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Analyzing Inequities in Health and Education among Marginalized Populations in Bolivia, Peru and Colombia

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Summary

This project proposes to use analytical tools in order to produce fact-based evidence about the degree of inequalities/inequities and their main determinants in health and education among marginalized populations in Bolivia, Colombia, and Peru. The value of this initiative is that it will assist in the identification of "blind spots" for the development, discussion and exchange of more accurate health and education policies.

Context

Development literature, research documents and data show that outcomes in health and education indicators of marginalized populations such as indigenous people and Afro-descendants in Latin America and the Caribbean (LAC) differ significantly from the rest of the population.

Given this reality, Bolivia, Colombia and Peru have undertaken reforms. In 1992, Bolivia promoted education reform. In 1993, Colombia began to reform its health system. In Peru, changes were made in both areas. In the Nineties, Bolivia, Colombia and Peru also started, with different degrees of intensity, **decentralization processes** in order to give local governments more power to implement more focused and effective policies.

Despite these efforts to reduce levels of inequity through social policy revision and reform, the results have fallen far short of the desired outcomes. Improvements are related to better access and supply of both education and health services in the urban and surrounding areas, which are reflected in better health and education indicators at the **national level.** However, marginalized populations (indigenous, Afro-descendants) at the **local level** are continuously confronted with growing disparities and high levels of inequalities and inequities in the provision of and access to health and education services.

For example, in Bolivia 55 per cent of non-indigenous women but only 30 per cent of indigenous women give birth in a hospital. In Peru, indigenous adults have 6.4 years of schooling while non-indigenous adults have 8.7 years.

Measures were taken to overcome these inequalities/inequities on the **supply side** (e.g. outsourcing medical services, intercultural bilingual education, etc.) and/or **demand side** (e.g. conditional and unconditional cash transfers). Yet, the general result of the reforms and corrective measures was still not the desired one. Impact evaluations, specific studies, national data compared with local data and other sources of information tell us that social policies applied by the governments on health and education in our objective countries **are more likely to reach the better-off households rather than the poorest**—which are generally the target population.

If that empirical fact is to change, its causes must be understood and policies must be devised and implemented to tackle the **blind spots**, so governments can more accurately deliver their health and education policies.

Project Objectives

- Discuss policy options to improve education and health outcomes among marginalized populations.
- Review tools and policy options to measure, identify and analyze inequalities/inequities in health and education among marginalized populations in Bolivia, Colombia and Peru.
- Gather, discuss and share best practices on how to overcome health and education inequalities/inequities.
- Facilitate connections and exchanges between stakeholders in Canada and Latin America on emerging issues in health and education policy.

Proposal

The project has the following two main complementary components:

1. Policy Discussion

An examination of the primary needs in health and education policy in our target countries will provide the foundation from which to start a regional discussion. Projects undertaken in different countries and/or may provide ways to solve inequities/inequalities also will be studied and integrated in this exchange. The implementation and viability of programs such as intercultural bilingual education, intercultural health, and conditional and unconditional cash transfers are some examples of discussion topics for analysis. Participation of stakeholders with relevant expertise will add value to these exchanges.

2. Analytical Tools

The second component is based on the utilization of technical tools to identify and measure inequalities/inequities amongst marginalized populations. Gini coefficients, McLoof and Concentration indexes along with Benefit Incidence Analysis, among others, will allow us to precisely visualize the depth of gaps between Afro-descendant and indigenous communities and the rest of the population. The distribution of government expenditure between rural and urban areas, according to gender and ethnicity is another research area that could provide important information to devise corrective measures in the policy design.

In the first phase, analyzing general inequalities will let us confirm the relationship between poor outcomes in health and education indicators, income levels, ethnicity and geographical localization. Studying specific inequities/ inequalities, in a second phase, in variables such as resource allocation and national and local government expenditures will provide the required information to identify blind spots not yet touched by education and health policies. Combined, these policy dialogues and analytical tools will provide ideas and options for policymakers.

Anticipated Results

- Awareness increased about health and education inequalities/inequities among distinct communities within a country.
- Inequalities/inequities in health and education outcomes examined as well as specific variables affecting them.
- A dynamic exchange between stakeholders.
- Policy options to overcome inequalities/inequities.