafael Landívar and Mariano Gálvez is not in line with their nursing programs.
- Regarding the Directorate of Human Resources, it seems that some of its units do not have the experience and technical capability to provide guidelines on education and training of human resources. Given this reality, some other educational units having technical links with the Directorate, do what they consider more convenient from the standpoint of technical training for their units, regardless of what the relevant section of the management should state.

The processes for admission to nursing schools do not have the same parameters. At the University of San Carlos, applicants are given biology and language tests; ethical values and technical capacity are measured. In private universities,

that system does not exist, so the quality of nurses who graduate from these schools is not guaranteed.

As for nursing wages, the salaries paid by the IGSS are higher than those paid by the Ministry of Health. That causes recruiting problems for the Ministry because nurses prefer to seek opportunities where they are better paid.

To strengthen the Ministry of Health, the Interagency Committee is very important in terms of human resource development. It is assumed that the Committee can help, but it needs information. Hospitals are representing the facility for academic programs and caring-teaching integration.

### 6.3. Recommendations

- It is urgent that the Ministry has a policy on human resources to be used by all organizations comprising the health sector regarding training of human resources; the policy is to be a reference to guide their actions in the same direction taken by the Ministry of Health in human resource development.
- It is necessary that the Ministry of Health has as primary goal the establishment and institutionalization of a Model of Human Resource Management for all health areas in the country.
- Overcoming inequality in the distribution of human resources will require a long time. In the meanwhile, inhabitants of the areas identified as deficient and unprotected get sick and die without care from health personnel. In an attempt to reduce this, establishing partnerships with local communities is suggested, in order to identify local leadership to educate and train new human resources for health that are allocated to health activities in the community. As background, in Guatemala during the 1980s and 1990s, there was an experience in Escuintla, where the Ministry of Health and Social Security Institute merged. At that time basic teams of health volunteers were formed; they consisted of physicians, nursing assistants, midwives, and a figure that was significant, the “Health Radar.” These people called “radar” were responsible for giving medicines to patients in addition to providing health information to a group of one hundred people, or twenty families assigned to them. The Ministry of Health gave accreditation certificates to these people, designating them as “Health Technicians,”<sup>28</sup> and they became the cornerstone of the Epidemiological Surveillance System at the community level.

28. Ministry of Health, Pan American Health Organization, Guatemalan Institute of Social Security (IGSS) 2008: Health Management and Technology. Final Report. Evaluation of Coordinated Care Model in Health in the Departments of Escuintla and Suchitepequez. p.21.

- Having an information platform is necessary in order to know staff distribution in different regions in the country by specialty; this would facilitate the planning process in the development of human resources for the Ministry of Health as lead agency for health and the Interagency Committee for Joint Actions.
- A review on the Observatory of Health's functioning has to be made in order to strengthen it with baseline data, feed it with information from primary sources and by system actors; this allows ongoing interaction between the objectives of institutional plans.
- While some universities carry out activities that stimulate students and medical professionals in order to promote the regionalization of education, it is imperative to insist on keeping and increasing the activities with subsidies tending to encourage training in those areas that are deficient in human resources for health.
- Carrying out specific activities to revitalize the Directorate of Human Resources to enable it to achieve the stewardship of management and guidance within and outside the Ministry. There are some administrative bodies of the Ministry that still do not recognize the Directorate of Human Resources as directly responsible for management and guidance of the human resources of the Ministry of Health.
- Concluding and ensuring the institutionalization of the Health Career Law which is in the process of discussion and approval in Congress. This law will be useful in ensuring the permanence of human resources in the health sector, and therefore will facilitate long-term planning.
- In light of the support that ONSEC has raised through the 185 governmental agreements, the Ministry of Health must not only support and facilitate their application, especially as far as the appointment of staff, but also must ensure they have the resolutions supporting the recruitment of proper staff.
- It is important to review and update the agreement between the academic sector and the Ministry of Health with the aim at strengthening the activities, and expand its field of action in the advisory role in human resources.
- Paragraph e) of Article 3 of Ministerial Agreement No. SP-M-1814-2005, and paragraph 9 of the Declaration of Working Together (concluded by the schools of medicine of the three universities) empowers the Committee to invite other units and academic, service, and research institutions to join and participate in this effort. Hence, there are other universities in the country in charge of professional training in medicine and nursing whose

inclusion as Committee members would be important when reviewing the agreement.

- In the same way, the School of Nursing of the Ministry of Health is somewhat isolated from the process and from the Committee, despite the fact of being a union of great importance in health care and human resource development. It is recommended that its inclusion be seriously considered in the Interagency Committee with the same responsibilities and the same obligations of other members. With the inclusion of the School of Nursing, the Committee could ensure that educational programs at the national level have the same parameters, which would be subject to analysis and negotiation within the Committee.
- It is important not to sacrifice the quality of education. It is necessary to maintain and improve the standards defined in educational programs.
- It is urgent to carry out a review of the 10-year plan 2006-2015, comparing the achievements with regional goals, which would set the tone for guidance or to reframe what the Ministry of Health has outlined in order to re-address the development of human resources for health and compliance with these regional goals accepted by the country.

## Annex 1. Summary of Challenges and Evaluation of Goal Compliance

A summary of assessment of compliance with challenges and goals follows. It was taken from that document in order to visualize graphically the scope in each of the challenges and goals. A numerical scale from 0 to 4 was applied, which was evaluated by the author of this document as described in the header of the following matrix; it is based on the wording provided for each of the challenges and goals. Further assessments may have different results from different evaluation criteria.

EVALUATION OF CHALLENGES AND GOALS (4=100%, 3=75%, 2=50%, 1=25%, 0=0%)

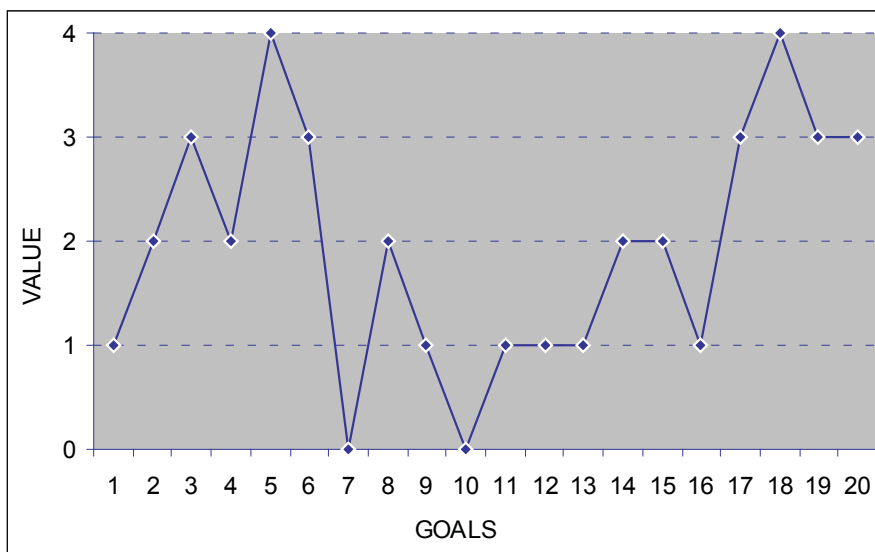
Regional Challenges and Goals	Local Level of Application				
	0	1	2	3	4
<b>CHALLENGE 1.</b> Define policies and long-term plans to adapt the workforce to changes anticipated in health systems.					
	No national policy exists. The absence of an integrated health system and continuity of national policies on health care with a review of Civil Service Law it is possible to occur. The Ten-Year Plan was not taken into account.				
<b>Goal 1.</b> All countries in the region will have achieved a density of 25 professionals of Human Resources per 10,000 inhabitants.					
	The goal will not be attained due to the projection of Human Resources for the next 6 years and the lack of midwives in the country. Progress can slowly be made if the number of professionals whose training is less than 5 years increases.				

Regional Challenges and Goals	Local Level of Application									
<b>Goal 2.</b> Regional and sub-regional proportions of primary care physicians will be higher than 40 percent of the total medical workforce.	<table><tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td></tr></table> <p>No policy exists, nor does apparent intention to establish the Primary Health Care as a model of care in the country. Some elements have been implemented but this is not a widespread strategy.</p>					0	1	2	3	4
0	1	2	3	4						
<b>Goal 3.</b> All countries will have formed teams of primary health care with a wide range of skills. Teams will systematically include community health workers to improve access, serve vulnerable groups and mobilize community networks.	<table><tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td></tr></table> <p>Only one degree is offered by the Rafael Landivar University. The coverage extension strategy implies the involvement of community workers whose training is provided through contracted services from NGOs. Community participation remains low.</p>					0	1	2	3	4
0	1	2	3	4						
<b>Goal 4.</b> The ratio of qualified nurses to physicians will reach at least 1:1 in all countries.	<table><tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td></tr></table> <p>The ratio will decrease but the goal will not be achieved.</p>					0	1	2	3	4
0	1	2	3	4						
<b>Goal 5.</b> All countries in the region will have established a unit or direction of human resources for health responsible for: policy development and Human Resources Plans, the definition of strategic management, and negotiation with other sectors.	<table><tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td></tr></table> <p>In 1999 the Ministry of Health established a Department of HR, which has an excellent level of organization to influence policy development, but it remains weak.</p>					0	1	2	3	4
0	1	2	3	4						
<b>CHALLENGE 2.</b> Placing the right people in the right places to achieve an equitable distribution, according to the population's health needs.	<table><tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td></tr></table> <p>The allocation of human resources is inadequate and inequitable; it is concentrated mostly in the metropolitan area. It is a pressing situation, due to the relationship between poverty rates and low availability of human resources for health.</p>					0	1	2	3	4
0	1	2	3	4						
<b>Goal 6.</b> The gap of the distribution of health personnel between urban and rural areas will be reduced by half in 2010.	<table><tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td></tr></table> <p>Given the magnitude of the events, the goal's achievement is not expected. In some professions, such as nursing and medicine, in some departments the goal can be reached, but the situation is urgent in some places and actions are not expected in that vein.</p>					0	1	2	3	4
0	1	2	3	4						
<b>Goal 7.</b> 70 percent of primary health care workers will have inter-cultural and comparable skills in public health.	<table><tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td></tr></table> <p>No actions indicating the possibility of reaching the goal are seen.</p>					0	1	2	3	4
0	1	2	3	4						
<b>Goal 8.</b> 70 percent of nurses, nursing assistants, health technicians and community health workers will have improved their skills and competencies according to the complexity of their functions.	<table><tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td></tr></table> <p>No actions aimed at developing skills, according to the complexity of functions exist; and the actions do not always have the precise orientation for those who need them.</p>					0	1	2	3	4
0	1	2	3	4						
<b>Goal 9.</b> 30 percent of primary health care personnel will have been recruited from their own communities.	<table><tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td></tr></table> <p>The community has interest in recruiting health personnel but they are not available. Migration of nurses due to the increasing demands for qualified personnel is a risk.</p>					0	1	2	3	4
0	1	2	3	4						
<b>CHALLENGE 3.</b> Promote national and international efforts for countries affected by migration in order to retain their health workers and avoid workforce shortage.	<table><tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td></tr></table> <p>Although migration occurs, it is not yet a problem. Applications have been placed for training schools that provide support and incentives to study abroad.</p>					0	1	2	3	4
0	1	2	3	4						
<b>Goal 10.</b> All countries in the region will have adopted an international code of practice or developed ethical standards in international workforce recruitment.	<table><tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td></tr></table> <p>This is not considered to be a problem for the country. Therefore, probably no action will be taken in this regard.</p>					0	1	2	3	4
0	1	2	3	4						
<b>Goal 11.</b> All countries in the region will have a policy of self-sufficiency to meet their own needs for human resources for health.	<table><tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td></tr></table> <p>While extending the goal is unpredictable, it seems that it will not exist. Cuba participates in the training of physicians, and it will probably keep training for some time.</p>					0	1	2	3	4
0	1	2	3	4						

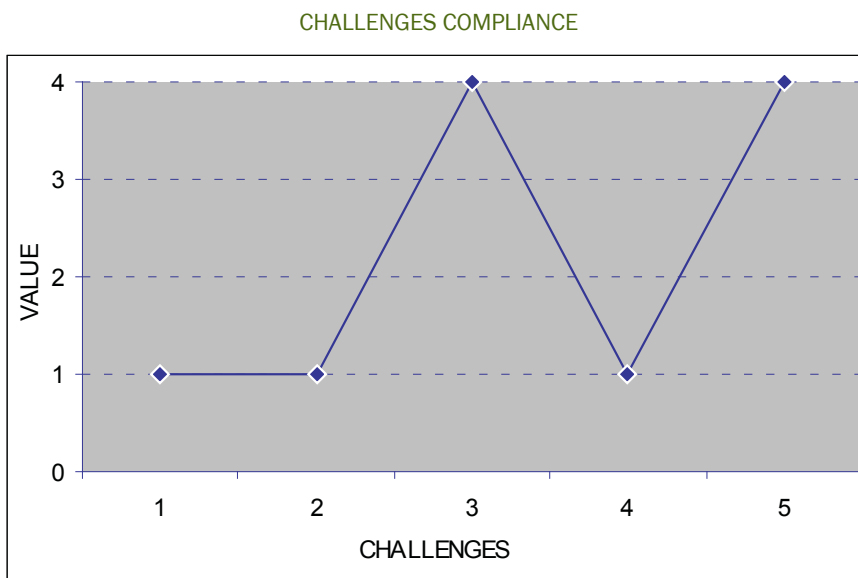
Regional Challenges and Goals	Local Level of Application				
<b>Goal 12.</b> All sub-regions will have made mutual agreements and implemented mechanisms for the recognition of foreign trained professionals.	0	1	2	3	4
	No actual actions in this regard have been taken. However, there are initiatives regarding the accreditation of courses given by the Central American University Higher Council (CSUCA) and Central American System of Higher Education Evaluation and Harmonization (SICEVAES) for public education.				
<b>CHALLENGE 4.</b> Build healthy work environments that foster institutional commitment to the mission of ensuring the provision of quality health care for all people.	0	1	2	3	4
	Low wages, not good physical conditions and minimal economic incentives are delivered through bonus that does not impact on labor liabilities. Low pay leads to moonlighting. Between 45 and 65 percent had more than one job.				
<b>Goal 13.</b> The proportion of precarious employment, without protection for health care providers will be reduced by half in all countries.	0	1	2	3	4
	It is envisaged that this will not be achieved. Instead of reducing precarious employment levels, there are upward trends of temporary employment with no employee benefits.				
<b>Goal 14.</b> 80 percent of the countries in the region will have implemented health and safety policies for health workers, including support programs to reduce occupational accidents and diseases.	0	1	2	3	4
	No initiatives exist in this direction, but it might be achieved in the coming years before 2015, although it entirely depends on political decisions.				
<b>Goal 15.</b> At least 60 percent of managers of health services and programs will meet specific requirements for public health skills and management, including ethical standards.	0	1	2	3	4
	Progress could be made in this regard if universities, training schools and training units of the health institutions work with purpose. However, it is not feasible to reach the goal.				
<b>Goal 16.</b> 100 percent of the countries in the region will have mechanisms for negotiation and effective legislation to prevent, mitigate or solve disputes and ensure the provision of essential services.	0	1	2	3	4
	Legislation exists, but the participation of unions is complex in Guatemala; for that reason concluding collective agreements is difficult. No significant progress is expected.				
<b>CHALLENGE 5.</b> Set up mechanisms of cooperation between educational institutions and health services to produce sensitive and skilled health professionals.	0	1	2	3	4
	Guatemala was the first country to develop dialogues between lending institutions and schools of human resources for health). A ministerial agreement was signed on this matter. It was subdivided into three subcommittees: (1) workforce development; (2) teaching and health care integration, and (3) research.				
<b>Goal 17.</b> 80 percent of schools of health sciences will have reoriented their education programs towards primary health care and community health needs, and will have incorporated strategies for inter-professional training.	0	1	2	3	4
	Most schools of health sciences have strengthened Primary Health Care in the study program. However the scientific hospital model still predominates in technical resource schools. There is only one nursing degree at Landivar. Goal likely to be achieved if appropriate changes are made.				
<b>Goal 18.</b> 80 percent of schools of health sciences will have adopted specific programs to attract and train students from underserved populations, with emphasis, where appropriate, on indigenous communities or people.	0	1	2	3	4
	Universities provide academic courses in public health, nursing and medicine in populations where Human Resources for Health are deficient and with high indigenous populations. They attract students and grant scholarships to students from villages and towns in main counties. This trend will remain				
<b>Goal 19.</b> Dropout rates of medical and nursing schools will not exceed 20 percent.	0	1	2	3	4
	The drop between 20 percent and 85 percent in nursing is a little lower. The economic situation is one of the causes of dropouts. The decline at the level required by the goal is not likely to happen.				

Regional Challenges and Goals	Local Level of Application				
<b>Goal 20.</b> 70 percent of health science schools of and public health schools will be accredited by an authorized entity.	0	1	2	3	4
	Progress will be made by 2015, but the goal will not be reached. The interest of schools in health sciences to seek accreditation is evident.				

#### GOALS COMPLIANCE



Based on the method used, only two goals reached a maximum of 4 points, that is, 100 percent; Goals 5 and 18. Five goals reached the third level or 75 percent. And 13 goals had levels from 0 to 2 (Zero to 50 percent). All these results were taken four years after the definition of challenges and goals.



Two challenges have been achieved to date: Challenges 3 and 5, which is 40 percent effectiveness. The remaining challenges (60 percent) showed low effectiveness.

## Annex 2. Actions and Strategies for the Development of Human Resources for Health

### *Actions*

1. Formulation of a national policy of development of human resources for health.
2. Creation of the civil service career for health staff in government.
3. Institutional strengthening of the bodies responsible for human resources development.
4. Improvement at the national level of health staff working conditions through legislation and government agreements. Provide worthy employment to increase contentment and personal motivation and reduce moonlighting.
5. Creation of information systems on human resources for health in the country and institutions with quality and permanence including jobs, education and training.
6. Identifying gaps in education and training of health personnel by region with specific characteristics.

7. Development of national plans and institutional participation and political support to meet the needs of regions.
8. Precise identification of employment profile of the human resources required by the employing institutions.
9. Identifying job skills that are a basis for recruitment, training, supervision and evaluation of staff, as well as for training the resources the country needs.
10. Approval of the minimum content of health degrees.
11. Opening locally relevant programs that facilitate the incorporation of local students who know the culture and needs and the parallel creation of employment opportunities.
12. Incorporation of the approach and content of primary health care in the technical and professional careers.
13. Increase of accreditations of technical and professional careers.
14. Raise ethical standards for negotiation of health personnel migration to other countries.

### *Strategies*

1. Strengthening of the National Observatory of Human Resources for Health.
2. Promoting, at the highest political level, the approval of the State Civil Service career and the Human Resources for Health National Policy.
3. Increasing the interaction between academia and the health care sector by strengthening the Interagency Committee of Joint Actions of Academia and Welfare sectors.
4. Exchanging experiences in teaching practices and the inclusion of primary health care in the curriculum of health technical and professional careers.
5. Strengthening institutions responsible for accreditation of health training of professional and technical levels, including institutional compliance with their decisions.

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## Introduction: A Basic Contextualization

Honduras is the second largest Central American country by land area (112,492 square kilometers) and number of inhabitants of 7,699,405 inhabitants; 48.3% men (3,720,160) and 51.7% women (3,979,245). The urban population is 46% (3,505,582); the Central District has approximately 27.6% of the urban population (966,239 inhabitants), and San Pedro Sula has 16.3% (570,497 inhabitants); 54% of the population is rural.

In recent years, the population has grown at an average annual rate of 2.3 percentage points throughout the country and 1.27 percentage points in rural areas. The population density is 68.5 inhabitants per square kilometer; it is slightly lower than the density of the Region, which is 72.9 per square kilometer.

The Republic of Honduras is divided politically into 18 departments and 298 municipalities.

The Honduran health system—as described in the document, “Analysis of the Situation of Human Resources for Health in Honduras,” of 2009, prepared by the Master of Public Health<sup>29</sup> program—is comprised of the Ministry of Health (SESAL is the Spanish acronym), which provides 60% of population with health care; the Social Security Institute (IHSS is the Spanish acronym), which covers 10% of the population; and providers from the private sector.

According to the country’s regulations, the Secretary of Health is responsible for coordinating functions with other State’s agencies, including the Social Security Institute (IHSS), the Secretary of Finance (SEFIN is the Spanish acronym), the General Directorate of Civil Service, the Secretary of Education and the National Autonomous University of Honduras (UNAH is the Spanish acronym), which governs the level of higher education in the country, and other universities and training centers related to the matter. In addition, the Secretary of Health must coordinate with other bodies such as professional associations and international bodies related to the health sector.

In order to facilitate its functions, the SESAL works throughout 20 departmental regions that coincide with the geographical and administrative organization of the country. It has 6 national hospitals in these regions, 6 regional hospitals, 16

29. Postgraduate on Public Health. Situation Analysis of Human Resources for Health, Honduras 2009. Faculty of Medical Sciences, UNAH/PAHO. Tegucigalpa.

hospitals of areas, 4 emergency centers, 380 local health centers with medical and dental care, 1,002 rural health centers (CESAR is the Spanish acronym), and 56 maternal and child health clinics.<sup>30</sup>

The funds used for financing SESAL were, on average from 2006 to 2009, 79.07% domestic funds and 20.93% other funds.<sup>31</sup> More than 50% of the total funds were used to pay for human resources for health.

TABLE I. BUDGET ALLOCATION OF SESAL/HUMAN RESOURCES FOR HEALTH SPENDING

Year	Current Budget SESAL (Ls)	Budget Percentage <sup>a</sup> Used in Human Resources for Health (Salaries/Training)
2006	5,803,382,431	52.2% / 3.36%
2007	7,164,126,024	49% / 3.3%
2008	7,658,884,373	54.8% / 1.22%
2009	9,417,888,582	54.82% / 1.03%
2010 (Approved)	10,032,846,511	57.3% / 1.1%

Note:

<sup>a</sup> This percentage includes books, magazines, training, textbooks and scholarships (This is to give a general idea of the amounts invested).

## Management of Human Resources for Health

In 2009, according to data from the Secretary of Finance, a total of 696 new positions were created for medical staff, nursing assistants, nurses, dentists, microbiologists, pharmacists, and technicians of various specialties.

The creation of 400 jobs is expected in 2010; they will be distributed among physicians, nursing assistants and nurses.

The distribution of new jobs maintains the trend has been observed since 2008 in terms of staff employed in relation to population size, a greater number of vacancies for nursing assistants, physicians and nurses in descending order.

In 2008,<sup>32</sup> the SESAL had a total of 17,699 health workers; 27.1% (4,797) were administrative staff and 72.9% (12,902) were professionals, assistants and technicians.

Of all health workers 57.33% (10,147) were health care workers; 64.87% nursing assistants; 12.24 % nurses, and 22.9% physicians (1,194 general practitioners and 1,129 specialist physicians.)

30. Source document: Postgraduate on Public Health. Situation Analysis of Human Resources for Health, Honduras 2009. Faculty of Medical Sciences, UNAH/PAHO. Tegucigalpa, considering data from IHSS and private hospitals that report to SESAL.

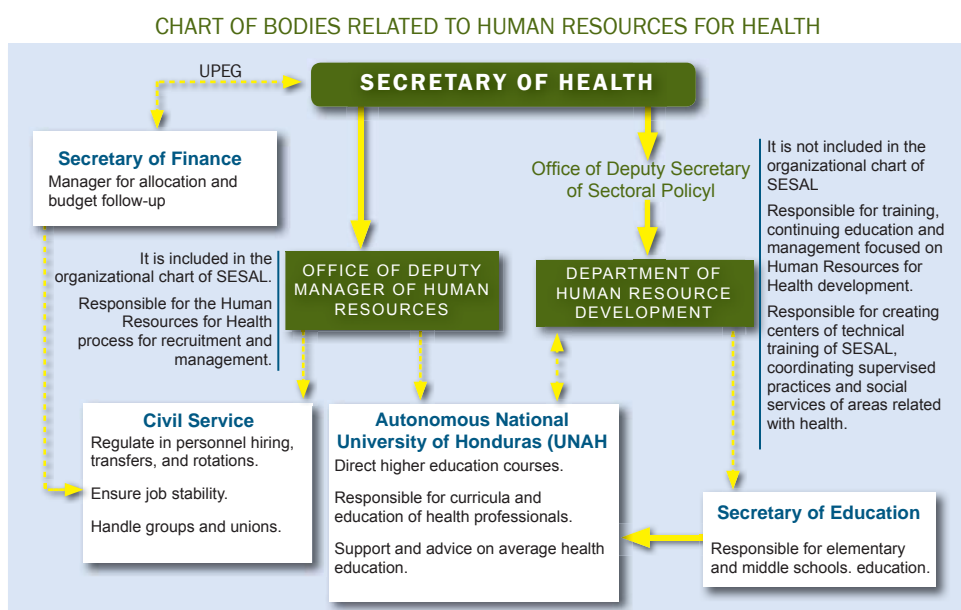
31. It includes resources from external credit, donations, external funds and debt relief funds.

32. Secretary of Health. Planning and Evaluation Unit.

In 2008, the average density ratio of Human Resources for Health according to SESAL's data was 3 physicians, 2 nurses, 3 dentists and 8 nursing assistants per 10,000 inhabitants<sup>33</sup> at the national level.

For the administration and management of human resources, SESAL has two bodies responsible for training, development, selection and personnel administration: the Secretary of Human Resources and the Department of Human Resources; they are independent and their interaction is occasional.

According to their functions and obligations, these bodies are related to other ministries or government organisms, with which they coordinate and establish partnerships within their competencies and needs. These relationships can be represented as follows:



The management of Human Resources for Health is divided into two key elements: staff updating and training—which is a Human Resource department's responsibility—and recruitment and management of personnel—which is the responsibility of the Human Resources Assistant Manager's Office. As a result of this organization and the functions related to Human Resources for Health, there are some characteristics that directly affect the achievement of regional goals. They are the following:

- The Department of Development of Human Resources has become the SESAL's point of reference for issues related to the Policy on Human

33. The ratio of the Department of Francisco Morazán-Distrito Central—to which Tegucigalpa belongs—was 23.78 per 10,000 inhabitants.

Resources for Health, plans and processes for improvement in terms of topics and sectors without considering its operational capacity and actual impact.

- The Deputy Manager of Human Resources has not been taken into consideration when developing the improvement of the Human Resources for Health process; this is reflected in plans for Human Resources for Health, which put a greater emphasis on training, continuing education and reference regarding the actual situation of Human Resources for Health and its responsiveness to the needs of the country.
- The implementation of personnel management with all the essential processes to ensure an impact resulting in actual and sustainable changes has not been achieved. This is particularly evident in the fact that no strategic planning exists on how to perform such management, existing elements are weak and not comprehensive, and evaluation processes and performance monitoring have not been developed.
- Very little has been done in generating a plan of Human Resources for Health management, especially as to the challenges related to the appropriate staff allocation and the creation of healthy work environments.

Currently the work of both instances—by having delimited actions—allows for a clear relationship between them and the challenges raised on the Regional Goals for Human Resources for Health 2007-2015. This relationship, considering the specific goals, raises a few shared challenges.

*Sub management of Human Resources*

- Build long range policies and plans. / Shared, but lies more in the management.
- Place the right people in the right places. / Shared.
- Achieve healthy workplaces and promote a commitment of the health workforce.

*Human Resources Department*

- Build long range policies and plans. / Shared.
- Retain health workers and avoid personnel shortages.
- Develop cooperation between training and health services delivery institutions.

## 1. Development of Human Resources for Health Policies and Transformation of Care Models

In Honduras, as mentioned above, according to regulations, the strategic direction and leadership to improve the health sector and Human Resources for Health—both in management and training—is the responsibility of the Ministry of Health. In this sense, this body should have a clear vision of the type of health system that should be developed in the country.

To achieve this, a series of processes has been generated at the level of the central state and SESAL to establish instruments for implementing common goals in improving the health system. Currently, the following guidelines exist:

- At the national level, the National Health Plan 2021 has been generated and designed for a long-term duration; it has political, technical and sector characteristics, which, as a planning and strategic instrument, facilitates leadership, harmonization, alignment of national resources and external cooperation in the health sector.<sup>34</sup>

This plan presents conceptual, effective and operational elements that should guide the actions of the sector until 2021 in a coordinated and intersectoral manner. Specifically, it is proposed as a core goal of the sector to raise performance to its responsiveness according to the expectations and needs of the population through effective, quality and equitable models.

Additionally, sector priorities for health promotion, especially in priority groups and vulnerable ones have been established: maternal health and child nutrition, monitoring of communicable diseases, monitoring of chronic non-communicable diseases, and health sector reform.

Currently, the National Vision for 2010-2038 and National Plan 2010-2022 should be considered as a guideline framework. This framework is a Republic Act passed by Congress; it is a benchmark for action for the coming government terms and therefore the harmonization of several activities, processes and sector plans becomes a necessity, with its strategy proposal.

The nation's vision would present the objective image of the social, political and economic characteristics that the country must achieve through the implementation of successive national plans and consistent government plans with each one describing the social aspirations in each area; it should be set for a 28-year cycle.

This National Plan sets out strategic directions addressing the challenges the nation faces and around which the public and private action should work to meet the intermediate objectives of the Vision of the Country.

*Definitions were taken from the official website of SEPLAN [Secretary of Planning] in: <http://www.seplan.gob.hn/index.php/vision-de-pais/informacion-general-.html>*

- **At the Secretary level**, a policy on Human Resources for Health has been generated, which focuses on the internal vision SESAL has of the management and development of the personnel working in that sector.

34. Source: Health Secretary of the State 2005. National Health Plan, 2021, p. 99. Available in Tegucigalpa.

The Human Resources Policy is outdated 25 years. The policy in force was approved in 1985; it has not been operatively applied.

Source: *Evaluación del Desarrollo de los Recursos Humanos para la Salud 2006-2009*.

An important aspect in terms of Policy on Human Resources for Health is the fact that two versions of it exist, which creates uncertainty when directing actions related to SESAL staff. On the one hand, there exists a version approved in 1985, which is in force; on the other hand, there is a proposal of 2006, which has been submitted to the SESAL authorities but has not been approved.

Both policies were created in a participatory manner and with the contribution of different players and organizations; they seek to meet some of the challenges posed by the country situation and regional and international approaches for the development of Human Resources for Health. The main characteristics of this policy are the following:

TABLE 2. MAIN CHARACTERISTICS OF THE POLICIES ON HUMAN RESOURCES FOR HEALTH OF THE SECRETARY OF HEALTH

Main Characteristics of SESAL Policies on Human Resources for Health	
Policy 1985 <sup>a</sup> - Effective Policy on Human Resources for Health	Policy 2006 <sup>b</sup> - Proposed National Policy on Development of Human Resources for Health
<p>The Policy is framed in:</p> <ul style="list-style-type: none"> <li>■ Global Development Strategy (1982-1986) which is a key objective of local development as a vehicle to: <ul style="list-style-type: none"> <li>▶ Execute strategies, policies and projects supported by intersectoral work.</li> <li>▶ It gives priority to rural and marginal urban areas.</li> </ul> </li> <li>■ The National Health Plan that incorporates the basic elements of human resource development, and definition and coordination of the Health Sector and: <ul style="list-style-type: none"> <li>▶ It recognizes the issue of multi-sector coordination.</li> <li>▶ It recognizes the needs to improve the effectiveness and efficiency of health sector services.</li> <li>▶ It conceives the creation of the National Committee of Resources for Health (CONARHUS).</li> </ul> </li> </ul>	<p>The Policy is framed in:</p> <ul style="list-style-type: none"> <li>■ The National Health Plan 2021c—prepared in 2005—which considers issues such as health determinants, primary health care, health promotion and the Millennium Development Goals. In addition: <ul style="list-style-type: none"> <li>▶ It poses principles of equity, universality, accessibility, solidarity, integration, social participation and sustainability.</li> <li>▶ It identifies among its strategic line sector policies and institutional strengthening; coordination of actions at the local level; health insurance; provision of adequate health services; and transparency in management.</li> </ul> </li> </ul>

Notes:

<sup>a</sup> See annex 1.

<sup>b</sup> See annex 2.

<sup>c</sup> The National Plan of Health is the guideline in force. It approaches the goal of transforming the health system and care model.

Characteristics of SESAL' Policies on Human Resources for Health	
Policy 1985 <sup>a</sup> - Effective Policy on Human Resources for Health	Policy 2006 <sup>b</sup> - Proposed National Policy on Development of Human Resources for Health
<p>Main approaches:</p> <ul style="list-style-type: none"> <li>■ Plan the development of Human Resources for Health according to priorities established in the National Health Plan.</li> <li>■ Promote training of Human Resources as a specific response to the reality in which they work, including administrative aspects.</li> <li>■ Promote multidisciplinary and intersectoral work.</li> <li>■ Design and maintain a system of personnel allocation to facilitate the permanent incorporation of Human Resources for Health, as required.</li> <li>■ Consider three strategic areas: planning, training and proper allocation of Human Resources for Health.</li> </ul>	<p>Main approaches:</p> <ul style="list-style-type: none"> <li>■ Strengthen SESAL to lead Human Resources management in the health system.</li> <li>■ Strengthen the National Committee of Resources for Health (CONARHUS).</li> <li>■ Strengthen SESAL's capacities to improve Human Resources management institutionally and, therefore, nationally. <ul style="list-style-type: none"> <li>► Establish a Human Resources unit allowing integrated management in SESAL.</li> <li>► Performance evaluation programs.</li> <li>► Address Human Resources training to country-area needs consistently with regional and international trends.</li> <li>► Strengthen continuing health education as a priority and integral activity.</li> </ul> </li> </ul>

Notes:

Source: Prepared by the author based on information from "Secretaría de Estado en el Despacho de Salud 2005. Plan Nacional de Salud 2021." Tegucigalpa. "Secretaría de Estado en el Despacho de Salud 1985. Política de RHS." Tegucigalpa and "Secretaría de Estado en el Despacho de Salud 2006. Propuesta de Política Nacional de Desarrollo de Recursos Humanos para la Salud." Tegucigalpa.

The policies on Human Resources for Health are aimed at improving the effectiveness and efficiency of health care staff and, therefore, the services provided to the population. However, core points have not been applied as proposals or strategic lines for achieving this purpose.

The proposed policy developed in 2006 has not been approved by the corresponding authorities due to frequent changes of the highest authorities of the Secretary in the last four years.

The analysis on the above evidence gives the following key points:

### *Policy of 1985*

- The current Policy on Human Resources for Health is consistent with Regional Goals for Human Resources for Health; however, it has not been applied and, therefore, aspects of planning and the use of Human Resources for Health have focused on demand or by circumstantial options.

On the other hand, although training was developed more intensively and coordinately, in many cases the curricula are outdated; they do not meet the country and region needs, and do not ensure promotions according to work demands and/or system needs.

- The Policy on Human Resources for Health has several elements that meet the 2021 National Plan; nevertheless, a number of processes and conceptual and political elements were not taken into account. Because this is the policy in force, it is necessary to bring both instruments into alignment.

### *Policy of 2006*

- The development of the policy on Human Resources for Health started in a process involving various stakeholders; it comes from reviewing the policy of 1985, evaluating the main needs of the country at that time, and changes in priority—when going beyond the pursuit of coverage expanding—to actions improving access, quality, care and efficient and transparent management of the sector.
- The policy of development of Human Resources for Health proposed emphasizes the achievement of aspects related to training, continuing education and management. A proposal for the consistent application of their approaches and strategies has not been developed.

#### ELABORATION PROCESS OF A NATIONAL POLICY ON DEVELOPMENT OF HUMAN RESOURCES FOR HEALTH

The elaboration process of the Policy on Human Resources for Health developed in 2006 is the result of a series of processes previously developed. This process involved various stakeholders such as representatives of UNAH, IHSS, Secretary of Health, Secretary of Finance (SEFIN), Secretary of Planning, Coordination and Budget (SECPLAN) and technical support from PAHO.

For discussion and further elaboration, a series of forums for reflection and exchange took place. The methodology applied in its elaboration can be summarized in the following steps:

- Review the progress and content of the policy of 1985.
- Create scenarios to review the concepts and provide the policy with a frame; this was intended as a platform for an intersectoral public policy.
- Exchange with different stakeholders that could become strategic partners for implementing the policy such as Congress, representatives of private business, and professional associations.
- Conduct an organization chart of players related to the sector. This mapping was a call for consensus on the critical path for policy formulation.
- Set working groups; hold periodic meetings to review progress and products.
- Prepare documentation of references of the policy.
- Adapt the document according to the National Plan 2021 frame.

To carry out the policy the planning matrix approach was used; it considers macro, medium and micro levels with their potential relationships and links and guided the components outlined in Human Resources management.

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## 1.1. Main Weaknesses of the Development of a National Policy on Human Resources for Health

The analysis of both policies shows a number of weaknesses in identifying critical paths, tools, strategies and mechanisms to ensure its application and implementation. The main identified weaknesses are the following:

- The proposed strategies have not been applied. This situation has prevented from their dissemination and implementation by different actors within and outside SESAL. This is reflected in the lack of clarity around competencies and contribution of each actor to the process like the irregularity and insufficiency in key aspects to improve the sector, especially those related to the management of Human Resources for Health.
- The implementation of policies has as a basic premise the support of a Committee / National Council of Human Resources for Health (CONARHUS), formed by sectors and actors involved in Human Resources for Health, which will have political and technical influence facilitating the processes through timely decision making and direction of processes. The activity of this body has been very irregular; it has not been consolidated to function effectively in the political and technical aspects.
- In order to facilitate and ensure the implementation of policies, unifying the SESAL's bodies related to Human Resources for Health management is fundamental. Currently, these bodies operate independently. There is no definition of the responsibility and contribution that each of them must take to achieve the policy implementation and achievement of regional goals. This is evident because the Deputy Manager has not been included as a key player of Human Resources for Health management.
- The existence of two policies creates a confusing process, especially considering that the planned actions after 2006 are in line with a law that has not been approved. Additionally, the law in force has not been applied and has remained invisible as a guiding framework for actions in the management of Human Resources for Health.
- Currently, both policies must be aligned with the Vision and the National Plan, which raises the need for strengthening the decentralization processes.

A particular weakness of the development policy on Human Resources for Health of 2006 is that it does not specify the importance of developing mechanisms for implementation and completion, despite the fact that it falls in the framework of the National Plan 2021, which covers matters such as primary health care, multiculturalism, equity in services, improvement of efficacy and system efficiency.

Additionally, at the time of disseminating it, many of the conceptual elements remained invisible because it does not have a proposal to apply it.

## 2. Development of Human Resource Plans and Coordination with Key Government Sectors

The elaboration of the Strategic Plan of Human Resource Development for 2006-2009<sup>35</sup> was based on: (a) the proposal of a policy for the development of Human Resources for Health, despite the fact that it has not been approved yet, (b) Regional Goals for Human Resources for Health for 2007-2015, and (c) the 10-Year Plan of Human Resources in Central America.

This strategic plan stated that the Department of Human Resources for Health of SESAL was responsible for its implementation. This department was responsible for the actions and processes that were being developed in 2005 in line with the Central American 10-Year Plan and various international commitments undertaken by Honduras in order to improve health systems and, therefore, the development of Human Resources for Health.

This fact shows that the strategic plan is to be considered more as an instrument to guide the task of the department, than as a guiding instrument for the management of Human Resources for Health for SESAL and the Health Sector.

In other words, the strategic plan defines the main steps to be developed to meet the challenges of the Regional Goals for Human Resources for Health; it is primarily focused on guiding the functions of the Department of Human Resources of SESAL.

We highlight the following as key elements of this strategic plan on Human Resources for Health:

- As a basic premise, it aims at transforming the Department of Development of Human Resources for Health into a General Directorate of Human Resources for Health, which would be responsible for the actions proposed in the policy and strategic plan. On the other hand, it points to the official national policy on Human Resources for Health as a guiding instrument for the actions for Human Resources for Health.
- It has a greater weight and precision in aspects related to training, continuing education, and management, and is focused on performance evaluation and incentives. This feature can become a risk because it does not specify the importance and strategies to ensure management, equitable

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35. See Annex 3.

distribution and use of Human Resources for Health, which is a responsibility of the Deputy Manager Office of HR.

- It states the need for an observatory of Human Resources for Health and a baseline in order to establish the type of personnel needed in the country and, therefore, to guide the selection process of Human Resources for Health according to the model of management and care.
- It emphasizes strengthening the agencies related to Human Resources for Health of SESAL in developing a culture of dialogue for solving conflicts and negotiating incentive programs with unions.
- Agreements and actions for training and continuing education of Human Resources for Health.

## 2.1. The Coordination Process with Key Sectors and Stakeholders

The Strategic Plan for the Development of Human Resources for Health was designed by the Department of Human Resources for Health; to coordinate its implementation it establishes as key players those entities related to training and continuing education in the health area, the application and guidance of management processes on Human Resources for Health, and the intersectoral mechanisms that allow their application and can guide policy and operational issues.

In this section we will analyze the major players directly related to the plan, the kind of relationship or contribution that is expected to facilitate the implementation of the strategic plan, and the current state of coordination and options or opportunities identified as elements facilitating the coordination of actions.

## SESAL – External Aspects

Autonomous National University of Honduras (UNAH)	Through the Office of the Academic Deputy Vice-Chancellor, Authorities and Technical Team of the Colleges Related to Health Sector Issues.
Type of Relationship	<p>Negotiation and coordination processes are conducted with this institution; they are generally stated in agreements in terms of:</p> <ul style="list-style-type: none"> <li>■ Establishment of guidelines to regulate supervised practices and community service of students from Health Sciences programs.</li> <li>■ Establishment of guidelines and regulations to give accreditation to staff graduated abroad, through the Council of Higher Education chairing the UNAH.</li> <li>■ Identify potential professional or technical careers that could be offered according to country needs in the health sector.</li> <li>■ Lobby to establish, within the Human Resources for Health, training in key elements such as the Primary Health Care approach, family health, technical degree programs, etc.</li> <li>■ Coordinate consistent and updated issues related to postgraduate and undergraduate programs according to country characteristics and regional trends</li> </ul>
Current Status	<p>The coordination between the two agencies is based on win-win, where SESAL improves coverage and capacity of care through service of various social-health personnel, and UNAH procures practices for the learning and development of its students.</p> <p>These actions of medical and community service coordination are governed by a tripartite regulation body formed of the Medical College of Honduras, SESAL and UNAH. This regulation operates based on characteristics of efficiency and transparency.</p> <p>Actions are coordinated to develop supervised practices and community service for students from medical and health schools. SESAL grants scholarships to support education and training and UNAH provides Human Resources for Health in training in order to support the health system care.</p> <p>UNAH has made a historic contribution by providing more than 40 percent of ambulatory care staff in places where students are assigned to health areas.</p> <p>A health-care-teaching agreement exists between UNAH and SESAL, but it does not have any regulation, and therefore it has not been possible to implement it</p>
Coordination Opportunities	<p>UNAH, through its new Organic Law of 2005, is developing a process of academic, administrative, legal, political and labor reform. It combines elements of internal and external quality assessment to establish a basis to further develop a plan for improvement and accreditation of degrees and curricula; this is aimed at ensuring responsiveness to the needs and characteristics of the country as well as academic and technical requirements posed at the regional and international level.</p> <p>In this sense, an element that promotes the reform is the inclusion of core topics that take into account the Millennium Development Goals, the strategy of poverty reduction, issues of violence, vulnerability, risk, ethics, bioethics, quality and living conditions. These elements are consistent with the approach of transforming medical education into education in health sciences.</p> <p>This process facilitates an economic opportunity to influence SESAL in academic and technical aspects that impact curricula and continuing education of future Human Resources for Health. Additionally, UNAH is a state agency governing the higher education in the country.</p>

CONARHUS	Formed of high level representatives and technicians related to Human Resources for Health issues, members of the Association of Physicians, UNAH, SEFIN, SETCO, School of Medicine, Secretary of Education, and Civil Service.
Type of Relationship	It has a political branch (decision making and setting of strategic guidelines) and a technical branch (ensuring follow-up decisions and the implementation of the Policy and Strategic Plan.)
Current Status	The Council is still legally valid but currently it is not functional.
Coordination Opportunities	According to the national policy, CONARHUS technically and politically influences decision making about Human Resources management and development.  This level of influence and the fact that on the board there are senior manager representatives related to the Human Resources for Health facilitate strategic decision-making processes to guide nationwide.

### *SESAL – Internal Aspects*

Office of the Deputy Manager of Human Resources	
Type of Relationship	SESAL is responsible for the management and administration of Human Resources for Health.  It is responsible for recruitment, placement and rotation of health staff.  It is responsible for working condition improvements and resolution of conflicts with labor unions.
Current Status	The Office of the Deputy Manager works independently of the Human Resources Department and is not directly involved in the Human Resources development process.  It is unclear how Human Resources management is planned and whether the policies have been implemented and are operative.  Its role has been minimal in the processes of setting a policy on Human Resources and a strategic plan.  A focus on Human Resources management is not seen as part of its work.

The Office of the Deputy Manager is responsible for Human Resources for Health management—selection, hiring and management. When performing its functions, it interacts with other units, as follows:

Secretary of Finance (SEFIN)	
Type of Relationship	It is responsible for budget allocation and monitoring the use of domestic and external funds.
Current Status	SEFIN advises on the formulation, implementation and evaluation of budgets allocated to SESAL. It is also responsible for obtaining the necessary funds for doing structural changes, staffing and / or administrative and operational expenditure proposed by SESAL' authorities that are not budgeted.  Their relationship is through the Planning and Management Evaluation Unit / UPEG and the General Directorates of Budget, Investment and Public Credit— in the technical aspects—, and Secretaries and Deputy Secretaries of State at the political level.
Coordination Opportunities	SEFIN's responsibility for obtaining funds and the funds requested by the SESAL would be easier if a plan existed, at least tentatively, to improve the projections for coverage and staff allocation.  This will ensure more effective management and financial support.

Civil Service	
Type of Relationship	<p>It has been conceived as a rational system of management in the Public Service to govern the relationship between public services and the State.</p> <p>It has to handle the classification of positions and staff rotation, by exchange, transfer or promotion, and should ensure the preservation of jobs to ensure effective development of the state's functions.</p> <p>Additionally, it has to support negotiations with unions.</p> <p>When creating jobs or reclassifying or promoting employees, it has to contact SEFIN to establish access to the resources needed to comply with the obligations toward public officers..</p>
Current Status	<p>It has entered into negotiations with some health worker unions to establish reclassification processes and, therefore, salaries.</p> <p>A baseline and characterization of the Human Resources are being made.</p>

### 3.2. Major Difficulties in Implementing the Strategic Plan of Human Resources for Health

The training of Human Resources for Health was diversified, and the Secretary of Health lost its supervision. Personnel profiles have not been reviewed since the 1980s; no work has been done on human resource management; rather it has detached from those functions; performances are not evaluated; the process has become politicized and the office of the deputy manager of Human Resources for Health emphasizes regulatory and administrative aspects.

*Source: Evaluación del Desarrollo de los Recursos Humanos para la Salud 2006-2009*

Currently, the main weaknesses of plan implementation are related to the following:

- The Strategic Plan of Human Resources for Health has focused on the activities of the Department of Development of Human Resources for Health of SESAL; thus, the actions proposed in the plan relate to aspects of training, continuing education and management.
- This aspect places a greater emphasis on the challenges that relate directly to that organization and does not include the goals associated with the work of the Office of the Deputy Manager of Human Resources.
- The strategic plan was proposed for 2006-2009 so, as of this year it is not covered.
- The strategic plan design had some weaknesses: (a) it did not address the management of Human Resources for Health comprehensively; it did not consider issues related to planning and management, which made it difficult to incorporate into the plan strategies and actions more related to the deputy manager office; (b) the plan was developed without considering a sector and systemic focus, (c) it did not meet all the criteria to be consid-

ered as a strategic tool to guide the process and facilitate its operational function, and (d) it appointed a specific agency to apply it, regardless of the scope of its functions and its ability to implement them.

- The basic premises on which the plan was based have not been achieved, namely: the establishment of the General Directorate of Human Resources for Health, the proper functioning of CONARHUS and approval of the new policy. In addition, it is assumed that with the change of status from department to directorate, processes are achieved automatically, especially the process of comprehensive vision of Human Resources for Health management; it is assumed that the implementation of the policy and plans are assured, when in practice it is a necessary processes of adaptation, integration and guidance to ensure the new responsibilities and challenges.
- The current organizational structure of SESAL makes it difficult to understand the management of Human Resources for Health as an integral, planned, sector element and core investment to achieve positive impacts on the health system and the population of the country.
- Actions related to the improvement, coverage distribution and use of Human Resources for Health is a responsibility of the Office of the Deputy Manager of Human Resources. Those actions include planning processes and performance evaluation; they have not been considered in the strategic plan. As a result, the coordination and inclusion processes established in the plan have not been continuous.

Due to the lack of sources and processes of reliable and timely information, it is not possible to analyze the situation and properly plan human resources management and training.

Recruitment of Human Resources for Health is a technical aspect, but distribution and allocation depend on political factors and, in some cases, local demands.

*Source: Evaluación del desarrollo de los recursos humanos en salud 2006-2009*

- This situation is reflected in the selection processes. Recruitment and allocation of personnel are not necessarily set according to the specific needs of the country, but rather according to local or political demands and needs. In addition, for departments like SEFIN, the criteria and projections for the opening and allocation of new positions are not clear.
- Entering into various agreements with training institutions to comply with the strategic plan has not been achieved. Not all of these coordination mechanisms have been regulated, and therefore implemented.

- Progress in the processes of training and continuing education has been made, but in practice work focused on the renewal of Primary Health Care was not necessarily established. Additionally, there are contradictions between the type and number of Human Resources for Health under training and the professional demand or need in the country.

At present, the processes of investment in training and updating Human Resources for Health are included in the budget heading that depends on funds from foreign loans, and the processes are not a direct responsibility of the state with its own funds. This aspect makes investment irregular and more focused on the payment of scholarships for the training of health personnel—community service and professional practicum—rather than for strengthening and updating the existing staff.

### 3.3. Strategic Plan Progress

The Strategic Plan of Development of Human Resources for Health was elaborated taking into account the needs identified in the last decade for development and management of Human Resources for Health in Honduras. This issue is no different from that identified in other Central American countries and, therefore, the goals are the challenges posed by regional goals for strengthening the Human Resources for Health.

Since 2006, there has been an imbalance in the composition of the health workforce, combined with unemployment and emigration of trained personnel, especially because the lack of plans or the system cannot provide employment.

In addition, trained personnel are not adequate for the services needed, training institutions offer too many assistants and health technicians, and there is diversity in terms of the quality of professionals' training.

*Source: Evaluación del desarrollo de los recursos humanos en salud 2006-2009.*

Actions in line with the plan have been implemented primarily by the Department of Development of Human Resources for Health of SESAL; however, its two basic premises have failed to materialize: creation of the General Directorate of Human Resources for Health and approval of the new national policy on Human Resources for Health. Additionally, the organizational structure of SESAL is still the same, and therefore the bodies related to Human Resources for Health are still working independently.<sup>36</sup>

36. The Office of the Deputy Manager of Human Resources focuses basically in the personnel selection, hiring and management. It does not address achieving the regional goals of the challenges.

Despite the above, taking into account challenges and regional goals, steps toward progress have been made in the last three years, as follows:

#### CHALLENGE 1: BUILD LONG-RANGE POLICIES AND PLANS

Goals	Main Progress
<ul style="list-style-type: none"> <li>■ Achieve a human resources density ratio level of 25 health professionals per 10,000.</li> <li>■ The proportion of primary care physicians will be higher than 40 percent of the total medical workforce.</li> <li>■ All countries will have formed teams of primary health care with a wide range of skills, including community health workers, care to vulnerable groups and community network activation.</li> <li>■ The ratio of qualified nurses to physicians will reach at least 1:1 in all countries.</li> <li>■ All countries will have established a unit of human resources for health responsible for the development of human resources policies and plans, definition of strategic directions and negotiation with other sectors.</li> </ul>	<ul style="list-style-type: none"> <li>■ The policy on Human Resources has been reviewed and updated. Its approval is pending.</li> <li>■ The National Council of Human Resources for Health in Honduras / CONARHUS is in effect and can be used to support Human Resources management processes.</li> </ul> <p>In 2008 the POSAP's<sup>a</sup> study reported the following:</p> <ul style="list-style-type: none"> <li>■ Most crucial human resources (64.87 percent)<sup>b</sup> are nursing assistants distributed throughout the service network of the Secretary of Health, 12.24 percent are professional nurses, and 22.9 percent are medical professionals.</li> <li>■ General practitioners accounted for 11.77 percent and specialists 11.13 percent. The national ratio of these types of physicians is 1:2, but in border areas between 1:5 and 1:7.</li> <li>■ The medical professional to nurse ratio is 1:2; the shortage is 46.5 percent to achieve a 1:1 ratio of both resources.</li> <li>■ The density ratio of human resources, according to SESAL's data for 2008, is 3 physicians, 2 nurses, 3 dentists and 8 nursing assistants per 10,000 inhabitants<sup>c</sup> at the national level.</li> </ul>

Notes:

a. Postgraduate Program on Public Health, School of Medicine, UNAH 2008. "Análisis de la situación de los recursos humanos para la salud, Honduras."

b. The total number of employees in 2008 was 17,699.

c. However, this density ratio is different in most populated centers. There are 23.78 physicians per 10,000 inhabitants in the Department of Francisco Morazán, Central District to which Tegucigalpa belongs.

#### CHALLENGE 2: TO PLACE THE RIGHT PEOPLE IN THE RIGHT PLACES

Goals	Main Progress
<ul style="list-style-type: none"> <li>■ The gap in the distribution of health personnel between urban and rural areas will be reduced by half in 2015.</li> <li>■ At least 70 percent of primary health care workers will have public health and intercultural skills.</li> <li>■ Seventy percent of nurses, nursing assistants and health technicians will have upgraded their skills and competencies in light of the complexity of their functions</li> <li>■ Thirty percent of health personnel in primary care services will have been recruited from their own communities.</li> </ul>	<ul style="list-style-type: none"> <li>■ Actions have been taken to reduce the Human Resources distribution gap by means of Human Resources continuing education and volunteering. In this sense, a proper distribution of health personnel in social service has been achieved by concluding agreements among health regions, hospitals and training institutions to promote the services in rural areas.</li> <li>■ Intercultural nursing courses have been developed in La Mosquita, with the participation of the Pech, Tawaka, Ladino, Garifuna and Miskito communities, courses for the Lenca and Tolupan communities, and for the Creole community in Bay Islands<sup>a</sup>.</li> </ul>

Note:

<sup>a</sup> Documents from the Department of Development of Human Resources.

### CHALLENGE 3: ENSURE AN ADEQUATE LEVEL OF STAFFING OF HEALTH PERSONNEL

Goals	Main Progress
<ul style="list-style-type: none"> <li>■ All countries will have adopted a global code of practice, or ethical standards will have been developed on the international recruitment of health workers.</li> <li>■ All countries will have a policy of self-sufficiency to meet their human resources for health needs.</li> <li>■ All sub-regions will have developed mechanisms for the accreditation of overseas-trained professionals</li> </ul>	<ul style="list-style-type: none"> <li>■ The UNAH's Directorate of Higher Education has mechanisms for official accreditation of certificates acquired at universities abroad. UNAH belongs to the Academic Harmonization System, Central American University Higher Council [CSUCA after its acronym in Spanish].</li> <li>■ In the "Rules of Procedure for Student Training Centers of Human Resources in Social Service" for the training programs of the Ministry of Health, the Department of Human Resource Development of the Ministry of Health has included the certification of assistant nurses and health technicians, using the curriculum homologation process<sup>a</sup>.</li> </ul>

Note:

<sup>a</sup> Document already reviewed and validated by the Legal Department of the Secretary of Health pending approval by the Office of the Secretary. Document Information: Secretary of State, in the Office of Health, Department of Human Resources Development, 2009. Assessment on development of Human Resources for Health, 2006-2009. Tegucigalpa.

### CHALLENGE 4: PROMOTE HEALTHY WORKPLACE AND THE COMMITMENT OF HEALTH PERSONNEL THROUGH COLLABORATIVE WORKING RELATIONSHIPS

Goals	Major developments
<ul style="list-style-type: none"> <li>■ The proportion of precarious jobs without protection for health care workers will be reduced by half in all countries.</li> <li>■ Eighty percent of countries will have a health and safety policy for health workers, including programs to reduce occupational diseases and accidents.</li> <li>■ At least 60 percent of managers of health services and programs will meet specific requirements for public health skills and management, including ethical concerns.</li> <li>■ All countries will have mechanisms for negotiation and effective legislation to prevent, mitigate or resolve disputes and ensure the provision of essential services, whenever they occur.</li> </ul>	<p>In force according to the law:</p> <ul style="list-style-type: none"> <li>■ Recruitment under the system Public Competition for Physicians and Nurses.</li> <li>■ Medical and dental services through the Honduran Social Security Institute (only in large cities) with financial contribution from the State and the worker.</li> <li>■ Retirement and pensions system (mandatory retirement at age 65 and optional at 58), under a system of contributions deducted from wages and the right to personal housing loans.</li> <li>■ Nurses, physicians, dentists, social workers are governed by their own regulations with different benefits in each case.</li> <li>■ Five-year salary increases based on seniority.</li> <li>■ Bonus for certain positions.</li> <li>■ Fourteen salary payments per year plus paid and proportional vacations according to the corresponding number of worked days. Vacations: number of days according to seniority, and sick days.</li> </ul>

Note:

<sup>a</sup> Document already reviewed and validated by the Legal Department of the Secretary of Health pending approval by the Office of the Secretary. Document Information: Secretary of State, in the Office of Health, Department of Human Resources Development, 2009. Assessment on development of Human Resources for Health, 2006-2009. Tegucigalpa..

## CHALLENGE 5: DEVELOP COOPERATION BETWEEN TRAINING AND HEALTH SERVICES DELIVERY INSTITUTIONS

Goals	Major developments
<ul style="list-style-type: none"> <li>■ Eighty percent of schools in health sciences will have reoriented their education towards primary health care and community health needs and will have incorporated strategies for inter-professional training.</li> <li>■ Eighty percent of schools in health sciences will have adopted specific programs to attract and train students from underserved populations, with emphasis, where it is appropriate, and on indigenous communities.</li> <li>■ The dropout rates of medical and nursing schools will not exceed 20 percent.</li> <li>■ Seventy percent of schools in health sciences and public health schools will be accredited by a recognized entity</li> </ul>	<ul style="list-style-type: none"> <li>■ The following agreements—which are not necessarily regulated or implemented—have been concluded: <ul style="list-style-type: none"> <li>▶ Agreement between the Secretaries of State and Health Education for the inclusion of health courses in the curricula of primary and secondary education.</li> <li>▶ Cooperation agreement between UNAH and SESAL to train physicians in family health.</li> <li>▶ Teaching- health care integration framework agreement between SESAL and UNAH to train undergraduate and graduate students from the School of Medical Sciences.</li> <li>▶ Agreement between UNAH and SESAL for the development of the postgraduate program in Epidemiology.</li> </ul> </li> <li>■ In 2007 the School of Medical Sciences included in the medical program the new approach of primary health care. Nursing programs have also incorporated this in their curriculum.</li> <li>■ In 2008 UNAH created the School of Health Sciences at its Regional Center in Valle de Sula, whose key curricular emphases are Primary Health Care and health promotion.</li> </ul>

## 4. Final Analysis

### 4.1. Conclusions

- A current priority is the promotion and recognition of the importance of investing in Human Resources for Health to strengthen the processes and services in the health sector; therefore, it is necessary to apply issues defined as priorities in the National Health Plan 2021, in international agreements and instruments for their application —the Toronto Call to Action and the 10-Year Plan of Human Resources.

Including the issue of Human Resources for Health management in the agenda of the political authorities is a key factor to ensure significant achievements on this issue; otherwise the processes will not be continued and consolidated.

- The national policy on human resources as an instrument of regulation and guidance of actions to ensure human resources development, according to the country's needs has not achieved its ownership, dissemination and application.

These aspects hinder the development of efficient and effective management processes in Human Resources for Health, which are reflected in the

indicators and situation in the health sector and conditions in Honduras. On the other hand, SESAL, —in its role for the development of Human Resources for Health— has failed to generate and establish internal, agreed and integrated procedures to facilitate the implementation of this policy and therefore, to become a leader on the issue.

As a result, no progress has been made in comprehensively meeting the challenges set as regional goals for the development of Human Resources for Health. This can be seen in: (a) So far, there has been much more emphasis on training and continuing education, whose results are relative and have responded more to short-term advantages in opportunities than in planning; additionally there are still key issues to be addressed to ensure the quality and quantity of appropriately trained health personnel, and (b) The elements related to Human Resources for Health distribution and planned and monitored management performance have been neglected, as well as the improvement of health workers' conditions and the services provided.

- The Strategic Plan of Development of Human Resources for Health of SESAL has been conceived as a specific targeting tool for one of the departments related to the issue, the Department of Development of Human Resources for Health. This leads to the management of Human Resources for Health being understood and approached incompletely, where the emphasis is related to the priority actions of the department, which are training and continuing education.

Consequently, the following aspects have not been achieved: (a) Having a proper design of Human Resources for Health management processes developed in SESAL and framed in the National Health Plan and agreements; (b) Developing a comprehensive plan that considers both Human Resources for Health departments and, therefore, the corresponding skills to complementarily perform the management of Human Resources for Health; (c) Including the Office of the Deputy Manager of Human Resources as a key player in achieving the regional goals and improving the situation of Human Resources for Health and, consequently, health care; and (d) Defining an approach strategy with sector and systemic scope.

## 4.2. Challenges

Considering the above, the following can be identified as key challenges for the implementation of the policy and strategic plan of Human Resources for Health:

- It is necessary to define a critical path to enable consensus and guide actions for the application and implementation of the national human resources policy; it should take into account as key or priority elements:
  - ▶ Performing policy harmonization with both plans, the 2010-2038 national plan —it is a Republic Act regulating the activities of the coming years— and the 2021 National Health Plan. This is for ensuring the effectiveness and coherence of raised strategic lines; for adapting their strategies and mechanisms to the requirements and repercussions arising from the plans and facilitating its further application by using and adapting to the mechanisms established in those national plans.
  - ▶ Ensuring harmonization with the different international agreements established in the development and management of Human Resources for Health, especially the Toronto Call and the Regional Development Goals of Human Resources for Health.<sup>37</sup>
  - ▶ Ensuring a process of consensus on national policy, its scope, validity and implementation.
  - ▶ Ensuring the implementation and responsibility of institutions and players related to Human Resources for Health. This is to ensure the generation of comprehensive processes, and therefore the progress towards achieving the regional goals and indicators.
  - ▶ Identifying strategies, mechanisms, players and key actions to ensure the dissemination, application, implementation, monitoring and evaluation of the strategies in political consensus. This should be done in an integrated, coordinated and complementary manner among the actors and organizations related to it, both inside and outside SESAL.
  - ▶ Ensuring actions and effective mechanisms for dissemination, application, implementation, monitoring, and evaluation of the policy in a continuing, coherent and inclusive manner.
- The development and strengthening of agencies and people on which the implementation of the Policy on Human Resources for Health relies. They are CONARHUS across sectors, the Department of Development, and the Office of the Deputy Manager of Human Resources inside SESAL. A reflection on the possibility of unifying the two bodies to facilitate a more integrated management of Human Resources for Health is necessary.<sup>38</sup>

37. In this sense, a core aspect is ensuring correspondence between the challenges and proposed goals. Additionally, it is essential to ensure activities for Primary Health Care.

38. While taking into account the possibility of developing processes to strengthen their work and ensure a change of attitude and skills appropriate for their new challenges. It is not intended to change the role and preserve the functions and vision that governs today.

- It is necessary to develop the Strategic Plan for the Development and Management of Human Resources for Health that will guide the actions from 2010. To make use of the economic opportunity, it is necessary to assure that with the new approach, the weaknesses in design and management of the previous plans will be corrected.

Consequently, the plan should be developed with the coordination of the players; it should be inclusive in terms of powers and responsibilities. The agencies related to Human Resources for Health must be harmonized with the policy, which should have consensus, and establish implementation mechanisms and steady actions. In this sense, it is necessary to determine the most competent agency for its implementation according to its regulation and capabilities.

### 4.3. Recommendations

- Consensus on a policy to guide the Human Resources for Health development process and then establish a critical path to ensure (a) its harmonization with national documents guiding the improvement of the health system; and (b) application and implementation of it through the identification of regulations, mechanisms and key actions for achievement. Designing and putting into operation a subsystem of operational planning, monitoring, and evaluation of the policy.

Additionally, it is necessary to ensure the dissemination processes facilitating the commitment of different sectors and players to the scopes expected from the policy and the repercussions in organisms and/or Human Resources for Health.

- Develop and strengthen the CONARHUS, which has the potential to influence both technical and political decisions for being the scenario for cooperation of institutions and actors involved in the management of Human Resources for Health. However, it is necessary to ensure not only its formation but also its functioning and timely response to the processes taking place and related to the policy and strategic plans of Human Resources for Health.
- It is necessary to reflect and then raise viable and effective actions to strengthen the organizational structure and Human Resources for Health management style utilized by SESAL. This is for ensuring the development and addressing the actions in an integrated, planned and sectoral manner, which will facilitate investment and development of processes to achieve positive impacts on the health system, the population and the country.

- Ensure the Strategic Plan for Management and Development of Human Resources for Health with the participation of the Office of the Deputy Manager of Human Resources and the Department of Development of Human Resources for Health as bodies related to matters of interest regarding the 10-Year Plan and the regional goals for Human Resources for Health. In designing the plan, it is necessary to ensure its subsequent management and application.
- The policy and strategic plan should be conceived as Human Resources for Health instruments that will have influence on other departments of the health sector. For this reason, it is necessary to capitalize on the experiences, progress and learning on this subject, and to ensure approaches that enhance their processes, growth and development.
- Promote the importance of Human Resources for Health development in the regulatory and operational bodies of the Secretary of Health by publishing the regional, sub-regional and national guidelines of the Decade of Human Resources for Health.

*The implementation of a communication strategy that supports and accompanies the process affects the commitment made in the decision-making and technical levels.*

- It is necessary to capitalize on the learning from informal training activities undertaken to support and promote Primary Health Care as a basic approach to work in the health system. Some of these practices meet the requirements of competencies, use learning-by-doing methodologies and especially the application and contextualization in specific health organizations.<sup>39</sup>
- Activate and maintain the Observatory of Human Resources for Health as an element that will generate objective and valid information for making decisions on Human Resources for Health management.
- Start a prompt and proper documentation process and an adequate systematization of processes and national experiences in the field of Human Resources for Health; this entails a gain in organizational learning and contributes to the continuity of the processes.

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39. See Annex 4. IHSS experience in training Primary Health Care national personnel.

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### 1. Policy Frameworks for Health Care System Transformation

#### 1.1. . Health Sector Situation

The health system in Paraguay is fragmented and segmented with weak coordination among its components and has a low level of regulation.<sup>40</sup>

It is made up of the public sector, led by the Ministry of Public Health and Social Welfare (MSPBS after its acronym in Spanish); Social Security, comprising units of the Institute of Social Welfare; units of the National University of Asuncion; the National Police; Armed Forces; and the private sector: clinics, professionals, pre-paid medical system and cooperatives. These subsystems interact to respond to various sectors of the population. Management among those parties is still weak, which makes the coordination within the system difficult.

One of the core problems of the health system is the high exclusion rate. Historical data show that 38 percent to 40 percent of society is excluded from health care.

Another problem is the high cost of health care for people.

The care model is based on hospital care and disease treatment, with little development of promotion and prevention.

Closely linked to this is the model for training health professionals, which is strongly oriented towards training specialists to work intra murus with highly concentration in hospitals.

The management model of the health system in Paraguay within public institutions is highly centralized, bureaucratic, with little spending quality and very vertical. It has to address a comprehensive vision of a territory or population, focused on health care outcomes.

#### 1.2. Proposals from the Ministry of Public Health and Social Welfare

In the MSPBS's "Public Policies for Quality of Life and Health with Equity", the Ministry states that life is a supreme ethical value and health is inseparable from it, and that for the government that took office in August 2008 is part of a larger effort aimed at establishing a social security system, within which the state seeks

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40. PAHO & USAID, 2008. Health Systems Profiles - Paraguay.

to establish the guarantees needed by society as a whole to exercise their social rights effectively.<sup>41</sup>

In this sense, health policy reflects a strong political will and new ideas about the health system that emphasizes the role of the state as guarantor of the right to health.

Thus, the right to health is inextricably linked to the right to life and is not given only by the existence of health services; it is the result of access to an environment and living conditions compatible with human dignity.

The policy is based on four essential areas: ensuring the right to health is to opt for universality for all people; ensuring access to those who were systematically excluded; integrity of the person, by considering the individual as an indivisible whole and seeking to respond to all human health problems; the ultimate principle of equity and social justice; and active society participation with decision-making power and management control by the state as an expression of democracy and citizenship.

The MSPBS's "Strategic Planning 2009-2013" comprises the Vision for the National Health System and the Mission of MSPBS.<sup>42</sup>

### *Vision*

A National Health System coordinated, structured and consolidated across all sectors, with a national health agenda coordinating them and addressing social determinants of health and disease to promote quality of life. It is supported by a strategy for Primary Health Care with Health Family Units in areas under its supervision, which manages the local health agenda. It has problem-solving capacity and is coordinated with other major networks and complementary health services ensuring continuing care, universal access, free access, fairness, non-discrimination and the elimination of social exclusion. It operates with broad community participation. It has a development and training plan for human resources; it has a budget directed towards fulfilling this vision.

### *Mission*

A Ministry of Health, leader of the National Health System that promotes a health care model oriented to guarantee universal access, free service, equity, social participation, quality care, with a focus on human rights, social areas and social determinants of health and illness. It promotes quality of life with other play-

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41. MSPBS 2009. Public Policy for the Quality of Life and Equitable Health.

42. MSPBS, 2009. Strategic Planning 2009-2013.

ers and sectors of the socioeconomic development. It organizes, coordinates, and integrates care networks to improve solving capacity; it has work teams that respect the dignity of human beings.

The five strategic objectives (SOs) outlined in the 'strategic plan' are the following:

- Health stewardship
- Promoting health and quality-of-life equity
- Establishment and strengthening of health care networks
- Institutional development
- Participation and social management

The SO1 and SO3 are aimed at promoting, integrating, building, coordinating and expanding primary and complementary health care networks throughout the country by starting with Primary Health Care as a means to coordinate the national health system under a new type of service aimed at meeting the needs of people in all stages of life. Priorities for 2009-2013 include: organizing the major networks into a Primary Health Care network of clinics and hospitalizations and emergencies; and organizing complementary networks: monitoring network, health information, pharmacological assistance, diagnostics support network, network of orthotics, prosthetics and rehabilitation.

In this regard it is noteworthy that since August 2008 the MSPBS has made a sustained and increasing investment to build or remodel the infrastructure, add equipment, provide medicines and supplies and hire staff for Primary Health Care, particularly in health family units (HFU), which at the date of this writing there were 270 providing service to 1,230,000 people representing 21 percent of the total population.

Another objective (SO4) states the duty of promoting plans and institutional development programs to create the conditions for transition from a curative care model to a care model based on the primary care strategy and respect for human rights by strengthening, training, and reorienting the human teams at various levels of health care. Priorities for 2009-2013 include: a plan for the development of a Policy of Human Resources for Health (Health Career Law, social security for health workers, etc.,) reorientation and integration of health services; promoting the stewardship of the National Institute of Health in training human resources for the development of new institutions in line with public policies for quality of life and health equity.

Since August 2008 the MSPBS has given priority to the following areas:

- Free health care, including provision of essential medicines and supplies for inpatients and outpatients
- Primary health care, with the opening of Family Health Units (None existed in August 2008, and 270 did in April 2010.)
- Integrated service networks where, in addition of having started a process aimed at the reorganization of the provision of services, investment were made in modernization and maintenance of infrastructure, purchase of high technology equipment for diagnosis and treatment, new fleet of ambulances, physicians hiring, nurses and biochemists.
- Decentralization, which includes the transfers of regional and local health councils through equity funds.
- Health promotion and constant presence in the mass media for the contingencies of acute respiratory infections, H1N1 and dengue, without neglecting permanent and widespread issues.

### 1.3. Major Challenges for Policy Implementation

- Ensuring the provision of financial resources to strengthen free health care, provision of essential medicine and the increase of Family Health Units to improve access and reduce social exclusion in a country where there is unanimity about the shortcomings of the health system but much resistance to pay the costs of its strengthening and expansion. At that time there was discussion about the need to double the funding in the 5-year period 2008-2013 to achieve the results sought by the new health policy. (Currently the MSPBS's budget is US\$381 million).
- Providing human resources with skills commensurate with the new requirements, adequate and properly distributed in relation to care demand in a country with a chronic shortage of health personnel, trained in the curative model of care and with no incentives to relocate to rural areas.
- Developing comprehensive service networks in all their breadth and complexity, in an organizational environment that is more conducive to fragmentation of work (which is the result of decades of working under the logic of unrelated vertical programs).
- Increasing decentralization so that communities will receive the best response to their problems and health needs more effectively and promptly.
- Management modernization at the central level and strengthening health regions and work teams to achieve results and not simply to comply with formal administrative processes.

- Obtaining a broad consensus on the health system that the country needs and collective commitment to achieve it.
- Having a not fragmented health information system with high quality standards to ensure the reliability of data for decision making.
- Elimination of institutional weakness coming from conditions that existed prior to the current health administration.

#### 1.4. Areas of Participation and Consultation in the Development of the Policy on Health Sector

There are several levels of consultation. One is the National Health Council, established by the National Health System Law,<sup>43</sup> which has national, departmental and municipal bodies and sub-councils in small communities.

On the other hand, there exist some institutions of coordination in terms of strategic areas such as the Council of Sexual and Reproductive Health or the Council for Children, which includes civil society organizations and government agencies.

As for health care networks, there is room for agreements, public/public works, such as social security and the ministry, or public/private therapy services, dialysis or transplantation where the public system purchases services from the private sector.

There are agencies for government participation; session days of government departments with ministers and the President of the Republic and workshops, for instance the Management Committee of Nursing Work with health workers.

The Social Cabinet of the Presidency of the Republic is a body of consensus for joint and coordinated actions of different ministries.<sup>44</sup>

## 2. Framework on Human Resources Politics

### 2.1. Current Situation

The situation of human resources for health in Paraguay is characterized by several historically underserved and neglected aspects in sector policies resulting in:

43. Law 1032/96 “Que crea el Sistema Nacional de Salud” [Creation of the Health National System].

44. Social Cabinet of the Presidency of the Republic for Everybody. Public Policy Proposal for Social Development 2010-2020.

- Inadequate distribution, availability and composition of the workforce.
- Deterioration of working conditions.
- Partisanship of public office and political patronage.
- Inadequate training and educational processes for health needs and development work in health services.
- Lack of medical and health research.
- Weak regulation and control of professions.

One of the objectives of the “strategic plan” is the definition and implementation of a national policy on human resources for health enabling the development of strategies and actions for the short, medium and long term; a policy defining the needs of quantity, distribution, adaptation, training, skills, incentives and regulation of the workforce, especially in the public sector which represents almost 80 per cent of the country’s service network.

Along with the need for health planning and regulation it is also necessary to bring together a significant number of professionals from different sectors and enable them to share new ideas in the human resources field for conducting the process as well as for the integration and improvement of record keeping and information systems. To progress at national and local levels, it is also necessary to create spaces for dialogue among the political, technical and social sectors in order to build the political viability of the proposal and its governance.

## 2.2. Lines of Action to Develop the MSPBS’s Human Resources Policy<sup>45</sup>

**Creation of the National Strategic Directorate of Human Resources for Health** (DNERHS is the acronym in Spanish) for:

- Developing a policy of strategic human resource planning, taking into account the different bodies involved in training, labor management, development and regulation.
- Organizing the area according to a comprehensive vision that can serve as a forum for discussion, and advice on drafting and developing national policies on human resources for health.
- Participating in planning and implementing plans by creating opportunities for participation and analysis from the field of education, management and regulation, building healthy work environments and working for the full development of them.

45. MSPBS. National Strategic Leadership on Human Resources for Health 2009. National Policy on Human Resources for Health 2008-2013.

- Implementing these policies in coordination with the General Directorate of Human Resources and Ministry of Public Health and Social Welfare, consistent with a systemic and decentralized model structured in networks.
- Participation in budget preparation committees on issues related to human resources by providing a global and strategic vision.

**Progress:** The directorate has been created; the other issues are being developed.

**National Registry of Human Resources**, for:

- Developing a policy that addresses the generation and management of strategic information updated in relation to the field of human resources for health.
- Making an up-to-date database that is updatable of human resources for health including the public sector, social security and the private sector, at every management level: local, regional and national ones; this will serve as a baseline for planning.

This database will be part of an information system of human resources available to the public; it will be developed under an integral concept with the Health System and the Secretary of Public Function.

**Degree of progress:** low. A consolidated database is not available yet. On the other hand, in late 2010, the Directorate of Human Resources Department will have a new information system; it will be fully shared with DNERHS.

**Regulation of health professions** for:

- Promoting a policy dialogue to create spaces for consultation and specific powers by harmonizing criteria for permanently checking the quality levels of health professions.
- Unifying the names of professions based on the relevant competencies.
- Adapting the norms to agreements and regional and sub-regional legislations aimed at the approval of professions and the mutual recognition of qualifications.
- Encouraging the adaptation of curricula to the new management and health care model developed according to a renewed strategic of primary health care.

- Promoting certification processes for all health professions as a mechanism for continuing quality control that guarantees service based on excellence.

***Degree of progress:*** beginning.

**Bureau of Labor Management in Health** for:

- Promoting policies for consultation and negotiation in labor relations based on worker respect and dignity to achieve the institutional mission by decreasing the levels of conflict and in order to ensure health care coverage.
- Forming a Health Work National Management Committee with regulators and managers of the public system, and workers and civil society to adapt the workforce to the needs of the National Health System.
- Coordination of legal actions and regulations that allow the organization of the health care system in a progressive manner, through:
  - ▶ Public competitions for management positions.
  - ▶ Consolidation of salaries and incentives to achieve full-time work at a regional level according to the needs of the population.
  - ▶ Setting procedures to reduce the country's quality as "ejector," and promoting incentives to encourage permanence in the country and decreasing the rate of emigration.
  - ▶ Reviewing and adapting the proposal for Health Career Law to include all public sector workers.
  - ▶ Forming management councils of medical specialties to establish the proper conditions of each specialty.

***Degree of progress:*** The committee has been formed. The public competitions undertaken are those of the Family Health teams Of the Primary Health Care (This is unprecedented in the MSPBS). The remuneration of officers has been raised; when approved, workers can have up to three contracts provided that the jobs have different schedules. However, the salary consolidation to work for a single institution is still pending. It is noteworthy that MSPBS has achieved for Family Health Teams (FHT) salaries higher than those normally assigned to physicians and nurses of the institution, although this has created dissatisfaction among those officers. These salaries are consistent with the greater number of hours that FHTs have. There is a commitment of salary leveling provided that re-categorizations are made by the Ministry of Finance and Congress.

### **Observatory of Human Resources for Health** for:

- Promoting the policy of research and work in the area of human resources at national level and facilitating its disclosure and dissemination of the conditions and trends for decision making.
- Creating the Observatory of Human Resources for Health (OHRH) as an area of coordination, production and analysis of information on the status and trends of the health human resource sector.
- Coordinating the Observatory of Human Resources for Health by the MSPBS and calling the human resource training institutions for health, health care providers and unions.
- Promoting research and producing and disclosing information through the development of studies and methodologies to guide analysis and policy making in human resources in the country.
- Promoting the coordination with other observatories at the sub-regional, regional and global level to form networks of information and knowledge.

***Degree of progress:*** The Observatory has been created and the participants have good expectations.

### **Strengthening the National Institute of Health**, with the purpose of:

- Developing a policy on training and continuing education of human resources under the model of primary health care and integrated networking.
- Developing master's programs in the area of Public Health and Service Management to provide teachers and managers with tools to respond to the needs of the health system and support the development of primary health care.
- National Council of Medical Residencies.
- Promoting the law governing the structure, organization and functioning of the National Council of Medical Residencies; it has to ensure its political, technical and financial independence, and continuing education.
- Defining and conducting a policy of continuing training for health workers to be adapted to new health policies, based on the primary health care model and its application in networks.
- Developing the ability to use Information and Communication Technology (ICT) and the capacity of the Institute to lead the use of information technologies for conducting training courses and processes, and continuing education programs.

***Degree of progress:*** under development.

Main challenges for the dignity of workers and work itself:

- Correspondence between worked hours and remuneration to have full-time professionals.
- Developing participatory management systems (collegiate management).
- Contest of technical capabilities for service management.
- Reorganizing the services by setting work technical conditions.
- Organizing a profitable security system to be working in a coordinated network of services.
- Providing access to continuing education and specialization for all workers.
- Ensuring social security for health workers (via IPS [Social Security Institute, from its acronym in Spanish]).
- Eliminating service partisanship and promoting work for the respect and appreciation of the workers.
- Monitor training quality through the certification of health care schools.

### 2.3. Indicators and Expected Outcome Monitoring System

A baseline was set by considering the Regional Goals of Human Resources for Health 2007-2015 and data from the Directorate of Statistics, Surveys and Censuses, General Directorate of Human Resources for Health of MSPBS, Directorate of Professions Registry of MSPBS, Institute of Social Welfare and Civil Registry of Persons.

The “strategic plan” of MSPBS contains goals and indicators for the Policy on Human Resources for Health. It is necessary to clarify its definition (it has goals for the years 2009, 2010 and 2013) and include all applicable indicators for the 20 regional goals.

### 2.4. Participation Process in Developing Policies on Human Resources

#### *The Formal Procedure to Formulate and Adopt the Framework of the Policy on Human Resources within the Government Apparatus*

In Paraguay, the Secretary of Civil Service, which has ministerial status and reports directly to the President of the Republic,<sup>46</sup> is the body responsible for set-

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46. Law 1626/2000 of Civil Service.

ting the state policy on management and training Paraguayan civil servants at the national, provincial and local levels. Therefore, the human resources policy of MSPBS should be in harmony with the Human Resources for Health State's Policy. For this, the SPF (Secretary of Public Finance) and the General Directorate of Human Resources (GDHR) of MSPBS work together because the Civil Service Law provides that the Human Resources for Health units of public entities are to be operating units of the SPF. In this context, the SPF has approved the Internal Regulation of Human Resources of MSPBS prepared in GDHR. It has also approved the matrix for public personnel competitions for Primary Health Care family health units, which standardized the selection process for Primary Health Care staff. Recently, the GDHR requested SPF approve the performance evaluation process of Primary Health Care staff. (It is the first public institution that initiated the process MSPBS).

### *Strategy and Consultation Process Used for Formulating the Policy on Human Resources*

At first, the Health Team of the Patriotic Alliance for Change (APC is the acronym in Spanish) designed the Public Policies for Quality of Life and Health with Equity with the participation of domestic and foreign health experts, union representatives of physicians, nurses, dentists, biochemists, etc., members of academia, private sector, social security administration, NGOs, economists, government officials and representatives of the Political Team of the APC. At this stage, the basic outline of the policy on Human Resources for Health was set.

Subsequently, for the specific development of the Policy on Human Resources for Health the same process was applied. A workshop was held with the aforementioned players and advisers from Ecuador in which the 20 goals of regional human resources were addressed, along with the situation in Paraguay. A diagnosis was made of these goals. It was linked to the Public Policies for Quality of Life and Health with Equity and with the issues of universality, comprehensiveness, equity and citizen participation, and the gaps in relation to these goals. Six guidelines of action were agreed upon for decisions regarding human resources.

Shortly after taking office, the new administration created the Strategic National Directorate of Human Resources for Health (SNDHRH), which since that time has been responsible for continuing the development and subsequent implementation of human resources policy. It worked with all the general directorates of the MSPBS but put more emphasis on Primary Health Care, Services (now Networks and Services), Administration and Finance, Human Resources (not to be confused with the SNDHRH) Planning and Evaluation, the National Institute of

Health, and with the cabinets of the Minister and Deputy Minister. The participation of representatives from health regions should have been more active in this sector.

Apart from MSPBS the Secretary of Civil Service, Ministry of Education, universities and national and private colleges, the Institute of Social Welfare, University Hospital (university), the Police Health Care and Military Health Care participated, as well as some private sector representatives. For the union sector, the Paraguayan Medical Circle, the National Federation of Health Paraguayan Workers, the Association of Nursing and several unions of MSPBS participated.

As to international cooperation, the most significant support was received from the local office of PAHO and PAHO-WDC.

At a later stage, negotiation committees or dialogue roundtables were formed for negotiation of conflicts, discussion on Human Resources for Health issues and putting forward possible solutions. As a result of these, the Health Career Project was submitted to Congress.

As a result of this process, the degree of coordination between the health policy and that of Human Resources for Health is high. It is evident from the facts: Primary Health Care is a priority of health policy. Since August of 2008, 65 percent of all newly hired personnel of MSPBS have been Family Health Teams. Recruitment was made by public competition. These workers receive higher pay than the average because they work overtime in order to expand the coverage.

### *Communication Strategy of Policy on Human Resources*

Currently, it is limited to the Observatory of Human Resources for Health.<sup>47</sup> In the Observatory, various measures to initiate discussions on specific topics were carried out. Discussion groups were formed; they have facilitators who are responsible for guiding and inviting people interested in the topic to participate.

The Observatory disclosed all available documents and diagnostics; more documents related to the country's Human Resources for Health are being added.

The SNDHRH manages a line of cooperation with the Spanish Agency for International Development Cooperation (SAIC) in order to implement wider disclosure of the Policy on Human Resources for Health.

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47. At: <http://www.observatorioparaguayorhus.ning.com>.

## 2.5. Development of Human Resources Plans and Coordination with Government Key Sectors

### *Development Status of the Plans of Human Resource for Health*

At the time of this writing, no formally structured human resources plan exists. The SNDHRH started its preparation through the observatory of human resources and in cooperation with the SAIC; technical support for the plan formulation is expected.

Until the formalization of the Human Resources for Health plan is complete, SNDHRH and GDHR work together in the implementation of specific actions due to the need to respond to health problems within the framework of priorities set by the national government (where Primary Health Care has the category of “Emblematic Program”) for Public Policies for Quality of Life and Health with Equity and the Strategic Plan 2009-2013. Likewise, SNDHRH and GDHR check to make sure that those actions are in line with the Policy on Human Resources for Health.

The actions mentioned are the same as those related to human resources for Primary Health Care.

Even without the plan, the MSPBS has defined a work agenda with the Secretary of Civil Service (See below in the appropriate section.)

The SNDHRH estimated a period of 4-6 months is needed to formulate, discuss, validate and approve the plan.

## 3. Process of Coordination with Government Key Sectors

### 3.1. Secretary of Civil Service (equivalent to the Ministry of Labor)

As explained above, the plan of human resources has not been developed yet; however, institutional and organizational work between the two agencies has been undertaken.

The agenda established between the SPF and MSPBS includes, among others, the following topics:

- Selection and training, performance evaluation, and employment termination.
- Work compensation and remuneration.
- Inclusion of disable people.
- Non-discriminatory policies.

- Adequate systems to solve the problems of workforce moonlighting (Salaries from several institutions are paid to one health care professional, which currently is not permitted by the Ministry of Finance).
- Redefinition of the term health worker and identification of occupational groups that form the sector.
- Working environment.

The SPF considers that public administration should be positioned to provide the services needed with excellence. Therefore, the civil servant is a key player along with a functional, adaptable, modern and innovative structure. The officer has to be a professional who knows what to do with all the skills and abilities required for the position, and to do what has to be done.

The SPF works on a new Civil Service Law. It considers a framework enabling coordination among all careers to be necessary. There are specific careers to be established, including the health career. It has to be linked to public service in general and other careers because SPF has a key objective of unified policies with their differentiation. It may exist but in the unified policy framework.

The SPF is very interested in health degrees related to degrees in public service. In this sense, it fosters a general discussion in order to avoid opposition or conflict and to promote a harmonious whole because it is desirable to avoid the continuation of the Paraguayan state mode, formed by compartmentalized organizations that are ultimately opposed and thus promote inefficiency.

The SPF has full institutional relations with the Minister of Health and the Minister of Civil Service at a senior management and operational levels.

The coordination between both institutions is regulated not only by the Civil Service Law, but also by agreements between the highest institutional authorities. Furthermore, the SPF is consolidating with Human Quality Network, which unites all those responsible for the Human Resources areas of the public sector, including, of course, the MSPBS. The SPF also provides MSPBS with international consultancy to support the design of human resource policies.

This interaction occurs regularly and periodically.

This relationship has enabled greater coordination and reconciliation of the interests of SFP and MSPBS. It has facilitated the joint search for solutions. Situations that were not addressed in the past have begun to be studied in the common workspace.

The process has been smooth, due especially to the absence of case law that would guide decisions. Everything has to be done in Paraguay regarding the pro-

fessionalization of public officers, which has been neglected for a long time. Not all the players are involved with the same enthusiasm. The Ministry of Finance is the best example. Moreover, bureaucracy is slow and the legal framework is not suitable for the peculiarities of the health sector; it is not consistent with the needs of the general population or with the insufficient number of health professionals. However, the SPF encourages and provides technical assistance in the formulation process of the Health Degree Project.

The factors that are positive influences are the political will and commitment of the highest authorities involved. It is widely known that the two ministers share a common history from their union ` membership as students in the School of Medicine.

However, the bureaucracy has to be reduced, and better communication between the operating levels of both institutions has to be improved.

Several cases of negotiation with the SPF can be mentioned:

- Currently, some alternatives are under study with the SPF to solve the problem of physicians and nurses receiving more than one salary from the State. Every year, their wages are retained because the software of the Ministry of Finance is configured to allow multiple payments exclusively to teacher and professors. The SPF is trying to have the data entry done directly through its electronic file system in order to give an institutional solution to a problem that has existed for about a decade, and that annually generates irritation and affects care quality in health institutions.
- The SPF, MSPBS and the Paraguayan Association of Nursing have succeeded in finding an institutional solution to the problem of nurses working in public institutions with overlapping schedules between the departure and entry.
- The approval for health professionals to have up to three contracts, provided that they don't have the same schedule, was achieved with the collaboration of the SPF. Since the 1990s there had been a rule that no officer could earn more than a deputy minister (whose salary is equivalent to US\$1400; this was a strictly administrative measure that did not take into account the shortage of human resources for health).

### 3.2. Ministry of Finance

Coordination with the Ministry of Finance has two areas, one formal and one informal. The formal area is within the Economic Team, which deals with issues and aspects related to the implementation of the current-year budget. The more

informal area is the Budget Negotiation Committee, which covers aspects related to the allocation of resources for next-year budget.

With regard to human resources for health, the Economic Team is responsible for new appointments, as well as salary increases or vacant positions. The Budget Negotiation Committee is responsible for issues linked to budget increases for human resources, such as determination of wage levels or bonuses, which is used as a compensation policy due to low salaries of public sector.

Among the aspects that prevent a more fluid dialogue and generate tensions are:

- The lack of human resources policy and a clear salary policy to respond to innovative approaches of performance evaluation rather than to complaints and pressure from unions.
- The weak information system does not generate sufficient information. As health professionals are able to have up to three contracts, the information system can only know the number of contracts and stops at the fourth contract; it does not provide the number of hours accumulated by the professional; consequently, no actual record exists; it would be possible that the total contracts a professional has add up to more than 24 hours a day, or even contracts that cannot be complied due to distance reasons; for instance, a professional has a position at a hospital 190 miles from the capital on Mondays until 5 p.m. and an emergency room position in the capital from 8 p.m. Given that professional's hours are not entered, such cases could not be detected.
- Needs for funds exceeding budgetary capabilities, such as shortage of funds to pay voluntary retirements.

The work agenda should include:

- Performance criteria on the wage-increase policy in order to improve the efficiency and effectiveness in the use of public resources.
- Optimization or adaptation of existing human resources.
- Alignment of policy and budgetary capabilities to facilitate full-time health professionals.

### 3.3. National Agency for Evaluation and Accreditation of Higher Education (ANEAES)

The National Agency for Assessment and Accreditation of Higher Education was created by Law 2072/03. It reports to the Ministry of Education and Culture,

but has technical and academic autonomy to carry out its functions, which among others are the following:

- Preparation of technical reports on academic projects approving academic courses and institutions, at the request of the respective authority of higher education.
- Serve as an advisory body for evaluation and accreditation on higher education.
- Serve as an advisory body at the request of institutions or organizations interested in matters related to this law and the terms of their scope.
- Assess the academic quality of graduate and postgraduate courses and programs externally evaluated by the same agency.

It is not possible to directly identify a thematic agenda for discussion because the Human Resources for Health plan is not available yet. The policy on Human Resources for Health, Line of Action 3, Regulation of Health Professions, states: “Promote the adaptation of curricula to the new management model and promote services developed under the strategy of Primary Health Care.”

The President of ANEAES, who is also a professor of Medicine, is willing to discuss the plan of Human Resources for Health with the SNDHRH once it is formulated. At the moment she has merely stated that:

- The Primary Health Care strategy is necessary, relevant and a priority, but teaching should be ranked with the design and implementation of a plan for a model center of Primary Health Care where physicians are an example of what should be done and how it should be done.
- The academic projects of schools of medicine should meet the guidelines of the Educative MERCOSUR.
- Stable positions and a sense of belonging should be generated through the health care career.
- Agreements between the MSPBS and universities should state with sufficient strictness the commitment or duty that educational institutions — using clinical areas of the ministry— should have when imparting priority programs of public health.
- It is necessary to improve the coordination between the MSPBS and training institutions.

There is still a bias toward professionals working in the MSPBS because in the recent past the recruitment was not based on skills but on political patronage. It will take some time for the stigma to disappear.

For now, the Observatory of Human Resources for Health is an ideal place for the exchange of proposals between the higher education sector and MSPBS.

#### 4. Analysis, Reflections and Recommendations

Three decades after the Alma Ata Declaration, the strategy of primary health care in Paraguay has its best chance to consolidate. Although the Primary Health Care has been present since the 1980s in the policies, strategies and operational plans of MSPBS, in practice its implementation has been low.

The present Policy of Quality of Life and Health with Equity has Primary Health Care as a key cornerstone. To make it a reality, the General Directorate of Primary Health Care (GDPHC) was created and it has been endowed with a large budget; the MSPBS has been reorganized for the directorates and programs to work in a more coordinated manner with the GDPHC.

Particular care has been taken for the formulation of the policy on Human Resources for Health; it is entirely consistent with the Primary Health Care. The SNDHRH and GDHR have focused their efforts on providing family health units with the necessary professionals, through public competition and better salaries; for this, the cooperation of the Ministry of Civil Service was very helpful.

Other general directorates, such as Planning and Evaluation, Strategic Health Information, Health Strategic Supplies, Health Programs, Health Surveillance and Health Promotion, within their respective spheres of action, also coordinate efforts towards the GDPHC to achieve better health outcomes.

In order to integrate, complement and enhance the health care system, the MSPBS has ordered the reorganization of the General Directorate of Health Services Development and the General Office of Networks and Services.

In turn, the Executive has taken Primary Health Care as one of its ten emblematic programs within the Social Cabinet.

However, the road is not free of difficulties. First, implementing a strategy to ensure its expansion and sustainability is a major challenge; it requires a cultural and behavioral change in health professionals. The main medical school has been functioning with no interruption for more than 110 years by training professionals according to the biological scheme where promotion and prevention are meaningless concepts, and analysis of health social determinants is almost nonexistent. All other medical schools formed their faculty with their graduates.

Deans of the longest-running private medical schools are open to make changes in the curricula, so that the graduate profile can be more consistent with the needs of the country. They are in favor of enhancing the role of Primary Health

Care in the health policy. They are open to receiving any initiative from the MSPBS in order to coordinate the process of curricula renewal, in which, of course, the MSPBS must be represented by people with similar profiles to that of academia speakers. (Currently, this does not pose any difficulty for MSPBS.)

It should be noted that the change in curricula content will not suffice if professors do not acquire new skills, abilities and readiness for Primary Health Care.

All this is completely applicable to the nursing sector, according to meetings held with the authorities of the two main schools of nursing in the country.

At the same time, the MSPBS should improve internal communication on health policy and especially on Primary Health Care since tensions exist among health professionals assigned to health institutions, due to wage asymmetries that originated with the best remuneration for staff of Family Health. On the other hand, salaries are linked to full-time work required prior approval of public competition, which is an institutional innovation.

It is also very important that the Human Resources for Health plan of MSPSB plan—as a concrete, documentary and reference to apply the policy on human resources for health— be fully formulated, validated, approved and disseminated as soon as possible, to give greater consistency to the development of health policy of MSPBS in general and Primary Health Care in particular.

Second, the historical deficit of Human Resources for Health is very significant and the implementation of Primary Health Care to achieve universal coverage demands a large additional number of Human Resources for Health. To have the necessary financial resources, the support from the Ministry of Finance is necessary in order to guarantee the provision of funds, and from Congress, which authorizes the budget for personnel services (appointed positions, contracts and other financial incentives).

The Ministry of Finance, which leads the State's reform and modernization, advocates improving the quality of public spending in general, including medical optimization or adaptation of human resources in state institutions and reduction of civil servants in general. Congress, in turn, is reluctant to increase budgetary allocations for personnel.

On the other hand, although there is as a mechanism for short-term planning at the institutional level, the budget formulation process has serious limitations as a tool for human resource planning. Some of the causes of the difficult to apply it are linked to the problems of basic information. The viability of the planning process is difficult because of the lack of reliable, comprehensive and continually up-

dated information regarding the number of appointed officers, contracts, workload, job descriptions, and personnel files.

Therefore, it is necessary for the MSPBS to reach a level of understanding with the Ministry of Finance comparable to that which it has with the Secretary of Civil Service. It is necessary an institutional relationship based on reconciliation between the policies of both ministries, based on a work plan with full-scale goals, indicators, actions, responsibilities and timelines. Every effort should be done to substantiate before senators and representatives the benefit of this social investment to the country's development.

In both cases, the best way to make these negotiations would be to provide evidence of progress achieved by health family units since their creation.

This leads to the third aspect that MSPBS must consider: supervision and monitoring system to provide timely and reliable information on the performance of Health Family Units (HFU). The system is under development; also HFUs have not been working for a time long enough to show results. In the meantime progresses have been made. The MSPBS could consider asking PAHO or another cooperating party to conduct an assessment on the Primary Health Care strategy in earlier settled places. The data will provide reasons for requesting budget increases for more Family Health Teams.

At a more ambitious level (because of the difficulty in having relevant data,) a comparative study between the costs of hospital care and the potential savings that Primary Health Care would entail, could offer a very consistent argument to be used in the negotiation of budget increases. Of course, if in addition to this restrictive economic approach, they are considered to under a right approach, improving the quality of life and reducing suffering, the argument in favor of Primary Health Care will be even stronger.

Despite the difficulties involved in a study of this nature, the MSPBS should strive to have this kind of information because the Executive Power does not have majority in Congress, and it is necessary to generate positive opinions, trust and support of Primary Health Care in order for lawmakers to approve the budget increases.

Also, there must be sustained advocacy with the Ministry of Finance and Congress with the support of the Secretary of Civil Service for the approval of a Health Career Law, which will improve the overall performance of human resources and health outcomes. This level of effort is priority and essential because the nature of work is little known by these organizations, which tend to harmonize it with the rest of the sector workforce. Also, the picture is compounded by the emigration of Human Resources for Health as physicians and, in recent years, nurses opt for

higher paying jobs in Spain and the United States of America. Health careers could mean a response to improving working conditions and encourage the permanent settlement of the resources in the country, and attract those who have migrated abroad for training.

A census of health personnel is essential for the implementation of the health degree and to plan the growth and composition of Human Resources for Health for this decade and the next. The MSPBS must prioritize the allocation of resources to finance the census.

MSPBS should support the development of human resource information appropriated to the health sector needs, network services for decision making, and promote studies and operational research on the dynamics of Human Resources for Health and include it in the national research agenda incorporating analytical tools for human resource planning: Human Resources for Health calculation methodologies according to the population needs, method of determining a work schedule and virtual scenarios for the future.

The creation of a roundtable or human resource technical committee within the National Health Council can become a participatory space that promotes the integration and coordination among educational institutions and administrative and regulatory bodies of the Ministry of Health to develop intersectoral consensus, social propagation and encourage the implementation of the National Human Resources Policy.

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Prof. Ana Bordon, Director of Networks and Services-MSPBS

Prof. Ana Campuzano de Rolón, President of National Agency for Assessment and Accreditation of Higher Education.

Prof. Juan Carlos Chaparro A., Dean of the School of Medicine - UNINORTE.

Lic. María Concepción Chávez, President of the Paraguayan Association of Nurses.

Lic. Magdalena Genest, Director of Nursing School, Catholic University of Asuncion.

Dr. Edgar Gimenez, Deputy Minister of Health and Welfare.

Dr. Carmen Gomez, Director-MSPBS GDPHC.

Dr. Esperanza Martínez, Minister of Public Health and Social Welfare.

Prof. Massolo José Marín, Director of DNERHS -MSPBS.

Lic.R. Rosalie Lopez, Director of Andrew Barber Institute, National University of Asuncion.

Mrs. Aida Robles, Representative.

Ms. Veronica Serafini, Ministry of Finance.

Prof. Sisa Caesar, Dean of the School of Medicine, Universidad del Pacifico.

Dr. Lilian Soto, Minister Secretary of Public Service.

Dr. Magdalena Tatter, National Federation of Health Workers.

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## Introduction

This report summarizes the situation of human resources for health in Peru as of April 2010. It is a short document intended to explain not details but large shifts of the situation, policies and public and private actions in the field of Human Resources for Health in Peru.

Being a report on the current course of things, it also shows what has happened in this ending decade, because, as we shall see, the great policy on human resources has been a shift in Peru since 2003, and this requires that the analysis unit be the last period 2003-2010. Also, since the situation of human resources for health is decided inside and outside the health sector and has a strong impact on health workforce policies and initiatives emanating from other ministries, and in particular from the Presidency of the Council of Ministers, reporting on changes in human resource for health policies means also to have an extra sector look.

In the 2000s, a change in the situation of human resources in Peru has occurred compared with the last decade, especially in the last three years, in the context of a re-powering of the Peruvian health system, particularly the significant increase in public health investment in the Ministry of Health (MINSA is its acronym in Spanish) and the Social Security Agency (EsSalud); the beginning of decentralized management in the Peruvian State, with regional and local governments; and the noticeable increase in human resources for health within the Ministry of Health and EsSalud. The change in the overall policy direction of resources, with the subsequent transformation, restructuring, reorientation of the field of human resources for health has to do with the necessary reinvention of the work system and health education, with the modification of inheritance of the 1990s and even 1980s. This challenge of reinvention is expressed, with all its shortcomings, by the wide legislation on State modernization and reform under building in this decade, somewhere between the bureaucratic model and precarious flexible model, while the way back to the previous model is expressed by the enormous resistance to regulate the Law on Public Employment and the ease with which it intends to continue accumulating exceptions in salaries and hiring. However, in a manner more slowly than desired, progress on this new route continues.

## 1. Background: Evolution of Human Resources for Health to the Year 2000

In Peru there have been three stages in the history of human resources: (a) the decades from 1950 to 1980 in which regulation of an interventionist type prevailed; (b) the 1990s, in which the prior regulation was destroyed and the way opened to labor flexibility with insecurity and the multiplication of health training institutions; and (c) the period 2003-2010, in which the rebuilding of the regulation started, but via a necessary reinvention of issues coming from the past.

The first stage spanned from 1950 to 1980, where the building of the public system took place under the bureaucratic model of that time. The starting point was the enactment of Decree-Law No. 11377 of 1950, which was the first law of public sector to comprehensively regulate public employment and that generated the first echelon of the Civil Service. Then the decrees and laws No.17876 and No.19847 on October 31, 1969 and April 1, 1973, respectively, were enacted; they regulated salary issues. Finally, on March 24, 1984 Decree-Law No. 76 was passed, along with the law Basis for Civil Service Career and Public Sector Remuneration. So, the two main pillars of public career of the bureaucratic model, the decrees No.11377 and No. 276 were issued between 1950 and 1984, 25 years apart but with the same spirit. The whole dynamic of this first stage was a dispute between those who sought to maintain the preset specific systems for the different groups of public servants and those who tended to suppress them to implement a general classification system of positions.

The second stage was from the 1990s to the 2000s; it explicitly shifted toward the flexible model with insecurity and a free way to create dozens of new universities and schools of health sciences.

In reality, the public career scheme devised by Decree-Law 11377 was diminished in the late 1980s. Studies show that there was a large reduction in public spending between 1975 and 1990, where it declined from US\$1,059 dollars per capita to only US\$178 dollars.<sup>48</sup> This strongly affected the public sector payroll, which contracted by 75 percent with no staff reductions, which implied a reduction in actual wages.<sup>49</sup> It was not strange that state employees overflowed the rules of public career, which did not guarantee a recovery of actual income through the statute mechanisms of promotion by means of ranks. The economic crisis of the years 1988-1992 was the context in which the bureaucratic model was given up

48. Webb, Richard. Prologue. In: Carlos Paredes y Jeffrey Sachs (eds.). *Peru's Path to Recovery: A Plan for Economic Stabilization and Growth*. Washington D.C., Brookings Institution.

49. Wise, Carol. "Reinventando el Estado: Estrategia económica y cambio institucional en el Perú." 1st Edition, Lima, University Pacífico, 2003.

and the floodgates opened for restructuring career from two fronts, the union corporate front, coming from the past, and the new orthodox approach.

In the 1990s the labor system of appointments or contracts of indefinite duration was replaced by a flexible system in the employment relationship with precarious remuneration. In 1991, the Supreme Decree No. 098-91-PCM, offered incentives for voluntary workers and technical assistants, and then it did the same with managers and technical staff throughout the public sector. This provision was not for health care professionals. According to the National Institute of Public Administration, which existed until 1995, as of December 1994 134,700 public workers had left in comparison with those existing in 1989. At the national level, this process represented the resignation of 12,000 non-health professional workers (administrative clerks, nursing technicians, administrative assistants and nursing assistants, etc.); those positions were not replaced.

On November 12, 1991 the Decree-Law No. 728 or Employment Promotion Act was passed. This rule did not include appointments, only fixed-time contracts, and ended with employment stability. The Decree-Law No.276 for appointments and contracts was not longer applied; the Civil Code started to be applied, which led to the old system of non-personal services. This type of contract was used especially in the Ministry of Economy and Finance (MEF), the National Superintendence of Tax Administration (SUNAT), Customs, the Office of the Comptroller of the Republic, health sector, the Superintendence of Health Care Providers, a sector of Health Administration Local Committees (CLAS is its acronym in Spanish) and Health, among others. Its impact not only on public employment but employment in general was important: stable contracts or appointments fell from 41 percent in 1991 to 24.8 percent in 1999;<sup>50</sup> workers with no contract increased from 33.2 percent to 45.4 percent in that period; casual workers increased by almost 5 percent, and the average length of employment was reduced from approximately 70 months in 1991 to 47 months in 1999. The two labor systems, public law (D. Leg. No.276) and private law (D. Leg. No.728) began to generate the current distortion. Out of the 80,000 non-personal service contracts of the State, 41,000 were from the Ministry of Health, particularly from the Basic Health Program for All. This type circumvented the scope of the administrative career, which was seriously affected. Before, a remunerative disorder in hierarchy existed; now a flexible and precarious replacement scheme has emerged.

Later, by 1994, the economic crisis was over and an expansion stage began in the production of services. This led to new staff recruitment, but as non-personal services. Professionals and health workers instead of being appointed were hired

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50. Chacaltana, Juan and Norberto García 2003. "Reforma laboral, capacitación y productividad." In: CIES, Políticas de empleo en Perú, Lima, T. II.

under contracts, and salaries were divided into multiple incomes, a basic salary and some additional resources collected directly, the project incomes and bonuses, and other moonlighting earnings. Thus, a scattered workforce was born that searched for additional earnings, rather than concentrating on their tasks.

On the other hand, in the world of education, in January 1995, the Law 26439 was issued creating the National Council for the Authorization and Functioning of Universities (CONAFU is the acronym in Spanish). Then, in November 1996, Decree-Law No. 882 of Promotion of Private Investment in Education was issued, which encouraged the unlimited proliferation of universities and schools whether or not work was available for their graduates. As soon as CONAFU was created, in a 5-year period, 21 new universities were opened; 18 were private universities and three public ones.

## 2. Development of Human Resources for Health in the 2000s

We are now in the 2000s in a phase of reconstruction and reinvention of the State, public service career and public health education in Peru; this reconstruction and reinvention is laborious due to the strong interests in all fields, taking place in a background of rapid economic growth marking the contrast with the more unhurried pace to reform the State, from which progress is being made in the new human resources policy, as we shall see.

### 2.1. Policy and Planning

The process of formulating the present policy of human resources for health was developed and refined throughout the decade. It started with the fourth overall policy guidelines for the health sector defined by MINSA in the document Sectoral policy guidelines for the period 2002-2012 and fundamental principles for the 5-year period August 2001-July 2006. Then, a four-year process started, which included development at its first stage; the first draft was submitted in late 2002; then, the unanimous approval by the National Committee of Service-Teaching Coordination and Research (CONADASI is the acronym in Spanish); and finally, the ratification on September 22, 2005 by the National Health Council of the document “National Policy Guidelines for the Development of Human Resources for Health,” which detailed the eight policy guidelines that are currently governing:

- **Guideline 1:** Training of human resources for health based on the model of comprehensive health care, the demographic, sociocultural and epidemiological profile of the population, taking into account regional and local particularities.

- **Guideline 2:** Strategic planning of human resources for health equity by considering the demographic, epidemiological and sociocultural and health needs of the population, particularly the most excluded people.
- **Guideline 3:** Decentralized management of human resources for health as part of the management of health services, recognizing the centrality and integrity of human resources in organizational development.
- **Guideline 4:** Management of effective, efficient and equitable processes for capacity building of health personnel in order to improve their performance and the health care of the population.
- **Guideline 5:** Assessment of community health agents and human resources relevant to the health system, and the appreciation of their contribution to health and development, locally, regionally and nationally.
- **Guideline 6:** Promoting a comprehensive employment policy framework that considers the income based on skills and occupational profiles by applying the public career advancement, benefits and work incentives, taking into account merit and criteria of justice and equity.
- **Guideline 7:** Improving working conditions and promotion of worker motivation and commitment, contributing to a renewed organizational culture and ensuring the delivery of quality health services.
- **Guideline 8:** Promoting consultation and negotiation processes of working relations based on respect and worker dignity to achieve the institutional mission.

Actually, this is the most comprehensive document of the decade related to human resources policy; it corresponds to the comprehensive diagnosis made in the field of human resources in Peru in the Country Report for the Meeting in Toronto held in October 2005.<sup>51</sup>

The National Health Plan, approved on July 20, 2007 by the new government, included human resource development as the Six Policy Guideline by proposing a strategic objective:

- “To identify, develop and retain skilled human resources, equitably allocated and committed to the health needs of the population.”
- Goals for 2011: “Accredit 100 percent of health training institutions.”
- “All of the country’s poorest regions will have increased 50 percent the human resources for health.”

51. MINSA-IDREH 2005. “Situación y Desafíos de los Recursos Humanos para la Salud, Gobernabilidad y desempeño con Desarrollo Humano.”

- “Implementation of the management competence model.”

This report will briefly review the implementation of the proposals made over the decade, with emphasis on the last four years.

## 2.2. Investing in Health: In Search of Lost Time

During 2006-2010 the re-powering of the Health System has been made in its two major subsystems, MINSA and EsSalud. The current situation is marked by three elements that have increased since 2006: decentralization, which ended up transferring the functions to regional governments in 2008; the definition of universal health insurance as a core goal from 2008; and the significant increase in health public investment over the last two years.

The growth of public investment in health in the years 2008-2010 addresses the paradoxical situation that existed in this decade, when there was a retraction of health spending in the midst of a growth cycle of the Peruvian economy covering the period 2003-2008, which has been resumed in 2010. It will probably take a ten-year increase in health care to fill the huge gap of needs.

The current economic developments in Peru give the possibility of finally experiencing a period of expansion in health spending, public spending on health and public investment in health. The first one depends on the population and the State, and the last two depend on the expenditures of the State. Since 2003 and especially in 2004, Peru has experienced a remarkable process of economic expansion, as during the period 2003-2008 a sustained growth of 70 months in a row occurred, if we count from 2003. The economy overcame the crisis of the years 1998-2001 and has resumed an upward trend until today. The annual variation in GDP was negative in 1998 (-0.7 percentage points) and with lower rates in 1999 (0.9 percentage points); in 2000 (3 percentage points) and 2001 (0.2 percentage points). From 2004 and especially from 2005 onwards the variation was significant. It was 4 percentage points in 2003, but rose to 5.1 percentage points in 2004; 6.7 percentage points in 2005; 7.6 percentage points in 2006; 9.0 percentage points in 2007; and 9.8 percentage points in 2008. In 2009, a year of international crisis, it was 0.9 percentage points.

However, the public health spending in the years 2004-2007 had a nominal spending growth, but decreased the ratio of public health in the total public spending. The revised figures of the Integrated Financial Management System (IFMS) show that nominal spending on health had a continuous growth in the last 8 years. In 1999 it was PEN S/. 1,643,402,351.82; in 2000 PEN S/. 1,727,158,614.93; in 2001 PEN S/. 1,938,662,537.21; in 2002 PEN S/. 2,135,299,017.52; in 2003

PEN S/. 2,080,729,635.17; in 2004 PEN S/. 2,379,803,926.80; in 2005 PEN S/. 2,460,430,550.00; and in 2006 PEN S/. 2,580,289,899.53.

However, the ratio of public spending on health declined. The state budget grew but not equally for the Ministry of Health. In the years 1999 and 2002 health spending was highest in the State's budget: 6.03 percent and 6.05 percent, respectively. However, in 2003 the least amount of the series was observed, with 4.92 percent; in the following years it did not reach the previous higher levels; it was 5.63 percent in 2004; 5.46 percent in 2005; 5.17 percent in 2006, and 5.35 percent until August 2007. In general, there has been a drop in the health spending average ratio; it was 5.3 percent in the period 2003-2007. This means that other sectors of the State were receiving most of the budget increase.

On the other hand, figures on health spending in Peru show that, in general, in Peru health and life are not appreciated as it is in other Latin American countries. Peru's health spending per capita in 2000-2004, according to World Bank figures, fluctuated around US\$100; it was below the Latin American average, which was US\$272 in 2004. These are, unfortunately, the latest figures available. Another indicator showing the lack of consideration for health spending is the rate of GDP. Peru had the lowest in Latin America between 2001 and 2004, with an average rate of 4.5 percent.

All this has changed in the last three years (2008-2010). The highest public investment in health in prior years was just PEN S/. 380 million between MINSA and the Regions. In contrast, the health investment budget in 2009 was PEN S/. 1.3 billion (PEN S/.1,300,000,000), and 2010 in PEN S/ 1.7 billion. An investment gap has been estimated in the order of PEN S/. 9 billion due to an oversight that has existed for years. However, a shift was made in the amount of resources allocated to health in infrastructure, equipment and human resources items. Thirty-one new hospitals are planned by MINSA and 19 by EsSalud: four new ones in Cusco; three in Ica; four in Lima; four in Cajamarca, and so on throughout the country. In addition, there exists an item of 165 million soles for equipment, which did not previously exist. In fact, the industry is catching up.

### 2.3. Availability and Distribution of Human Resources for Health: Workforce for Universal Coverage, New SERUM and PROSALUD Program

The years 2008-2010 showed a shift towards greater availability and better distribution of health professionals, with greater resources for health and incentives for living in remote and poor areas. This partially reversed the deficit caused by migration of professionals and their concentration in large cities.

Viewed over the long term, a progressive increase in human resources for health was made in Peru. In 1992 the total workforce of EsSalud and MINSA was approximately 66,000; in 1996 it increased to approximately 101,000; and in the years 2004-2005 it was 132,781 workers, including the two institutions: 97,382 in MINSA and 35,399 in EsSalud. There were also about 7,230 working for health care providers (HCP); this latter figure includes medical and nursing staff available in the directories of the HCP, with plant personnel only a bit smaller. The directory of physicians who work exclusively for HCP and therefore do not work in either MINSA or EsSalud shows a total of 3,240.

A total of 180,000 workers and professionals work for the Peruvian health system; 123,663 worked for the Ministry of Health and 36,063 for EsSalud, 2007. The HCPs have 7,230 workers and the health divisions of the Armed Forces and National Police have 14,587 professionals, technicians, and assistants. The 180,000 workers and health professionals serve the health of 29,461,000 Peruvians (2010 estimate.)

However, despite this progress, shortages and distribution problems exist. Distribution is not the only problem because even assuming a distribution according to population density and vulnerability of regions and districts, a shortage of health personnel exists. The study on the allocation of health professionals undertaken by MINSA in 2007 showed a gap varying from 8,446 to 15,363 physicians, depending on the standards used.<sup>52</sup> The concentration of health professionals continued in Lima and the urban coasts of the country. In the case of physicians, Lima had until recently had a 5.4-fold higher ratio of physicians per 10,000 than Huancavelica (17.7 versus 3.3) and almost double the national average, which was 11.5. Apart from Lima, only Arequipa, Tacna and Ica had a ratio equal or higher than 10 physicians per 10,000 inhabitants. Lima has 53.19 percent of all physicians existing in Peru. In the case of nurses, eight departments have a ratio per 10,000 inhabitants that is above the national average, showing a greater concentration on the urban coasts, although there is a significant presence of higher poverty in some departments. Out of the total of nurses, 40.23 percent work in Lima. In the case of dentists, the ratio per 10,000 inhabitants is much smaller than in other professions; they also have a concentrated distribution mainly in coast areas. Of all dentists, 44.25 percent are located in Lima. Of all technicians and assistants, 41.47 percent work in Lima.

On the other hand, the distribution of professionals has been inversely made with regard to poverty levels. For major occupational categories, there exists a difference between the group of human resources located in poor districts and the

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52. MINSA 2007. "Estudio de la dotación de profesionales de la salud en los establecimiento del Ministerio de Salud." MINSA.

group not located in poor districts. For physicians, the rate is 3.7 to 1 among non-poor strata and the poorest. For nurses the rate is 1.4 among non-poor strata and the poorest. For dentists, whose absolute number is lower, the rate is 1.43.

In response to this situation, over the last two years, an increase in the number of professionals in public services occurred, and incentives for staying in the poorest areas were given. The two major human resource policies in recent years were (a) the Marginal Urban and Rural Health Service (SERUM is its acronym in Spanish) that transformed into a tool to expand services, and (b) the creation of a special system to solve the shortage of specialists in the provinces. Both measures were agreed at the national meeting held in December 2007 with the regional health directors, regional managers and officers from the former Institute of Human Resource Development (IDREH is its acronym in English), which at the time was named III Sector Program.)

The number of physicians of the MINSA has increased from 12,000 to 17,000 in the entire country over the last three years. This has increased the availability in all regions, but it would be ideal for it not to be concentrated in the department capitals. This entailed radically transforming SERUM. The first change was the allocation mechanism for SERUM positions, which were previously drawn by lot and now on merit by means of a test. The second was the establishment of subsidies for candidates who opt for remote areas, a 10-point bonus to raise the score in merits. The third is the rigorous use of the Fund of Cooperation for Social Development (FONCODES is its acronym in Spanish) for the location of the priority districts in extreme poverty. SERUM professionals are under the private system of DL No.276, and now are given 10-point bonuses for remote location residence apart from a PEN S/. 3,500 salary or US\$1,200, social security, supplementary insurance risk, transportation tickets and half salary for moving costs.

On the other hand, there was a significant increase in the number of SERUM jobs, which for years had remained stable at 2,000 jobs and is now 5,700. The first increase was supported by the program Together and then with budget items requested to the Ministry of Economy and Finance.

Currently, it is mandatory that all SERUM jobs be at first level. Regional governments assign locations or institutions. This has changed the original situation of the 811 poorest districts in the country, which three years ago had 53 percent of SERUM physicians and 47 percent of non SERUM physicians. Now, 89 percent of these districts have health professionals using SERUM. Currently, the rate of physicians in the districts of the three poorest departments of Peru is higher: 95 percent in Ayacucho, 97 percent in Apurimac, and 95 percent in Huancavelica. In other words, SERUM was not coordinated with the health policy and now it is the main instrument to provide professionals to locations that did not have them

before. In current SERUM job allocations, 85 percent of SERUM workers choose districts in the two poorest zones (54 percent in zone 1 and 31 percent in zone 2.) The three poorest regions have access to the first level above the national average. The problem is no longer the number of professionals; this can be seen in outcomes as the case of Apurímac, which had the highest maternal mortality in the group.

The second major problem in the allocation and distribution of professionals is the lack of specialists. MINSA lacks about 6,000 specialists. Many regions do not have anesthesiologists, psychiatrists, cardiologists, gastroenterologists, etc. MINSA believes that the lack of specialists is increasing. The number of specialists in Peru does not suffice; this is the result of an increasing demand due to universal coverage policy. The current expansion of investment in equipment shows the gap even more; for example, one of the most advanced scanners in the country, located in Ayacucho, has no specialist to operate it. In Ayacucho, there are no psychiatrists. In Huancavelica, no cardiologist exists. According to the information provided by Social Security (EsSalud) the last public competitions for the second and third levels did not fill the vacant positions. In July of 2009, 345 positions were vacant. The same happened with public competitions for the Health Care of National Police, which in 2008 had 100 vacant positions for specialists, and none was filled. In 2009 it had 150 vacant and filled only 18. According to a study undertaken by the Ministry of Health, the shortage of specialists for the six areas of universal coverage is 1,774. In the three poorest provinces in the country, the regional hospitals lack 194 specialists.

In the end, in addition to the old lack of primary-care professionals there is a new lack for the complex layer, outside the third lack of capabilities. For years, Peru did pay attention for the first one, while the second gap was opening. This deficit has to do with the disconnection between the world of work and universities as well as the migration of physicians abroad and to Lima. Physicians who migrate are not only specialists but general practitioners.

Hence, the second strategy was structured, which is the new program PRO-SALUD [pro health], already designed; It is to be launched to provide the most vulnerable regions with professionals (not SERUM), through public competition. It will be similar to SERUM in its prioritization in districts with greater needs, but the workforce will be basic health teams (physicians, nurses, midwives and health technicians). Since by law they have to be employed through the public system, a negotiation with the Ministry of Economy and Finance was concluded so that health workers can have higher salaries —a maximum of 4,700 soles for physicians and 2,700 soles for nurses. They will also be given incentives for residency and public competitions. The contract of these specialists will be for three years, renewable

for another three years. At the end, these professionals will have a 20-point bonus for medical residency. In addition, these professionals will receive a 3-year training program, first in hospitals and then in their fields as students of Comprehensive Care. Afterwards, they will be specialists in family care or family health.

To achieve this, agreements with some universities were concluded: San Marcos, Cayetano Heredia and San Luis Gonzaga de Ica. The cost of this is included in the Budget of the Republic for 2010, which contemplates 128 million soles as reserves for contingencies, of which 50 million soles will be for new human resources for health to strengthen universal coverage. From this item, 40 million soles will be for this program to recruit 1,584 new professionals in MINSA, which will be added to the 6,000 SERUM.

However, MINSA needs an additional policy: promoting new universities inside the country to train specialists and preventing medical graduates from coming to universities in Lima, Trujillo and Arequipa, which make up 90 percent of the specialists in Peru. Most graduates from Loreto and Cajamarca leave their regions. No retention capacity exists. To change this situation, since last year other training centers has been opened (Junin, Loreto, Ayacucho and Ancash) to train specialists in the four basic specialties. This is done through partnerships of universities and regional health directorates, which allow the funding. Now, the health regions decide on the number of positions and specialties, unlike before, when they were set by universities. Now, universities open vacancies and applicants are chosen by merit. This is aimed at giving physicians more opportunities in their region.

#### 2.4. Regulation on Education: Culture of Quality, Accreditation and Certification (CAFME), SINEACE, and CONEAU)

In the 1990s, the old trend of multiplication of universities with schools in health careers deepened. This produced an imbalance between the supply and the demand of health professionals in public and private health services. In the last four years, the implementation of policies to regain the regulation of university and technical training with academic accreditation and professional certification started. Position profile definitions for SERUM and specialists were addressed, which should impact on university education.

In 1980, only 35 universities existed; 25 of them were public and 10 private, with a total of 257,220 students; 183,317 in public universities and 73,903 in private universities. In the early 2000s, 76 universities existed in Peru; 31 were public and 45 were private, with 35,455 professors, 415,465 enrolled students and 103,398 applicants. According to current data from the National Assembly of Chancellors, 102 universities exist, 35 of them are public and 67 private. Seventy-six universities are fully accredited, while 27 are in the process of organization. Most universi-

ties have health programs; 31 have medical schools, while 6 others are under an organization process.

Since no increase existed in the number of jobs in MINSA and EsSalud services, which are the two major employers in health, a surplus of graduates existed. They eventually ended up as emigrants or in forms of underemployment. Between 1996 and 2004 the National Directorate of Migration accounted for the emigration of 13,711 physicians, 7,340 nurses, 2,112 dentists and 1,110 midwives.

This demand-supply mismatch has been quantitative, but also qualitative since massification has made university and technical training mediocre and dull. Thus, the quality of trained personnel and the current status of health professionals in society is in doubt.

In response to this situation of the indiscriminate creation of schools of medicine, the Committee for the Accreditation of Schools of Medicine (CAFME) was created on July 11, 1999, by means of Law No. 27154. It is chaired by a representative of the Ministry of Health and formed by representatives from the Ministry of Education, the National Assembly of Chancellors, and the Council for Authorization of University Functioning and the Medical Association of Peru. This committee is responsible for conducting and managing the accreditation process. Thus, it was agreed that only physicians from accredited medical schools would belong to the association and be authorized to practice the medical profession. In 2000, the Regulation of Law No. 27,154 was approved; in 2001 the Minimum Standards for Accreditation of Schools of Medicine were issued by Resolution No. 013-2001-SA; the Minimum Standards for the Creation of Schools of Medicine was approved by Resolution 252-2001-SA. In the same year, auditing visits started. In 2003 the Code of Ethics for auditors and members of CAFME was approved by means of Ministerial Resolution 652-2003-SA as it was the update of the Minimum Standards for Accreditation by Resolution No. 004-2003-SA. In 2006 a new update of the Minimum Standards for Accreditation was undertaken.

In the end, this process of accreditation in Medicine was a reference to the creation of the National System of Evaluation, Accreditation and Certification of Educational Quality (SINEACE is its acronym in Spanish) and the beginning of the process of accreditation of university programs. In 2003 the General Law of Education was approved; it created the agency of SINEACE and ordered the creation of a organization to be generated and regulated by specific law, for higher education. Finally, the National Assessment, Accreditation and Certification of Educational Quality absorbed CAFME.

CAFME promoted a culture of quality in medical schools, and therefore accreditation. A minimum number of professors with master's and doctorates was

required, as well as verification of competencies in the curricula and a basic infrastructure and resources. However, in the end 100 percent of schools complied with the minimum standards for accreditation, which probably meant readjusting them upward. In practice, schools once accredited for five years indiscriminately increased vacancies. On the other hand, the National Assembly of Chancellors said it could not prohibit non-accredited schools from accepting applicants. So, the accreditation process lost legitimacy. Nevertheless, most sector players always saw CAFME with expectations for being one of the buttresses of deregulation in health education.

Unfortunately, the regulation of SINEACE, issued in July 2007, terminated CAFME. Before functioning the system, what had been done in health was cancelled, which generated a legal vacuum that has encouraged the creation of new schools of health. The project of SINEACE is broader and more ambitious; for that reason it worked at a slower pace. Now, the degrees with mandatory accreditation are all of the health and education programs. SINEACE is the body responsible for university accreditation and certification. The deadline to implement the system is December of 2010, and then the accreditation. In recent years, progress has been made in defining the model of university accreditation, criteria and standards for all education and health degree programs, with the registration process and authorization of accrediting agencies. CONEAU has to previously certify the evaluators because this is one of the prerequisites to grant permission to accrediting agencies. As noted, the process of accreditation will be transferred to the next government after July 2011.

The process of health professional certification began with the medical profession in 1998; it was an initiative of the Association of Physicians of Peru (CMP). The Peruvian experience, therefore, initially was a professional self-regulation rather than a regulation of the State. In the first two years of the program, 9,000 cases were presented, and over the next two years around 2,500. Professionals had to prove they had taken courses for more than 15 credits in the last three years to be recertified. In 2006, approximately 1,000 physicians were recertified. This decline and slowdown is explained by the lack of dissemination and promotion of the process, the relative lack of interest in re-certification and because it was voluntary. The CMP has approved a new regulation for medical recertification that includes the evaluation of professional practice as a first step towards the gradual introduction of the assessment of professional competence. However, mainstream acceptance of medical recertification coexists with doubts about its usefulness, low interest and the exigency to lessen the requirements.

As a result of the stationary condition of medical certification SINEACE was generated, in 2006, to include certification of all professions. In this case, unlike

accreditation, professional associations certify and CONEAU supports and advises them through its Directorate of Evaluation and Certification. In the period 2007-2009 progress was made in defining all the instruments for certification, with more emphasis on health professions than on those of education due to the internal difficulties experienced in recent years by the Association of Teachers. More than 200 evaluators of competencies from professional associations received training. The new system of competency assessment examines essential knowledge, expected performance in a simulated or actual work situation, and products of each profession. Not all professions are required to be certified because there are associations of mandatory certification (the thirteen health professions and teachers) and voluntary (the rest.) The rule states that associations have three years to certify professionals who were approved more than five years earlier. In the case of Medicine, general practitioners will be certified first. The deadline for professional associations to request CONEAU approval to be a certification agency expires in October 2010. Then, a verification of requirements for certification will be done. The Association of Nurses has been working on the issue for several years, so it is expected to be approved as a certification authority without any difficulty. From this picture, it can be inferred that it is the beginning of a long process.

## 2.5. Skill Development: Continuing Education, Postgraduate Degree Programs and CIRHUS

Despite everything, a significant change has taken place in recent years in the profile of the health workforce. In their professional and technical strata a major effort was made to upgrade and renew assistance and administrative issues.

This perception of professionals and technicians on the need to go “back to school” has surpassed the previous view of a stage and a subsequent study of professional practice. Training is now permanent and this has caused, too, the multiplication of specializations and graduate programs in Peru, and adaptation of methodologies for education at work. According to a survey of 1995, over 20 percent of physicians were in management positions. The proportion of health care professionals in management positions is increasing, which along with the strong job rotation has promoted training in management. On the other hand, scientific and technological advances in medicine are driving the knowledge updating to avoid mismatches.

This necessarily has changed the profile of capabilities and optimized performance. Until 1993, in the health sector the management paradigm had not existed; there were capabilities to offer health care but very few to manage. Empiricism was predominant in this field. This has partially changed; we can say that the health sector in general has care and management capabilities, although this is uneven

across occupational categories and has increased the gap between technical and administrative professionals. However, skill shortages of macro-management policies and governance still exist.

However, despite these advances, specialization and postgraduate program have also suffered from duality and informality in undergraduate education. While some have maintained their quality, another group of universities has increased its offer indiscriminately, without adequate teacher support and self-regulation in terms of quality, which has undermined the legitimate interest in the sector to catch up. This lack of regulation accompanies the development of many majors, master's and doctoral programs in general.

Given this enthusiastic shift of health staff to continuing education and management, the new emerging problems are the relevance of training programs and financial support for their development. In the 1990s projects such as the Project for Strengthening Health Services (PFSS), Project 2000 (Py. 2000) and the Project of Basic Health and Nutrition (PSNB) developed important training activities for health personnel. In the 2000s, the cooperation and training have been much less. An estimate of the training components of international cooperation projects in the 2000s showed that they are lower than required.

In fact, the most important institutional effort in terms of training and upgrading of health personnel in the field of human resources has been the systematic training track for managers of human resource policy with CIRHUS. It was first a Latin American course, and then given at national level with the support of PAHO, the Ministry of Health of Brazil, the University of Rio Grande do Norte in Brazil and the Cayetano Heredia Peruvian University. The Ministry of Health is investing in it and has provided two more cohorts. This Course of Specialization in Management of Human Resource for Health Policy has been promoted by the Andean Sub-regional Coordination of PAHO and the Brazilian international cooperation. It is an important action associated with the professionalization of the management of public policy; it has a strategic role in the specialization of this subject.

With regard to staff capacity building as a whole, the GDHR raises two cornerstones of in-service training. The first is in management, especially for regional health directorates, and the second in comprehensive care, which should involve universities because the current profile of graduates does not facilitate teamwork. The two training programs designed for staff training are the Management Education Program (PREG) and the National Family Health Program, which began with postgraduate certification, involving 250 participants.

Likewise, achievements in mapping competency has been made, which, unlike before, are no longer defined individually, but by category of health institu-

tions. The two critical types of institutions in the primary networks are classified as I-2 and I-4. In I-2 a general practitioner is available, and in the I-4 a basic health team is available, which must deal with situations of primary health care level. The objective of mapping is to identify the gap between what we should do and what is done to establish a training plan and a system of recognition. The performance evaluation system is also linked to this previous work, but will be completed later because the priority is closing the gaps in availability and distribution.

On the other hand, it is necessary to strengthen coordination among several State agencies responsible for capacity building, particularly between the National Secretary of Decentralization Secretariat (SND) of the PCM and the National Civil Service Authority because they are responsible for developing the State's capacity. The SND is in charge of the decentralization process, which was essential for having a capacity development plan for the municipal staff and the new regional government leading to the formulation of the National Capacity Building, which is the cornerstone for strengthening the management of the functions transferred. This plan took a long time to develop; it was approved on January 12, 2010 by Decree 004-2010-PCM. In the meantime, the Multisectoral Committee for Capacity Building in Public Management of Regional and Local Governments was created by D.S. 002-2008-PCM. It has been training public officers. In the case of SERVIR, on June 21, 2008 Decree-Law No. 1025 was issued approving the Standards of Training and Performance for the Civil Service; it is in charge of the National Civil Service Authority. A SERVIR management office is in charge of this issue; it has an initial funding requested to Ministry of Economy and Finance (MEF).

## 2.6. Labor System: Framework Law on Public Employment, Civil Service Authority and Administrative Contract of Services (CAS)

Given that in the 1990s the focus of overseeing the Civil Service changed, and the system of appointment was replaced by a contract recruitment system, in the 2000s the foundations for a public career were rebuilt. Most progress has been made by the education sector by implementing the teaching degree. The design basis is currently under development. The General Directorate of Resources says the first step is to build an integrated system of recruitment and selection because currently, each unit handles its own recruitment and selection process according to its criteria. The implementation of regional public competitions for the future and recruitment based on merit is under consideration.

However, the issue of career program transcends the health sector; it is molded jointly by the Presidency of the Council of Ministers and the Executive. According to the Data Bank of the State Civil Servants of the Ministry of Economics and

Finance,<sup>53</sup> 1,372,742 people are paid by the State. There are of 623,019 active employees and 688,366 retired. These figures do not include FONAFE [National Fund for the State's Entrepreneurial Activity, after its acronym in Spanish] companies or local governments. A MEF census showed that most active staff belonged to regional governments (314,836); this figure includes education and health staff, and also Interior staff (94,645), which includes Police, Education (92,176), Defense (55,654) which includes Armed Forces personnel; and Health (25,909, Lima personnel only.)

The total Health workforce is 160,000 and nearly 1,400,000 existing public employees have multiple pay and working systems. Most of them, except for 6,490 private workers, should be embedded in some structure of public career. But the administrative disorder of past decades has been inherited; as a result the current situation is complex. In August of 2009, Dr. Nuria Esparch, President of the National Civil Service Authority (SERVIR) reported that more than 30 ways to contract existed in the State, and 157 salary scales had been approved by supreme decree; informal ways were not included in the count, and no exact number of public employees was unknown.

Two strategies have been implemented in this first decade of the new century for the public career: First, a "big bang" reform, which attempted to globally redefine the State's policy on this matter with a comprehensive framework law. Second, a general transformation by stages and specific actions was taken, which is the strategy currently used. The first strategy was implemented by the Public Employment Framework Law of February 19, 2004. The second strategy was the creation of the National Civil Service Authority (SERVIR) in 2008, with specific assignments.

In the first five years of the 2000s there were two major frameworks: the modernization of the State and public employment. On January 30, 2002 Law No.27658 was passed; it is the Framework Law for the Modernization of Management State, which raises the issue of public employment as key for achieving the objectives of the modernization of the State. Subsequently, on February 19, 2004, Law No. 28175 of Public Employment Framework was passed. It comprises the civil service career and public sector salaries; it unifies the existing labor systems into one and defines a structure classification of State personnel in groups. The Framework Law is a general rule that established the beginning of a change in public employment through new laws and regulations, as stated in its second transitional provision, which gave a period of 120 days from the publication of the Law for the Executive referred to the Congress legislative proposals on the Civil

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53. Ministry of Economy and Finance 2008. "Banco de Datos de Servidores Públicos del Estado," (Data Base of State's Public Servants). Executive Summary.

Service Career, the Regime of Public Officers and Trusted Employees, the Public Employment Remuneration System Act, the Public Employment Management Act, and the Act of Incompatibility and Responsibilities.

The Public Employment Framework Act came into force on January 1, 2005; however, to date —April 2010— it is not applicable. It requires the approval of the aforementioned complementary bills, which are still in Congress.

Faced with this four-year deadlock, in which framework laws could not be applied, the State chose another route in order to continue the modernization and renovation of public employment, with tools related to Civil Service, in relation to the powers given to Executive by the Free Trade Treaty with the United States. Thus, on June 21, 2008 Decree-Law No.1023 created the National Civil Service Authority (SERVIR). Until then no system and regulating entity existed. Decree 1023 established the Human Resources Management System, having the authority to make human resources policy in the public sector and in human resources offices of public sector entities. On the other hand, it gave the new human resources system functions beyond traditional personnel functions such as planning, organization and distribution of work, in addition to monitoring and evaluation of performance, compensation, development, human relations and conflict resolution. SERVIR encompasses the entire State, including independent agencies of the public sector and State enterprises, with the exception of personnel of the Armed Forces, the National Police of Peru, of the Judiciary Career, and the Public Ministry.

On the other hand, it created the Civil Service Tribunal as final administrative body for individual disputes; its resolutions are only contested by the Supreme Court by administrative litigation process. Before, the administrative recourse could go until the second instance appeal in the institution; now there is a final instance outside the institution. The second regional instances often establish jurisprudence in their fields; they often understand the law at their discretion with a national impact. This was inconsistent with the effective regulatory framework. On January 14, 2010 regulations of the Civil Service Tribunal (TSC) were approved. TSC is an agency belonging to SERVIR.

Furthermore, on the same day, June 21, 2008, the Executive issued Decree-Law No.1024 creating the Agency of Public Managers. This opened the path to incorporating high-level technical cadres with state salary ranks. Thus, SERVIR is responsible for selecting qualified personnel for public administration by means of public competitions to fill key positions; they will be granted special salaries, higher than those for similar non-key positions. To date, SERVIR has launched two public calls, having recruited 70 public managers for several state entities at the central and regional levels.

Additionally, Decree-Law No. 1025 was issued, which approves the Standards of Training and Performance in the Public Sector. It categorizes the training into three levels: (a) post-graduate, (b) job training, and (c) update. Until then, postgraduate programs were not considered as training but as education. It is proposed that training will be developed through programs via universities and colleges accredited in accordance with the authority regulating the Civil Service. It mentions the need for training funding, with no details. SERVIR estimates the annual investment in training to be over 200,000,000 soles (US\$75 million).

Regarding performance evaluation, the decree states that it should be as objective as possible, with a frequency not higher than two years; evaluation is a mandatory, comprehensive, systematic, continuous, objective process; it should be applied at work on measurable, quantifiable and verifiable factors; it should be applied to all staff of the State; it must be periodically performed, and the results should be public and recorded by the Authority. It also establishes that as a result of the assessment, incentives and rewards should be granted, preferably to those qualified with distinguished performance, for career development and stability in the institution. On the other hand, the evaluation of proven deficiency can lead to employment stability loss. The Regulation of Decree-Law No.1025 related to training and evaluation was approved on January 17, 2010 by means of Supreme Decree 009-2010-PCM. In November of 2009, SERVIR carried out the first pilot evaluation of knowledge on more than 10,000 public servants of the National System of Public Investment.

Additionally, Decree-Law No. 1057, published on June 28, 2008 created a new procurement system, the Special System for Public Service Procurement (RECAS.) This law represents a historic turning point of the procurement system by eliminating the contracts in the form of Non-Personnel Services (SNP) and provides a type of contract with schedules and activities to be undertaken, with the stipulation of registering in EsSalud and of making contributions to the social security system. Before, the SNPs were not covered by EsSalud or the pension system. The new thing is that CAS is an intermediate system between the public employment system and the rendering of services. In short, it is flexible but not always precarious; it is a way of partially breaking the flexibility formula with the precariousness of the 1990s. During this period all workers under the SNP system, quite numerous in the health sector, have become CAS.

Finally, a subject that has spanned the decade has been the rehiring of those terminated in the 1990s, a process that started with Law No. 27.487 of June 9, 2001 and its following provisions. It allowed the review of the collective dismissals for personnel evaluations undertaken in the last decade in compliance with Decree-Law No. 26093. The law of 2001 was then regulated with the Supreme

Decrees No. 021-2001-TR and N° 022-2001-TR and Decree-Law No. 26093 was repealed. The creation of special committees in ministries was authorized; they were responsible for reviewing the collective dismissals undertaken in the public sector. To date, four groups of dismissed staff have been rehired.

## 2.7. Management: from the Public Health National School of Peru (ENSAP) to the Institute of Human Resource Development (IDREH) and then to the General Directorate of Human Resources

In the last six years, Peru was in search of a better institutional design for the stewardship of human resources for health. As mentioned in the Country Report on Human Resources of Peru presented at the Toronto meeting in October 2005, in the 1990s, the relative lawlessness of health education and labor conflicts increased in Peru due to the multiplication of training institutions and lowering wages. The upside of this crisis in leadership, however, is that the disorder resulted in a reaction that led to the emergence of regulators. As a consequence, the Committee on Accreditation of Medical Schools (CAFME) was created to control the exponential growth of Schools of Medicine. The Peruvian Association of Schools of Medicine (ASPEFAM is its acronym in Spanish) started to be under this regulation in the late 1990s; a professional qualifying test is given each year. In 2005 and 2006, the Undergraduate System in Health and the National Accreditation and Certification were created. To guide and promote this process, the Ministry of Health reorganized its Human Resources Unit twice, first by cancelling the Public Health National School of Peru (ENSAP) and creating the Institute of Human Resource Development (IDREH) and then repealing it and creating the current General Directorate of Human Resources.

The Institute of Human Resource Development was founded on the assets and liabilities of the National School of Public Health of Peru that Dr. Mario León Ugarte created in 1963. Health academia in Peru point out the important role played by the school in knowledge production and academic material reproduction, especially in the fields of public health and health planning in its first decades. At that time, the school met all state provider functions and, therefore, was not only a regulator but also a training and health education provider. Moreover, it was better able to train than promote research or regulate health education or employment. However, in the 1980s it experienced a slow decline. When in the Peruvian government the market approach was hegemonic in the 1990s, the school was dismantled of resources and functions, and no traces were left of its origin and original path. The school did not notice the change in time and continued trying to be what it could no longer be and should not be: a manager of increasingly questionable academic programs, without taking its responsibility for the strategic role, regulation, and critical research issues to decision making.

While the School declined, universities with postgraduate degrees in health covered the country; it lost legitimacy and asked the Minister Eduardo Pretell of the Transitional Government to form a committee responsible for formulating the proposed restructuring of the ENSAP, which was approved by Ministerial Resolution No. 106-2001-SA/DM of February 15, 2001. The committee formulated the proposal for a national institute by following the model of the Mexican Institute of Public Health of Cuernavaca, which incorporated the former School of Public Health of Mexico within its priority tasks of scientific research and development. The final report of this committee was submitted to the Minister of Health in June of 2001. Finally, in 2002, the Institute of Human Resource Development (IDREH) was created based on ENSAP with a different model than the Mexican, though under the denomination of institute and the organizational characteristic of being a decentralized public body with autonomous management.

Thus, the Health Ministry tried to acquire a fundamental unity to take the responsibility for fully structured human resource policies and address the difficult issue of teaching and services coordination in health institutions. While IDREH was created in 2002, in practice, it began to work in 2003 and fully in 2004. Its chart comprised two main areas: the Directorate of Policies and the Directorate of Training and Improvement. In practice, all the new functions relating to policy formulation, strategic planning, regulation of Human Resources for Health education, and labor management were merged under the Directorate of Policies whereas the old functions of direct training of the National School of Public Health were transferred to the Directorate of Training and Improvement. According to the opinion of the persons interviewed, this generated a bifurcation or two institutional logics.

Nevertheless, in its short life, IDREH was a great coordinator of initiatives set by different institutions of the health sector, and a facilitator of the process between 2003 and 2006 until it was closed in February of 2007. With the participation of national and regional players, it made the eight Human Resources for Health Policy Guidelines official and outlined an implementation plan for policies similar to the 10-Year Plan created in Toronto in 2006. Likewise, it undertook the Study of Medical Specialization Priorities as guidance for the National Medical Residency System. It proposed the creation of the National System of Health Care, Teaching, and Research Integration in Undergraduate Health (SINAPRED) in order to regulate access and management of clinical fields. It stated that the Rural and Urban Marginal Service of Health (SERUM) had criteria for the allocation of staff in underdeveloped areas and significant poverty zones, and was part of a new Community Health Service. It made the Together Program that funded employment for three professions (Medicine, Nursing and Midwifery) under the strategy of work teams for the most distant provinces of the country. Likewise, it proposed the creation of the National Medical Residency (SINAREME) to integrate all health

professions and to establish a tripartite system with regulators (the Association of Physicians, ASPEFAM and MINSA), providers (MINSA and EsSalud) and trainers (universities) agreeing on a national committee and regional committees. Finally, in November 2005, the IDREH held the First National Meeting of Human Resources for Health to discuss human resource policies, an event that featured a series of preparatory meetings at regional and macro-regional levels. The Regional Meeting of Observatories of Human Resources for Health held in Lima in October 2006 was part of this process.

On August 13, 2004 the Ministerial Resolution No. 804-2004/MINSA was signed, and in August 26 was published; it created the Committee for Undergraduate Medicine (COPREME). This committee came as a joint initiative by IDREH and ASPEFAM and created a means for coordination of the Ministry of Health with medical schools. The resolution stated that “this Committee is responsible for planning, organizing, monitoring and evaluation of the teaching-service integration process and undergraduate research in health institutions of the Ministry of Health and universities having Schools of Medicine.” Although a proposal of COPREME regulation was formulated, in practice, this proposal was subsumed in what would be the National Board of Health Undergraduate of SINAPRED.

The proposal of SINAPRED represented a qualitative leap with regard to the Committee on Undergraduate Medicine (COPREME) to incorporate a holistic, national and decentralized approach to the relationship between training and services. In October 2005, the Supreme Decree 021-2005-SA was published in the newspaper *Diario El Peruano*, which created the National Coordination System of Teaching, Services and Research in Undergraduate Health (SINAPRES). The system was defined as the agency of coordination between the institutions that train health professionals, the institutions providing health services in the Ministry of Health, geographical areas and health care, with full respect for university autonomy. This standard established that the Committee on Undergraduate Medicine (COPREME), which had been created by Ministerial Resolution 804-2004/MINSA, would be formed as a Sub-Committee of Undergraduate of Medicine (SINAPRES.) The committee was called CONAPRES. The opening ceremony of the National Committee on Undergraduate Health Degrees (CONAPRES) was held in January 2006. The whole system of regulation was starting to work when the disappearance of IDREH interrupted the process.

The IDREH was questioned as an organizational model of health authority of human resources, not because of its degree and accomplishments but as a result of general provisions related to the State’s reform from the Executive between November 2006 and February 2007. The new government that took office in August of 2006 decided to merge the 86 agencies in less decentralized agencies, and the

social programs that had proliferated in the 1990s because of the duplication and inefficiencies that this generated. Thus, Supreme Decree 080-2006-PCM, published on November 4, 2006, ordered the update of the inventory of social programs and the establishment of guidelines for their merger, joint and/or integrating. This inventory and joint merger proposal was completed in January of 2007 and in less than 30 days, between February and March, supreme decrees on OPD [Peruvian Observatory of Drugs, by its acronym in Spanish] the merger took place. This process was unimaginable before, due to the long tradition of feudalization of institutions in Peru.

At the time, the merger of IDREH was made under the form of absorption by MINSA; it no longer existed as a decentralized public organism; it was joined with agencies of the Ministry in a transitional formula (Pliego Sectorial III) while the new Regulation of Organization and Functions (ROF) of MINSA was issued. This transitory situation lasted a little more than a year. A new general directorate was created as an agency with the functions of the former IDREH in addition to the work management role, which had been undertaken by the General Directorate of Public Health; it was called General Directorate of Human Resources, and remained apart from the General Office of Human Resources Management (ROF), which is responsible for personnel policy. At present, the new ROF makes up this General Directorate with two sub-units, the management of labor and management of education, following the Brazilian model (SEGETES.) The new General Directorate has been operating for a year and a half; it is responsible for formulating and conducting national and sector policies in human resources. The new General Directorate has been leading the aforementioned human resource processes.

## 2.8. Intergovernmental and Interagency Coordination: Committee of Coordination with Regional Directorates of Health and Cooperation Role, in Particular PAHO's

In the last four years, the Peruvian State was effectively decentralized, which has led to a reorientation of the functions of MINSA at the central level and, therefore, all its general directorates. This has brought further work in intergovernmental and interagency coordination for the current General Directorate of Human Resources of the Ministry of Health.

As of October 2009, 98 percent of the 4,810 projected functions were transferred to regional governments. Therefore, processes were carried out to certify, accredit and show effectiveness to check the institutional capacities. If lacking, intergovernmental framework agreements were signed stating deadlines to meet the requirements. Similarly, the decentralization of the national budget has advanced: the regional government budget was increased by 44.19 percent between

2005 and 2008. The funds from the exploitation of natural resources, through fees and overcharges, have markedly strengthened the resources of local and regional governments. On the other hand, in 2008, the Fund for the Promotion of Regional and Local Investment (FONIPREL) was created by Act No. 29125 which has made calls for bid for 650,000,000 soles (US\$ 232 million).

This highlighted the need for intergovernmental coordination between the national government and regional and local governments, and identified the main functions of national directorates by focusing on policy design and monitoring. Today, regions are able to change their health organization and networks, and create others according to their vision for reorganizing their service systems. The Executive Fundamental Law states the creation of an Intergovernmental Coordination Committee for smoother relations between the national, regional and local levels, but to date has not been implemented. This has obliged ministries to take the initiative in coordination with sub-national agencies. This is the case of MINSA and the Directorate of Human Resources for Health, which regularly coordinates the respective units in DIRESEs. A committee has been created, chaired by the Minister of Health and composed of general directors and health regional directors. Agreements on critical issues such as the distinctions, personnel mobility, funding and others are concluded at their meetings.

For now, MINSA relations at the central level with the regional directorates are more systematic than the relations between ministries and public bodies that handle issues of public sector human resources. Thus, the coordination between MINSA, SERVIR and SINEACE are not permanent but still timely. The coordination between MINSA and the Ministry of Finance for issues on financing is made through the General Office of Planning and Budget of the Ministry of Health. The communications with the Human Resources Management of EsSalud are sporadic.

It is clear now, however, unlike thirty years ago when the state was the all-around player, that social actors of human resources in Peru have multiplied; this necessitates extending interagency and intergovernmental coordination to achieve results. In the field of human resources for health today we have:

- Governmental players: Ministry of Health, General Directorate of Human Resources, Regional Directorates of Health (DIRESEs), SERVIR, Ministry of Education, Ministry of Labor and Presidency of Council of Ministers (PCM).
- Service providers (and central employers): services from the Ministry of Health, EsSalud, Armed Forces and Police, health care providers, and mainly private clinics.

- Training institutions: the many schools of health sciences and the three national associations with more activity and technological schools: the Peruvian Association of Schools of Medicine (ASPEFAM), the Peruvian Association of Schools of Nursing (ASPEFEEN), and the Peruvian Association of Colleges of Midwives (ASPEFOBTS.).
- Corporate and union players: professional associations and unions, in particular organizations of physicians (Association of Physicians of Peru and the Peruvian Medical Federation), nurses (Association of Nurses of Peru and Peru's Federation of Nurses) and obstetricians (Association of Obstetricians of Peru.)
- Scientific societies and organized groups of civil society (NGOs, Health Forum, specialty societies, etc.)
- International cooperation agencies and inter-country agencies.

This latter type of actors—international cooperation and intercountry agencies—requires special attention, given the importance they have had and still have in supporting human resource policy for health, including PAHO and Andean Sub-regional Coordination with offices in Lima.

This has determined the Human Resources for Health activities that are being carried out in the Andean countries and particularly in Peru. Of particular importance were the annual meetings of country representatives, sponsored by the Andean Coordination of PAHO since 2005. At these meetings the assignment of tasks is discussed and followed up; the Andean Plan of Human Resources for Health was formulated. This management tool has also been submitted and approved at the Meeting of Ministers of Health of the Andean Community (REMSA-ORAS). Achievements have been made; they were driven by Andean Coordination through the following initiatives, among many others: (a) building skills with the CIRHUS course, which was incorporated by Human Resources for Health directorates in three of the six countries for training Human Resources for Health professionals. The ministries have a regular budget for its development, an element that shows the importance given to it: Ecuador is in its first cohort, PERU has two cohorts projected, and Chile is in its third cohort; (b) monitoring the progress of Human Resources for Health plans through the measurement of regional goals for Human Resources for Health. There exists a good basis for building plans aimed at improving tracking indicators in line with the Primary Health Care and universal health systems; (c) posing the migration of professionals while running a multicenter sub-regional study and ensuing policy debate; and (d) building the Andean Observatory of Human Resources for Health, which implements many developments and an information and analysis system. In short, the inter country agenda has mobilized the sub-region, has impacted on Peru and has allowed the

exchange of experiences. As a result, the quality of Human Resources for Health interactions and policies in Peru has been significantly helped.

Another important platform in human resource work, driven by the Andean Health Organization, CAN and PAHO, has been UNASUR, which mobilizes resources in the region. For the first time, directors of Human Resources meet at the international level in the Committee of Human Resources for Health. Starting this month, Peru takes the coordination of the Committee for the period 2010-2011.

### 3. Analysis, Reflections and Recommendations

- A significant work in the field of human resources for health was made in the ending decade. Today, there is a community knowledgeable in human resources in Peru; it is a community of managers, donors and researchers. By contrast, this community does not exist in the field of health services. A line of research and publishing was implemented, which supports the actions and policies in human resources. Advanced have been made in human resources resulting from the implementation of key ideas and initiatives that have achieved political support and funding.

The members of this knowledgeable community eventually occupy leadership positions, often turning the managers of universities, researchers and donors into officers, and vice versa. It has established a minimum of coordination between theory and practice, although much remains to be done by leaving the empirical and circumstantial style of leadership that prevails in the Peruvian health sector. But this marks the difference between this thematic area and others in the Ministry of Health, where no connection exists between this community of reflection and officers, or they do their apprenticeship on the issue just after their appointment.

This relationship between managers, donors and researchers is crucial, because a distance is needed for continuous evaluation of management, as objective as possible. In turn, it requires a careful involvement of donors and researchers in action in order to be connected with reality. The review of all proceedings in the decade in human resources for health should strengthen this three-way relationship among managers, donors and researchers, which has been important for the progress made. This intermingling occurred before in the IDREH and in the Human Resources Committee of the National Health Council.

- It is important to notice that whenever any member of the learned community has held key positions in leading human resources policy, major advances have been achieved. It is the current case and CONEAU and GDHR. Conversely, when directors or officers who do not know the issue

have been appointed, based only on the criterion of trust, the directional sense becomes erratic, precious time is lost or even important initiatives are blocked. This was the case of CAFME; the high performance of its two first directors decreased in the third term, when a trusted advisor was chosen. It is recommended that before a minister of international cooperation who has a neutral input to the topic is changed, he should present the new minister the issues and community by promoting and encouraging progress and supporting developments.

- An overview of the decade shows that there are two types of outputs or outcomes: (a) those that are already realities, and (b) those under design or initial implementation.

If we were to sum up keywords of the decade on the human resources for health field, they would be: IDREH, the General Directorate of Human Resources (GDHR), greater workforce, better distribution, SERUM transformed, CAFM as accreditation precursor, CIRHUS for management capabilities, appointment of dismissed employees, SERVIR National Civil Service Authority, CAS and new procurement system. There are probably some more that exist, but these words do not refer to abstract projects to be undertaken, but effective changes that have marked and a mark on the future of human resources for health and will leave a legacy to the next decade. They are the first kind of achievements or results that are now realities.

Along with these effective keywords a much larger number of ideas exists, profiles and projects that are sprouting or being worked on or still in the initial stages, which are the second type of achievement and have been explained before: the PROSALUD program for specialists; structuring health degrees; coordination among the GDHR, SERVIR and SINEACE; the still very early operation of CONEAU-SINEACE for accreditation and certification; the Management Education Program and the Family Health Program, among many other initiatives.

- By analyzing from where and how these initiatives were developed in the area of human resources for health, we can see that the driving forces came from different sectors of the state and had different motivations.

The IDREH emerged during the transitional government, in 2001, as a result of the severity of the chronic crisis of ENSAP; it was a success because it gave autonomy to the field and closed a long period of decline of the ENSAP, the previous whole unity of human resources in MINSA.

The disappearance of the constitution IDREH in 2007 and the subsequent formation of the General Directorate of Human Resources Department in

the ROF of the Ministry of Health came from a Central Government initiative to reduce the number of decentralized public agencies in 2007. Therefore, it was an initiative exogenous to the Health Sector, which left Human Resources Unit in the vacuum, and had a happily auspicious outcome.

The largest allocation and best distribution of professionals in the provinces, with the transformed SERUM, came from the experience of the team that has been running SERUM from years and found its opportunity by ensuring universal coverage, and the urgency for more professionals in remote areas of the country.

CAFME, the precursor of accreditation during the years 1999-2006, was a response to the proliferation of medical schools and although it was the result of a very broad coalition, the initiative came from the Association of Physicians and universities that had maintained a quality level and noticed the increasing mediocrity of medical education.

CIRHUS, the course to develop skills for managing human resources for health, emerged from the interweaving of efforts between the Andean Sub-regional Coordination of PAHO and Brazilian cooperation.

The appointment of those dismissed in the 1990s was proposed by the Medical Federation in the health sector. They relied on the appointments statewide undertaken from 2001 and were processed by the Ministry of Labor, the Cabinet of Ministers and the Ministry of Health.

The National Civil Service Authority (SERVIR) and the CAS or new procurement system of the State, arose from the Executive, which previously formed committees in the Ministry of Labor and PCM to address issues of public career and salary system.

- It is noticeable that human resources for health are molded from inside and outside the health sector. When an initiative is from outside, MINSA is not always consulted or involved. Therefore, its effects are not always conscious, and sometimes produce unwanted collateral damage. It results from the removal of IDREH and a long hesitation to replace it which weakened the field. Another case is the cancellation of CAFME, which has not been replaced yet.

A review of issues of the decade shows that the Human Resources Unit is responsible for human resources of MINSA, not for human resources for health in general, and it has institutional scope. This leads to a recommendation for a greater extra-sector initiative in the General Directorate of Human Resources. It is necessary to have close coordination in the sector with EsSalud, military health units, private sector, and outside the sec-

tor with SERVIR and SINEACE, as well as the Ministry of Labor and the Secretary of Public Management of the Council Ministers Presidency. The current coordination with DIRESAS should continue and be strengthened.

- The great achievement of the decade is the significant expansion of human resources in MINSA and EsSalud and its redistribution to the poorest areas through SERUM transformed. This has led to an increase in the response capacity of health units and care centers and made care service in long-time-excluded populations possible. This has been achieved under the impetus of the strong idea of the current ministerial management and universal health insurance. However, the subject of SERUM and redistribution of positions had been under discussion, with initiatives such as the Community Health Service and others. This means that to search for windows of opportunity the GDHR must have a portfolio of projects or programs that it permanent supports.

Through the increased investment in infrastructure, equipment and human resources the contrast or paradox of a crippled health sector in a context of economic boom occurring in this decade in Peru has been broken. The gaps experienced for decades have not been solved, but distances have been shortened.

- One of the key challenges for policy formulation, managing and planning of human resources for health in Peru will be to differentiate the needs of re-strengthening and reorienting, and learning how to calibrate them. Not only are more human resources needed, but also other policies and practices on human resources. The gap of the health system compared to the growth of demand and the weak investment in health have placed re-strengthening at the forefront, but also it requires innovative human resources policy and the Health System. This is for core achievement; it is not a simple mirror effect of economic growth, which doesn't deal with problems of inefficiency, ineffectiveness and job dissatisfaction.

In recent years, the underlying pillars of human resource policy have been based on an internal view in MINSA, bypassing community health agents and resources relevant to the system, excluding services with the consent of the indiscriminate multiplication of universities and the disconnection between teaching and services, leaving the training to the individual efforts of its staff, accepting the normalcy of job dissatisfaction, putting quality management in the background, and dismissing agenda issues. The need to broaden the human resource work agenda is noticeable in issues of staffing system, salary scales, a national program in health capacity building, readjustment of health university reform, building a monitoring and performance system, incentive systems, a sector information system,

a research program, among others. This requires strengthening the Human Resources Unit and investing in the institutional platform of management on the field.

- It was always thought that human resource policies were policy means defined in function of policy goals, which are those of each health system and its services. Hence, the human resources reform was understood as a 'parasite-reform' of the systemic reform, quoting Schneider. This, viewed indirectly, is totally true, but if it is taken to extremes, it becomes a utilitarian human resources policy leading to the old formula of the 1990s in Peru: performance increase by reducing the development of human resources for health. This expanded the coverage and lowered the product cost per unit, but affected governance. Today, multiple jobs is still the indicator of overexertion required to maintain the old system. In that sense, the human resources policies have a specialty with regard to human resource policies for services summarized in the alignment. Not only does the health system have problems with human resources but also human resources have problems with the health system. Although one of the core health slogans in Peru says: "people serving people," this subtle distinction has been lost or blurred in the case of human resources for health because the means —persons— are means and targets and they do not work with fervor without a motivation, which is not necessarily material. Human resource policy has this responsibility. The Peruvian society builds organizations like Up-To-Date Citizens [Ciudadanos al Día], which reward best practices, or charismatic efforts by building joint projects.

## **Annexes.**

### **Tables with Total of Human Resources for Health MINSA - 2009 and 2007**

*(on next page)*

TOTAL OF HUMAN RESOURCES, MINSA - 2009 (BY REGION AND PROFESSION)

Profession \ Region	Physicians	Nurses	Obstetricians	Dentists	Biologists	Health Engineer	Nutritionists	Psychologists	Pharmacist	Technician Physicians	Veterinarians	Social Workers	Other Care Professions	Chemists	Health Care Technicians	Technical-Administrative Staff	Health Care Assistants	Administrative Assistant	Administrative Professional	Others <sup>a</sup>	No specification	Total
Amazonas	180	187	186	32	22		8	9	10	14	2	8	1		802	200	61	102	39	31	4	1,898
Ancash	486	485	372	61	27	1	45	18	34	33	2	64	51	2	1,662	608	144	133	155	17	6	4,406
Apurímac	264	509	247	81	35		35	32	25	5	4	11	10		937	225	48	159	60	45	8	2,740
Arequipa	802	879	400	170	65		52	59	58		8	96	28	5	1,173	498	230	370	104	24	29	5,050
Ayacucho	305	612	379	89	92		13	18	36	1	4	38	30		1,226	341	59	71	89	11	1	3,415
Cajamarca	431	686	431	62	44		31	14	45	12	11	16	24	1	1,550	351	153	191	154	79	3	4,289
Callao	819	471	161	60	12		22	54	25	167		74	17	3	1,207	564	424	355	131	28	6	4,600
Cusco	531	701	380	90	77		18	23	24	2	1	20	77	10	1,276	516	54	163	72	23	13	4,081
Huancavelica	175	333	128	46	3		6	23	12	7	1	10	36	1	486	153	118	48	31	11	2	1,630
Huanuco	281	509	354	40	11		22	25	18	6	8	7	29		736	220	176	39	91	2	1	2,575
Ica	450	391	160	114	20		13	14	83	6	5	9	33	2	843	449	54	265	97	15		3,023
Junín	453	772	356	74	19		17	31	56	13	3	58	105	5	1,480	565	155	202	48	13		4,425
La Libertad	811	753	340	56	48	1	70	15	65	17	3	58	31	2	1,271	462	389	265	129	20	1	4,807
Lambayeque	413	358	251	40	49		28	9	20	34	8	17	9	2	897	334	170	372	96	9		3,116
Lima	8,209	6,518	2,242	848	171	12	303	532	549	922	30	676	372	19	11,700	7,955	3,292	3,273	1,322	327	84	49,356
Loreto	301	369	222	46	35		10	11	23	8	1	9	73	1	1,244	504	262	479	69	23	5	3,695
Madre De Dios	88	92	62	16	13		5	7	6	3		3			332	139	59	16	41		2	884
Moquegua	145	205	98	45	7		16	13	13	2	2	22	75	1	296	164	37	96	29	15		1,281

Continues on the next page...



**TOTAL OF HUMAN RESOURCES, MINSA - 2009 (BY REGION AND EMPLOYMENT STATUS)**

Employment Status Region	Appointee	Distinguish	Under Contract 276	Under Contract 728	CAS	Others <sup>a</sup>	SERUMS 2008-II paid work	SERUMS 2009-I paid work	No specification	Total
Amazonas	631	15	89	105	891	16	52	98	1	1,898
Ancash	2,667	176	94	118	1,075	45	40	183	8	4,406
Apurimac	1,065	46	79	136	985	30	72	325	2	2,740
Arequipa	2,623	92	219	588	460	889	53	121	5	5,050
Ayacucho	1,852	23	198	69	953	10	32	278		3,415
Cajamarca	1,733	28	71	392	1,688	23	77	269	8	4,289
Callao	2,453	108		13	1,818	171	6	8	23	4,600
Cusco	2,181	134	69	94	1,346	40	60	145	12	4,081
Huancavelica	668	135	140	5	335	1	24	320	2	1,630
Huanuco	1,139	152	55	253	746	0	43	173	14	2,575
Ica	2,140	37	106	159	330	79	71	99	2	3,023
Junin	2,943	30	71	83	1,033	4	76	182	3	4,425
La Libertad	2,636	93	204	142	1,482	25	41	184		4,807
Lambayeque	1,679	54	26	8	485	741	22	101		3,116
Lima	29,695	792	138	61	17,918	636	37	62	17	49,356
Loreto	1,831	27	38	199	1,454	1	34	105	6	3,695
Madre De Dios	408	3	120	158	138	1	13	43		884
Moquegua	783	9	56	152	200	2	16	63		1,281
Pasco	497	5	45	58	317	7	20	90	3	1,042
Piura	2,258	325	197	258	1,704	37	60	197	73	5,109
Puno	2,901	43	139	95	1,043	27	48	223	13	4,532
San Martin	1,706	31	21	155	765	59	46	128	11	2,922
Tacna	1,062	21	18	348	359	6	10	51		1,875
Tumbes	514	8	63		347		18	51		1,001
Ucayali	1,026	1	54		729		26	75		1,711
<b>Total</b>	<b>69,091</b>	<b>2,388</b>	<b>2,310</b>	<b>3,649</b>	<b>38,601</b>	<b>2,850</b>	<b>997</b>	<b>3,574</b>	<b>203</b>	<b>123,663</b>

Note: It includes administrative staff from Ministry's Office, DIRESA, DISA, Redes; and SERUMS paid work.

a. Ministry, Deputy Minister, directors, managers, senior staff and consultants.

Source: National Database of Human Resources, 2009, MINSA. Prepared by the Observatory of Human Resources, DGGDRH-MINSA.

### HUMAN RESOURCES IN HEALTH INSTITUTIONS, MINSA - 2009 (BY CATEGORY)

Only MINSA					
EESS Category	Physicians	Nurses	Obstetricians	Dentists	Health Care Technicians
I-1	94	2,001	1,292	43	5,325
I-2	1,611	1,526	1,312	371	3,286
I-3	2,300	1,729	1,585	827	5,799
I-4	1,367	1,077	1,070	377	3,597
II-1	1,578	1,717	78	165	4,146
II-2	1,820	2,044	57	114	3,640
III-1	4,263	3,870	50	102	6,189
III-2	1,070	1,403	19	36	2,176
No category	10	119	73	10	279
Total	15,054	15,486	7,390	2,045	34,437

Note: It includes SERUMS 2008-II y 2009-I.

Source: National Database of de Human Resources, 2009, ONRHUS - DGGDRH - MINSA. Prepared by the Observatory of Human Resources, DGGDRH - MINSA.

## HUMAN RESOURCES FOR HEALTH BY REGION, MINSA - 2007 (BY PROFESSION)

Profession \ Region	Physicians	Nurses	Obstetricians	Dentists	Biologists	Health Engineer	Nutritionists	Psychologists	Chemist Pharmacist	Technician Physicians	Veterinary	Social Worker
Amazonas	181	188	165	34	12		11	9	9	12	1	6
Ancash	459	503	355	69	19	1	44	17	28	22	3	52
Apurimac	262	386	251	88	20	1	19	7	32	3	2	13
Arequipa	903	1,053	494	197	69		55	69	50	18	6	98
Ayacucho	283	451	353	85	84		14	15	48		7	39
Cajamarca	457	648	390	53	23		19	11	22	18	11	13
Callao	679	360	85	41	3		13	40	18	148	2	62
Cusco	505	701	389	130	69		15	28	34	1	2	4
Huancavelica	225	271	234	69	8		4	7	9	4	1	11
Huanuco	286	436	302	44	3		9	14	10	9	6	5
Ica	475	347	153	109	12		8	8	75	3	6	9
Junin	396	630	215	65	11	1	17	19	18	8	1	32
La Libertad	755	568	272	56	44		60	17	46			39
Lambayeque	402	327	239	51	39		21	4	18	20	4	7
Lima	6,031	4,135	1,123	407	99		168	279	234	653	31	491
Loreto	309	336	176	55	40		12	10	22	5	2	9
Madre De Dios	81	84	48	18	5		4	4	4	2	1	3
Moquegua	130	184	115	47	8		10	14	6	3	2	21
Pasco	116	116	88	28	2		9	11	9	7	1	4
Piura	520	349	420	85	19		24	16	22	15	4	10
Puno	525	751	353	77	36		26	9	21	3	20	74
San Martin	244	206	242	38	4	1	7	4	25	5	12	2
Tacna	192	318	158	60	19		6	7	8	2	1	24
Tumbes	99	104	88	23	4		8	3	5	2	2	5
Ucayali	174	244	124	30	11		7	6	9	3	2	4
Total	14,689	13,696	6,837	1,959	663	4	580	628	782	966	130	1,037

Source:

1. Data from DISA and DIRESAS Census - 2007.
2. Data submitted by Central Management Office of Human Resources for Health - 2007.
3. Registry of Enterprises and Entities Related to Superintendence of Health Care Providers (SEPS-2006).
4. Published in "El Perú respondiendo a los desafíos de la década de los recursos humanos para la salud", page 28 (2005).

# Annex 1:

## Workshop Program

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### **Human Resources Plans AND PRIMARY HEALTH CARE: CHALLENGES OF INTERSECTORAL AND SOCIAL COORDINATION**

**Workshop Organized by the Global Alliance on Health Workforce (GHWA)  
and the Pan American Health Organization/World Health Organization  
in collaboration with the Ministries of Health of El Salvador and Brazil**

**San Salvador, El Salvador  
4-6 May 2010**

### **Objectives**

1. Analyze the situation of developing Human Resources Plans in the transformation of health systems towards primary health care renewal and integration of services.
2. Identify priority issues for an agenda of work between the health sector and the finance, labor and education sectors, to develop Human Resources Plans.
3. Characterize the practice of relationship between Ministries of Health and its counterparts in Finance, Labor and Education in the construction of viability of Human Resources Plans.
4. Identify the main successes and problems, characterize good practices and make recommendations for strengthening intersectoral work on the development of plans and coordination with interested stakeholders.

## Preliminary Program

*Tuesday, May 4, 2010*

Time	Session	Moderator
7:30 - 8:30	<b>Registration of participants and distribution of documentation</b>	
8:30 - 9:00	<b>Opening ceremony</b> <i>José Ruales, PWR/ELS</i> <i>José Luis DiFabio, Manager, PAHO</i> <i>Francisco Campos, GHWA</i> <i>María Isabel Rodríguez, Minister of Health, ELS</i>	Master of Ceremonies: <i>María Teresa Escalona</i>
9:00 - 9:20	<b>Presentation of the program and workshop organization</b> <b>Presentation of the delegations and participants</b> <i>Charles Godue, PAHO</i>	
9:20 - 9:45	<b>The development of Human Resources Plans for health in the Region of the Americas</b> <i>Charles Godue, PAHO</i>	
9:45 - 10:30	<b>The Kampala Declaration and the 2<sup>nd</sup> World Conference on Human Resources for Health</b> <i>Francisco Campos, GHWA</i>	
10:30 - 11:00	Break	
11:00 - 12:00	<b>Building hope: transforming the health system and human resource policies in El Salvador</b> <i>María Isabel Rodríguez, Minister of Health</i>	<i>José Ruales, PAHO</i>
12:00 - 12:30	<b>Human resource policies and the transformation of health systems</b> <i>Guillermo Enrique Echeverría Peralta, Vice Minister of Health, Guatemala</i>	
12:30 - 2:00	Lunch	
2:00 - 4:00	<b>Human resource policies and the transformation of health systems</b> <i>Nila Heredia, Vice Minister of Health Promotion, Bolivia</i> <i>Manuel Núñez, Ministry of Health, Peru</i> <i>Francisco Campos, Ministry of Health, Brazil</i>	<i>José Luis DiFabio, PAHO</i>
4:00 - 4:30	Break	
4:30 - 5:30	<b>Human resource policies and the transformation of health systems</b> <i>Edgar Daniel Gimenez Caballero, Vice Minister of Health, Paraguay</i> <i>Javier Rodolfo Pastor Vásquez, Assistant Secretary for Sectoral Policy, Honduras</i>	<i>Norbert Dreesch, WHO</i>
5:30 - 6:00	<b>Critical reflections on the progress and challenges of human resource policies for the transformation of health systems</b> <i>Pedro Brito and Hugo Mercer</i>	

Wednesday, May 5, 2010

Time	Session	Moderator
8:30 - 9:00	<b>Collaboration and coordination between sectors and actors: an introduction to the day's activities</b> <i>Hirotsugu Aiga and Carlos Rosales</i>	
9:30 - 11:30	<b>Intersectoral coordination for the development of Human Resources Plans: towards the universal coverage and the renewal of the Primary Health Care: the experience of El Salvador</b> <i>María Isabel Rodríguez, Minister of Health</i> <i>Carlos Enrique Cáceres Chávez, Minister of Finance</i> <i>Victoria Marina de Aviles, Minister of Labour and Social Welfare</i> <i>Salvador Sánchez Ceren, Minister of Education and Vice president ad honorem of the Republic of El Salvador</i>	José Ruales, PAHO
10:30 - 11:00	Break	
11:00 - 12:30	<b>Intersectoral coordination for the development of Human Resources Plans: the Brazilian experience</b> <i>Francisco Eduardo de Campos, Minister of Health</i> <i>Jeanne Liliane Marlene Michel, Minister of Education</i> <i>María Emilia Piccinini Veras, Ministry of Labour and Employment</i> <i>María Gabriela Moya Gannuny El Bayeh, Ministry of Planning and Budget</i>	Judith Sullivan, PAHO
12:30 - 2:00	Lunch	
2:00 - 3:30	<b>Intersectoral coordination for the development of Human Resources Plans: the experience of Peru</b> <i>Manuel Núñez, Ministry of Health</i> <i>Victor Bocangel Pucila, National Budget</i> <i>Nuria Esparch, National Civil Service Authority</i> <i>Victor Carrasco Cortez, CONEAU</i>	Mónica Padilla, PAHO
3:30 - 4:00	Break	
4:00 - 6:00	<b>Building a thematic agenda for cooperation between sectors and actors in the development of Human Resources Plans</b> <b>Work groups</b> <u>Group 1:</u> Financing Facilitators: <i>Rubén Suárez and Hernán Sepúlveda</i> <u>Group 2:</u> Labour Facilitators: <i>Carlos Rosales and María Helena Machado</i> <u>Group 3:</u> Education Facilitators: <i>Rosa María Borrell and Ana Estela Haddad</i>	

Time	Session	Moderator
4:30 - 5:30	<b>Human resource policies and the transformation of health systems</b> <i>Edgar Daniel Gimenez Caballero, Vice Minister of Health, Paraguay</i> <i>Javier Rodolfo Pastor Vásquez, Assistant Secretary for Sectoral Policy, Honduras</i>	Norbert Dreesch, WHO
5:30 - 6:00	<b>Critical reflections on progress and challenges of human resource policies for the transformation of health systems</b> <i>Pedro Brito and Hugo Mercer</i>	

*Thursday, May 6, 2010*

Time	Session	Moderator
8:30 - 10:00	<b>Results of the work group discussion</b>	Rubén Suárez, PAHO
10:00 - 10:30	<b>Reflection on main findings of country studies</b> <i>Hugo Mercer and Carlos Rosales</i>	
10:30 - 11:00	Break	
11:00 - 12:30	<b>The prospect of non-governmental actors</b> <i>Zoila Annette Morales de Fortín, Interagency Commission of Academic and Health Sectors, Dean of Medical Sciences and Health, University Mariano Gálvez, Guatemala</i> <i>Aída Máxima Robles Di Benedetto, National Deputy, Paraguay</i> <i>Mourad Ibrahim Belaciano, Brazilian Association of Medical Education</i>	Eduardo Espinoza, Ministry of Health of El Salvador
12:30 - 2:00	Lunch	
2:00 - 3:30	<b>Planning of human resources for health: challenges and prospects for action</b> <i>Pedro Brito</i> Comments: <i>María Isabel Rodríguez</i> <i>Edgar Daniel Jiménez Caballero</i> <i>Nila Heredia</i> <i>Manuel Núñez</i>	
3:30 - 3:45	<b>The Declaration of El Salvador</b>	
3:45 - 4:00	<b>Closing activities</b> <i>José Ruales, María Isabel Rodríguez and Francisco Campos</i>	

# Annex 2:

## Workshop Participants List

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