



**INTERNATIONAL SOCIETY FOR EQUITY IN HEALTH  
1<sup>st</sup> REGIONAL MEETING – CREATION OF THE AMERICAS' ISEqH  
CHAPTER  
São Paulo, Brazil, 1-2 April 2004**

**REPORT**

**São Paulo, April 2004**

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## 1. INTRODUCTION AND SUMMARY

The International Society for Equity in Health (ISEqH) was formed for the purposes of encouraging the development of knowledge that assists in advocacy to improve equity in health throughout the world. Its formation was initiated by two individuals from the Americas: Dr. Jose M. Paganini and Dr. Barbara Starfield. From the beginning, the PanAmerican Health Organization was very supportive, both financially and otherwise, of the development of the Society. Early discussions within the Executive Board, foresaw the development of regional affiliates of the ISEqH. It was logical to take the first formal steps in developing a regional affiliate within the Americas.

With the financial and logistical support of PAHO/OMS, the 1<sup>st</sup> Regional Meeting and Creation of The Americas' ISEqH Chapter, was held in São Paulo, Brazil, 1-2 April 2004.. The meeting was hosted by the Latin American and Caribbean Centre on Health Sciences Information/BIREME/ PAHO/WHO – BIREME, and coordinated by the ISEqH Secretariat. During the two days of meetings in April, Yves Talbot, President of ISEqH and 18 participants (see Annex 1) <sup>1</sup> discussed issues concerning “Opportunities and Challenges of Equity Research in The Americas”, and the “Creation and Organization of The Americas' ISEqH Chapter”. (Annex 2 –Agenda)

The country specialists presented the situation in their respective countries by responding to six questions (Annex 3) proposed by the meeting organization committee. During breakout sessions, proposals were discussed, concerning possible collaborative programs and a plan of action to achieve them. PAHO/WHO was represented at the meeting by Richard Van West-Charles, Area Manager, Information Knowledge Management, who in addition to his participation, presented PAHO's outlook on equity. Elenice de Castro, represented BIREME as an observer to the meeting . The major outcome was a proposal to collaborate on a project to enhance equity in health in Bolivia, one of the five priority countries for PAHO in the America's region.

Discussions by the participants enriched the meeting, especially those concerning equity concepts and the relationship between social determinants and equity. Research on equity in health and even a research observatory<sup>(2)</sup> were considered essential by all participants. Plans were made to develop working groups to further these activities within the context of a new Americas ISEqH chapter.

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<sup>1</sup> from Argentina, Bolivia (2), Brazil (2), Canada, Chile, Colombia, Costa Rica, Cuba, Guatemala, Jamaica, Mexico, Peru and United States of America,

<sup>3</sup> This term ‘observatory’ or research observatory’ originates in Spanish is used extensively throughout the document. It may be interpreted as ‘clearinghouse’ and/or conducting and monitoring an agreed upon research agenda.

## 2. OPENING REMARKS

Yves Talbot, President of the International Society for Equity in Health opened the meeting with the Society's welcome and related the history of the meeting to the relationships established with the new PAHO/WHO administration in Washington. Dr. Mirta Roses, the recently appointed Director, demonstrated her organisation's commitment to equity in health, not only by receiving ISEqH representatives at the beginning of her mandate, but also by encouraging leadership on equity in health by the Americas.

PAHO/WHO considers "Equity" a very important subject and has approved the objectives proposed for this meeting to:

- ? facilitate the interchange of knowledge;
- ? advance research in the field;
- ? build, maintain and strengthen relationships with other regional organizations;
- ? promote research initiatives in primary health care and equity in health;
- ? promote the interaction between researchers, policy makers, advocates and practitioners.

Dr. Talbot expressed the society's gratitude to Richard Van West-Charles, PAHO/WHO for his support, to the BIREME/PAHO/WHO local organization group, to Silva Takeda for reviewing the literature and identifying researchers, and to the Executive Director of ISEqH, Monica Riutort.

He read a message sent by BIREME/PAHO/WHO director, Abel L. Packer, on the importance of equity and the contribution of BIREME/PAHO/WHO to information and research on Equity in America as: "a link between producers and users aiming at the development of health sciences"; a network of information sources from the Internet; and, a network of national information centers in Latin America and the Caribbean. He added that the Virtual Health Library is bringing visibility and accessibility to research efforts.

Yves Talbot mentioned the challenges to achieving equity, the pathways to reach it that demand changes in each country and stated that research plays a significant role in equity development, but that research alone cannot bring changes. He cited Pierre Bourdieu's words concerning the use of socially oriented research as a basis for action. Dr. Talbot also thanked each participant and Barbara Starfield, founding president of ISEqH for her support,

remembering her words that the work of ISEqH is not only to identify pathways to equity or inequity as the case may be, but also pathways to change.

### 3, Opportunities and Challenges of Equity Research in THE AMERICAS

Dr. Barbara Starfield, Johns Hopkins University, USA, ISEqH founding president

Starfield expressed her view that no further research is needed to demonstrate the existence of social inequities everywhere. What is needed is greater understanding of the mechanisms producing inequity, and how to change them. She described her own concepts of equity and those of others on the subject, stressing the importance of systematic differences between population subgroups. Equity research is not exactly the same as social determinants research - which assumes an individual model of health, and generally neglects influences other than social characteristics. Equity research assumes a population model of health and includes many other effects, such as the policy context, and their inter-relationships. In her opinion, equity research is in its infancy because it lacks a widely accepted conceptual framework, and standardization of measurements of the variables.

She showed the two models of influences on health, one at the individual and one at the population level, stressing that the main interest of the former is average health and of the latter, distribution of health. She presented some general considerations for research on equity, adding that a characteristic of equity research is that most researchers choose only one outcome, usually mortality, but more than one outcome would be desirable;

Dr. Starfield proposed some questions about equity studies: their usefulness, generalizations that can be made, international collaboration, and the need for common indicators. She concluded by noting some points of agreement in case studies from different countries, the explicit recognition of an equity problem and the specification of alternative strategies.

As the first president of the Society, she concluded by stating its objective— a society devoted to producing knowledge that assists the advocacy efforts of others. Its organization, and future collaborative actions would help to develop the framework for establishing knowledge on health inequity; help to develop validated instruments; bring different cultural and political perspectives to organizing research on health equity; and help to broaden the impact of knowledge on advocacy in different places. Starfield expressed her wish that the America's Chapter be the leader for other chapters in the world.

In discussing Dr. Starfield's remarks, some participants maintained that it was still important to focus on social determinants but acknowledged that they are not the only influence to be considered.

The issue of measurement also engendered discussion; - it was pointed out that the use of measuring instruments has limitations when examining or explaining complex problems. In answer to the question of what research should be done, Starfield pointed out that most research focuses on a very limited set of variables, whereas a much wider range of likely influences on the distribution of health is required to understand the dynamics of the production and maintenance of inequity in health.

On the question of an individual's decision not to use health services by choosing other alternatives, the author stated that the individual's choice becomes an equity problem when his decision also becomes a social group's decision.

Other subjects that were debated included: political framework, citizen or society's power, the amount of money available for health services; the measure of adequacy of primary health care; how to encourage collaboration among researchers.

#### 4. COUNTRY PRESENTATIONS

In response to the list of questions posed in advance of the meeting, some of the participants responded specifically to the questions while others provided information they considered relevant to explain their country's equity situation or primary health care system. Historical backgrounds were generally similar, with political crises having influenced development everywhere and economic problems tending to be a constant in all countries.

Most of the country reports indicated similarities: a high level of inequities in health and also in health services. Ethnicity is an important factor to consider when researching inequities in health as indigenous populations have higher rates of all factors that hamper health equity when compared to other groups.

The following are summaries of the country presentations.

##### **BRASIL**

Claudia Travassos, Fundação Oswaldo Cruz, Ministry of Health

*Brazilian studies on health inequality in the use of health services*

Dr. Travassos presented a review of Brazilian studies on social inequalities and health in order to discourage repetitions and also to direct political decisions. Twenty-three papers were published on this subject from 1995-2003. The states of São Paulo and Rio Grande do Sul have the largest volume of studies using original data; other states use secondary data.

The increased number of studies on inequities in the area, was supported by The PNAD, 1988 (Sampling of Households National Survey) that includes data on health services.

Income and educational status were the social factors primarily used; only one paper dealt with social classes. For most papers, outcomes were measured by the number of office visits, the hospitalization rate, and the use of health services, in general.

Results indicate that: - inequality is present in the use of health services, but is reduced in cases of chronic diseases. In data from the state of Rio Grande do Sul it was observed that educational status modifies the effect of income, an important factor to consider in reducing inequality. Father's educational status is a more important determinant than the mother's - it has a higher effect on reducing inequalities in health.

Social inequality in hospitalization is less and tends to favor the poor, as corrected for need. Private health insurance and the government SUS (Unified Health System) cover most of the population, including the elderly and the covered population is higher than the population not covered. Inequality is not an apparent effect of reduced supply of services. Neighborhood is an important factor - demonstrated by poor people living in richer areas having higher access to health services. The effect of race on inequality in health service utilization is small. Few studies are based on a theoretical model of the use of health services, and different methodologies were used. Most of the reviewed studies were across sectors.

Norberto Dachs,  
*Statistician, University of Campinas, São Paulo, Brazil*

Dachs presentation introduced participants to his web page on equity in health. He described inequality in Brazil as an “integral part of the landscape”.

He suggested that the main problem concerning equity in health is how to go from research to practical action, proposing that journalists might influence policy makers, as change in health policy requires more than just research.

## **COSTA RICA**

Carlos Zamora, researcher, Social Security

Zamora mentioned the Brazilian Eloy Chaves, born in São Paulo, the first person in America who worked on the approval of a social security law, and mentioned that there have been important achievements in equity in health.

Costa Rica has developed a well-organized Social Security system, which has contributed to decreasing inequities in health. The universal health care system in Costa Rica also covers 450 medications.

There is some current apprehension concerning the liberal policy that may affect social security services and consequently increase inequalities in health.

**CUBA**

Caridad Teresita Garcia-Alvarez,  
*Instituto Nacional de Endocrinología*

Most studies in Cuba refer to reproduction and human sexuality; only recently have gender studies been encouraged.

WHO sponsored research, which was conducted with adolescents in rural and urban areas, concerning gender, aiming at a healthy sexual life and the use of contraceptives. In rural areas, male / female differences were not found.

In looking to identify when women, in larger cities, start their sexual life and if there is a contrast between urban and rural areas, a kind of ritual of transition was found in urban areas, mainly in Havana - that was not found in smaller cities. In larger urban areas, after their 15<sup>th</sup> birthdays, women tend to initiate their sexual life, whereas for men, no specific age was determined. Their sexual life is usually initiated with women who have already been sexually active.

**COLOMBIA**

Carlos Agudelo,  
*Director, Instituto de Salud Pública, Universidad Nacional de Colombia*

Agudelo described the historical background of the economic circumstances in his country, which now follows the new liberal market model. This model has led to inequalities, and today about 50% of the population lives below the poverty level, although there has been an improvement in education levels. The National Health System was remodeled and the Sistema General de Seguridad en Salud created two kinds of contribution – subsidized and contributive - that increased inequalities in access to the health system. This resulted in 48.3% of the population not being linked to a source of health services.

Agudelo, through tables and graphics, showed the rates of health, problem situations. He discussed the state of research on equity in health; 90 papers studied different kinds of social and health inequalities.

**GUATEMALA**

Walter Flores,

*Asesor en Temas de Equidad (Equity Specialist and Advisor), Ciudad Guatemala.*

The author's paper *Inequities in Health in Guatemala* was sponsored by the European Community, Rockefeller Foundation and other institutions. Flores began his speech stating that producing evidence on health inequities is mostly insufficient to bring about change. All specialists should also be activists for equity, involving themselves with community-organized groups. Specialist should also ensure that the evidence is delivered not only to policy-makers but also to civil society.

A social and economic disparity in the country, as reflected by the difference in income between the rich and the poor, is also reflected in the health of the population. Child and maternal mortality rates have improved, but they are still below other countries in the region. Inequities concerning maternal mortality rates persist especially in areas with higher Indigenous populations and extreme poverty. The gap in attendance at health services, during delivery, and access to prenatal care from qualified medical personnel have increased between population groups (indigenous versus non-indigenous and rural versus urban). The national government recognizes the seriousness of the situation, but despite some policy changes, concrete actions to reduce inequity in maternal health have been insufficient.

Flores proposed that due to the extent of disparities, a strategic approach is required. This includes measures to:

1. Assess the effect of public policies aimed at reducing inequities in health;
2. Strengthen institutions to deliver innovative pro-equity interventions, mainly through skill development and training of their personnel;
3. Activate the existing political and legal framework to influence and create a favourable environment through work with congressmen and decision makers;
4. Citizen's participation.

Flores concluded his presentation by pointing out the need to position the topic of inequity on the country's social agenda.

**BOLIVIA**

Ricardo Batista Moliner

*Professor of Epidemiology, Advisor Ministry of Health (analysis of the health system in Bolivia)*

Batista Moliner provided general information on Bolivia, with a population of 8.2 million, where 62.43% are living in urban areas, and 37.57% in rural areas. The poverty level is highest in the West part of the country where most of the population is Indigenous.

Officials project, equity as a priority theme, when appearing for political speeches, but there is little if any action towards equity.

Various institutions conduct studies on social economic inequalities, but few analyses deal with inequalities in health. UDAPE – Unidad de Analisis de Politicas Economicas y Sociales, with the support of international organizations, develops research concerning equity. PROCOSI, a Non Governmental Organization (NGO), has designed research aimed at identifying inequities in immunization programs and other health services. UDAPE and other NGOs receive support from many international organizations.

**PERU**

José Martín Valdivia, Researcher, GRADE – Grupo de Análisis para el Desarrollo, Alianza para la Equidad en Salud (AES)

Valdivia reported that the new government has made public commitments to equity and social justice. For instance, in the context of the *Acuerdo Nacional* which is a government-sponsored multi-partisan forum that tries to set agreements on basic long-term policies, one of the agreed upon goals is to promote universal access to health care and social security. Nevertheless, the implementation of the Integral Health Insurance (SIS, Seguro Integral de Salud) underlines the struggle to achieve universal access given budget constraints. At the moment, the SIS has been limited to children and to women of reproductive age, exclusively for reproductive health services.

The second area discussed in his presentation was the advocacy initiatives in Peru regarding health issues. He pointed out that the literature identifies three approaches to policies which favor the disadvantaged: the anti-poverty approach, the health equity approach; the health as a basic human right approach. In Peru, the advocacy movements use mostly the human rights and anti-poverty approaches, and the health equity approach is not well recognized as

yet. For that reason, it is important for a health equity initiative to analyze the relationship between these three approaches to identify areas where they complement each other.

Finally, Valdivia identified a list of topics that deserve special attention these days, and have important linkages with health equity issues. The first one is barriers, financial and non-financial, to access to health care. Needing special attention is the identification of policies that can help reduce ethnic gaps in health status and access to health care services. Another important topic is the decentralization of health, and what kind of policies can help to reduce the risk that decentralization will accentuate inter and intra-regional health inequalities.

## **MEXICO**

Dr. Guillermo J. González-Pérez,

*Director, Centro de Estudios en Salud, Población y Desarrollo Humano, Universidad de Guadalajara*

Co-author Dra. Maria Guadalupe Vega-López

Dr. González-Pérez initiated his presentation with demographic statistics on society and health in Mexico, with a population of 105 million, 75% living in urban areas. The country also has a large indigenous population.

Some factors stressed by the author were:

- ? while fertility rates are lower, the birth rate has remained the same;
- ? life expectancy has increased and is expected to reach 80 years by 2025 - an increase in the number of elderly will require important decisions in health care;
- ? there is also a growing child population which will mean coexisting demands on the health system;
- ? there is a negative emigration rate, concentrated in specific areas, so that there are many municipalities with children and women, but few men;
- ? some developed states have 5% fewer children than in the less developed, but with a higher number of pediatricians.

Despite rhetoric, government policies on equity in health in Mexico tend to be inadequately concerned with the poor population's health, leading to inequality especially in rural areas. The Seguro Popular de Salud (People's Health Security) tends to reduce the gap between those with social security and those who lack it.

Research on equity in health in Mexico has looked at some important areas such as, descriptions of inequities, comparisons on inequity, and evaluations of interventions. Research on equity, despite the shortage of research funds, is supported at universities by international financing agencies, and by the federal government through CONACYT (National Council on Science and Technology).

Challenges are as follows: the identification of inequalities, and mainly of inequities in areas or populations still not studied; evaluation of government programs; the proposal of significant elements to authorities, in order to develop strategies aimed at decreasing setbacks in health.

## **CHILE**

Dr. Carlos Montoya -Aguilar,

*Advisor, Division of Planning and Budget, Ministry of Health*

Chile has 15 million inhabitants, a lifelong expectancy of 76.7, an infant mortality rate of 8.3/1000, and social security available to all workers. An examination of inequalities reveals inequity of: income, education and health and primary health care. Other survey research, conducted with educational groups, social security groups and geographic areas has already been published in Chilean and foreign journals.

Funding for the primary health care system is per capita and adjusted according to the level of poverty and the needs of a community.

From 1991-1997 the focus on equity in health was conducted in 42 counties - some of the poorest in the country – and surveyed 12 health services. A follow up of the results showed that it had an impact on attitudes, management, education and training. At the moment a monitoring program on inequality is under way, and is being conducted in all counties, surveying 4 health services. The study includes the measurement of inequality variables, the search for inequality causes in the counties, the design of health programs aimed at reducing existing disadvantages, and reducing inequalities.

A follow up of the monitoring is being conducted and the results will be used by government institutions. Montoya-Aguilar mentioned statistical data on health inequalities that the journal Cuadernos Medico Sociales (Chile) (*Salud Publica y Medicina Social*) has published. He also presented tables with details of the methods used in the monitoring program.

**JAMAICA**

Dr. Eva Lewis-Fuller,  
*Dr. of Public Health, Ministry of Health*

The population of Jamaica, a West Indies island, is about 2.7 million, with a relatively large young population and also with an increasing proportion of the elderly.

There is no specific program focusing on equity, but equity appears in several documents and in the health policy, implemented mainly through the Primary Health Care System, in place since the 1970s.

It is the country's policy, for example, that no one should be turned away from the health system for lack of ability to pay fees, and the Patient's Charter states the patient's rights with a system for complaints and appeals in place. Pharmaceuticals are provided for those who cannot afford them, through the Drug for the Elderly Programme (JADEP) and the National Health Fund (NHF), the fore-runner of a National Insurance Program.

The Social Safety Net System recently underwent reform, involving the integration of fragments, which were managed by different government agencies. Benefits are now conditional, based on the fulfillment of set targets for accessing health care and education by family members.

All the above mentioned measures contributed to some achievements in health and social conditions, these include: poverty reduction – 16% of the population is below the poverty line; malnutrition rate is less than 5% of children under 5; elimination of some, not all, communicable diseases and containment of others; general improvement in health status, with a reduction in infant mortality rate (IMR) and maternal mortality ratio (MMR), for example.

The Planning Institute of Jamaica conducts an annual **Survey on living conditions** – generating data and information on gender imbalance, distribution of wealth, occurrence of illness and utilization of services. This is a helpful instrument for research in equity. The planning, execution and interpretation of the results of this survey also involves, directly and indirectly, the Ministry of Labour and Social Security, the Ministry of Health, the University of West Indies, and other organizations such as PAHO/WHO.

A comprehensive study on equity is long overdue in Jamaica and, indeed, in the Caribbean. This is especially necessary since the recent reforms in the health sector, involving the decentralization of health care to four (4) somewhat autonomous regions. Specific and distinct equity indicators, targeted for each region, are necessary in order to monitor the impact of these changes and ensure that equity is not eroded but improved. The perception of equity by the population is very important and indicators will help to measure this. In the final analysis, however, it may come down to patient satisfaction with the health services. We may have to settle with intermittent surveys to measure the level of satisfaction in the population as a proxy for equity in the mean time, until more specific indicators can be formulated and implemented in the health regions.

Lewis-Fuller finished her speech by pointing out the need for a *watch dog* for equity in the country and, perhaps, in the Caribbean sub-region, to monitor equity issues, analyzing these issues with policy makers, health administrators, other relevant units of the government, other stakeholders and the communities. This could stimulate necessary action towards ensuring equity.

## **CANADA**

Yves Talbot, Professor and Director, Department of Family and Community Medicine, International Programs, Faculty of Medicine, University of Toronto and ISEqH President.

Talbot provided general information on his country. Canada occupies a large territory, with areas where the population is scarce, making the access to resources difficult due to large distances. Due to its long border with the USA, there is a strong American influence, but Canada has its own universal health system, which is distinct from the neighboring country. This closeness to the USA is one of the country's challenges. Talbot presented some data concerning health in the country: life expectancy is 81.4 for women and 79 for men and most causes of death are cancer and cardiopathies.

Tax surpluses are not reinvested, but used to pay the country's debts. This has caused some cuts in the public funded health care system. Our national health care system is seen in some quarters, as unfair competition to private system health, despite its being one of the best things that exists in the country. Drugs in hospitals are free only to the very poor, so many lower income people do not have access to them. The impact of this situation is greatest on children from poor families. The expenditure on the health care system is 70% of the country's budget, while in the UK it is more than 85%.

Despite some reduction of funds applied to research, due to the new liberal policy, some research initiatives should be mentioned. In the Canadian Institutes for Health Research (CIHR), a group of 13 scientific/medical institutes have a program Promoting Equity for Vulnerable People. One of the key initiatives of this program is to try to reduce disparities and promote equity; one example is “Responses of childbearing newcomers to referrals for care”.

Another initiative is the Global Health Research Initiative (GHRI) undertaken by a group of four agencies, which provides the means to interact and conduct research with other countries. This initiative has already funded 29 projects - out of 76 submitted - 65% of them were research projects.

## **UNITED STATES OF AMERICA**

Barbara Starfield

*Equity research in the USA*

*Health US 2010*, published in 2000, lists 2 overall goals: 1. to improve overall health; 2. to eliminate disparities across the population, particularly by gender, age, disability, income, race, and ethnicity. The Report does not identify any mechanisms to accomplish these goals and few of its approximately 500 specific objectives concern improvement in primary care.

There is no research on equity in the US, but on ‘disparities’. (In the US, equity is a term related to the stock market).

Most of the attention is on race (especially African-American) and on ethnicity (especially Hispanic), trying to explain disparities in health, and most existing data sources contain no information on socioeconomic status.

There is no research program specifically targeted at interventions to decrease disparities and there are no models for it. However, most of the major national research agencies encourage research on ‘disparities’, and many researchers are documenting inequities and factors that are associated with it.

## **ARGENTINA**

Debora Tajer,

*Southern Cone Coordinator, ALAMES (Asociación Latinoamericana de Medicina Social)*

Debora Tajer described the political situation stating that there are two Argentinean countries, one before the coup d’etat of the 70’s and the other after the neoliberal policies of the 90’s.

During the dictatorship of the 70's many research units were eliminated and today researchers' careers are shattered. Funds for research on public health come from the Ministry of Health, Secretary of Science and Technology, Universities, Medical Associations and unions, and international funds for research have decreased. There are no university programs leading to a doctorate in Public Health, but many master programs in Public Health began on the 90's. The lack of Ph.D. programs is one of the obstacles for researchers applying for international funds.

At the moment, 50% of the population lives below the poverty level. Taking the 70's as a comparison, we may say that since then poverty has increased 6 times, unemployment 5, and the international debt 20 times. Salaries have decreased 4 times – hence, inequity is nowadays part of the landscape of a country that used to enjoy have a fair situation of equity. There are historical differences between urban and rural areas in the health care system and primary health care has not yet reached many regions.

## **5. BREAKOUT SESSION – IDENTIFYING COMMONALITIES**

Discussion to focus on: the context, role and action plan for THE AMERICA'S ISEQH CHAPTER

### **Specific next steps FOR THE AMERICAS' ISEQH CHAPTER**

Question: How can we meet the objectives that the ISEQH proposed to PAHO/WHO to develop an Americas chapter? In order to address this challenge, the participants were divided into two groups (A and B below)

### **REPORTS**

#### ***Discussion group A (Northern America, Brazil, Peru and Guatemala)***

Members: Claudia Travassos, Norberto Dachs (Brazil), Juan Martin Valdivia (Peru), Walter Flores (Guatemala), Richard VanWest-Charles (PAHO/WHO), Eva Fuller (Jamaica), Yves Talbot (Canada), Barbara Starfield (USA), Reporter

Suggestions as agreed to by the group;

- 1) To review articles on interventions towards equity if there are articles to be reviewed;
- 2) To support traveling experts to countries in need of a special consultancy.
- 3) To interpret already existing data in a way that is more useful to policy makers

Yves Talbot presented the questions: What do we know about policy making? Is what is done in northern America translated to the southern hemisphere and vice versa? Are we deepening differences between South and North?

#### ***Discussion group B Spanish speaking specialists***

Carlos Agudelo (Colombia), Debora Tajer (Argentina), Carlos Zamora (Costa Rica), Ricardo Batista Moliner (Bolivia), Guillermo Gonzalez-Perez (Mexico), Carlos Montoya-Aguilar (Chile), Monica Riutort (ISEqH)

Reporter: Caridad Teresita Garcia-Alvarez (Cuba)

#### **Needed Intervention Identified:**

To do an inventory of evaluations on Equity in Health;

To do an inventory of information on equity researchers and interventions;

To gather information on groups and societies which focus on equity, through a questionnaire to be sent to 250 specialists/organizations. The Secretariat of ISEQH could coordinate this task.

**Identifying trends, actions**

Identify the trends and the basic indicators for each country by using the indicators of PAHO/WHO as follows:

Equity in health in the context of economic indicators

Equity and primary health care

Equity and expenditure

Equity and access to health services

Using these four indicators it may be possible to create a formula, taking into consideration the existing review (WHO Newsletter) and the work conducted in Chile that includes research, action and evaluation.

**Collaboration**

One way to undertake and facilitate collaboration would be the publication, on the Society's Web page, of some tables showing the most important indicators in each country. This would help to improve access to each country's information.

**Methodology**

As a variety of methodologies are identified, the group proposes that an analysis be conducted of what methods are actually being used.

**Others**

Make strategic alliances with other network groups, but keep these alliances under the Society's control.

**Funding** is needed so that the Society:

- ? becomes a communication channel in order to obtain the funding of relevant proposed projects;
- ? supports the publications of Southern region papers to reach the English-speaking specialists in order to bring greater impact from the southern part of to the Region;
- ? makes an effort to provide better quality translations into English, and to find a faster way of reaching different language groups in the Region;
- ? supports scientific journals in Spanish and Portuguese in order to increase the regularity of their publication with enhanced funding; and, to support research not only at national, but also at local and sub-regional levels.

*Questions, answers, comments, suggestions*

Some of the items raised in this session covered:

Communication, information and the lack of it, ISEqH meetings, how to reach a larger number of specialists and organizations, how to persuade specialists already involved with other organizations to join ISEqH and The America's Chapter.

It was noted that:

1. reviews and articles can be published in the electronic journal (International Journal for Equity in Health) and that at the biennial conference there is an opportunity to present papers;
2. mechanisms for researchers to pass information to policy makers and activists should be developed;
3. the Society should join with larger associations, jointly publicize activities with them and be present at their meetings;
4. the Toronto Declaration should be re-visited at the next international meeting, (in South Africa in June 2004);
5. timely information needs a special mechanism, to be devised;
6. a proposed 2005 meeting should gather people with similar interests in concepts and methodology.

PAHO/WHO added:

1. that PAHO always tries to collaborate with other organizations that focus on Equity;
2. that the BIREME/PAHO/WHO Virtual Health Library provides space to access scientific and technical information to promote virtual communities on equity.

## **6. EQUITY WITHIN PAHO/WHO**

Richard Van West-Charles, Area Manager,  
Information Knowledge Management, PAHO/WHO

Van West-Charles started his speech on the values, vision and mission of the Pan American Sanitary Bureau (PASB), the secretariat of PAHO/WHO, where all countries are represented, and whose mission it is to co-operate technically with the countries members. One of its values is equity, striving for fairness and justice by eliminating differences; one of its missions is to promote equity in health; thus indicating the importance of equity work for PAHO/WHO.

Global poverty is also a main concern as it is increasing in Latin America, hampering development. Priority for action by PAHO/WHO is concentrated in five countries with the greatest poverty: Bolivia, Nicaragua, Honduras, Guyana and Haiti.

PAHO is also involved with the (United Nations) UN Millennium Development Goals (MDG) with its concern for equity - an important focus of this program - besides poverty.

Research is central to the activities of PAHO. There are thesis grants focused on equity at the doctorate level, and there are also grants for multi-country projects. All PAHO institutions are involved in research, but one of the common issues raised at PAHO is that research across the Ministries of Health is too low.

PAHO also works on the building of researchers' capacity and of their research ability; equity is essential to strengthen human capital, a central issue in the process of development.

The speaker considered how to identify the existence of inequity and considered the approaches towards it that could be political or economic, through health or social determinants. Bolivia was chosen to be used as a case study. Discussions of a collective body of specialists, was aimed at supporting its process of development, hopefully, clarifying which approach is best to identify inequities, and proposing solutions to its remediation in this country. To this end, PAHO/WHO invited Alfredo Calvo, a PAHO/WHO/ Bolivia specialist to present the country's situation.

## **7. CASE STUDY: BOLIVIA**

Alfredo Calvo  
PROFESIONAL NACIONAL EN DESARROLLO  
DE SISTEMAS Y SERVICIOS DE SALUD  
OPS/OMS BOLIVIA

Calvo described the ethnic make-up, political, geographic, and economic aspects of his country, stressing social and health inequalities, which vary not only according to geographic areas, but also within different ethnic groups. The author added that migration also plays an important role in the situation, with migrants' having a higher death rate.

The author illustrated this situation with valuable statistical graphics, demonstrating the extreme poverty, inequities and the low levels of health and health services. For example: the total population is about 8 million out of which, about 62% are identified as Indigenous. Poverty, measured by the unmet basic needs method, affects 59% of the population (91% in

rural and 39% in urban areas). Extreme poverty (below the poverty line) affects, 22%; life expectancy is 64 years; infant mortality is 66/1000. The mortality in children under 2 years in the Quechua community in the Altiplano or mountain plateau, is 206/1000; deaths in children under 5 (1994 data) were caused mainly by diarrhea (36%), pneumonia (20%) and malnutrition (28%).

Other considerations: the existing extreme poverty of part of the population suggests a situation of complete destitution, but at the poverty level, people do have access to food, clothing, and housing; causes of mortality, besides communicable diseases, malaria, violence, include occupational accidents (the highest rate in Latin America). Human resources for health services are provided by the Ministry of Health, the municipalities are responsible for the health infrastructure management.

A problem in the country is the low health services coverage. Health assistance is provided by different sectors; Ministry of Health, municipalities, social security and, the private sector. Only 27% of the population is covered by social security but this proportion represents 40% of the country's total health expenditure. The population covered by the Ministry of Health is 30%, private sector 10%; approximately 30% does not have health coverage. Traditional medicine is a common practice in the Bolivian population.

The country has great expectations in the years to come because the Constitution is to be reviewed through discussions in the Constitutional Assembly (2005-2006). There is a commitment that privatization will be reconsidered and that a referendum will be held concerning liquefied gas production and commercialization.

## **8. DISCUSSION OF THE ROLE OF THE AMERICAS' ISEqH CHAPTER ACTION PROPOSAL FOR BOLIVIA**

Dr. Calvo conducted the discussions, wrote this report, and was applauded after presentation of the conclusions. The specialists present at the discussion, willingly contributed a variety of suggestions, enhancing the Society's decision to use Bolivia's situation as a case study. Calvo synthesized the many proposals as follows:

- Prepare a legislative framework, and a plan for a health research observatory. Form a working group on inequity in Bolivia; co-ordinate the creation of this group with UDAPE, INE.
- Examine non-economic barriers to equity in health such as equity in vulnerable population groups (Indigenous populations).
- Develop a plan for integrating the health services provided by Social Security (Seguridad Social) and Public Health (“Salud Publica”) services using research on the relative efficiency of both existing models of primary health care.
- Develop a plan for decentralizing health services, and supporting municipalities to provide them.

### **9. Cooperation in other Projects of Research, Education and Training, and Advocacy**

In order to develop a plan of action for other aspects of the chapter's work, areas of interest and expertise were provided by the participants. The following section summarizes their presentations.

<b>PARTICIPANTS</b> Areas of Interest and Expertise	<b>AREAS OF WORK ,</b> Qualified Contributors
<p>Carlos Zamora, Costa Rica</p> <ul style="list-style-type: none"> <li>- Legal framework</li> <li>- Health services</li> </ul> <p>Débora Tajer, Argentina</p> <ul style="list-style-type: none"> <li>- Gender equity</li> <li>- Primary health care quality</li> <li>- Vulnerable populations</li> <li>- Research observatory on inequity in health (Planning)</li> </ul> <p>Ricardo Batista, Bolivia</p> <ul style="list-style-type: none"> <li>- Information analysis</li> </ul> <p>Teresita Garcia – Alvarez, Cuba:</p> <ul style="list-style-type: none"> <li>- Gender and sexual reproductive health</li> <li>- Qualitative research</li> </ul> <p>Carlos Agudelo, Colombia:</p> <ul style="list-style-type: none"> <li>- Comparative analysis of health systems</li> <li>- Education and Training</li> </ul> <p>Norberto Dachs, Brasil</p> <ul style="list-style-type: none"> <li>- Survey analysis, and information</li> <li>- Database</li> </ul> <p>José Martín Valdivia, Perú</p> <ul style="list-style-type: none"> <li>- Observatory on inequity in health</li> <li>- Research</li> </ul> <p>Yves Talbot, Canadá</p> <ul style="list-style-type: none"> <li>- Primary health care</li> </ul>	<p>Access, use, quality:</p> <ul style="list-style-type: none"> <li>- Travassos</li> <li>- Fuller</li> </ul> <p>Data analysis:</p> <ul style="list-style-type: none"> <li>- Batista</li> <li>- Dachs</li> <li>- Flores</li> <li>- Travassos</li> </ul> <p>Development of capacity/training:</p> <ul style="list-style-type: none"> <li>- Agudelo</li> <li>- Fuller</li> <li>- Talbot</li> </ul> <p>Gender issues:</p> <ul style="list-style-type: none"> <li>- Tajer</li> <li>- Garcia-Alvarez</li> <li>- Gonzales</li> </ul> <p>International (UK,Canada, Australia) comparisons:</p> <ul style="list-style-type: none"> <li>- Travassos</li> </ul>

<p>Walter Flores, Guatemala</p> <ul style="list-style-type: none"> <li>- Analysis of health information systems for equity</li> <li>- Equity observatory</li> </ul> <p>Claudia Travassos, Brasil</p> <ul style="list-style-type: none"> <li>- Social inequality</li> <li>- Health services</li> <li>- Accessibility, quality, equity or inequity in health</li> <li>- Survey and data analysis</li> <li>- Methodology for the assignment of financial resources</li> </ul> <p>Bárbara Starfield, EEUU</p> <ul style="list-style-type: none"> <li>- Primary health care and health systems</li> <li>- Primary health care concepts and evaluation</li> <li>-</li> </ul> <p>Carlos Montoya, Chile:</p> <ul style="list-style-type: none"> <li>- Planning</li> <li>- Evaluation</li> <li>- Communication channels</li> </ul> <p>Eva Fuller, Jamaica</p> <ul style="list-style-type: none"> <li>- Primary health care: education and training</li> <li>- Access evaluation</li> <li>- Education and Training</li> <li>- Research observatory on equity in health</li> </ul> <p>Guillermo Gonzales, México</p> <ul style="list-style-type: none"> <li>- Research</li> <li>- Qualitative and quantitative studies</li> <li>- Vulnerable Population</li> <li>- Gender equity</li> <li>- Research observatory</li> </ul> <p>Van West-Charles, PAHO/WHO</p> <ul style="list-style-type: none"> <li>- Research observatory</li> </ul>	<p>Legal framework:</p> <ul style="list-style-type: none"> <li>- Zamora</li> </ul> <p>Observatory of Equity:</p> <ul style="list-style-type: none"> <li>- Tajer</li> <li>- Valdivia</li> <li>- Flores</li> <li>- Fuller</li> <li>- Gonzales</li> <li>- Dachs</li> <li>- Van Charles-West</li> <li>- Travassos</li> </ul> <p>Primary care/Health system Trends in inequity:</p> <ul style="list-style-type: none"> <li>- Tajer</li> <li>- Flores</li> </ul> <p><u>Observation:</u> Agudelo indicated that his group can support some activities, as there is already an Andean, Cuban and Dominican Republic collaboration that would be supportive of Observatory and Trends in inequity</p>
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## 10. Specific Next Steps for THE AMERICA' ISEqH CHAPTER and Closing remarks (Yves Talbot, Chair)

Talbot expounded on the main issues that came from the general discussions - besides the potential role of The Americas' ISEqH chapter on Bolivia. These include grants, surveillance issues in equity, the creation of a network of researchers, the chapter's meetings, and communication problems.

There is a possibility to generate some *grants* especially those aiming at promoting changes in Bolivia. The intent is to apply for a PAHO/WHO grant to support this work. Flores, Calvo and Batista are willing to work on the proposed grant. It was proposed that countries work in close collaboration on projects, since situations could be approached in complementary ways by different countries. It was suggested that the Executive Director of the Society centralize all information concerning proposals, meetings, ongoing research, and funds. Martin and Agudelo are willing to collaborate on preparing grant proposals.

As **surveillance of equity** in health is necessary for the continent, a working group was formed by Claudia Travassos and Norberto Dachs (Brasil), Carlos Agudelo (Colombia) and Carlos Zamora (Costa Rica), whose main concerns are: national policies on equity or their absence, results of existing policies, critique of situations likely to create inequity, data base on existing policy on equity in health, inequality in primary health care, and expenditures on health.

As linkages between centers of excellence and those with less experience have proved fruitful in other countries, the creation of a network of researchers was proposed. Barbara Starfield (USA) is willing to work on it in conjunction with the effort she and Bo Burstrom (Sweden) are expending on the ISEqH.

Some suggestions were made concerning The Americas Chapter's next **meetings**: reserving the use of space and dates within other meetings and holding Chapter meetings in between the Society's international meetings. The first meeting will be in conjunction with the ISEqH Conference to be held in Durban, South Africa, June 2004. Hopefully, the following meeting of the Chapter will be held at the 2<sup>nd</sup> Regional Meeting, Bahia, Brazil, 20-23, September 2005, during the World Congress on Health Information and Libraries. The Chapter could organize its own booth at the exhibition area of the Congress.

Other meetings were also mentioned: the ALAMES meeting to be held in Lima, August 2004, the Andean y Caribbean Health Network meeting, October 2004, the Sociedad Boliviana de Salud Publica meeting, La Paz, September 2004. The presence of health equity researchers in these meetings was encouraged, among other ways to increase the society's visibility. Deborah Tajer (Argentina) is willing to coordinate these activities as appropriate.

Yves Talbot, despite leaving the Society's presidency next year, is willing to continue working towards the development of some of the proposed actions.

In answer to the question of how BIREME/PAHO/WHO could help **communication** between equity specialists, Elenice de Castro stated that BIREME runs the Virtual Health Library (VHL). VHL has, among others, a methodology aimed at supporting the development of a virtual community on equity to be promoted by the research group.

Van West-Charles also reported that PAHO/WHO has developed a share point methodology for specialists' communication, which can be used to manage conference calls among participants, but that a Group Moderator is needed.

As a last note, it was mentioned that in 2002 UNESCO and the Brazilian Ministry of Health arranged for translation and publishing of Barbara Starfield's book on *Primary Health Care*. The version in Portuguese (*Atenção primária*) is already on the website of the Ministry of Health, Brazil. Spain has a version in Spanish, but it is not being marketed in Latin America. It was urged that BIREME contact Masson to encourage distribution of the Spanish version in Latin America.

The symbol for the first meeting was a Brazilian agate clock, signifying that it is time to start the discussion on equity research in Americas. In presenting one to each of the participants, Dr. Talbot commented that it symbolized the timeliness of our future work together. He expressed his gratitude to all those who have worked on the organization of the event held at the headquarters of BIREME/PAHO/WHO.

## **ANNEX 1**

### **Questions to be answered by the country specialists, as proposed by the Meeting Organizing Committee:**

1. What is your country most hoping to achieve with regard to equity concerning health?
2. Who supports equity research in your country (national government, other levels of government, foundations, universities or other educational institutions, other)?
3. Of the equity research done in your country, what does it mostly address? (Philosophy and concept of equity; descriptions of inequities; comparisons of equity in different areas; evaluation of interventions to improve equity in health; other issues?) Please give an example of what is being done by researchers in your country.
4. What kind of collaboration would be of benefit to equity researches in your country?

Your written summary will help us make sure that our written summary of the meeting is accurate and reflects what you have said about research on equity in your country.

**ANNEX 2- Agenda****Regional ISEqH meeting*****Creation of the Americas' ISEqH Chapter*****São Paulo, Brazil, 1-2 April 2004**

<b>April, 1<sup>st</sup></b>	
9:00 am – 9:15 am	Opening Remarks: Yves Talbot, ISEqH president
9:15 am – 10:00 am	Presentation: Barbara Starfield - "Opportunities and Challenges of Equity Research in the Americas"
10:00 am – 1:00 pm	Responses from participants according to country experiences (10 minutes each)
1:00 pm – 2:30 pm	<i>Lunch</i>
2:30 pm – 4:00 pm	Creation the Americas ISEqH chapter society
4:00 pm – 6:00 pm	Organization of an agenda for the Americas ISEqH chapter
8:30 pm	<i>Dinner</i>
<b>April, 2<sup>nd</sup></b>	
9:00 am – 9:30 am	Dr. Richard Van West-Charles/PAHO
9:30 am – 1:00 pm	Case Study: Bolivia
1:00 pm – 2:30 pm	<i>Lunch</i>
2:30 pm – 6:00 pm	Bolivia's case study: discussion and action proposals

**ANNEX 3 – List of Participants**

<b>Participants</b>	<b>Countries/Organisations</b>
Agudelo, Carlos	Colombia
Batista, Ricardo	Bolivia
Calvo, Alfredo	Bolivia
Dachs, Norberto	Brazil
Flores, Walter	Guatemala
Garcia-Alvarez, Caridad Teresita	Cuba
González-Pérez, Guillermo J.	Mexico
Lewis-Fuller, Eva	Jamaica
Montoya-Aguilar, Carlos	Chile
Riutort, Monica	ISEqH
Starfield, Barbara	United States of America
Tajer, Debora	Argentina
Talbot, Yves	Canada
Travassos, Claudia	Brazil
Van West-Charles, Richard	PAHO/WHO
Valdivia, José Martin	Peru
Zamora, Carlos	Costa Rica
Observer	
Castro, Elenice	BIREME/PAHO/WHO

**Annex 4** – References submitted

AGUDELO, Carlos. *Equidad en salud en Colombia*

BATISTA MOLINER, Ricardo. *Informe a la reunión de la Sociedad Internacional de Equidad en Salud. São Paulo, 1 y 2 de abril 2004.*

FLORES, Walter. *Inequidades en salud en Guatemala: Magnitud y propuesta de intervención.*

GARCIA-ALVAREZ, Caridad Teresita. *Construcciones de género y barreras para el uso del condon en adolescentes de zonas urbanas y rurales de Cuba.*

GONZALEZ-PEREZ, Guillermo J. & VEGA LOPEZ, Maria Guadalupe. *Documento presentado en la reunion sobre investigación en Equidad en Salud en América Latina. São Paulo, Brasil, Abril, 2004.*

LEWIS-FULLER, Eva. *[Equity in Jamaica]*

MONTOYA AGUILAR, Carlos. *[Equidad en Chile]*

STARFIELD, Barbara. *Opportunities and Challenges of Equity Research in THE AMERICAS.*

TALBOT, Yves. *Equity research [in Canada]*

TRAVASSOS, Claudia. *Desigualdades sociais e utilização de serviços de saúde do Brasil.*

ZAMORA, Carlos. *Equidad: una perspectiva de Costa Rica*