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Canada's Spotlight on the Americas

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Delay in H1N1 vaccine production

Despite promising the availability of 30 million doses of the H1N1 vaccine, the government of Mexico now anticipates having only five to eight million doses available by December. The United States is also having trouble meeting its target. Unforeseen difficulties in developing the vaccine are rendering the process more time-consuming than expected.

Regardless of fears following a high incidence of the H1N1 virus or "swine flu" in the spring, Mexico has yet to see a large number of deaths due to the pandemic. Of the 20,000 H1N1 cases reported in Mexico since September, 61 people have died, according to authorities. Mexican officials are downplaying the severity of the disease, likening its effects to those of the standard flu.

FOCUS ON HEALTH

Colombian Indigenous Health Promoting Enterprises: A Power Shift?

Javier Mignone

Indigenous organizations have used the legal framework of Colombia's 1993 healthcare reform to create health insurance and health delivery entities, thus achieving more autonomy and control over their community's health than before. Nonetheless, a number of tensions and limitations persist.

The objectives of the reform were to create a general system of social health security through decentralized health insurance, with the goal of achieving universal coverage within a decade. It was initially foreseen that, by 2001, the benefits of the subsidized regime would equal those of people who contributed a portion of their wages for healthcare coverage. However, universal coverage remains out of reach and, overall, health indicators have not improved and disease control programs have deteriorated.

The reform's legal framework created Health Promoting Enterprises (*Empresas Promotoras de Salud*, EPS), essentially health insurance companies, financed through the subsidized and contributory systems. The health plan managed by the EPS covers a package of health interventions. Under the subsidized system, the EPS functions as a not-for-profit responsible for contracting health promotion, organization and delivery of medical services. Healthcare delivery organizations (*Instituciones Prestadoras de Servicios de Salud*, IPS) and the autonomous hospitals and health centres (*Empresas Sociales del Estado*, ESE) can be public, private or mixed and for-profit or not-for-profit. Some indigenous organizations have created their own IPS that mostly work with the indigenous EPS.

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Note from the Guest Editor - Reviewing Health Reform in the Americas

Social policy practitioners have always sought to improve health and education because they would lead to better opportunities for the population.

In South America, in particular, during the last 20 years, several reforms have been undertaken in both areas to reach the same goal. Reforms in the health sector such as the Brazilian Programa de Saude da Familia in 1994, the Colombian Health Sector Reform (Law 100) in 1993 or the Chilean Chile Solidario in 2000 are good examples of this dynamic.

At the same time, in countries such as Colombia in 1991, Bolivia in 1994 and Peru in 2002, with different degrees of intensity, decentralization processes accompanied the reforms in order to give local governments more power to enable them to make more effective decisions. Additionally, corrective measures such as conditional and unconditional cash transfer programs were carried out to complement the reforms, to increase coverage and more particularly to encourage the population to use health services.

Several years after the implementation of these reforms, an important baseline has been created to evaluate their impact and outcomes. Unfortunately, the results have fallen far short of the desired results. The

observed improvements are related to better access and supply of health services in the urban and surrounding areas. These improvements are reflected in better health outcomes at the national average level. However, what these average figures hide is the local reality rife with inequalities in the provision and access to health services between urban and rural residents, men and women, rich and poor and between different ethnic groups (such as indigenous and non-indigenous).

Impact evaluations, specific studies, national data compared with local data and other sources of information tell us that social policies applied by governments on health are more likely to reach the better-off households rather than the poorest, which are generally the neediest. If this situation is to change, its causes must be understood and policies must be devised and implemented to tackle the blind spots of the health sector.

To ensure that health policies produce the desired results, governments must face these different challenges. The research agenda and policy dialogue should be about how to generate and implement accurate policy options, analyzing if conditional and unconditional cash transfers or in-kind transfers are more effective; precisely target the population for whom health services are going to be delivered; transform successful local health projects into national policy options; develop and reinforce capacities within the health sector; clearly identify the determinants of health inequalities within a country; and develop solid research networks to use research as a policy-making tool.

In this Health edition of *FOCALPoint*, we seek to highlight the challenges ahead for the health sector in some countries of the region, present projects and policies that were attempted in Latin America and the Caribbean, and underline the significance of the effectiveness of health policies to improve the actual health outcomes of the region's population. 🌐

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Colombian Indigenous Health Promoting Enterprises

(continued from page 1)

The Asociación Indígena del Cauca (AIC), with headquarters in Popayán, Cauca, created the first indigenous EPS, currently with a roster of approximately 180,000 members. It started operations in 1998 and is politically accountable to the Consejo Regional Indígena del Cauca (CRIC), which also spurred the creation of six other IPS with which it contracts. Because of the political representative nature of CRIC, the communities are not simply users of the system, but through it they take part in broad decision-making processes related to the indigenous association and the IPS.

The other indigenous EPS are Anas Wayuu EPS Indígena, with headquarters in Maicao, La Guajira; DUSAKAWI EPS Indígena, based in Valledupar, César; EPS Indígena Mallamas in Ipiales, Nariño; Pijaos Salud EPS Indígena in Ibagué, Tolima; and Tayrona EPS Indígena in Villavicencio, Meta. The average membership roster is 100,000, and all have supported the creation of indigenous IPS with whom they hire services. As well, they contract with other IPS and with the autonomous hospitals and health centres. The mission statement of the DUSAKAWI EPS encapsulates well what appears to be a shared vision: “Strengthen our traditional knowledge, and the results and autonomy of Indigenous Peoples in the territories. Defend and promote our policies, organizing and administering the resources dedicated to health, to guarantee services in accordance

with the socio-cultural characteristics of our peoples.”

In the hands of these indigenous organizations, this type of health-care appears to have resulted in a power shift that has enhanced true community-based health promotion and preventive services as well as intercultural health initiatives, bilingual services, and the collection of social and culturally relevant individual, family and community level information related to social determinants of health. Further, within the constraints of the legal framework, the indigenous EPS have done their best to support traditional indigenous medicine. As well, as public hospitals are now contracted by the EPS for services, this has forced the former to treat individual indigenous patients and their families with more cultural and social respect. Through the EPS, Indigenous Peoples have gained more leverage with public hospitals.

However, some indigenous organizations, including CRIC, have become increasingly critical of the healthcare system. Indeed, CRIC voted at its General Assembly in May 2009 to opt out of the system over the lack of autonomy in the governance of their EPS.

A number of serious issues remain that not only curtail the autonomy of the indigenous organizations, but that limit the potential for improved care and coverage, ultimately putting the entire system into question. The lack of full coverage has forced the indigenous EPS to

use their scarce resources to provide some types of services to individuals for which they do not receive funding.

Further, the system itself does not necessarily foster solidarity among the indigenous EPS, instead providing incentives for competition. Although the indigenous EPS have sought to restrain competition for membership, the incentives have still created some degree of tension and hurt the possibility of enhanced collaboration.

Finally, the system is so highly regulated that innovative initiatives, for instance those related to intercultural health, must be financed through savings from the eight per cent of funding allocated to administration. Even funding for health information systems must be carved out of administration. As well, the government has used the threat of EPS closure to try to curtail broader demands from indigenous organizations. Unless Indigenous Peoples can obtain more autonomy in the governance of their health organizations, more of them may follow CRIC and seek to opt out of the system. 🌐

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Public Health Insurance in Bolivia and Gaps Between Rural and Urban Areas

Rory Narváez

In Bolivia, public health insurance programs are publicly financed, primarily from federal taxes that are transferred to municipalities. The country's high level of extreme poverty, 38 per cent of the population in 2006, makes it very unlikely that another health insurance model, based on individual beneficiaries' contributions to market-based health insurance, could be implemented.

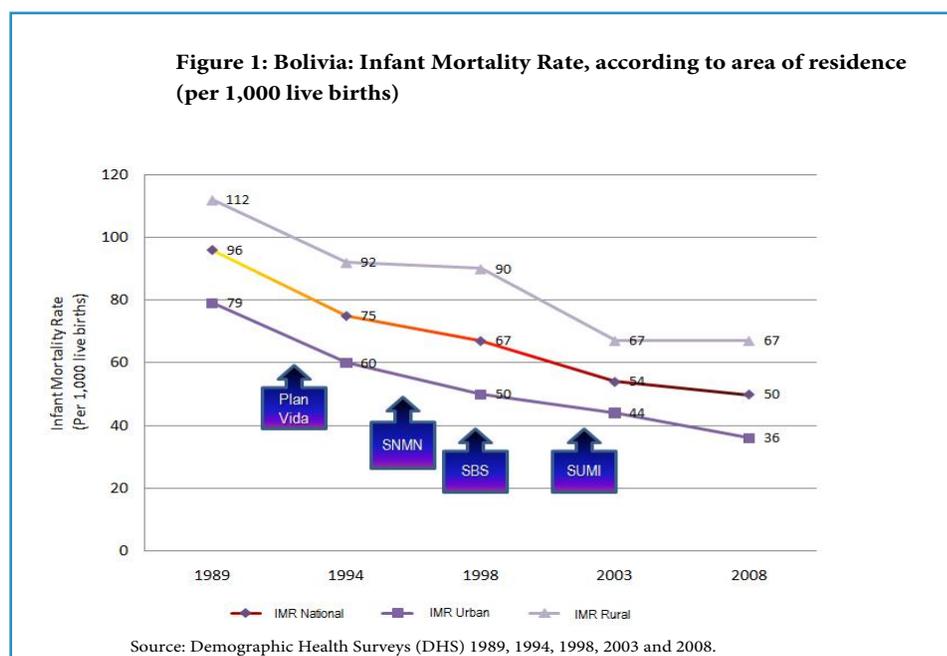
Between 1993 and 1996, Plan Vida was implemented: it sought an accelerated reduction of maternal, perinatal and infant mortality. The National Insurance for Mothers and Children (SNMN) program, established in 1996, provided 32 health services to children under five and to pregnant women. Between 1997 and 2002 the Initiative for Heavily Indebted Poor Countries (HIPC) was an incentive for the Bolivian Government to develop the Bolivian Poverty Reduction Strategy that led to the creation of Basic Health Insurance (SBS), which expanded the number of SNMN health services to 92. In November 2002, Law 2426 created the Maternal and Child Universal Health Insurance (SUMI), which increased SBS health services to 547. As seen in Figure 1, Plan Vida marks the start of a declining trajectory of Infant Mortality Rate (IMR) at the national level from 96 per 1,000 live births registered in 1989 to 50 per 1,000 observed in 2008.

One of the biggest challenges of the next administration will be to find convergence points among the regional health insurance programs and the Universal Health Insurance (SUS) to implement a national health insurance program that improves the health of all Bolivians and diminishes the urban-rural gap.

Between 1994 and 1998, there was a decrease in the infant mortality rate by only two points in rural areas, with a greater decline of 10 points in urban areas. The difference between rural and urban can be explained by the SNMN inability to eliminate the economic barrier to accessing health services, due to the limited number of free health services and, fundamentally, the capacity limitations of the health network in areas with a dispersed population.

After the implementation of basic health insurance in 1998, there was an accelerated 23-point reduction of the infant mortality rate in rural areas from 90 to 67 per 1,000 live births. In the urban area, infant mortality decreased by only six points between 1998 and 2003. Thus, the infant mortality gap between the urban and rural areas was reduced from 40 points in 1998 to 23 in 2003.

After 2003, despite the SUMI strategy aiming to eliminate the economic barrier, through its free quasi-universal health services are free for mothers and children, the program's benefits were more favourable in the urban area, where the infant mortality rate was reduced by eight points, while in the rural area there was no variation (see Figure 1).



Similarly, between 1989 and 2003, the health insurance programs prior to SUMI, above all the SBS, were more effective in reducing the maternal mortality ratio (MMR). Preliminary estimates of the National Demographic and Health Survey in 2008 have shown that the MMR may have fallen by less than 10 points between 2003 and 2008. This result indicates that the markers for maternal and child health have entered a plateau. This is a challenge for public policy; it points to the need to explore other types of intervention in order to increase the probability of Bolivia achieving the Millennium Development Goals in the area of

health.

Regional and universal health insurance

It has been more than 15 years since Bolivian health policy targeted its efforts toward protecting the most vulnerable population: children younger than five, pregnant women and senior citizens over 60. Health Insurance for Senior Citizens (SSPAM) was implemented after the failure of the Free Health Insurance for Seniors (SMGV), which had offered health services through the social security system whose facilities are concentrated in the urban area, resulting in the exclusion of senior

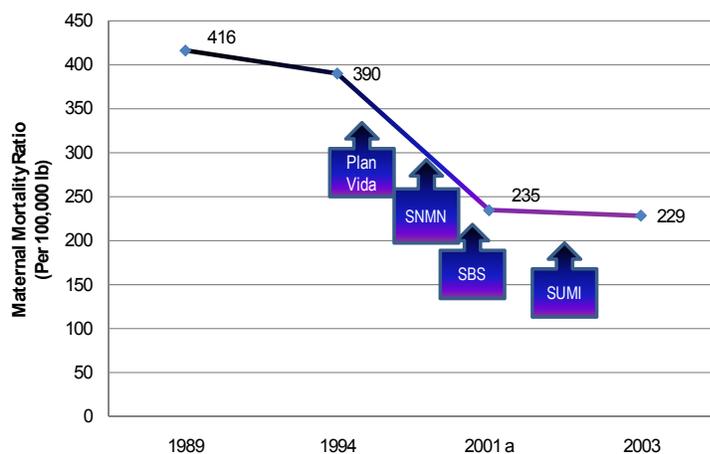
citizens who live in rural areas.

Currently, two departments (Tarija and Beni) that are in opposition to the ruling party took the initiative to implement health insurance that is complementary to SUMI and SSPAM, protecting the population between five and 60 years old in their jurisdictions with the aim of providing universal insurance for their population. These initiatives took advantage of the federal level's inability to provide the resources to implement a similar program at the national level. As Tarija is a department that has traditionally seen a positive evolution of its social indicators (it has already achieved the Millennium Development Goal for infant mortality, see Figure 3), this additional health insurance program could deepen the disparities and inequities in health by region.

Statistics show that the elimination of the economic barrier is not enough to increase the coverage of health services. The current government is implementing the Bono Juana Azurduy, a matching grant program with conditions to encourage mothers to use health services for themselves and their children, mainly antenatal care, delivery and monitoring of their children's growth and development. This program lacks a geographical targeting component, which could maintain or exacerbate the rural-urban gaps.

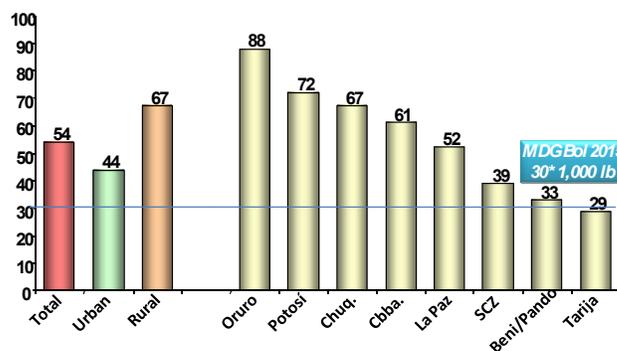
One of the greatest challenges for the next administration will be to find the convergence points between the regional health insurance programs and the federal Universal Health Insurance in such a way as to take the regional lessons learned and apply them to the design and implementation of a health insurance program to protect the popula-

Figure 2: Bolivia: Maternal Mortality Ratio 1989-2003 (per 100,000 live births)



Source: DHS 1989, 1994 and 2003. Estimates based on Post-Census Survey.

Figure 3: Bolivia: Infant Mortality Rate by Departments (per 100,000 live births)



Source: DHS 2003 and Fifth Report of Progress of the MDGs (2008).

tion between five and 60 years old. Potentially, in the medium-term, this system could merge with the current insurance programs being implemented (SUMI and SSPAM), resulting in a single universal health insurance program at the national level to improve the health of all Bolivians and reduce social exclusion and inequities in the access and utilization of its services. 

Rory Narváez is an economist who served as a Senior Analyst in the Unit for the Analysis of Social and Economic Policies (UDAPE) in Bolivia and as an officer in strategy positions in cooperation agencies such as USAID and the United Nations World Food Programme. Currently, he is serving as a short-term consultant for the World Bank and the Pan American Health Organization.

Drug-resistant TB in Peru

Peru's overcrowded Lurigancho Prison has become a breeding ground for drug-resistant tuberculosis (TB). The spread of the disease is propelled by the close living conditions of the 11,000 inmates in a building designed to hold 2,000. In response, the International Committee of the Red Cross has introduced laboratory facilities and health staff into the prison to better identify and treat the illness. Insufficient funding, continuous exposure to the infection and unhealthy living conditions make the standard treatments for TB ineffectual. Few patients are able to complete the lengthy and difficult course of treatment required to cure tougher strains of TB.

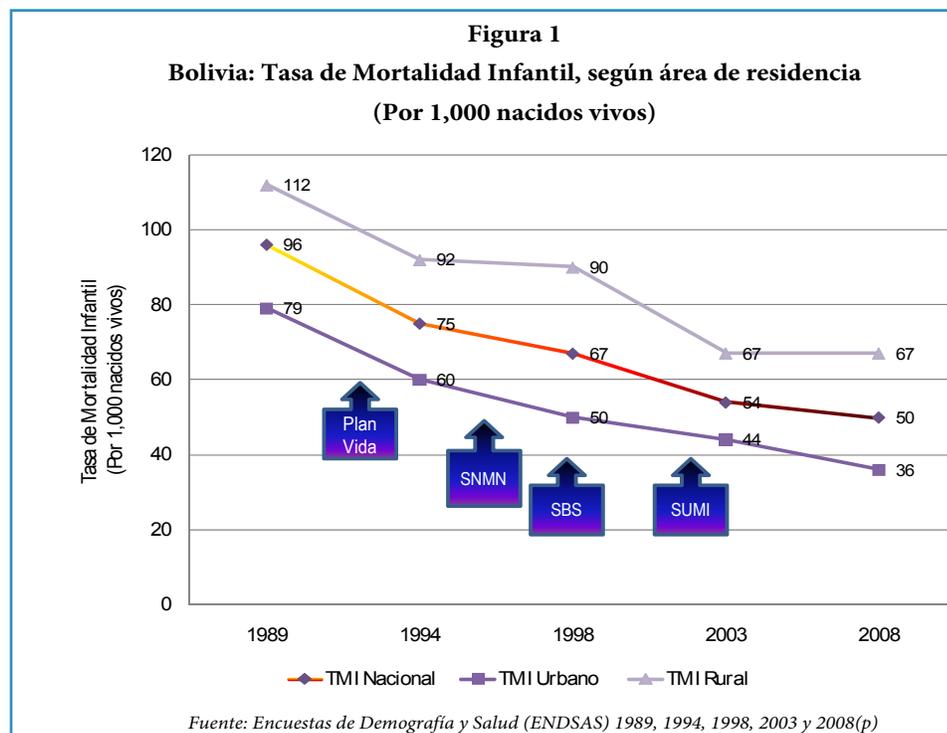
El Aseguramiento Público en Salud en Bolivia y las Brechas Urbano Rurales

Rory Narváez

En Bolivia, los programas de aseguramiento público de salud se basan en financiamiento público, proveniente principalmente de impuestos, que son colectados por el nivel central y son transferidos a los municipios. Es muy difícil que otro tipo de modelos de aseguramiento, que contemplen aportes individuales basados en el mercado de seguros de salud, puedan implementarse considerando el elevado nivel de extrema pobreza del país que alcanzaba al 38 por ciento para 2006.

Entre 1993 y 1996 se implementa el Plan Vida que buscaba una reducción acelerada de la mortalidad materna, perinatal e infantil. En

1996, se crea el Seguro Nacional de Maternidad y Niñez (SNMN) que brindó 32 prestaciones a los niños menores de cinco años y a las mujeres gestantes. Entre 1997 y 2002 la Iniciativa de Países Pobres Altamente Endeudados (HIPC) motivó a que el gobierno de Bolivia elabore la Estrategia Boliviana de Reducción de Pobreza en cuyos componentes sociales se plantea la creación del Seguro Básico de Salud (SBS) que amplía el número de prestaciones del SNMN a 92. Hacia noviembre de 2002 se promulga la Ley 2426 de creación del Seguro Universal Materno Infantil (SUMI), que amplía las prestaciones del SBS a 547. Como se puede apreciar en



la Figura 1, el Plan Vida marca el inicio de una trayectoria importante de descenso de la tasa de mortalidad infantil (TMI) a nivel nacional de 96 por 1000 nacidos vivos registrada en 1989 a 50 por 1000 nacidos vivos observada en 2008.

Uno de los mayores desafíos de la próxima gestión de gobierno será encontrar puntos de convergencia entre los seguros regionales y el Seguro Universal de Salud para diseñar e implementar un programa

nacional de aseguramiento que mejore la salud de todos los Bolivianos, disminuyendo las brechas urbano-rurales.

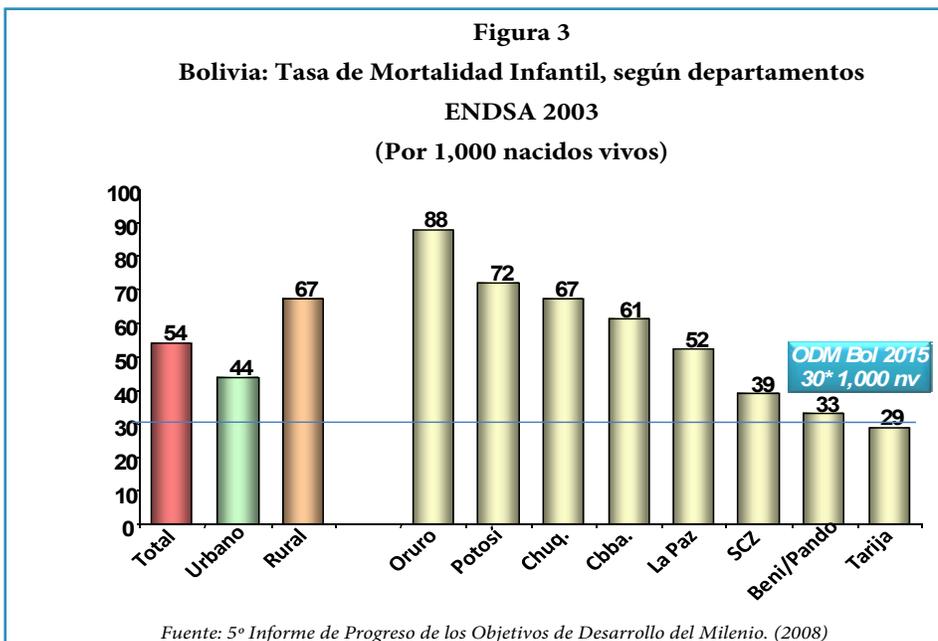
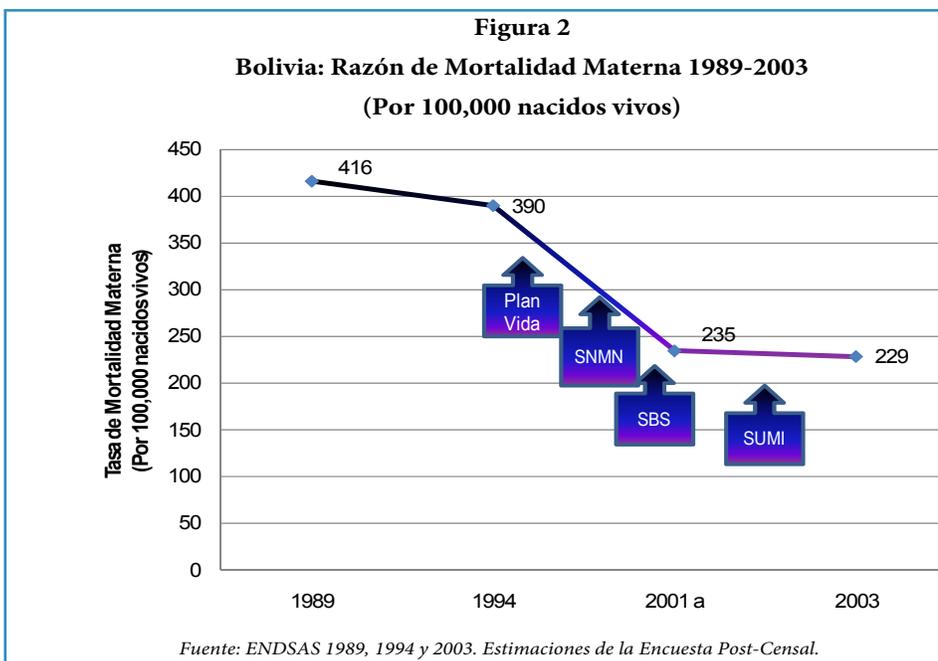
Entre 1994 y 1998, en el área rural, se observa una disminución en la TMI de tan sólo dos puntos, en tanto que en el área urbana el ritmo de disminución fue mayor, habiéndose reducido la TMI en 10 puntos. Esto podría explicarse porque el SNMN aún no pudo eliminar la barrera económica para el acceso a

los servicios de salud, debido al limitado número de prestaciones gratuitas que ofrecía y fundamentalmente a las limitaciones de la capacidad resolutive de la red de servicios en áreas dispersas.

Luego de la implementación del SBS en 1998, se observa una acelerada disminución de la TMI en el área rural de 90 a 67 por 1000 nacidos vivos, representando una reducción de 23 puntos, en tanto que en el área urbana esta reducción significó sólo seis puntos entre 1998 y 2003. La brecha entre el área urbana y rural se redujo de 40 puntos en 1998 a 23 en 2003.

A partir del 2003, pese a que el SUMI es una estrategia dirigida a eliminar completamente la barrera económica, debido a la gratuidad de las cuasi-universales prestaciones de salud dirigidas a proteger a la madre y niño, se observa que los beneficios de ésta fueron más favorables en el área urbana, pues la TMI se redujo en ocho puntos, en tanto que en el área rural no hubo variación alguna (ver la Figura 1).

De igual forma, entre 1989 y 2003, los programas de aseguramiento previos al SUMI, sobretudo el SBS han sido más beneficiosos en reducir la razón de mortalidad materna (RMM). Estimaciones preliminares de la Encuesta Nacional de Demografía y Salud de 2008 señalan que la reducción en la RMM entre 2003 y 2008 sólo representaría menos de 10 puntos, señalando que los indicadores trazadores de la salud materno infantil entraron en una especie de meseta y constituye un desafío para la política pública explorar otro tipo de intervenciones para incrementar la probabilidad de cumplimiento de los Objetivos de Desarrollo del Milenio (ODM) en el área de salud.



Los seguros regionales y el seguro universal de salud

Son más de 15 años en los que la política sanitaria boliviana focalizó sus esfuerzos en proteger a la población más vulnerable: los niños menores de cinco años, las mujeres embarazadas y el adulto mayor de 60 años. Esta última población cuenta con el Seguro de Salud Para el Adulto Mayor (SSPAM), que es una estrategia que se encuentra en plena implementación luego de la fallida iniciativa del Seguro Médico Gratuito de Vejez que ofrecía servicios de salud a través del sistema de seguridad social, cuyos establecimientos se concentran en el área urbana, generando un importante proceso de exclusión de los adultos mayores residentes en áreas dispersas.

Actualmente, dos departamentos que son de oposición al partido de Gobierno (Tarija y Beni), tomaron la iniciativa de implementar seguros de salud que son complementarios al SUMI y al SSPAM, protegiendo a la población entre cinco y 60 años en sus jurisdicciones, aproximándose a contar con un aseguramiento universal para toda su población. Estas iniciativas tomaron ventaja del nivel central que no pudo gestionar los recursos para implementar la iniciativa a nivel nacional. Estos procesos pueden ahondar las disparidades e inequidades en salud por región, considerando que Tarija es un departamento que tradicionalmente ha mostrado una evolución favorable de sus indicadores sociales, inclusive ya habría logrado el ODM de reducción de la TMI como se puede observar en la Figura 3.

Las estadísticas muestran que la ruptura de la barrera económica no parece ser suficiente para incremen-

tar la cobertura de los servicios de salud. El actual gobierno se encuentra implementando un programa de transferencias condicionadas, denominado Bono Juana Azurduy, para incentivar a las madres a que acudan a los servicios de salud para atender sus controles prenatales, su parto y los controles de crecimiento del niño. Este programa no cuenta con un sistema de focalización geográfica, por lo tanto, podría mantener o exacerbar las brechas urbano-rural.

Uno de los mayores desafíos de la próxima gestión de gobierno será encontrar puntos de convergencia entre los seguros regionales y el diseño del Seguro Universal (SUS) de Salud a nivel nacional, de manera que sobre las lecciones aprendidas a nivel regional pueda construirse un programa de aseguramiento a nivel nacional que proteja a la población entre cinco y 60 años y potencialmente en el mediano plazo se fusione a los seguros en actual vigencia (SUMI y SSPAM) de manera de contar con un solo seguro a nivel nacional que mejore la salud de todos los Bolivianos, disminuyendo la exclusión y las inequidades en el acceso y uso de los servicios de salud. 🌐

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PAHO promotes strategy for mental health in the Americas

The Pan American Health Organization (PAHO) took advantage of World Mental Health Day on Oct. 10 to draw attention to the unmet needs of the millions of mentally ill in the Americas. Mental health services in Latin America and the Caribbean are impaired by a chronic lack of funding.

PAHO estimates that the average Latin American country allocates less than two per cent of its national health budget to the mental health sector. In addition to lack of funding, the stigma and isolation of conventional mental health treatments further deter people suffering from mental illness from seeking medical help.

Inaccessibility and insufficient funding can be mitigated by the integration of mental health services into existing 'primary care' institutions, according to PAHO. This strategy will be pursued within the framework of PAHO's Regional Plan of Action on Mental Health, a document officially endorsed by Latin American health ministers in September 2009.

Twenty countries in the region have recently completed appraisals of their own mental healthcare systems in preparation for the implementation of this plan, which could form a critical first step in providing much-needed mental health reform in both South and North America.

The Persistence of Health Inequities in Colombia

Francisco J. Yepes

The 1993 Colombian Health Sector Reform (Law 100) established a national health insurance system with two regimes: 1) contributive for those with formal employment and those who can afford to contribute and, 2) subsidized for the poor. People with formal employment share the payment of the insurance premium (12.5 per cent of declared income) with the employer who pays two-thirds of it. Independent workers must pay the full premium.

The health reform was, among other things, intended to address Colombia's status as one of the most inequitable countries in the Americas. According to the report of the Misión para el Empalme de las Series de Empleo, Pobreza y Desigualdad (MESEP), 45.1 per cent of the population lives under the poverty line, with 12 per cent in extreme poverty. Colombia's Gini coefficient (0.59), an inequality indicator, is the third worst in the world and the worst in the Americas. Present health inequities are a result of this situation and especially of health policies' failure to alleviate them.

Although Colombian health reform was intended to decrease or eliminate financial barriers to health

services by increasing public health expenditure and establishing solidarity mechanisms in the financing structure, access inequities still remain. The uninsured population has less access to health services than the insured. Among the insured, those in the subsidized regime have

The differentials ... are inequitable in the sense that they are unjust and avoidable. They also reflect the profound unfairness of Colombian society and the limitations of a health policy centered on the provision of medical care through health insurance.

less access than those in the contributive. In the case of maternal services, Luís Miguel Tovar Cuevas and Gustavo Adolfo García reported in 2007 that mothers in the subsidized regime have less chance of using adequate maternal health services than those in the contributive.

Furthermore, the Standardized Package of Services (SPS) has structurally entrenched inequities of ac-

cess to health services. The SPS was created as a means to guarantee that all insurers provided the same package of services to the affiliated population. However, it has had regressive effects, because the actual services provided have been different for those in the contributive and those in the subsidized (which are the poorest), in effect discriminating against this part of the population according to socioeconomic level, urban-rural localization, and education. As a result, poor households have limited access to insurance and a more restricted package of health services.

These restrictions in some instances particularly affect women's health. Some basic exams for early detection of breast and cervix cancer are not covered for poor women.

A 2007 study by the Fundación Corona observed large differentials in mammography by region, urban and rural areas, and income levels. Official data shows 87 per cent coverage in health insurance, a figure that does not reflect the Colombian reality.

Moreover, health outcomes present huge gaps if they are classified by income level (rich-poor), geograph-

ical localization (urban-rural), and the education level of the mother. In 2005, infant mortality was 20.5 per 1,000 newborns in urban areas, while 26.4 in rural ones. While the Eastern region presents the lowest rate, 19.6, the Pacific region has the highest, 27.8. Notably, the richest income quintile has a rate of 16.6 per 1,000 newborns.

A similar situation is observed in the prevalence of chronic malnutrition. In 2005, there was 7.6 per cent of chronic malnutrition in urban areas and 14.9 per cent in rural ones, with 2.1 per cent in the richest income quintile and 16.9 per cent in the poorest.

Maternal mortality in Colombia demonstrates similar paradoxes. Despite having a high proportion of pregnant women with prenatal care (93.5 per cent in 2005) and deliver-

ing in hospitals with a physician's assistance (90.7 per cent in 2005), Colombia still has an disproportionate maternal mortality rate (75.0 per 100,000 live births). In the case of Bogotá, where less than one per cent of maternal deaths are unregistered, in 2006 women under the contributive regime had a maternal mortality ratio of 27.2 per 100,000 live births, while women in the subsidized system, 106.3, and those uninsured, 44.6. Even when taking into account socioeconomic differences among women in different insurance regimes, observed differences in maternal mortality ratios are wholly unacceptable and pose questions about service quality.

The Colombian experience is an important lesson for other countries in the region. Colombian health reform has several serious limitations.

These are related to the centering of the reform mainly on the mere provision of health services, with an unbalanced system of incentives that privileges the financial ones and ignores those based on health outcomes. This imbalance has affected the quality of services, with a significant fragmentation of the system, deterioration of public health activities and serious deficiencies in the control role of government.

The differentials in insurance coverage, in access to services and in health outcomes are inequitable in the sense that they are unjust and avoidable. They also reflect the profound unfairness of Colombian society and the limitations of a health policy centered on the provision of medical care through health insurance. Obviously, this approach is not enough. A modern health policy must address the socio-economic, political, environmental and cultural conditions that are closely associated with health.

A serious question Colombians now must consider is whether it is worth continuing with the current system. If the answer is yes, it would require profound changes in the role of government, in the incentive system, in the accountability of the health insurers and in the whole transparency of the public health information system. 

Dr. Francisco J. Yepes is the Executive Director of the Asociación Colombiana de la Salud (ASSALUD) and can be reached at franciscoj.yepes@gmail.com.

Figure 1: Infant Mortality and Chronic Malnutrition for Children under five years old (Colombia 2005)

	Infant mortality rate per 1,000 newborns	Percentage of children with chronic malnutrition
Zone		
Urban	20.5	7.6
Rural	26.4	14.9
Region		
Eastern	19.6	9.1
Central	19.8	8.5
Bogotá	21.9	9.5
Atlantic	23.6	12.1
Pacific	27.8	10.1
Income quintile (q)		
Richest (q5)	16.6	2.1
Poorest (q1)	42	16.9

Source: Flórez Carmen Elisa, Soto Victoria Eugenia, Acosta Olga Lucia, Karl Claudio, Misas Juan Diego, Forero Nohora, Lopera Carolina. "Avances y desafíos de la equidad en el sistema de salud colombiano." Fundación Corona, 2007.

Capacity Development for Health Research

Victor R. Neufeld

“We need to look more closely . . . at the nature of capacity and capacity development, including individual skills, institutions and societal (system) capacities,” said Mark Malloch Brown of the United Nations Development Program (UNDP), in the foreword to the 2002 report “Capacity for Development.”

This statement provides an excellent context for thinking about strengthening the capacity of health research systems. Capacity development for health research is an essential component of a health system and ultimately a key determinant of improved health outcomes. Using the trilevel framework described above —individual, institutional and “system”— Canada’s role is illustrated in the following three Latin American stories.

Capacity development of individuals

The Canadian Coalition for Global Health Research (CCGHR) is a Canadian-based not-for-profit organization that is committed to “better and more equitable health through the production and use of knowledge.” Each year, the CCGHR conducts a Summer Institute for New Global Health Researchers, where pairs of researchers—a Canadian and a partner from a low or middle-income country— participate in a 10-day training event. The main emphasis is on the application of research (“research to action”).

In 2006, the National Institute for Public Health (Instituto Nacional de Salud Publica, INSP) in Cuernavaca, Mexico hosted this event. Participants came from many countries around the world, including Bolivia, Brazil, Mexico and Nicaragua. The program included a preparation phase using a designated web-space, an intensive “face-to-face” component, and follow-up activities. The main event included field trips to allow the participants to witness “public health in action”; a specific example was the role of researchers working with community groups, schools and local health staff to solve the problem of vector-borne diseases. In the evaluation, one participant said: “My participation in the summer institute has opened my eyes to ‘the bigger picture’. My future projects . . . will include the global impact of research.” Now there are more than 120 graduates of this annual Summer Institute, many of whom are from Latin America.

Capacity development of institutions

Universities are key institutions for the production of new knowledge and the education of the next generation of health leaders. For many years, “south-north” collaboration has been considered as an important strategy for strengthening the capacities of universities in developing countries. More recently, both partners—south and north—have realized that they have much to

learn from one another and much to contribute.

An example of institutional capacity development through reciprocal learning is a partnership between the University of British Columbia in Vancouver, Canada and four Ecuadorian universities in different parts of the country, along with a leading environmental health non-governmental organization. The goal of this collaboration is to build human resources and institutional capabilities for reducing health impacts associated with environmental health risks. Building upon this partnership, in 2008, the Universidad Andina Simon Bolivar (UASB) and the University of British Columbia (UBC) created a collaborative PhD program on “Health Environment and Society,” linked to the new Andean Region Commission on Social Determinants of Health. The first students, from Ecuador and other Andean countries, began their studies in July 2009.

Capacity development of systems

Around the world, there is growing interest in how research and research capacity can be strengthened at a national or “system” level. This is a particularly difficult challenge for low-income countries where resources, capacities and infrastructure are weak. Despite this, many countries are taking steps to develop national health research systems. Bolivia, one of the poorest countries in Latin America, is one of these.

In December 2007, with the support of the Pan American Health Organization (PAHO) and in collaboration with a CCGHR team, a workshop was held in Cochabamba. One of the goals of this event was to begin stakeholder planning toward strengthening a Bolivian national health research system (NHRS). Participants, including both researchers and research users, recognized that there was a “system” but it lacked coordination and infrastructure. Important workshop outcomes included: the development of a proposal for the structure of the NHRS; a declaration on the Bolivian NHRS; a plan to present a proposal to key actors in government; and an electronic forum to facilitate communication among stakeholders.

CCGHR's contribution to the efforts of our Bolivian colleagues has been a “linking” function. This involves communication and coordination with various Canadian agencies working in Bolivia (such as the Canadian International Development Agency and the International Development Research Centre) to facilitate a “harmonized” Canadian contribution to health and health research in Bolivia. We have also communicated with Swedish colleagues whose development program (SIDA) has contributed to strengthening the role of Bolivian universities in national development. While there have been some delays, a core team of committed individuals continues the work toward the realization of a national health research system in Bolivia.

The UNDP's 2002 “Capacity for Development” report identifies features of a “new paradigm for capacity development”, some of which are illustrated in these three stories.

How Scientific Evidence Can Inform Health Policy and Decision-making in the Americas

Nathan Mendes Souza

In many countries in the Americas, the systematic input of the best available scientific evidence and best practices is commonly missing in healthcare and public health policy-making.

The social actors involved in the policy-making process are government officials, researchers, and people from organized civil society and the private sector. Government officials face challenges ranging from designing to implementing policies. They often have short timelines to deliberate and make decisions that inevitably have an impact on citizens' health. Researchers normally undertake research on issues of interest to them, that they know most about, and for which there is financial support. As such, this research may not necessarily respond to the needs of society or of governments.

The three levels (layers) of capacity need to be cross-linked. Individuals with appropriate training and skills require a strong institutional base for on-going support. To function well, institutions must find their place within a larger national system. Local capacity, at all three levels, must be at the centre of all capacity development activities.

Nevertheless, in this globalizing world where scientific activity is increasingly collaborative across institutions and countries, local (na-

Civil society and the private sector advocate for specific issues, which may influence the policy agenda.

While all of these social actors are involved in the policy-making process, they poorly understand each other, have few incentives to work collaboratively, and struggle to incorporate evidence into decision-making. In response to these problems and to ensure the use of evidence in areas other than health policy, the science of Knowledge Translation was created. In health policy, this emerging science attempts to build partnerships among different social actors to generate, disseminate, and use research evidence. Involvement in these processes increases collaboration, transparency, and accountability in the decision-making process.

Integrating research evidence
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tional) capacities must also include the capacity to participate in global networks and skills to negotiate the rules of globalization. 

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into policy decision-making is important. Knowledge generated through research and that is systematically and transparently synthesized through systematic reviews provides a state-of-the-art view of a health problem and of policy options to address it. Social actors gain the most comprehensive and best available evidence when it is drawn from both qualitative and quantitative approaches. Thus, questions of comparative effectiveness (whether one intervention is more effective than another), acceptability (whether interventions fit in social and cultural norms and values), and the satisfaction of healthcare providers and patients are more likely to be addressed. Circulating in advance scientific evidence in a way that is “translated” to meet the needs of each social actor involved improves and facilitates the policy-making process.

What could governments in the Americas do to increase local research production and synthesis in ways that better inform policy-making? First, governments in the Americas must acknowledge the importance of health research to people’s health and to national development. According to various international recommendations, such as those from the Council on Health Research for Development (COHRED), progress in evidence-to-policy in the Americas may be enhanced if national health research policies are first developed and implemented.

The Bolivian government, for instance, lags behind this essential requisite, which is hindering health research priority setting, infrastructure and human capacity building, and focused funding allocation pro-

cesses. Similarly, the governments of Peru and Ecuador could increase current health research expenditure from 0.10 per cent of their countries’ gross domestic product (GDP) to at least 0.54 per cent of the GDP, the Latin American average. Furthermore, according to a *Lancet* article published by Anastasia Moloney in September 2009, the government of Colombia could increase the number of postgraduate degrees and scholarships on offer, which would increase the current 1.8 per one million Colombian graduates with doctorates annually to at least the Brazilian 50 per one million.

International research and development agencies could also help countries in the Latin American and Caribbean region to ensure they use five per cent of international aid for the health sector on research, as recommended by the CORED in 1990. The largest Latin American economies such as Brazil, Mexico, Chile, and Argentina could also enhance health research partnerships with neighboring countries, and with Canada and the United States.

Second, social actors should support Knowledge Translation initiatives aiming to improve policy and decision-making processes. Such initiatives are comprised of researchers “pushing” evidence to government, civil society and private groups; government, civil society and private groups “pulling” research evidence; and “exchange” among these social actors.

Bolivia, Mexico and Canada are examples of societies striving to foster Knowledge Translation initiatives to varying extents. In 2007, Bolivia and Mexico joined the Evidence-Informed Policy Networks (EVIP-Net, www.evipnet.org), sponsored

by the World Health Organization. Canada has provided Knowledge Translation expertise and research and development funding to EVIP-Net and similar initiatives. The Canadian Coalition for Global Health Research, with the support of the Pan American Health Organization, also organized in 2007 a workshop in Bolivia aiming at perfecting the proposal for research in health for Bolivia. Substantive government stewardship and investment remains essential to strengthen national research capacity in Bolivia.

Mexico’s Knowledge Translation experiences entail relative advancement and complexity. This came about partially due to the Mexican statement in the 2004 Ministerial Summit on Health Research, which called on establishing national Knowledge Translation programmes. Moreover, Mexico’s decentralization of healthcare services increased the autonomy of municipalities and states. Thus, building on close ties between the Mexican Ministry of Health and research institutes, including the National Institute of Public Health, networks composed of researchers, government officials, and activists in civil society groups started to be trained through initiatives such as the Research Consortium for the Development of State Health Systems. This initiative included Mesoamerican countries and counted on Canadian collaboration. Despite Mexico’s attempts to implement such initiatives, it faces challenges common to other Latin American countries: socio-economic inequalities, deficient Knowledge Translation-designated research funding, difficult access to high-quality scientific databases, and lack of expertise.

Canada constitutes one of the best examples in the Americas of the development of Knowledge Translation science and of the application of various strategies and tools to support the use of evidence in health policy and decision-making. Canada has designated specific, publicly-funded Knowledge Translation research chairs, which help to support graduate training of international students such as myself. Canadian research funding bodies also require the incorporation of innovative Knowledge Translation components and partnerships with knowledge users in research grant calls. Canada also maintains institutions such as the Canadian Health Services Research Foundation that develops important tools for the field (e.g. Acquire, Assess, Adapt, and Apply evidence). A final example is the open access Canadian citizens have to high-quality evidence through the Cochrane Database and most recently PubMed Central Canada. One identified challenge for Canadian Knowledge Translation activities is the engagement of civil society. This is why the McMaster Health forum is conducting the "Dialogue about Engaging Civil Society in Supporting Research Use" workshop at McMaster University on Nov. 23-24, 2009.

Knowledge Translation initiatives are gaining momentum in setting health policy across the Americas. The Bolivian, Mexican and Canadian examples demonstrate the spectrum of this new field's development and initiatives. As there are great differences in expertise among these countries and others in the hemisphere, there could be increased multilateral partnerships and greater exchange on using research for

Improving Health from Cradle to Grave in Canada and Latin America

Claire de Oliveira

The existence of health inequalities has become a major concern for researchers and policymakers for both developed and developing countries.

While population health levels have improved substantially over the last few years, many Latin American countries continue to exhibit a high degree of health inequality. They are not alone in this regard. Despite Canada being a developed country, it also has health inequalities among different population groups, such as those between high- and low-income individuals.

To fully address health inequalities, one must also address income inequalities, as both concepts are intimately linked. Rich people live longer and exhibit lower morbidity and mortality rates than the general population. This relationship between income and health is evident across the entire income distribution scale, as considerable research has shown for different countries.

For example, according to the Canadian data, 44 per cent of women and 46 per cent of men from low-

policy and decision-making among government officials, researchers and people from civil society and private organizations. Both multilateral collaboration and greater exchange among key stakeholders may ensure the long-term sustainability of initiatives leading to better health for citizens in the Americas. 

to lower middle-income groups report fair to poor health, compared with eight per cent of women and seven per cent of men from higher-income groups. Similar cases can be found for Latin American countries. Moreover, this relationship between income and health applies not only to adults, but to children as well.

Social policy advocates believe that health inequalities among children should be addressed early on, since adverse health effects in childhood have potentially important consequences that last over a lifetime. Poor health in childhood is associated with lower educational attainment and worse health in adulthood, both of which can affect labour force participation and, ultimately, economic growth. Thus, in order to address health inequalities in adulthood, one needs to address health inequalities in childhood. This reasoning applies in both the developed and developing world contexts.

Policy tools: cash vs. in-kind

In designing specific initiatives it
(Continued on page 15)

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is important to have a clear understanding of the factors that affect children's health status and their later life outcomes. Policymakers also need to understand how the available tools for improving the health outcomes of children in low-income families work. The type of tools chosen will, however, differ accordingly with the type of country in question.

One option is to provide cash transfers—money directly to parents—such as the Ontario Child Benefit or the Familias en Acción Program in Colombia. Cash transfers can reduce material poverty because they raise the overall income of the poorest. The second approach is in-kind benefits. These include government-provided goods or services, typically targeted to low-income families such as the Ontario Rent Bank or school lunch programs in Brazil.

For developed countries, such as Canada and the U.S., in-kind transfers, as opposed to cash transfers, have the largest effect in improving overall health for children. In-kind transfers are more effective in encouraging the consumption of specific goods and services, such as primary and secondary education, nutritional supplements and medical care. Moreover, in-kind programs for disadvantaged families are likely to reduce health inequality, improving productivity and the future labour supply.

For developing countries, as in Latin America, both cash and in-kind transfers can be effective. In recent times, conditional cash transfers have emerged in many Latin American countries with the objectives of reducing current and future poverty and inequality. The main

goal is to provide families with the resources they need most today (to alleviate situations of poverty) but also to link these transfers to incentives for investments in human capital (through health and education) tomorrow.

Also important is the impact of parents' health and health behaviours on children's health. Maternal health has a large impact on child health through *in utero* conditions. Illness in early life due to material deprivation in the womb can have large, lasting effects on adult health and other adult outcomes. For example, a comprehensive study from Douglas Almond at Columbia University found that American children born at the end of the 1918 influenza epidemic were less likely to complete a high school diploma, and more likely to live in poverty, be social assistant recipients, and have health problems in adulthood.

Roughly one in every nine children in Ontario lives in a household whose income is below the low-income cut-off (after tax), a measure traditionally used to define poverty. This reality is far worse in most Latin American countries. As part of its Poverty Reduction Strategy, in 2008 the Ontario government invested in a Student Nutrition Program, which created 700 new breakfast programs and expanded 300 existing ones.

Other initiatives include increasing the number of parenting and family literacy centres, investing in local communities, and facilitating parents' transition from social assistance to employment. These programs clearly aim at delivering in-kind goods and services, giving them a higher likelihood of achieving their targets.

Recommendations for Canada

Thinking of the next generation, we should ensure our governments effectively tackle health inequalities in childhood. Specifically regarding the Canadian case, there are several ways in which this can be achieved. Provincial and local governments could focus more on in-kind transfers to children, such as healthy breakfasts and lunches in schools, rather than cash transfers to parents. Another measure would be to implement policies that focus on parents' health by seeking to improve, for example, the health and health habits of soon-to-be mothers.

Currently, provincial governments handle the provision and partial funding of most child-targeted programs, while at the federal level Ottawa provides the remaining funding. For programs aimed specifically at low-income families, this model should remain as it is.

For programs or services aimed at the entire child population, governments could charge a fee that would vary accordingly with household income; low-income families would not be charged.

The health and well-being of children is an important policy issue and a concern shared by all governments. In recessionary times, the need to effectively target policy is greater than ever. 

Claire de Oliveira is currently the Research Lead at the Health Council of Canada. She manages the organization's flagship projects on the utilization of health services and aboriginal health. Her main areas of research are in health economics, specifically in child health, as well as health and social policy.

Migration and Health: Implications for Development

Janet McLaughlin

This case study of Mexican and Jamaican migrants in Canada's Seasonal Agricultural Workers Program highlights issues of workers' healthcare access in the three countries; discusses implications for long-term health and development; assesses current health initiatives for migrants and makes policy suggestions to benefit stakeholders. Visit www.focal.ca.

Making a Case for Reform: Non-Access to Social Security Measures for Migrant Workers

Barbara MacLaren and Luc Lapointe

This new paper from FOCAL's Labour Mobility Project Manager, Barb MacLaren, and Luc Lapointe, President of Connexion Internationale concludes that temporary foreign workers should have better access to employment insurance benefits and other social assistance programs, and recommends a number of policy options. Visit www.focal.ca.

Escenarios post-Durban: Para pueblos y personas negras, afrocolombianas, raizales y palenqueras

Claudia Mosquera Rosero-Labbé, Ruby Esther León Díaz, and Margarita María Rodríguez Morales

This paper in Spanish by the Centro de Estudios Sociales of the Universidad Nacional de Colombia discusses the progress made for Colombia's Afro-descendants since the 1991 Durban World Conference Against Racism and ways forward. The report discusses improvements in Colombia's legal framework, the recognition of social inequalities by the World Bank and its impact, and Afro-reparations, among other issues. Visit www.focal.ca.

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