

HEALTH AND WORKING CONDITIONS OF HEALTH CARE WORKERS



NESCON

núcleo de **educação em saúde coletiva**
FACULDADE DE MEDICINA - UFMG

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**HEALTH AND WORKING CONDITIONS
OF HEALTH CARE WORKERS**

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FOREWORD

This document sets out a Plan for the countries of Latin America and the Caribbean (LAC) produced by the Workshop on the **Health and Working Conditions of Health Sector Workers** organized by NESCON/ UFMG in January 2006 in the city of Ouro Preto, and sponsored by the Brazilian Federal Ministry of Health, the Pan-American Health Organisation, the World Health Organisation and health specialists from various countries in the region of the Americas.

The general objective of the Work Plan for **Consolidating the Health of Health Workers** is to help improve health and working conditions of health workers as part of the “Decade of Human Resources in Health” initiative. The Plan’s specific objectives include: 1) supporting the development of intersectoral public policies to improve health and working conditions of health workers: a) a rights-based approach to social protection; b) health care systems; and c) healthy work environments; 2) evaluating and strengthening institutional capacity to address the work and health conditions of health workers; 3) assessing the determinants of the work and health situation of health workers; and 4) developing indicators to

monitor and assess the work and health situation of health workers.

The stated objectives are consistent with the activities set out in world declarations of “Health for All” and regional efforts to harmonize policies with a view to maximizing the efficiency and effectiveness of actions designed to address the problems of health worker safety and health.

To understand the new complexities inherent in the health work field is to realize that society must assume the enormous responsibility of preparing health workers with the skills they need to provide health care the population and, at the same time, to inspire health workers to feel confident in their jobs and view them as a source of satisfaction and personal growth.

However, this course of action requires us to accept the existence of factors that have yet to be explored in much depth, but which have an impact on health system objectives. Working conditions of health workers are one such factor, the effects of which, together with other determinants, define both the health of those who operate our health systems as well as the means they have at their disposal to fully achieve their potential.

This document seeks to usher in a new era in Latin American health reform by linking actions in health, labor, the environment, and human resources, as illustrated in Figure I.

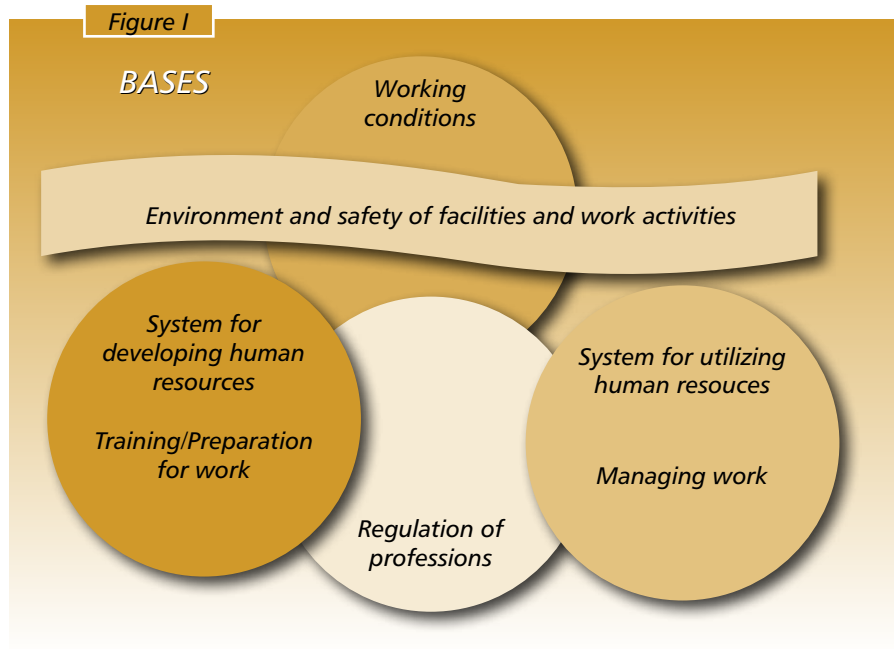


Figure I. Spheres of action impacting the development of health of health workers

1. INTRODUCTION

1.1 Why the health of health workers is a United Nations area of action

Working conditions refer to circumstances under which work is carried out, and, for purposes of analytical distinction, exposure to risks, whether physical, chemical, mechanical (i.e. equipment/gear that cause accidents and strenuous musculoskeletal work) or biological. Cited as factors that aggravate exposure to risks are the effects of over-burdening human capacity in daily work activities of the technical-organizational system, known as factors linked to the organization of work.¹

Working conditions are linked to the general living conditions of nearly 220 million workers in Latin America and the Caribbean (IDB, 2001). According to forecasts, the economically active population of the Region will reach 270 million by 2025.

In 1997, WHO sounded a warning on exposure to occupational risks, underscoring that 30% of the work force of the developed world is affected by ergonomic and physical

risks, while noting that the corresponding figure for the developing countries is between 50 and 70%. Contributing to the seriousness of the problem are some 200 biological agents and 100,000 different chemical substances used in the different areas of production, exposing thousands of workers.

Work-related accidents, occupational disorders, layoffs due to illness or the aftermath of an accident, as well as temporary and permanent worker disability are traditional indicators of the health situation of workers. According to estimates of the International Labor Organization (ILO), 13.5 fatal work accidents occur for every 100,000 workers in Latin America. The list of work-related disorders is expansive and varies by country. In addition to cases of heavy-metal and agrochemical poisonings, respiratory illness caused or exacerbated by mineral dust or other airborne particles, the results of recent scientific studies have called attention to occupational cancers

and workplace mental health disorders. With regard to risks and their determinants, one study consistently points to psychosocial factors stemming from paradoxes in the methods of human resource management methods, in the control of productivity, and in the goals of product and service quality.²

Disparities in occupational health are associated with: 1) the existence of unavoidable and unacceptable risks for certain groups of workers; 2) the superimposition of the effects of poverty on the effects of exposure to hazardous work environments, i.e. the fact that workers in dangerous and unhealthy jobs are also among the poorest of the poor and subject to inadequate living and workplace conditions; 3) the fact that most workers do not have access to occupational health services; and 4) the expansion of the informal economy, hazardous work, and the marginalization of work.

Measures for transforming occupational health have been unsuccessful, as obstacles stand in the way of achieving the proposed goals. These include, *inter alia*: 1) limited acknowledgement of occupational health in the public policy arena (primarily political and social policies);

1 European Agency for Safety and Health at Work. *Expert Forecast on Emerging Physical Risks Related to Occupational Safety and Health. Belgium, 2005*

2 TAKEDA, F. The Relationship of Job Type to Burnout in Social Workers at Social Welfare Offices. *Journal of Occupational Health*, v.47, p. 119-125, 2005.

2) the shrinking role of the State, and particularly weakness on the part of the Ministries of Health and Labor (trend toward deregulation), 3) limited coordination between the health and labor sectors; and 4) mistaken, curative-based approaches followed by the health services and the absence of preventive health policies to address the causes and determinants of accidents and illness.

1.2 Why the Health Working Conditions are Targets of PAHO Action

Present conditions require health researchers make greater efforts to understand the recent changes in the health sector that impact the way work is done, influence the susceptibility of health workers to the risks of falling ill, in general, and expose them to the effects of new demands for which workers do not always possess the necessary skill set in order to address.

On the whole, health services have suffered an erosion and shortage of investment, endured structural adjustments and funding cuts—i.e. nurse layoffs in Kenya, Tanzania, and Zimbabwe—despite need. The heavy workload and less-than-motivating working conditions (including risks) are significant causes of the health workers’ “push” into other countries. In response, guidelines such as the ones developed by the U.K. on the ethical recruitment of overseas medical professionals have recently been issued.

To illustrate this point, according to the American Medical Association (2002), in Canada 23% of practicing doctors were trained overseas,

whereas the corresponding figure in the United States was similar, 23.5%. In a recent survey, 75% of the responses in a sample of immigrant doctors cited a desire for better access to technology, health equipment, and resources in the practice of their profession. At the 2002 and 2004 World Health Assemblies, concern was expressed over the negative effects on developing country health systems caused by physician migration, based on the hypothesis that the populations most in need are those with least access to up-to-date health care techniques and precisely the populations that would be losing their physicians.³

Human resources policies often fail to take the occupational aspects of health workers into account. Oftentimes these policies view health workers as mere instruments for providing health services and fail to consider the conditions they face on the job which impact their health and lives. Nevertheless, pandemics such as SARS and avian flu underscore the vulnerability of health systems and their lack of preparation to protect their workers.

³ AVRAHAM, A. et al. *Physician Migration: Views from Professionals in Colombia, Nigeria, India, Pakistan and the Philippines. Social Science & Medicine*; v. 61, p. 2492-2500, 2005.

In 2000, the American Psychological Association convened a consensus panel meeting in Washington, D.C. focusing on the mental health needs of providers of emergency medical services for children (EMSC).⁴ The panel identified the primary clinical stressors and adverse psychological and behavioral reactions among EMSC providers. At the close of the meeting, the panel recommended a review of intervention strategies and also proposed widespread dissemination of the lessons learned from the experiences of EMSC providers, with a view to instituting psychological support services for EMSC workers, as well as pediatric patients and their families.

The critical situation of emergency care is by no means the only area of health work that gives rise to emotional stress among workers. Literature on the subject mentions the constraints faced by health workers, which can lead to unspecific symptoms and impact their quality of life and professional careers.

Based on the proposition that workers are not neutral participants when it comes to their work,⁵ research is under way on the objective and subjective experiences of health workers, linking the analysis of difficulties in the worker-user relationship to the evaluation of practical and technical-organizational components in the health systems in which they operate.

Evidence points to restrictions on care owing to the structure of the health system, particularly with regard to the organization of services. The guiding hypothesis of the research under way supposes that, in addition the extrinsic difficulties of their work (i.e., volume of procedures, available means, and measurable, well-known risks), workers must contend with the daily uncertainties of their relationship with users, which is typical of work in the health field.

Study results support the current paradox, which nurtures the difficulties experienced on the job, and which may or may not take into account the demands

of those well-trained employees with initiative and diverse skills, but who do not have leeway to make decisions with respect to means or ends. Projects under way, based on only partial results, give the impression of horizontal and apparently more autonomous forms of health work organization may favor greater intensification of the exploration of work, such as the study done by Castels (1999).⁶

In addition to greater flexibility in the management of work, the employment relationship in the health sector has also become more relaxed, as it is now possible to hire workers without assuming the obligations inherent in labor legislation which, over the last forty years, has been responsible for strengthening rights and minimum guarantees for workers.

Scientific studies have shown that the quality of health care depends on how the system addresses the needs and subjectivity of workers in the exercise of their duties. For example, allotting time to review adopted practices, providing social support to help workers cope with the hardships and shortages experienced by users, and the promotion for formal and informal intra- and inter-team

4 LIPTON, H.; EVERLY Jr., G.S. Mental Health Needs for Providers of Emergency Medical Service for Children (EMSC): a report of a consensus panel. *Prehosp Emergency Care*: v. 6, n 1, p 15-21, 2002.

5 DEJOURS, C. Travail: usure mentale. De la psychopathologie à la psychodynamique du travail. Paris: Bayard Éditions, 1993.

6 CASTELS M. Trajetórias organizacionais na reestruturação do capitalismo e na transição do industrialismo para o informacionismo, pp. 174-187. In ____ A sociedade em rede. Editora Paz e Terra: São Paulo, 1999.

cooperation strategies to provide guidance on the organizational objectives of work at the health services, which can be more effective than the traditional cost-benefit approach in the search for health sector efficiency.^{7 8 9}

The incidence of cases of abuse and violence in the workplace is on the rise involving workers who put their personal dignity and self-esteem at risk. Such events have direct repercussions on the quality of care provided. In this regard, since 1993 the International Council of Nurses has identified an increased risk of violence in the health care setting, pointing out the negative impact such incidents have on the professional and personal lives of workers.¹⁰

In a recent article,¹¹ in Jamaica, workplace violence is cited as an occupational risk which, according to the authors, deserves attention from the health sector. According to the results of a cross-section study supported by a self-administered questionnaire, targeting different establishments-specialized, third-level, secondary, and general hospitals, and health centers-both in urban and rural areas, the prevalence of psychological violence was found to be greater than physical violence. Moreover, the study pointed to differences by the type of job and age of worker, work schedule, and type of care provided.

Table I summarizes the reasons health workers should be

7 JOHNSON, J.F. et al. *The psychosocial work environment of physicians. Journal Occupational of Environmental Medicine*; v. 37, n. 9, p.1151-1159, 1995.

8 HAM, C. *Improving the performance of health services: the role of clinical leadership. Lancet*; v. 363: p. 1978-1980, 2003.

9 ARNETZ, B.B. *Psychosocial challenges facing physicians of today. Social Science & Medicine*; v. 52: p. 203-213, 2001.

10 CONSEJO INTERNACIONAL DE ENFERMERAS (CIE). *Directrices para hacer frente a la violencia en el lugar de trabajo. Ginebra, Suiza, 1998. Disponible em: http://www.icn.ch/guide_violencesp.pdf.*

11 JACKSON, M., ASHLEY, D. *Physical and psychological violence in Jamaica's health sector. Rev Panam Salud Publica/Pan Am J Public Health*, v.18, n.2, p. 114-121, 2005.

the target of integrating policies in the context of the Millennium Development Goals.

TABLE I
MAIN ARGUMENTS IN DEFENSE OF A WORK PLAN FOR
CONSOLIDATING THE HEALTH OF HEALTH WORKERS (CST/SAÚDE)

1. Deindustrialization is a consolidated trend in world production and occurs in parallel with growth of the services sector, particularly the health sector;
2. Improved health care for the public also represents the demands of society and the commitment of our leaders;
3. Health workers account for a significant segment of the population—on the order of 20 million in Latin America, the Caribbean, and the United States—and make up a representative sample of the disparities in health;
4. The importance of the health sector in absorbing jobs that have been contracted under a variety of different vehicles: service contracting, outsourcing, triangulation, and public bidding.

2. FRAME OF REFERENCE

At the social level, the **Work Plan for Consolidating the Work of Health Workers** (CST/Saúde) aligns with those principles seeking to improve the living conditions of the most disadvantaged segments of the countries under the United Nations system.¹² It bears mentioning that the content related to health problems is found in its three goals and eight targets, which comprise the set of eight Millennium Development Goals (MDGs) and 18 quantifiable targets, which were prepared and adopted by the representatives of 189 countries meeting at the 2000 Millennium Summit. It is clear that the content of the Millennium Declaration is directly related to improving the health of the general population, yet it also touches on specific health issues such as diseases requiring mandatory notification, access to drugs, reproductive health, and potable water. It is estimated that the Plan will take ten years to implement.

The serendipitous prominence of human resources in health on the national, regional, and global

agendas marked the initiative of a decade of sustainable investment with a view to building human capital for health systems.

The plan for a global agenda features, *inter alia*: 1) a World Bank/WHO high level forum: the Millennium Development Goals (MDGs) and human resources which generated a proposal for a global platform, with notable concern for Africa; 2) WHO initiatives such as: *The World Health Report 2006*, commemoration of World Health Day: “Working Together for Health” 7 April 2006, and the idea of “A Decade in Human Resources for Health.”

In the Region, PAHO has a long history of accumulating knowledge in the field of human resources through initiatives that promote cooperation between countries; for example, over the past five years, a number of projects have reinforced human resources in health as a central topic, including: 1) a 2001 Resolution urging the development and strengthening of human resources management in the health sector, 2) a 2004

Resolution on observatories of human resources in health, 3) Pan American Health Week in April 2006; and 4) The Pan American Decade of Human Resources in Health (2006-2015).

The **Toronto Call to Action for a Decade of Human Resources in Health in the Americas** (2006-2015) is based on the need for sustained investment to address challenges and ensure medium- and long-term results with regard to policies designed to build a complex institutional framework. The Toronto Call echoes the need for an international commitment and the continuity of policies and action plans in keeping with the MDGs (2015).

Worthy of mention is the commemoration of World Health Day in April 2006. This year’s theme is human resources in health, promoting a shift in the paradigm geared toward the formulation of sector policies. Promoting CST/Saúde on World Health Day is a strategy in keeping with the decision of the Directing Council. In this regard, since the 1990s, human resources policies in health have sought, to introduce, *inter alia*, new methods for managing work based on incentives for productivity and quality,¹³ whose effects on workers in certain

¹² NACIONES UNIDAS. *Objetivos de desarrollo del milenio. Una mirada desde América latina y el Caribe*. Santiago del Chile, agosto del 2005.

¹³ BRASIL. Ministério da Saúde. *Secretaria de Projetos Especiais de Saúde. Coordenação Geral de Desenvolvimento de Recursos Humanos para o SUS. Agenda de prioridades para a política de recursos humanos na gestão do SUS*. Brasília: Ministério da Saúde, 1997. 11 p.

situations-although yet to be fully studied-have had a negative impact on their health, as we will see further on.

This agenda provides an excellent opportunity to call attention to the problem of subjectivity in health work. If the resource in question is a human being, it is better to give thought to the human dimensions and demands implicit in that resource, which may favor less superficial approaches to quality-related problems in the health care of the population.

However, at the political level it is important to point out the strategic alliance between the Organization of American States (OAS) and PAHO. Since the 2001 Summit of the Americas (Quebec), the representatives of states and governments in all the countries have recognized that work is the best means for linking economic activity to a better quality of life for citizens.¹⁴

In this same regard, PAHO, encouraged by the support of the Ministers of Labor of 34 OAS member countries, incorporated the topic of worker health as set out in the ILO's definition of "decent work" and the "Healthy Work Environments" initiative of WHO/PAHO,¹⁵ with emphasis on proactive actions targeting the following populations: immigrants, child laborers, working women, persons with physical disabilities, elderly workers, indigenous peoples, and people living with HIV/AIDS. Accordingly, "decent work" will become the foundation of global, national, and local strategies to achieve equitable, global, and sustainable development.¹⁶

At the political level, the Regional Plan on Workers' Health stems from the decision of the 45th Directing Council which, in response to the recommendations of the Report of the XIII Inter-American Conference of Ministers of Labor, decided to coordinate activities in the labor,

environment, and education sectors, with a view to improving working and employment conditions, especially in the health sector.¹⁷

The strategy to promote the health of health workers and its intersectoral approach, as approved by the 45th Directing Council, may encourage the development of public policies that can produce quality of life. With regard to the common objectives inherent in an intersectoral approach, this Plan seeks to build a strategic core to carry out planning and define priority areas for joint action, to be achieved by including health within policies at the macro and/or sector level. This represents a change of course with respect to the current situation in which health goals take a back seat to defining the directives and priorities of development plans.¹⁸

In view of all of the above, in 2005 PAHO developed a manual entitled "Health and Safety of Health Sector Workers" [*Salud y Seguridad de los Trabajadores del Sector Salud*] for health system managers and administrators and for the health services. The manual provides information on the basic operational concepts regarding the health and safety of work performed at health

14 OPS – ORGANIZACIÓN PANAMERICANA DE LA SALUD. *Informe sobre la salud y la seguridad en el trabajo en la región de las Américas: Alianza estratégica entre los ministros de trabajo y de salud*. Bogotá, julio de 2004, 20 p.

15 OPS – ORGANIZACIÓN PANAMERICANA DE LA SALUD. *Informe sobre la salud y la seguridad en el trabajo en la región de las Américas: Alianza estratégica entre los ministros de trabajo y de salud*. Bogotá, julio de 2004, 20 p.

16 OIT – ORGANIZACIÓN INTERNACIONAL DEL TRABAJO. *El trabajo decente es fundamental para el progreso social*. Disponible em: <http://www.ilo.org/public/spanish/decent.htm>.

17 OPS – ORGANIZACIÓN PANAMERICANA DE LA SALUD. *45° Consejo Directivo. Decisión propuesta por el Relator*. Washington, D.C., EUA 27 de septiembre-1 de octubre 2004.

18 *ibdem*.

establishments and presents the most common occupational risks gleaned from health sector studies (private and public). Finally, the manual furnishes some practical guidelines and instruments for implementing occupational health and safety programs. It can be used to plan workshops for policy development, to identify and prevent the symptoms of occupational health problems (or stop them from becoming worse), or as a means to carry out targeted interventions aimed at correcting precarious conditions in the health sector.

There was consensus among the participants at the Ouro Preto Workshop regarding the importance of having a health workforce free of occupational risks as a key element of sustainable development. Moreover, it is also clear that health system performance—especially with regard to the quality of care provided to patients—is closely related to occupational health and safety conditions under which its workers perform their jobs.

The issue of health worker vulnerability is increasingly evident, given workers' exposure to serious occupational and environmental risks as part of their routine workday. For instance, ever-developing and increasingly

sophisticated technologies place innovative tools in the hands of health workers with no guarantees they will get the necessary training to use them safely. As a consequence, workers are exposed to new occupational risks that need to be addressed, controlled, and/or eliminated. Well-known risks associated with biological agents such as AIDS and hepatitis B, physical risks associated with radiation and ergonomic disorders, and chemical risks inherent in the use of anesthetics and sterilizing agents, continue to pose a high level of risk to health workers.

Health sector reform, the outsourcing of support services, and the loss of valuable professionals who make the decision to emigrate for a better future are just a few of the factors contributing to new psychosocial risks. Moreover, risks due to improper management of hospital waste or the effect on health attributable to poorly maintained work facilities and infrastructure are another category of risks constantly faced by health workers.

The Ouro Preto Workshop reaffirms the consensus established previously on the advisability of developing an initiative for the Americas to

include a broad and inclusive platform based on a country-centered approach and specific commitments. The core idea is to facilitate a qualitative leap in the participative development of national action plans and of systems to monitor their progress, and for ensuring accountability at the national and global levels. Also needed are an intensification of technical cooperation among countries with a shared frame of reference, sustained investment, and the creation of national and international partnerships.

The strategy of the **Work Plan for Consolidating Health Worker Health** seeks to promote a setting to facilitate the sharing of power, as well as the meshing of interests, knowledge, and practices of the different organizational actors, with a view to generating knowledge and developing policies for solving problems.

3.1 Health Workers

Health workers are directly involved in health actions with system users and with those who provide clinical/care management support, regardless of the type of contract or employment relationship, both in the public and private sectors. These workers may have jobs as managers, as direct caregivers to affected patients, or as part of health promotion programs, but may also work in the areas of diagnostic support or therapy, or in the management or production of technology.

The paradigm shift of the health-disease-care process supports national policies that affect employment and labor, without either of these spheres having been the focus of government action.

The recent global transformations of capitalist production are also at work in the health sector, which, much in the same way as other productive sectors, has experienced not only the effects of advancements in science and technology, but also the exacerbation of disparities and social injustice afflicting the countries of Latin America and the Caribbean.

3.2 Working Conditions in the Health Field

Working conditions is a term used to designate the health and work levels depicted in Figure 1, which regard the circumstances under which workers perform their tasks and how they are able to meet the demands of their job.

Table II presents the current trends in the structure of work (Table II), according to Antunes and Alves,¹⁹ followed by the changes these trends caused in work activities (Table III).²⁰

19 ANTUNES, R.; ALVES, G. *As mutações no mundo do trabalho na era da mundialização do capital. Educação e Sociedade*, vol.25, n.87, p.335-351, 2004.

20 ASSUNÇÃO, A.A. *Uma contribuição ao debate sobre as relações saúde e trabalho. Ciência & Saúde Coletiva*, v.8, n.4, p.1005 – 1028, 2003.

TABLE II

CURRENT TRENDS IN THE STRUCTURE OF WORK AND ABSORPTION OF THE WORKFORCE

1. Reduction of the industrial proletariat of specialized workers in the manufacturing applications of traditional industries—the legacy of the vertical integration model pioneered by Taylor and Ford;
2. Worldwide emergence of the new manufacturing and service proletariat, working in different modalities of precarious labor. Their ranks include, *inter alia*, the outsourced, subcontractors, and part-time employees, and are expanding on a global scale;
3. Significant increase in the numbers of female workers, accounting for more than 40% of the workforce in a number of advanced countries, and that has been absorbed by capital, preferably in the universe of part-time, precarious, and unregulated work;
4. Exclusion from the job market of young people of working age and who, without employment prospects, find themselves swelling the ranks of precarious workers or the unemployed, with no job prospects, given the current structural unemployment in society;
5. Exclusion of workers around the age of 40 considered “too old” for work, who, once excluded from jobs, have a hard time reentering the job market;
6. Growing expansion of “third sector work,” assuming a type of alternative employment through community-based companies, predominantly motivated by forms of volunteer work, and embarking on an ample array of activities;
7. Expansion of home-based work.

TABLE III

HYPOTHESES ON THE RELATIONSHIP BETWEEN CHANGES IN WORK ACTIVITIES AND HEALTH PROBLEMS

1. Exposure to harmful conditions on the job follows the same discriminatory logic as hiring workers who put down women, blacks, the illiterate, immigrants, young people with no experience, and elderly persons who do not have the physical strength to do the job;
2. Prospects for employment, labor contracts, salaries, and professional mobility depend on the characteristics of the workers, but these are also determined in the social sphere;
3. The signs that health has been altered within society can be seen both in theory and in practice—the result of the inequitable distribution of goods produced, the acquisition of stores of knowledge and of mistakes, the possibilities of gaining dominion over territories and behaviors, and the constant clash of conflicts;
4. The health of workers was altered by the restructuring of production attributable to the social, political, and economic climate in the wake of the crises of the 1960s and 70s.

Serving the user is a social activity of mediation, involving the interaction of different actors in a specific context for the purpose of responding to different needs. The task of the health worker is the product of a multi-faceted process that takes place

against an institutional backdrop, where objectives, organization processes, and existing structure are essential elements that set the stage for attending users.²¹

The “invisibility” in terms of managing of the system’s work,

guidance on safety policies, and promotion of working conditions, indicate an absence of acknowledging investments in human resources. In the psychodynamic theory of work, this concerns acknowledging the value of work performed, which is

²¹ FERREIRA, M.C. *Serviço de atendimento ao público: o que é? Como analisá-lo? Esboço de uma abordagem teórico-metodológica em ergonomia. IX Congresso da Associação Brasileira de Ergonomia – ABERGO 99, Salvador, 3 a 6 de novembro [CD-ROM], 1999.*

achieved through the mediation of two types of judgments. The first is judging the beauty of the work, which is made by those who understand the job and can evaluate it on the basis of its conformity to rules of art and in terms of its originality. The second is judging its usefulness, which evaluates the objectives achieved with no regard for the means used to achieve them. In the case of health work, it is the user who makes the judgment based on: the guarantee of his access to customer service and on the methods of diagnosis and treatment; his clinical improvement; the remission of symptoms. After all, the job is “to examine,” “to treat,” and “to cure.”²² So when do users react and express their dissatisfaction with the failure of the aforementioned objectives?

In a nutshell, the work of health professionals is a negotiation between the aims of the health

system and the demands of users, which are not always compatible with one another. The experiences of providing or managing care are not unscathed by the psychological economy, as one is pitted against the other, and this other finds itself in a unique situation.

Extrapolating from the traditional health indicators (useful but insufficient when considering the changes in employment and labor witnessed over the last 30 years), studies evidence exposure to multiple risk factors and construct hypotheses on the interaction among these factors, which require the development of new indicators²³ and necessitate a multidisciplinary, intersectoral approach.²⁴

22 MELO, E.M. *O pediatra e o trabalho em plantões de urgência: um estudo das tarefas e dificuldades vivenciadas pelos pediatras em um serviço de urgência*. Tese de Doutorado. Programa de Pós-Graduação em Saúde da Criança e do Adolescente. Universidade Federal de Minas Gerais, 2006.

23 OPS – ORGANIZACIÓN PANAMERICANA DE LA SALUD. *Fichas técnicas de indicadores de salud de los trabajadores para América Latina y Caribe*. Área de Desarrollo Sostenible y Salud Ambiental. (en fase de preparación).

24 TEIXEIRA, C.F.; PAIM, J.S. *Planejamento e programação de ações intersetoriais para a promoção da saúde e da qualidade de vida*, pp. 59-78. In: C.F. TEIXEIRA, J.S. PAIM & A.L. VILASBÓAS (orgs.). *Promoção e vigilância da saúde*. Ed. Cooptec/ISC, Salvador, 2002

4. CURRENT SITUATION

4.1 The Contradictory Forces of Sectoral Reform

The health systems of today must contend with contradictory forces at the local and transnational levels. At the local level, communities are demanding that governments make good on their stated guarantees of the right to health for all. Regionally, some areas of tension are observed between conservative health care projects, which favor the small-scale health provider and defend the interests of a fraction of health system actors and their private health establishments, and socially-based political projects for workers and health services.

At the transnational level, new forms of regulatory control implemented via state policies in a number of countries coexist with market competition and sophisticated technologies that encourage—and indeed have been encouraged—by capital accumulations in the sector—i.e., medical equipment and supplies, drugs, and techniques used to diagnose illness. Simultaneously,

the increasing uniformity of curriculums facilitates professional mobility between countries. On the one hand, this fact strengthens the dissemination of diagnostic procedures, but on the other, it opens the door for precarious working conditions—i.e. physician migration.

These areas of tension collide and are reflected in different health sector reforms, which can be contradictory in themselves. Such contradictions include: equal access and competition in the market for the supply of services and inputs; professional development of workers and guidelines increasingly bogged down in measures and processes designed to control activities and procedures issued by the State, by labor unions, and by corporations; new demands for purchasing advanced technology for diagnostic and treatment applications in the face of budgetary restrictions; and emphasizing quality within an approach that is eminently qualitative with respect to the evaluation of results.

The implementation of the reforms and the growth of the sector explain the changes in the composition of the workforce and in the processes of professional development and regulation. Disparities abound in the rules governing the hiring and remuneration of workers, which follow the reasoning described by Zarifian^{25 26} in his analysis of the work in the services sector—namely to ensure that demands are met that were not taken into account when planning goals and the methods for managing the workforce.

The manner in which health sector reforms are implemented is unique to each country. However, according to data from the observatories for human resources, health services are concentrated in the major cities, leaving rural areas isolated or without coverage. The phenomenon of public safety has had the effect of emptying those health centers located on the outskirts of urban areas, which must also endure shortages of water, electric power, and lack professional staff on hand during operating hours to ensure that users are attended. Incentives for professional development are weak. In fact, health workers in some countries are left to foot the bill for their own ongoing professional development.

26 ZARIFIAN, P. Valor, organização e competência na produção de serviço. Esboço de um modelo de produção de serviço. In SALERNO, M. S. (org.) *Relação de Serviço- produção e avaliação*, São Paulo: Ed Senac, 2001a, p. 95-149.

27 ZARIFIAN, P. *Mutação dos sistemas produtivos e competências profissionais: a produção industrial de serviço*. In SALERNO, M. S. (org.) *Relação de Serviço- produção e avaliação*, São Paulo: Ed Senac, 2001b, p. 67-93.

4.2 “Flexibilization” and Precariousness of Work and Employment in Health

Not only do companies undergo restructuring by arriving at a consensus, but also as the result of social conflict over the traditional methods of organizing work and production.

The greater integration and flexibility of companies has emerged as a way of responding to the social crisis and increasing productivity in an unstable market. The features of this process profoundly affect work and its social expression: employment.

In the current context of ongoing economic crises, the “flexibilization” of work has emerged as the only strategy companies have to guarantee their future, and this also includes health establishments. The changes stemming from the overhaul of the productive sectors have brought a new flexibility to the labor market, where we observe changes in the job relationship, a modification of labor unions, and the externalization of risks

for companies that hire the new salaried workers.

In order to keep their jobs, health workers submit to the flexibility of the workforce and to the flexibility attributable to changes in the productive sectors. In turn, this generates a state of precariousness between work and employment, manifesting in movement from one sphere to another affecting different levels as illustrated in Figure 2. This is transversal, precarious movement—constant movement from one sphere to another, touching on a continuum of different contracts, different types of unemployment, management models, the organization of work, and exposure to environmental risks.

Employment, following the restructuring of the productive

sectors, becomes precarious employment; a continuum between permanent employment and unemployment. In contrast to permanent employment (unlimited duration, full-time, and in service to a single employer), precarious employment is for a finite period and work is performed for one or various employers.

With regard to unemployment, the notion of precariousness is defined as a succession of a number of precarious work engagements (for a person); it concerns an absence of real employment history, personnel files, and a career stream, resulting in a group of workers without jobs.

Between permanent employment and unemployment

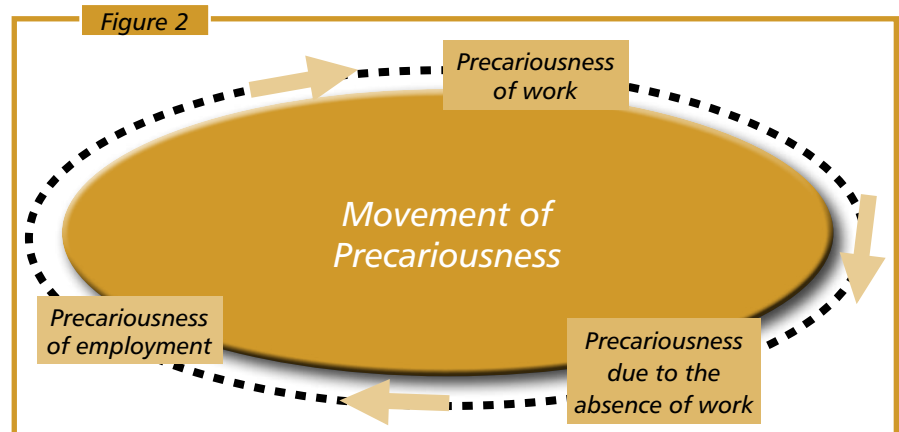


Figure 2. Diagram depicting precarious movement and its two poles: the precariousness of work and the precariousness of employment. (Assunção & Belisário, 2005)²⁷

27 ASSUNÇÃO, A.A.; BELISÁRIO, S.A. (2005). *Precariedade e precarização do trabalho no setor saúde. Projeto do Grupo de Estudos em Gestão do Trabalho e Formação em Saúde. Faculdade de Medicina. UFMG, Belo Horizonte*

one may find work without a contract or work with erratic contracts, such as part-time work on contract, temporary work, and home-based work. (Figure 3).

The proliferation of informal contracts and nonpayment on the part of health sector employers of employee social benefits favors a situation of deregulation, which is literally the absence of rules and regulations, as has been occurred legally in Brazil, through verbal contracts (for community health agents) or irregular arrangements (through cooperatives or for a limited period of time), hiring through offices charged with providing health care services directly to the population.

Outsourcing is one aspect of the flexibilization of the workforce. Although its full dimensions and scope have yet been determined, flexibilization is the starting point of exposure to disease risks, as health workers, in order to compensate for insufficient salaries, take on more than one job. Consequently, they become subject to fatigue, which increases their susceptibility to environmental risks and erodes the quality of care provided.

The expansion of services and increase in contract hiring in the health sector contradicts

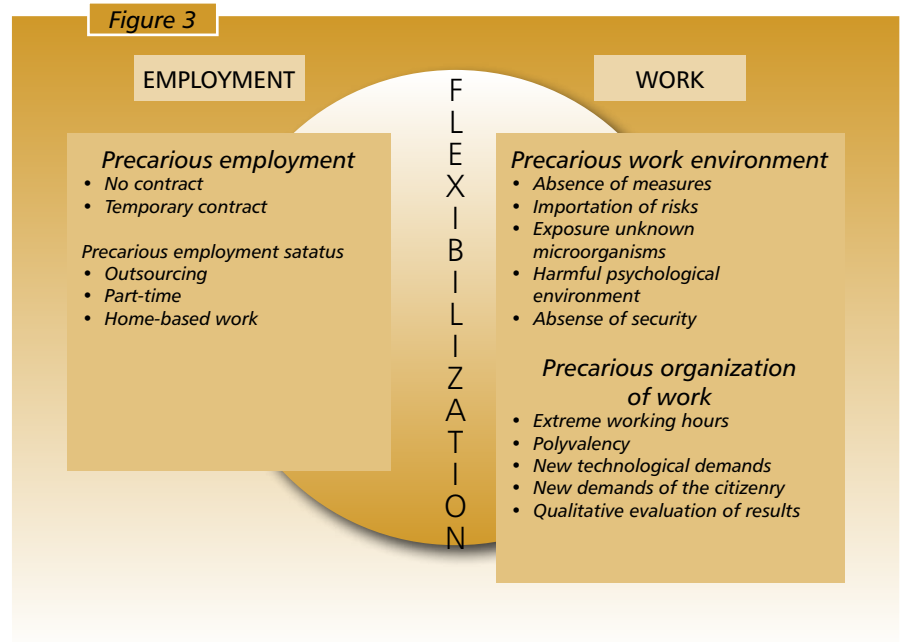


Figure 3 – Diagram depicting the different levels of flexibilization. (Assunção & Belisário, 2005)²⁸

the trend in the labor market while cutting costs and reducing the need for salaried staff. The workforce management techniques reproduce a modern industrial version of the Taylor model, which integrate the total quality goals evaluated in quantitative terms relative to the number of staff and the volume of production.

In the workplace, the reforms bring about the implementation of new care models and encourage the organization of work into teams. Very quickly, under the

paradigm of health promotion and primary care, a new range of required skills guides the definition of tasks.

The workforce management techniques reproduce a modern industrial version of the Taylor model, which integrate goals of overall quality that are in turn evaluated in quantitative terms, relative to the number and volume of production. This gives rise to the paradox between the expansion of the sector, limiting costs, and the quantitative evaluation of results.

29 *Ibidem*

4.3 Institutional Situation

According to the accounts of the representatives of the countries at the Office on Health and Occupational Conditions of Health Sector Workers (CST/Saúde), the health profile of health sector workers, not unlike workers as a whole, is quite deficient. These representatives claim that where information does exist, it is usually data on injuries, specifically data compiled on workplace accidents and disorders. In terms of work activities in particular, there appears to be no institutional efforts to collect data on the different technical and

organizational factors affecting the work environment and safety at health facilities.

Worthy of mention is the fact that despite the precarious state of information, over the past ten years scientific literature has provided the results of studies concerned with issues of interest to CST/Saúde. It has furnished a wealth of different information, providing results indicating a low prevalence of immunization among health workers, a high prevalence of job-related musculoskeletal problems among certain groups of workers, and mental disorders associated with health work, with emphasis on having experienced incidents of violence.



Therefore, there is an enormous gap created by the absence of an information system on health workers' health and the scientific knowledge accumulated thus far.

The amount and quality of the information collected nationally on CST/Saúde reflect the fact that the available data on occupational accidents and disorders are insufficient, as this type of data are only beginning to be collected. Health data captured in the public sector is even less than that collected in the private sector. In addition to the scarcity of data, the information that is available does not take some basic aspects into account; for instance, whether the reason a health worker sought care was due to a workplace accident or some other kind of occupational problem.

The lack of integration between the local and central health systems poses challenges to the collection of data on the health workforce, which, in most countries, is linked to the municipalities. In other words, management deficiencies in hierarchical, decentralized systems have negative repercussions on the capacity of national institutions to perform their regulatory and oversight functions, as is true of the Ministries of Health.

TABLE IV
PROPOSALS FOR ACTION TO IMPROVE INSTITUTIONAL CAPACITY
AT THE COUNTRY LEVEL TO FIGHT AGAINST CST/SAÚDE

1. Elaborate an institutional survey to assess the current situation in each country, owing to the different complexities of each health system at the different stages of health system development;
2. Improve data production and collection instruments at the municipal level, and integrate this data in a national and regional database;
3. Cultivate political and other arrangements to link actions at the municipal, state, national, and regional levels within a climate of political will and networking;
4. Expand the number of forums for worker participation through organizations representing: professional organizations, trade associations, unions, professional schools, and health and safety committees;
5. Ensure more effective participation of the Ministries of Health and Labor in coordinating efforts to develop, implement, and oversee public policies, and to identify the pertinent indicators to be observed;
6. Develop strategies to facilitate the use and improvement of existing data production and collection processes.

Another aspect that influences the quantity of data collected concerns the fact that workers eventually resort to care at health establishments or social centers that, while welcoming, are less accustomed to following the formal aspects of registering the care they administer. Another distortion of the system concerns informal care that workers receive in their own workplace establishments, which are not recorded or reported.

From a qualitative perspective, the difficulties are due to the fact that no specific classification system has been

developed to facilitate even a basic categorization of the health problems for which health worker seek treatment. In this regard, there is a disconnect between the goals that motivated the creation of the current processes for registering information on the operation and management of health systems, and the level of detail required to produce information and develop indicators to improve the management of CST/Saúde.

The purpose for promoting public policies whose aim is to intentionally change working conditions in the health sector get bogged down in the challenge

of preparing a conceptual framework that can facilitate consensus building on issues such as the flexibilization of work and the precariousness of employment. What does the term *working conditions* refer to? Who are the workers of the health sector? What is meant when we speak of entering the *work environment*? Accordingly, changing concepts such as these require ample debate if we are to strengthen their definitions.

Meanwhile, there is consensus among the participants at the Office that the approach of the CST/Saúde cannot be

TABLE V
MAIN RESULTS EXPECTED FROM INSTITUTIONAL ACTIONS

1. Cultivate labor relations between workers and health organizations that promote healthy work environments and encourage commitment to the institutional mission of providing quality health services for the entire population;
2. Develop mechanisms of interaction between training institutions and the health services which facilitate the adaptation of training to a model of equitable, quality, and universal health care, serving the health needs of the population.

disassociated from the global analysis of and intervention in health systems and services. When discussing exposure to the *risk of accidents* it is necessary to consider, for example, the workers *bond of employment* with the institution, because they are related categories that lose their meaning if looked at in isolation. In other words, the proposal of public policies, from a preventive standpoint, speaks to the need to define concepts and to identify indicators. This involves a perspective that seeks to define the relevant agents and their respective institutional responsibilities with the Ministries of Health and Labor at the national level, and with WHO and the ILO at the regional level.



- Human resources are the foundation of the health system.
- Work in health is a public service and a social responsibility.
- Health workers play the leading role in their development.
- The problems and development of human resources are primarily a matter of citizen interest and as such they have the right to participate in the development of such policies.
- The health conditions of health workers are a relevant topic for the decade of human resources in health.
- The analysis of the problems of coordinated action and synergy with the countries and the cooperation agencies for the development of 10-year human resources plans to include the health and safety of health workers.
- Mobilization of resolve and resources for the sustainability of human resources management processes and for the health and safety of health workers.
- Expansion of the cognitive basis and skills of health administrators in order to manage the health of health workers.
- Effective application of a multidisciplinary and intersectoral approach through strategic partnerships (health/labor/education/environment) adopted at the IV Summit of the Americas.
- Support development and the sharing of experiences on the creation of mechanisms for financing, for ending flexibilization, and for developing working conditions in health from the standpoint of productivity and quality of health services.

6. THE WORK PLAN

AREAS OF INTERVENTION	KEY ACTIVITIES	SPECIFIC ACTIVITIES	TIMEFRAME	RESOURCES/COSTS
Support for the development of intersectoral public policies for improving the health and working conditions of health workers.	Development of opportunities for coordinated action	■ Preparation of a document containing guidelines and principles (position papers) as a foundation for embarking on coordinated action at the national and regional levels (forums, workshops, opportunities for national and inter-country coordination activities).	April 2006	PAHO/WHO NESCON SEGETES
		■ Preparation of awareness-building materials for different actors on the situation of workers and their relationship to the quality of services. Includes the identification of actors at the national and regional levels in the areas of health and labor.	April/ December 2006	PAHO/WHO NESCON SEGETES
	Preparation of position papers	■ Joint Health and Labor Forum (SGT 10 and 11) within MERCOSUR.	June 2006	PAHO/WHO SEGETES Countries of the Region
		■ Workshop to develop and prepare a brochure of unacceptable work in the health field.	July 2006	PAHO/WHO Countries of the Region
		■ Regional and national to conduct situation analysis and make decisions (add this topic to regional and interagency agendas, including the Meeting of the Observatory to be held in Lima, Peru, in October).	April 2006 thru May 2007	PAHO/WHO SEGETES Countries of the Region
		■ Prepare regional and national documents of situation analysis and proposed actions.	April 2006 May 2007	PAHO/WHO SEGETES Countries of the Region
		■ Preparation of a chapter on health conditions of health workers at the national observatories on human resources in health	April 2006 December 2007	PAHO/WHO NESCON Countries of the Region
		■ Support for and formulation of national and regional policies to address specific health problems of health workers.	April 2006 December 2007	PAHO/WHO NESCON Countries of the Region

AREAS OF INTERVENTION	KEY ACTIVITIES	SPECIFIC ACTIVITIES	TIMEFRAME	RESOURCES/ COSTS
Analyze and strengthen institutional capacity to address the work and health situation of health workers.	Preparation of rules, regulations and procedures.	■ Analysis of the existing content of programs of study of priority health professions on the topic of health worker health.	April 2006 December 2007	PAHO/WHO NESCON Countries of the Region
		■ Advocacy for the hiring of specialized personal specializing in the health of health workers.	April 2006 December 2007	PAHO/WHO
	Training	■ Development of directives (rules, guidelines and orientations) for establishing work processes of health workers.	April 2006 December 2007	PAHO/WHO NESCON Countries of the Region
		■ Establishment of quality assurance processes with regard to the quality of working and health conditions of health workers (create opportunities to study and modify existing regulatory frameworks).	April 2006 December 2007	PAHO/WHO NESCON Countries of the Region
		■ Develop and utilize instruments to create healthy work environments.	April 2006 December 2007	PAHO/WHO NESCON Countries of the Region
		■ Training with existing educational materials for health sector managers and workers.	April 2006 December 2007	PAHO/WHO NESCON Countries of the Region

AREAS OF INTERVENTION	KEY ACTIVITIES	SPECIFIC ACTIVITIES	TIMEFRAME	RESOURCES/COSTS
Analyze the determinants of the work and health situation of health workers.	Prepare protocols and multicentric research projects.	■ Create a technical conceptualization group (with professionals from different levels, including academicians, health service professionals and managers) in order to develop the dimensions, categories, indicators of the CST and for the quality of and satisfaction with health care.	April/ December 2006	PAHO/WHO NESCON SEGETES Countries of the Region
		■ Expansion/creation of a set of basic data and indicators, based on that prepared by the Human Resources Observatory.	April/ December 2006	PAHO/WHO NESCON SEGETES Countries of the Region
	Establish a set of basic data.	□ Prepare an inventory in each country of the existing data on the health of health workers with a view to subsequently proposing some common regional indicators.		
		□ Define the purpose for collecting data and the process through which it will be used, and decision-making based on that data.		
		□ Based on existing information, systematize a set of basic common data.		
		□ Based on existing information, generate situation indicators on the health of health workers.		
		■ Analysis of existing studies relevant to the indicators used.	April/ December 2006	PAHO/WHO NESCON SEGETES Countries of the Region
	■ Promotion of in-depth studies (multicentric) using as a basis the health manual for health workers.	April/ December 2006	PAHO/WHO NESCON SEGETES Countries of the Region	

AREAS OF INTERVENTION	KEY ACTIVITIES	SPECIFIC ACTIVITIES	TIMEFRAME	RESOURCES/ COSTS
Develop indicators to monitor and evaluate the work and health situation of health workers.	Formation of networks.	<ul style="list-style-type: none"> ■ Promotion of virtual opportunities for the exchange of information and experiences (virtual forums, virtual library, video conferences, Workers Health Network [<i>Red de Salud de los Trabajadores</i>]). 	April/ December 2006	PAHO/WHO NESCON SEGETES Countries of the Region
		<ul style="list-style-type: none"> ■ Sharing of experiences and best practices at the national and regional levels. Development of an ongoing strategy for situation analysis and for implementing the plan in the different decision-making spheres, with a view to making the necessary adjustments. 	April 2006 December 2007	PAHO/WHO NESCON SEGETES Countries of the Region
	Intercambio de experiencias y buenas prácticas en el ámbito nacional y regional	<ul style="list-style-type: none"> ■ Execution of workshops on evaluating results and defining new activities. 	April 2006 December 2007	PAHO/WHO NESCON SEGETES Countries of the Region
		<ul style="list-style-type: none"> □ National level □ Regional level 		
		<ul style="list-style-type: none"> ■ Sharing of inter-country monitoring and evaluation experiences. 	April 2006 December 2007	PAHO/WHO NESCON SEGETES Countries of the Region

ABREVIATURAS

- CGVAM** - Coordenação Geral de Vigilância Ambiental em Saúde
- DEGERTS** - Departamento de Gestão e da Regulação do Trabalho em Saúde
- HC** - Health Canada
- MS** - Ministério da Saúde
- MT** - Ministério do Trabalho
- NESCON** - Núcleo de Educação em Saúde Coletiva
- OEA** - Organização dos Estados Americanos
- OIT** - Organização Internacional do Trabalho
- CST** - Condições de Saúde do Trabalho
- OMS** - Organización Mundial de la Salud
- OPS** - Organización Panamericana de la Salud
- PNH** - Política Nacional de Humanização
- PMOP** - Prefeitura Municipal de Ouro Preto
- SGTES** - Secretaria de Gestão do Trabalho e da Educação na Saúde
- SMSOP** - Secretaria Municipal da Saúde de Ouro Preto - Brasil
- UCR** - Universidade da Costa Rica
- UFMG** - Universidade Federal de Minas Gerais
- UFRJ** - Universidade Federal do Rio de Janeiro

Sunday 1/22/06	Inauguration
20:00	<p>José Saraiva Felipe (MS – Brazil) Ângelo Oswaldo de Araújo Santos (PMOP – Brazil) Ariosvaldo Figueiredo Santos (SMSOP – Brazil) Francisco Campos (SGTES/MS – Brazil) Luiz Galvão (PAHO – United States) Ronaldo Penna (Office of the Vice-Chancellor/UFMG – Brazil) Soraya Almeida Belisário (NESCON/UFMG – Brazil)</p>
21:00	Reception
Monday 1/23/06	Topic 1. Proposal for a conceptual framework and situation analysis on information and institutional capacity.
9:00	<p>Frame of Reference and Workshop Objectives Pedro Brito (PAHO – United States)</p>
9:30	<p>Presentation of a proposal for a conceptual and operational framework for addressing health problems of health workers</p> <p>Ada Ávila Assunção (NESCON/UFMG – Brazil)</p> <p>Panelists Francisco Campos (SGTES/MS – Brazil) Luiz Galvão (PAHO – United States) Charles Godue (PAHO – United States) Gerry Eijkemans (WHO – Sweden) Maria Helena Machado (MS – Brazil)</p>
11:00	Coffee Break
11:30	Debate
12:30	Lunch
14:00	<p>Group Break Out Session Analysis of the situation of information and institutional capacity (Work Guide 1)</p>
16:00	Coffee Break
16:30	<p>Group Presentations Presenters: José Manuel Valverde Rojas (UCR – Costa Rica) – Group 1 Emilio Ramírez (MS – Chile) – Group 2</p>
18:00	Close of Work

Tuesday 1/24/06	Topic 2. World Health Day and Forum on Decent Work in Health
9:00	<p>Call to action for a decade in human resources in health and its development from the standpoint of health conditions of health workers. Charles Godue (PAHO – United States)</p>
9:30	<p>Analysis of the frame of reference and objectives of the activity on Health Conditions of Health Workers in the Context of World Health Day, Pan American Health Week. Charles Godue (PAHO – United States) Luiz Galvão (PAHO– United States) Carlos Rosales (PAHO – United States)</p>
10: 30	Coffee Break
11:00	Debate
12:30	Summation
13:00	Lunch
14:00	<p>Analysis of the frame of reference and objectives of the Forum on Decent Work (PAHO/ILO/Ministries of Health and Labor) in the Context of World Health Day, Pan American Health Week. Marta Novick (MT – Argentina)</p>
16:00	Coffee Break
16:30	<p>Health Situation of Health Workers: The Canadian Experience (Part I) Sandra MacDonalds Rencs (HC – Canadá)</p>
18:00	Close of Work

Wednesday 1/25/06

Topic 3. Institutional Strengthening, Technical Cooperation, and Indicators in CST/Saúde

9:00 **Health Situation of Health Workers: The Canadian Experience (Part II)**
Sandra MacDonalds Rencs (HC – Canada)

10:30 Coffee Break

11:00 Group Break Out Session
Presentation on the work proposal for the development of activities (Work Guide 2)
Carlos Rosales (OPS – United States)

12:30 Lunch

14:00 Group Break Out Session

18:00 Close of Work

Thursday 1/26/06**Topic 4. Operationalization of Activities and Data Collection**

9:00

Group Presentations

Presenters:

José Manuel Valverde Rojas (UCR – Costa Rica) – Grupo 1

Diego González Machín (PAHO – Brazil) – Grupo 2

10:30

Coffee Break

11:00

Summary of Workshop Projects

Carlos Rosales (PAHO – United States)

Charles Godue (PAHO – United States)

12:30

Lunch

14:00

Preparation of the Work Plan

Ada Ávila Assunção (NESCON/UFGM – Brazil)

Carlos Rosales (PAHO – United States)

Gerry Eijkemans (WHO – Sweden)

Soraya Almeida Belisário (NESCON/UFGM – Brazil)

18:00

Close of Work

Friday 1/27/06**9:00****Preparation of Work Plan – Continued**

ANNEX 2. LIST OF TALLER PARTICIPANTS

Ada Ávila Assunção (NESCON/UFGM – Brazil)
 Anamaria Testa Tambellini (UFRJ/CGVAM/MS – Brazil)
 Antônio Carlos Ribeiro Filho (MT – Brazil)
 Carlos Rosales (PAHO – United States)
 Charles Godue (PAHO – United States)
 Ciro Echegaray (MS – Peru)
 Cristina Boaretto (MS – Brazil)
 Diego González Machin (PAHO – Brazil)
 Emilio Ramirez (MS – Chile)
 Francisco Campos (SGTES/MS – Brazil)
 Gerry Eijkemans (WHO – Sweden)
 Henrique A. Vitalino (DEGERTS/MS – Brazil)
 José Manuel Valverde Rojís (UCR – Costa Rica)
 José Paranaguá de Santana (PAHO – Brazil)
 José Saraiva Felipe (MS – Brazil)
 Luiz Galvão (PAHO – United States)
 Maria Helena Machado (MS – Brazil)
 Marta Novick (MT – Argentina)
 Pedro Brito (PAHO – United States)
 Ricardo Augusto Alves de Carvalho (NESTH/UFGM – Brazil)
 Ronaldo Pena (Office of the Vice-Chancellor/UFGM – Brazil)
 Sandra MacDonalds Rencs (HC – Canada)
 Serafim Barbosa Santos Filho (PNH/MS – Brazil)
 Soraya Almeida Belisário (NESCON/UFGM – Brazil)
 Valéria Cristina Aguiar (COSAT/MS – Brazil)
 Zaíra G. A. Botelho (DEGERTS/SGTES/MS – Brazil)

Coordination:

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 Ada Ávila Assunção (NESCON/UFGM – Brazil) Carlos Rosales (PAHO – United States)

Technical Coordination:

Mariana Lelis (NESCON/UFGM – Brazil)

