

One of the reasons why the environmental issue has become a priority for almost all the countries is the implication of its illness load generated by environment factors, concentrated in turn in the most vulnerable populations. It is estimated that 24% of world morbidity and 23% of all deaths can be attributed to environmental factors. In children from 0 to 14 years old the percentage of deaths that could be attributed to environment was 36% (Prüss-Üstin & Corvalán, 2006).

Among the illnesses with the highest absolute attributable load to modifiable factors are diarrhea, lower respiratory infections, accidental injuries and malaria. In the case of intense diarrheic illness, its morbidity load is associated in approximately 94% to environmental factors such as the consumption of non-potable water, and insufficient sanitation and hygiene (Prüss-Üstin & Corvalán, 2006). Similar patterns of children morbidity and potable water and sanitation coverage are found, being an important indicator in environmental health in general (Organización Panamericana de la Salud, 2000).

When comparing the morbidity patterns and death related to the environment in different countries, meaningful differences are observed according to the development level of the population where the exposition takes place. The evidence shows that while mortality for diseases related to environmental issues in developing countries was 25%, in the developed countries mortality for that same cause was 17%. Likewise, when comparing the lost years of life per inhabitant due to environmental factors, we find this indicator is 15 times higher in developing countries. 120% more for diarrheic diseases and 150% more due to lower respiratory illnesses is noted (Prüss-Üstin & Corvalán, 2006) (Prüss-Üstin & Corvalán, 2006).

This outlook has once again set the need to articulate policies, plans and programs of *Health and*

Environment sectors in many countries around the world, in an area of transdisciplinary knowledge known as ENVIRONMENTAL HEALTH.

In Colombia some contradictory events have occurred. While in the 70s y 80s the health sector was in charge of many environmental management and control programs due to Act 09, 1979 and its mandatory decrees, in the 90s, from Rio Summit, and the Environment Ministry and the National Environment System were created, the published legislation since Act 99 de 1993 divided and disarticulated the competences among health and environment. In spite of this situation, the same health and environment institutions have been amending the error through intersectorial roundtables, and have redirected their path in terms of the intrinsic functions they share.

In recent years, the country has achieved an important development in the legal framework that regulates the environmental health. CONPES 3550, 2008 defined 17 components of environmental health that must be subject to norms, policies and health integral protection practice. These components are: potable water, basic sanitation in hygiene, water resources and contamination, solid wastes and soil protection, atmospheric contamination, food innocuousness, occupational health and security, chemical security and hazardous waste, housing environments and healthy spaces, vectors control and veterinary public health, ionizing and non-ionizing radiation, noise contamination, tourism and environmental health, urban planning and ground use, transport security, medicine quality, worldwide environmental aspects, and natural disasters. In the other hand, Public Health Decennial Plan 2102-2021 states the following dimensions: environmental health, healthy life and non-transmissible conditions, social cohabitation and mental health, food and nutritional security, sexuality, sexual and reproductive rights, healthy life and

transmissible diseases, public health in emergencies and disasters, health and labor area. Objectives, goals and strategies are established for each one of the previous dimensions.

It is perceived that the organization in environmental health services has become more complex in terms of the resources, the activities and the human talent of this sector. Specifically, decree 4107, 2011, Article 27 proposes five central concepts for human talent management related to health: a) policies formulation for formation, practice and performance of human talent in health, b) design and coordinate the formation and training policy of human talent in health, c) protect the improvement of human talent to improve its efficiency and productivity at work, d) design and develop strategies for applied research and evaluation of technologies aimed at the improvement of human talent, and e) advance in studies on

composition, distribution and incentives for human talent.

In this context, it is worth highlighting that currently there is no sufficient information about the characteristics in terms of the formation and performance on human talent regarding environmental health that must pay attention to each one of these topics. It is also important to underline that the success of the implementation of policies in any performance area in the human activity and the very development of the programs is mediated significantly by the role played by human talent in its interpretation and start-up, who in turn end up being the actors of a knowledge area; and here is when High Education Institutions (IES in Spanish), including Universidad Distrital, are called to answer the need for formation of this human talent, and this could be the field that allows structuring our future Faculty of Healthy Sciences.

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