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August 21st - 25th
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SECTION 1

Proceedings of IDRC’s participation in the 11th World Congress on Public Health/ 8th Brazilian Congress on Collective Health
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IDRC sponsored 8 panels in the Congress program. Four of these panels were comprised of Ecohealth partners, while the other 4 were made up of GEH partners. A total of 28 partners participated as coordinators and speakers in these panels. Additionally, many researchers presented their work in other panels at the Congress.
Chapter 1

Panel 1 - An Ecosystem Approach to Environmental Pollution and Public Health in Rural Areas. Research to Policy Linkages

This panel took place on Tuesday, August 22 from 9:30 - 11:00 am in Room C of Pavilion 5 of the Rio Centre.

Panelists analyzed strategies implemented to bridge research into policy and practice in the context of ecosystem-based research projects on environmental pollution in developing countries. Presentations addressed the challenges for a better understanding of social, ecological and health determinants enabling the implementation of evidence-based integrated policies and strategies for better ecosystem management, linking researchers, decision-makers and civil society.

Four panelists from 3 different countries presented their work in this panel, which was coordinated by the Regional Director of IDRC’s Regional Office for Latin America and the Caribbean, Federico Burone.

Panelist 1 – Fadya Orozco, "Human health and changes in potato production technology in the Andean region of Ecuador"

Fadya Orozco, from the International Potato Centre (CIP) in Ecuador presented on "Human health and changes in potato production technology in the Andean region of Ecuador." Her abstract and short paper are found below along with a link to her presentation in the Congress.

Abstract

Fadya Orozco, Centro Internacional de la Papa, Ecuador; Donald Cole, University of Toronto, Canada; Guillermo Pino, Diego Pulgar, Paul Solís, Nelson Rosero, Héctor Chávez, David Guerrero, Plataforma de Productores de Papa, COMPAPA, Ecuador; Ernesto Bravo, Municipalidad de Montúfar; Rodrigo Morales, Municipalidad de Quero, Ecuador.

Since 2005 the International Potato Centre (Centro Internacional de la Papa) and local health and agricultural stakeholders have been implementing a participatory
research-intervention project focused on the impact of pesticides use on agricultural production, human health and the environment. This project is being carried out in the Andean region of Ecuador utilizing four components: data collection on the use, management and health effects of agrochemicals; the application of an epidemiological surveillance system to improve the reporting and recording of pesticide intoxication cases; the development of interventions in agriculture which incorporate aspects of healthy cultivation management; and the development of policies geared to the elimination of highly toxic insecticide use. Using an ecosystem methodological approach, this project promotes the articulation of stakeholders in inter-related networks at parish, county, municipal and provincial levels, as well as the strengthening of institutional and community capacities. Within this participatory decentralised management model, descriptive and experimental studies are carried out in 24 communities. Information gathered through surveys, participatory observations, interviews and focal groups, is analyzed using analytical cross-tabulation, comparative analysis, multi-variate regression and auto-regression analysis. Up to now the main results related to the implementation of processes are:

- The generation of evidence supporting the elimination of environmental and health risks in pesticide use.
- The interest of municipal governments in developing programs to control the agrochemicals trade and residue disposal.
- The demand of farmers for active participation in decision-making in regard to industry involvement in community agricultural activities.
- Health sector involvement in the design and implementation of inter-sectorial strategies to reduce health risks in agriculture.

The expected impact of the project is a reduction in the severity of effects on the environment and human health from the use of agrochemicals on small-scale farms in the Andean zone of Ecuador. This will be achieved through a strong social participation and empowerment process for stakeholders articulated in inter-sectorial networks at different geographical levels.

**Short Paper**

Fadya Orozco, Centro Internacional de la Papa, Quito, Ecuador
Donald Cole, University of Toronto

**Summary**

This article was presented at the 11\textsuperscript{th} World Congress on Public Health, as part of the Research to Policy Linkages Panel organized by IDRC. It focuses on the issue of human health and technological changes in potato cultivation within a process of participatory research-action, applied at different geographical levels together with local stakeholders from the health and agricultural sectors. In this context, it describes
stakeholder decision making-processes, their level of intervention in the reduction of health risks caused by pesticide use, and actions implemented by the Ecohealth project to support this decision-making. Some questions are raised about the process in relation to empowerment, social capital building and sustainability. A study of the process reveals two different approaches for the implementation of research to policy: a macro approach that works with high level bodies and emphasizes the development of innovative systems and a micro approach that begins on a local level emphasizing empowerment and social participation aspects.

Introduction

As an introduction, I would like to briefly share with you some aspects of potato cultivation in Ecuador and externalities in health associated with it. Later I will concentrate on the research-action methodology, addressing the methodological axes, stakeholders and intervention levels involved in the project. Looking at these elements I will raise some questions about the policy-making process and finally I will share with you some reflections.

In Ecuador potatoes and rice are the basic food products, forming the greater part of families’ diets. The extension of potato cultivation is calculated at approximately 50,000 hectares, with an annual production of 450,000 tons, 88% of which is destined for domestic consumption. Potato cultivation and related activities generate employment for more than 100,000 people every year, of which half are women. Some 90% of producers are small and medium-scale.

However, potato cultivation entails externalities in human health related to pesticide use. Our current research, for example, reveals a range of between 1 and 15 pesticide applications per potato cycle, the most widely used products in these types of application being those classified as Ib and II by the WHO. We found that as a result of this usage 6% of cultivation workers have suffered pesticide intoxication in their lives and 2% in the last six months.

Research Process Methodology

The main methodological axes on which the research-action is based are:

- Articulation of inter-sectorial networks: health and agriculture;
- Application of research-action methodology on interrelated geographical levels: communities, parishes, municipalities and provinces;
- Participation and consensual decision-making in different research phases by potato producers, community leaders, specialists and decision-makers on each geographical level;
- Inter-sectorial health and agriculture interventions; and
- Healthy cultivation management approach.
Discussion

In the context of this research methodology, I will identify stakeholders that the project works with at different geographical levels and the relationship between their decision-making and interventions supported by the project in order to influence this decision-making and policy-making.

The first geographical level that I will refer to is that of the community and parish. We are working in 24 communities and 12 parishes. Stakeholders with whom we articulate actions are: formal and informal leaders, agricultural producers and health service providers, all of whom take operative and/or policy decisions that have implications for the individual and collective health of the people. Leaders for example are making operative decisions with collective implications when they allow for the creation of spaces for the promotion of healthy cultivation management practices and their integration in community planning. Potato producers make individual operative decisions when they acquire knowledge, adopt certain approaches and implement practices to reduce health risks from pesticide use. As we see, there is a direct relationship between the decisions made by leaders and those made by potato producers, because the former to a considerable degree facilitate the latter.

In the parish context there are health service providers, mostly of primary health care, who make decisions with implications for individuals in connection with the implementation of diagnosis protocols and treatment for pesticide intoxication patients. They also make decisions with collective implications when they implement information dissemination, the promotion of healthy practices and intoxication prevention activities, and when they record intoxication cases in the monitoring system. This last type of decision in turn supports policy decision-making by stakeholders from other geographical levels.

This decision-making is supported by the project through activities such as the development of field schools; the provision of revolving funds for the purchase of personal protection kits; the presentation of research findings through education and health promotion activities; the promotion of civil rights related to pesticide use and management; and training for health personnel in diagnosis protocols, treatments and health education and promotion techniques.

The second geographical level is that of the municipality. At present we are working in four municipalities. At this level, stakeholders include technical staff from the production and environment departments of Municipal Governments, politicians, mayors, councillors and from the field of health, providers and managers from the national health system. They make operative and policy decisions. In the case of the technical staff, their operative decisions have a collective implication for the distribution of institutional resources to the implementation and monitoring of project intervention activities in parishes and communities. Policy decisions made by mayors
and councillors have a significant impact on the collective health of farmers because these are regulatory decisions aimed at reducing health risks associated with agrochemical use. Such decisions however are conditioned by institutional capacity, political cost and the balancing of impacts, both expected and unexpected, that they will generate. There is a close relation between the technical operative decisions of municipal governments and their policy decisions: these policy decisions facilitate the routine implementation and sustainability of institutional operative decisions. Health areas make an operative decision with consequences for collective health when they implement an epidemiological surveillance system.

These decision-making processes are supported by the project through: technical and financial support for the implementation of activities with farmers; operative research into the political aspect of local government to evaluate the political will for, and feasibility of, implementing intervention policies on pesticide use and health; and through training in the EPIINFO computer system for monitoring system management. At a provincial level our stakeholder partners are agricultural associations of potato producers and provincial health departments, both of whom take operative decisions that have significant consequences for collective health. For example, the associations make decisions about the promotion and marketing of cleaner potatoes and the provision of long term training for associated producers in healthy cultivation management practices. Provincial health departments make decisions regarding the analysis of surveillance systems, the control and monitoring of intoxication cases at the parish level and their reporting at national level. At this level the project’s interventions include financial and technical support for the implementation of activities and the provision of training in surveillance system management. Decisions are mostly operative at this level. At this stage of the project’s development we are still unable to assess their repercussions on decision-making at a national level.

Stakeholders and partners with whom we are working at the different geographical levels and the type of decisions made by them are summarized below. Figure Nº 1.

**Reflections On The Process**

With this methodological background, I want to convey to you some questions regarding policy-making that arose out of our research process:

- Can operative decisions made by stakeholders at the different community levels translate into policy decisions?
- Can policy decisions made at the different community (micro) levels influence policy-making at macro levels (national/international)?
- Can policy-making be influenced by stakeholder mobilization, involvement and empowerment at different geographical levels?

I also want to introduce some reflections on our process and its relation with policy-making:
We think that working with decision-makers and their teams fosters a contextually understanding of the problems they have to deal with in the formulation and implementation of policies.

Some research approaches begin at a micro level and through actions push towards the macro level. In terms of policy-making, results from these cases can be uncertain, their sustainability for example, but achievements such as empowerment, equity and a transdisciplinary perspective of the problem being studied have great significance.

Other approaches can involve very intense work at a macro level (national and international) and may be stronger in sustainability issues, however the weaknesses here are in issues such as equity, empowerment, social capital building and participation.

Bibliography

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Power Point Presentation

Fadya Orozco’s presentation in PDF format is available at http://www.idrc.ca/uploads/user-S/11556750901/orozco_presentacion.pdf
Panelist 2 – Jaime Breilh, “Methodological Innovation, Intercultural Knowledge-Building and Empowerment: Research and the Struggle to Include Ecosystems and the Health in the Agro Industrial Floricultural Region"

Jaime Breilh, a scientist and author from the Health Research and Advisory Centre (CEAS) in Quito, Ecuador presented on “Methodological Innovation, Intercultural Knowledge-Building and Empowerment: Research and the Struggle to Include Ecosystems and the Health in the Agro Industrial Floricultural Region." The abstract of his presentation is found below along with a link to his presentation.

Abstract


Ecuador is one of the largest producers of cut flowers in the world - a typical case of agro-industrial expansion and of the aggressive penetration of new methods of rural capital accumulation. CEAS is well known for its contributions to scientific innovation in the field of collective health and presents the transdisciplinary and compelling results from the first phase of its participatory ecohealth research aimed at: 1) producing research-based knowledge that can be used as a lever for change and in the struggle for equity in addressing ecosystem dynamics and human deterioration linked to floriculture; 2) understanding local conditions for community participation; and 3) determining the feasibility of legal, technical and organizational measures, provided the appropriate research information.

Research questions were focused on: economical and socio-cultural transformations provoked by agribusiness; leadership systems and local water/natural resources
management systems; pesticide dynamics, water demand and sustainability; development of community-based instruments for studying the impacts on biodiversity; ways of life in farms and communities and their relation to exposure patterns; innovative health monitoring and management resources (computer software for clinical health management and worker health prevention monitoring on flower farms); alternative toxicity screening instruments (to replace the incomplete Erythrocyte Acetylcholinesterase screening systems with an alternative affordable test battery to be applied in prevention and control programs and community participative programs); and finally, the experimental development of a community-driven water monitoring system.

Diverse types of high prevalence health impacts were identified (especially chronic low dose forms of neuro-behavioral, blood marrow, liver and genetic toxicity, and the mental health impacts from stressful social relations). However useful and operative results were obtained to address and prevent them. The struggle for fair and ecological floriculture is on the way. The people of the Granobles River Basin are consolidating the new spirit that makes this possible. In this context, the EcoHealth Program is playing an important role to raise awareness and develop resources for protecting human life and nature.

Power Point Presentation

Jaime Breilh’s full presentation in PDF format is available at http://www.idrc.ca/uploads/user-S/11576346761breilh_presentacion.pdf

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Panelist 3 – Horacio Riojas, “Design of a management plan based on the results of an ecohealth study in a manganese basin in Hidalgo, Mexico”

Horacio Riojas, from the National Public Health Institute (INSP) in Mexico, has a doctorate degree in Public Health Sciences with a concentration in epidemiology. The abstract for and his paper on his presentation on the “Design of a management plan based on the results of an ecohealth study in a manganese basin in Hidalgo, Mexico” are found below along with a link to his full presentation made at the Congress.

Abstract
Dr. Horacio Riojas Rodríguez
Instituto Nacional de Salud Pública de México, México

Introduction
The second largest manganese deposits in the Americas, the fifth largest in the world, are found in the north of the State of Hidalgo in northeast Mexico. The exploitation of this mineral in that area has generated concern in neighbouring communities and local governments over the possible effects on health of emissions generated by this activity.

During the period 2002-2004 we carried out a study using the ecosystem approach to human health. The main result showed that the population was exposed to manganese concentrations greater than maximums stipulated by international safety recommendations and that the principal medium of exposure was air. This exposure was associated with under-performance in neuromotor tests.

Management plan design
The partial and final results were presented to and discussed with local communities and other involved stakeholders. Out of this discussion a Management Plan was jointly formulated aimed at reducing exposure. The plan is currently in its first phase of implementation and has five interrelated components:

1) Interventions to reduce exposure;
2) Development and implementation of new regulations;
3) Social participation and risk communication;
4) Epidemiological surveillance and environmental monitoring;
5) Research
6) Inter-institutional coordination.
The function of the research component will be to orientate future actions within the management plan.

**Short Paper**

Dr. Horacio Riojas Rodríguez  
Instituto Nacional de Salud Pública de México, México

**Introduction**

The objective of this presentation is to show how the results of a research project carried out with an ecosystem approach methodology have translated into a management plan involving local community and municipal participation and linked to the public policy of the Hidalgo State government, Mexico. Professionals and researchers from the National Autonomous University of Mexico (Universidad Nacional Autónoma de México), the National Neurology and Neuropsychiatry Institute (Instituto Nacional de Neurología y Neuropsiquiatría) and the National Public Health Institute (Instituto Nacional de Salud Pública) participated in the study, along with the Molango regional inter-sectorial round table, all linked through the State Ecology Council (Consejo Estatal de Ecología) and the State Health Department (Secretaría de Salud Estatal).

This experience is set in the context of a socio-environmental conflict in which inhabitants of communities close to manganese mines and processing plants mobilized and brought complaints to the state authorities about negative impacts on their health and well-being resulting from mining company activity. As a result of these complaints, and at the request of the state government, a pilot study was carried out in which high concentrations of manganese were found in the air and other mediums, as well as in the blood of residents in one of the communities closest to the processing plant. However, in spite of recommendations made to the company based on these findings, the study was questioned on the grounds of being non-representative because it was only carried out in two communities. Subsequently, a more comprehensive project employing an ecosystem approach was designed in meetings and workshops with the participation of several social stakeholders involved in the issue. In 2001 this project was implemented incorporating interdisciplinary and social participation elements in its environmental and health studies. Based on the results of these studies and contributions from involved social stakeholders, a management plan was designed which is currently in its first phase of implementation. Parallel to this, pending research issues are being addressed that will provide a basis for further development of the management plan.

**Objective And Methodology**
Utilising three discipline groups (health, environmental and social sciences) our work had as its objective the understanding of how human activities were altering the dynamics of manganese in the environment and how this translated into undesirable exposure and eventual effects on health. The initial stage of the interdisciplinary approach comprised the discussion of boundary knowledge from those three areas; the determination of research questions based on socially expressed concerns; the construction of a common framework to delimit the ecosystem based on a study of the manganese basin; and the selection of a representative population sample to apply the study to. The second stage comprised the coordination of field work, the definition of the team’s commitments to communities and other involved stakeholders (state institutions and the company) and the presentation of progress reports and results. The third stage involved the discussion of results, agreement on the study’s principal conclusions and, very importantly, the joint presentation of results, conclusions and recommendations.

It must be emphasized that we do not view communities or government stakeholders as homogeneous blocks. We found that the communities’ interests and needs were related to their individual history with the mining industry. Within each community we identified different groups with differing information related to the problem. We observed, for example, clear gender and generational differences in our work with women’s groups, community assemblies, school and youth groups, and through in-depth interviews with the elderly. With government institutions, we found some, typified by the state environment department, that were interested in developing a regulative and self-regulatory policy towards the company based on the best evidence, and others that favoured protecting the company’s interests. The environment department (COEDE) was the institution in charge of coordinating the “Molango Regional Intersectorial Table” (Mesa Intersectorial para la Región de Molango), which played a very important role in the presentation of results and their translation into public policy.

Results

The results of the study included an assessment of manganese levels in drinking water, sedimentary water, river water, soils and air. Here we will only refer to concentrations in air as these are the most relevant from a toxicological point of view. We found significantly higher manganese concentrations in communities located closest to manganese operations than in those further away and that these concentrations were up to three times higher than the maximums recommended by the World Health Organization for populations not occupationally exposed (0.05 micrograms per cubic meter). In addition, we found a relationship between manganese concentrations in the air and poor performance in neuromotor tests, as had been reported in previous studies.1

The presentation of the final results included a workshop in which there was greater community and municipal authority participation than in the prior workshop. The causes of contamination in the zone were analyzed in this workshop and the project’s
conclusions and recommendations were presented. These discussions served to outline the main elements in a plan of action.

The proposals produced by the workshop addressed different lines and levels of action. This workshop was significant in that it marked the beginning of public policy-making based on a consensus about the magnitude of the problem and the principal mediums of exposure to be dealt with. We must point out though that disagreements continued to exist in regard to some significant aspects, but there was agreement that a program of action should proceed with the participation of the three stakeholder groups involved.

In subsequent meetings outlines for management plan programs were worked out with those responsible for the coordination of each one. It was also agreed that each of these sub-groups would formulate their program including a schedule and budget. This stage coincided with a change of state authorities and the challenge was not only to ensure continuity in this process but also to formally incorporate in the program the government of the next six years. Fortunately, the people in the environment department who continued in their positions from the old government to the new one were able to provide continuity for the inter-sectorial round-table and build the foundations of a regional program.

Strategies were formulated to ensure an effective implementation of the management plan and its long term sustainability. One of these was inter-sectorial round table strengthening and broadening with the regular incorporation of community representatives in its sessions. This was not an option in the past as institutions preferred to design and agree on actions themselves and only afterwards inform the communities of them, a state of affairs that is now changing. It was also clear from past experience that greater incorporation of municipal authorities was necessary since they are the link between communities and state institutions. As municipal governments were also about to change at that time, we designed a presentation of study results and the management plan for municipal authorities with a view to promoting better connections and collaboration. In addition, as has already been mentioned, it was strategic under these circumstances to secure the availability of public resources for this plan. To this end, the program sub-groups included their program in the 2006 public budget. Finally, it was necessary to continue the research to further strengthen the management plan.

Operative programs linked to the regional state government project “Integral Care Management for Molango Mining District” (“Gestión para la Atención Integral del Distrito Minero de Molango”) are currently being run by several state offices. The principal elements and guidelines for these programs came from the planning workshop proposals. The inclusion of these proposals in government programs demonstrates the value of an ecosystem approach in the generation of public policy for exposure reduction. An integral approach and linkage with stakeholders have been very important in achieving that.
The Present And The Future

Activities now being developed include:

1. The discussion of a new regulatory framework based on research project results with a view to establishing progressive health goals until manganese levels that are safe for the population are achieved. Some issues that need to be addressed in order to facilitate progress are: the definition of environmental and health authorities’ jurisdiction; the feasibility of monitoring manganese levels for regulatory control; and the necessary capacity building for the establishment of an adequate monitoring system.

2. Linked to the above, a mobile monitoring unit has been set up but there are plans to establish fixed units on the basis of results from a particle diffusion study currently in progress.

3. An analysis of manganese production processes to determine where the company should invest in emission reduction.

4. A training program for environmental promoters aimed at establishing a permanent network in which institution personnel and community members can participate.

5. The prohibition of the use of mining produced slag for road surfacing; a program of covering open pits with native trees; and the clearing of waste situated by the side of country roads.

It should be pointed out that government announcements in support of these actions would not on their own guarantee their realization, in fact we think that various factors have still to be taken into account for the management plan to be considered as being truly functional. We consider that this project has facilitated regional level decision-making based on the results of the study and that it has contributed to the generation of a process aimed at improved ecosystem management. However it has to be clarified that:

1. This management plan is at an initial stage but it needs to generate results that are visible to involved stakeholders in the short, medium and long term.

2. Some resistance still has to be overcome, for example to a cleaner production process and the generation of regulations in the near future.

3. The intervention and decision-making capacity of communities is still minimal and the creation of synergies with the municipal authorities is necessary to
strengthen their participation in decision-making. Similarly a strengthening of coordination between municipalities and state institutions is needed.

4. Capacity building at an institutional, municipal and community level is required in order to guarantee the development program’s long term sustainability.

TABLE 1

<table>
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<th>RISK MANAGEMENT PLAN FOR MANGANESE EXPOSURE. PROGRAMS ORIGINATING IN THE PLANNING WORKSHOP AND THEIR IMPLEMENTING BODIES</th>
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<td>• Integral Deposit Management: SEMARNAT-COEDE</td>
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<td>• Epidemiological Vigilance and Integral Management of Populations at Risk: SSH</td>
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<tr>
<td>• Regulatory Framework: PROFEPA-INSP-SEMARNAT-SSH (federal and state)</td>
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<td>• Monitoring and Surveillance Systems PROFEPA-INSP-COEDE-COMPANY</td>
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<td>• Communication and Environmental Education INSP-SEMARNAT</td>
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New Knowledge: INSP-PUMA-INNN
Community infrastructure: MUNICIPALITIES-COEDE-DEPARTMENT OF THE INTERIOR (SECRETARIA DE GOBIERNO)
Ecological Recuperation: SEMARNAT-COEDE
Corporate Practice Improvement: STATE MINING INSTITUTE (INSTITUTO DE MINERÍA DEL ESTADO) -COMPANY
Health authority practices: SSH

SEMARNAT. Environment and Natural Resources Department (Secretaría del Medio Ambiente y Recursos Naturales).
COEDE. State Ecology Council (Consejo Estatal de Ecología)
SSH. Hidalgo Health Services (Servicios de Salud de Hidalgo).
PROFEPA. Federal Environmental Protection Agency (Procuraduría Federal de Protección al Ambiente).
INSP. National Public Health Institute (Instituto Nacional de Salud Pública)
PUMA. University Environment Program. National Autonomous University of Mexico (Programa Universitario de Medio Ambiente. Universidad Nacional Autónoma de México).
INNN. National Neurology and Neuropsychiatry Institute (Instituto Nacional de Neurología y Neuropsiquiatría)

Referencias


Power Point Presentation
Panelist 4 – Mitko Voutchkov, “Ecohealth of Lead and Cadmium in Jamaica”

Mitko Voutchkov, Senior Research Fellow at the International Centre for Environmental and Nuclear Sciences in Kingston, Jamaica presented on the Ecohealth of Lead and Cadmium in Jamaica. The abstract of his presentation can be found below along with a link to his presentation.

Abstract

Mitko Voutchkov, Gerald Lalor
International Centre for Environmental and Nuclear Sciences
University of the West Indies, Kingston, Jamaica

Lead and cadmium are cumulative poisons with long biological half lives in the bodies. While lead affects primarily preschool-aged children, cadmium causes disease in adults. Exposure to lead is a major concern because the metal can damage the brain and reduce a child’s intelligence. Cadmium accumulates over a lifetime in the body and can cause kidney failure, bone fractures and other health problems in adults.

The first reported cases of lead poisoning in Jamaica appear to have been the “dry belly ache” that afflicted members of the Jamaica garrison in 1786 who drank rum stored in lead-glazed earthenware pots and was diagnosed by the surgeon John Hunter. In 1956 a two-year-old child was lead poisoned as a result of playing with a smashed motorcar’s lead acid batteries in the yard. A survey conducted in 1985 of residents living near lead smelters in Jamaica found that more than 51% of children
and 60% of adults were lead poisoned with blood lead levels > 40 µg/dl. The lead exposure of lead-acid battery workers identified 65% of repair-shop workers and 28% of manufacturing workers with blood lead levels > 60µg/dl. Secondary lead smelters also caused the lead poisoning of over 100 children. In 1996 several children were severely lead poisoned by some mine waste containing lead in their schoolyard. An intervention campaign, which included the encapsulation of lead contamination, nutritional enhancement and community lead-safe education significantly reduced children’s blood lead levels. The follow-up screenings in 2002 and 2005 did not find any children with blood lead levels greater than 10 µg/dl. Island-wide blood lead screenings carried out in 2002-2005 confirmed that today backyard lead smelters cause most cases of lead poisoning in children. Many children were lead-poisoned and several received chelation therapies. Members of the affected communities, teachers and parents were involved in all aspects of the mitigation and education activities and contributed significantly to the successful reduction of children’s blood lead levels. Cadmium is present in unusually high concentrations in Jamaican soils and as such is present in the food chain. Elevated levels of cadmium were found in several food crops grown in high cadmium areas. It is being transferred to animals and people however to date no adverse health effects have been found. Food is the main source of human exposure to cadmium and a dietary survey is currently being carried out to assess the cadmium intake of farmers and residents in these areas. To evaluate the relationship between cadmium exposure and health effects, biomarkers of lifetime exposure such as urine and autopsy kidney samples were collected and analysed for cadmium. Further results from this study will contribute to a better understanding of the health effects of cadmium.

Power Point Presentation

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Chapter 2


This panel took place in Room E of Pavilion 5 of the Rio Centre between 3 and 4:30 pm on August 22nd.

The objective of this panel was to discuss the use of research results in the formulation and implementation of health policies, with the view to induce the incorporation of proven scientific evidence in the creation of policies, which are more effective in overcoming inequalities and reaching greater levels of equity in health services.

Celia Almeida from the Sergio Arauca National School of Public Health (ENSP) in Rio de Janeiro, Brazil, coordinated the four panelists who originated from Canada, Brazil and the United States.

Panelist 1 – Victor Neufeld, “Promoting the use of research results: the experience of The Canadian Coalition for Global Health Research”

Victor Neufeld, is a physician, educator and international consultant, as well as the National Coordinator for the Canadian Coalition for Global Health Research in Ottawa, Canada. The abstract for his presentation entitled “Promoting the use of research results: the experience of The Canadian Coalition for Global Health Research” is found below.

Abstract

Vic Neufeld -Canadian Coalition for Global Health Research, Ottawa, Canada

The Canadian Coalition for Global Health Research (CCGHR) is a not-for-profit organization committed to promoting increased Canadian investment and involvement in global health research—that is, research on problems borne by societies in low and middle-income countries (LMICs). In order to carry out its mission, the CCGHR has several task groups, one of which - the task group on “Research to Action” - provides products and services on the strategies by which health research is translated into
changes in policy-making, program management, practitioner behavior and community action.

A flagship activity of the CCGHR is an annual “Summer Institute for New Global Health Researchers”. The summer institute (SI) is a 5-day intensive workshop designed for pairs (“dyads”) of researchers with one participant from a LMIC and one from Canada, who are members of the same project or program team. The goal of the SI is to promote and support research partnerships in addressing a specific research to action challenge. Participants are expected to develop a specific “research to action” implementation plan by the end of the institute.

Each SI involves up to 12 “dyads” (24 participants) along with faculty facilitators and resource persons. The first institute took place in Halifax, Canada in 2004, which the second was held at the Ifakara Health Research and Development Centre in Tanzania. The 3rd SI will be held in Cuernavaca, Mexico from July 9 to 15, 2006.

This presentation will report on the outcomes of the first three Summer Institutes, with a particular focus on the most recent experience in Mexico. The presentation will include examples of “research to action” projects developed by participants, and will describe the outcomes to date. The presentation will also summarize lessons learned and challenges for the future.

**Power Point Presentation**

![Presentation Plan]


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Panelist 2 – Eduardo Levcovitz, “Use of Research Results in Decision-making, Formulation and Implementation in Health Policies”

Eduardo Levcovitz is the Chief of Health Systems and Policies Unit at the Pan American Health Organization (PAHO) in Washington DC. The link to his presentation on the Use of Research Results in Decision-making, Formulation and Implementation in Health Policies is found below.

Power Point Presentation

Eduardo Levcovitz’s full presentation is available in PDF format in its original language (Spanish) at:

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Panelist 3 – Linda Murphy, “One Funder’s Experience With The Challenges And Opportunities Of Increasing Research Use In The Canadian Health System: Our ‘Push’ And ‘Pull’ Strategies”

Linda Murphy, from the Canadian Health Services Research Foundation (CHSRF), in Ottawa, Canada presented on “One Funder’s Experience With The Challenges And Opportunities Of Increasing Research Use In The Canadian Health System: Our ‘Push’ And ‘Pull’ Strategies”. The abstract, short paper and link to her complete presentation are found below.

Abstract

Linda Murphy -Canadian Health Services Research Foundation (CHSRF)

Purpose

The Canadian Health Services Research Foundation (CHSRF) has worked for almost ten years to strengthen Canada’s applied health services and policy research evidence base and to support its use by health system policy makers and managers and their organizations. The foundation’s key strategies to strengthen the capacity of and to build bridges between the health services and policy researcher and research user communities, will be outlined with emphasis on research use capacity development initiatives and initial data about early impacts and outcomes.

Methods

CHSRF’s key concepts of linkage and exchange, and its ‘push’ and ‘pull’ strategies for research use will be outlined briefly with reference to key foundation programs, including:

1) the Executive Training for Research Application (EXTRA) program, designed to develop the skills of healthcare leaders to find, assess, interpret and apply research evidence to bring about innovation and change within their organizations;

2) the knowledge-brokering demonstration site program, which enabled six organizations to implement context-specific knowledge brokering within their organizations with the aim of linking decision makers and researchers, and;

3) the “Is Research Working for You? A Self-Assessment” tool, developed to help organizations, benchmark, and advance their capacity to gather, interpret and use research evidence in decision-making.

Conclusions

Early evaluative research data on the EXTRA program demonstrates some of the changes occurring within leadership ranks and host organizations, and other data on
the lateral impact of these programs. There is broad international interest in the foundation’s efforts to support the use of research health system managers and policy makers to promote evidence-informed management and innovation in healthcare and this has been an important catalyst for other exciting ventures in this domain.

**Power Point Presentation**

![Push and Pull' Strategies for Research Use in the Canadian Healthcare System](image)

Linda Murphy’s presentation in its original language (English) is available at: [http://www.idrc.ca/uploads/user-S/11581699201murphy_presentation2.pdf](http://www.idrc.ca/uploads/user-S/11581699201murphy_presentation2.pdf)

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**Panelist 4 – Patricia Pittman, “Translation of Research into Policy and Practice: Trade-Offs in the Design of Knowledge Transfer Strategies”**

Patricia Pittman is a Vice President at AcademyHealth, based in Washington, D.C. Please read her presentation abstract below on “Translation of Research into Policy and Practice: Trade-Offs in the Design of Knowledge Transfer Strategies” and access her presentation through the link to the IDRC website.

**Abstract**
Interest in moving research into policy and practice in health care has existed since the consolidation of health services research as an applied field of study in the early 1970s in the United States. During this time leaders and funding organizations in the field have moved the blame for the minimal uptake of research from researchers to the politics of policymaking and decision makers themselves. This paper reports on the preliminary results from the first 18 months of the Knowledge Transfer (KT) Program at the Agency for Healthcare Research and Quality (for which AcademyHealth serves as a contractor). It uses the program as an example for examining the range of translational activities that are being employed in the U.S to ensure that research is not forgotten on the shelf.

Despite their preliminary fascination with peer exchange through formal learning networks, teams involved in this program increasingly recognized that individual or group opportunities for client designed technical assistance (TA) ensure the best results for research uptake – at least in a situation relatively free from financial constraints. Similar to the notion of Allied Research that was used in the design of the Pan American Health Organization - International Development Research Centre project on social protection in health, TA is at the interface of both the push and pull of research uptake. It can only be successful when there has been relevant research and decision makers are interested in using evidence to help inform policies. Unlike Allied Research, the focus of TA is not restricted to a single research project or program; includes transferring experiential knowledge, as well as research based knowledge; and it occurs following completion of, rather than during, the research design and implementation policies. While group TA is effective, it is also highly time consuming and costly, which brings to light long overdue questions about cost and effectiveness trade-offs in the design and implementation of KT strategies.

**Power Point Presentation**

Patricia Pittman’s presentation is available in PDF format (in English) at: http://www.idrc.ca/uploads/user-S/11570319681pittman_presentation.pdf
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Chapter 3

Panel 3 – An Ecohealth Approach; Globalization, Urban Challenges and Public Health. Research to Policy Linkages

On the second day of the Congress, from 9:30 to 11:00 in Room E of Pavilion 5, Ecohealth partners presented their second panel.

The focus of the panel was on the environmental and human health challenges posed by human activities and uneven development in urban environments, especially in slums or informal settlements where they are particularly acute. Not only are slums vulnerable places, but they also house vulnerable people - children, the aged, the handicapped, women and the socially disadvantaged - with a predisposition or sensitivity to be stressed by events, leading to illness, harm or other negative outcomes. Using international case studies, panelists discussed some of the complex linkages between globalization, urbanization and human health, and some of the challenges in linking participatory research, decision-making and policy influence.

Three panellists from Latin America, Asia and Africa presented their work in this area. Ana Boischio, IDRC Senior Program Specialist from Ecohealth, coordinated the activity.

Panelist 1 – Robert Fincham, “An Integrative Framework for Policy Formulation at the Local Level: The Case of Health and Housing in Pietermaritzburg, South Africa”

Robert Fincham, from the Centre for Environment, Agriculture and Development at the University of KwaZulu-Natal in South Africa was first to present. His abstract of and the link to his presentation on “An Integrative Framework for Policy Formulation at the Local Level: The Case of Health and Housing in Pietermaritzburg, South Africa” are found below.

Abstract

Professor Rob Fincham, Centre for Environment, Agriculture and Development, University of Kwa Zulu-Natal, South Africa
Dr. Allison Goebel, Queen’s University, Kingston, Canada
Processes of globalization, interacting with the post-Apartheid context in South Africa, have contributed to institutional and policy developments with critical impacts on municipalities. These include the devolution of key responsibilities such as the delivery of low cost housing to municipalities, while expanding their areas of jurisdiction to encompass and integrate formerly “white” with “black” areas. These developments have resulted in over-stretched services and drastic capacity shortages at the municipal level. Housing and health have emerged as top national priorities, while concern over environmental sustainability consistently emerges as a long-term strategic issue. Little research or policy exists, however, that investigates or addresses the important relationships among these three elements. Our project attempts to fill this gap, by utilizing a transdisciplinary approach that builds partnerships amongst local government officials, civil society groups, communities and researchers. Our project is focused on low cost housing developments in Pietermaritzburg, the capital city of the province of KwaZulu-Natal - demographically the largest of the nine provinces in South Africa. Using a set of integrative methodologies, including database searches, key informant interviews, workshops and interview instruments designed to enhance participatory community interactions and longitudinal community studies, a number of significant research findings are emerging. A mismatch exists between the data available to analyse health, housing and environmental conditions at the local level and the implementation of the national policy framework intended to address these selfsame issues. Furthermore, the policy framework to address these issues remains fragmented. In spite of laudable Integrated Development Plans (IDPs) and Spatial Development Frameworks, health, housing and environment remain separate, poorly integrated portfolios at the local level. Ongoing research will target the refinement and acceptance of a research instrument that will integrate research processes and findings into a holistic policy framework at the local level. The survey instrument is designed for longitudinal research, and includes scientific questions relating to a range of health outcomes and their relationship to specific housing policy interventions and environmental disruptions. A range of subjective questions is designed to provide insight into people’s well-being, happiness and sense of place.

**Power Point Presentation**

Robert Fincham’s full presentation in its original language (English) is available at: [http://www.idrc.ca/uploads/user-S/11556773521fincham_presentation.pdf](http://www.idrc.ca/uploads/user-S/11556773521fincham_presentation.pdf)
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Panelist 2 – Durga Datt Joshi, “An Urban Ecosystem Health Approach to Make a City and Better Health in Kathmandu, Nepal”

Durga Datt Joshi from the National Zoonoses and Food Hygiene Research Centre, Kathmandu, Nepal presented his work on “An Urban Ecosystem Health Approach to Make a City and Better Health in Kathmandu, Nepal”. The abstract for the presentation, a short paper on the project and the link to the presentation itself are found below.

Abstract

Durga Datt Joshi, Minu Sharma - National Zoonoses and Food Hygiene Research Centre (NZFHRC), Kathmandu, Nepal

The growth in population, housing, roads, and small-scale industries in Kathmandu over the past three decades has created very serious health hazards. There is severe water pollution in the Bishnumati and Bagmati rivers in the Kathmandu Valley and air pollution from gas vehicles and agro-based industrial sources. This means that people suffer from many airborne, waterborne and Zoonotic diseases.

A research study was carried out between 1992 and 2001 in Kathmandu Metropolitan City (KMC). Initially designed to investigate risk factors for cystic hydatidsoes, and to create effective programs to prevent its transmission, the work was carried out in two project stages (from 1992-1996 and 1998-2001). There were three main phases of activities in the development of the project: epidemiological investigative phase (1992-1996); analytical systemic phase focusing on the link between social, ecological, and health variables in an ecosystem approach to health (1998-2001); and synthesis phase employing a variety of systemic, narrative, and participatory research tools (2001). With funding from Canada’s International Development Research Centre (IDRC), the National Zoonoses and Food Hygiene Research Centre (NZFHRC), has joined forces with the Nepalese community agency Social Action for Grassroots Unity and Networking (SAGUN). The research has been
used to influence policy in Nepal, resulting in the new Animal Slaughtering and Meat Inspection Act, modification of the Nepal Food Act, modification of the Infectious Disease and Public Act, revision of the Kathmandu valley housing plan, and revision of the Nepal Drinking Water and Sewerage Plan. The Nepal Butchers’ Association and Nepal Meat Marketing Association are helping to change present animal slaughtering practices and improve their communities not only in and around the Kathmandu valley but also in other parts of the Kingdom of Nepal. One of the impacts of the urban ecosystem health project has been the reduction of disease in KMC due to the enclosure of slaughter yards and the provision of clean drinking water.

In addition to the policy influence outlined above, other project outcomes include positive development impacts on the two wards of Kathmandu involved in the study and improved stakeholder capacity from training. The results of the research have started to be communicated to a larger audience but more effort needs to be made in this area. The results have also been used by the commercial sector to innovate in the meat-processing field. Finally, the project researchers themselves have been introduced to the participatory approach to research for their future work.

**Short Paper**

*Durga Datt Joshi, Minu Sharma* - National Zoonoses and Food Hygiene Research Centre (NZFHRC), Kathmandu, Nepal

**Introduction**

Nepal is often portrayed as a land of rural villages and hamlets. Nevertheless, it is also a land of ancient cities such as Kathmandu, which has one of the fastest growing populations in the South Asian region. The growth in population, housing, roads, and small-scale industries in Kathmandu over the past three decades has created very serious health hazards. There is severe water pollution in the Bishnumati and Bagmati rivers in the Kathmandu Valley and air pollution from gas vehicles and agro-based industrial sources. This means that people suffer from many airborne, waterborne and Zoonotic diseases. Previous research on urban Echinococcosis/hydatidosis in Kathmandu Metropolitan City (KMC) wards 19 and 20, conducted between 1992 and 1998 has shown that public health concerns in this area include sanitation, unhygienic open air slaughter houses and carcass disposal, food hygiene, and zoonoses. It is important to understand that these seemingly independent concerns are in fact part of an overall eco-system, connected to one another through obligatory relationships, interdependence, and causal relations. Participatory Action Research (PAR) projects on Urban Ecosystem Approaches to Health, were conducted in two phases (Phase 1: 1998-2001, Phase 2: 2003-2006) in Kathmandu, supported by the International Development Research Centre (IDRC), Canada. The effort was based on the belief that improvements in ecosystem management through community initiatives can also improve human health and well-being.
Objectives

The specific objectives of the project were:

- to assist communities in wards 19 and 20 to define and describe the socio-ecological systems in which they live and work;
- to identify stakeholders with their needs, problems and indicators of ecosystem health;
- to set short and long term goals;
- to monitor the activities and assess the health indicators.

A further objective is to disseminate and share the findings of research from the first phase of the project.

Methodology

The relationship between urban ecosystems and public health, the activities of different stakeholders, their needs and their resources were studied in relation to water food and waste. Issues affecting butchers were studied in detail in the form of a stakeholder case study. Wards 19 and 20, situated in the inner city, have dense populations and much of their economic activity is related to butchering and meat sales, produce sales and the hotel trade. For these reasons, the wards constitute a substantial share of Kathmandu’s solid waste generation. In a survey carried out for the purpose of the project, 27% of households in the two wards perceived the garbage situation as extremely hazardous.

A research study was carried out between 1992 and 2001 in Kathmandu Metropolitan City (KMC). Initially designed to investigate risk factors for cystic hydatidosis, and to create effective programs to prevent its transmission, the work was carried out in two project stages (from 1992-1998 and 1998-2001). There were three main phases of activities in the development of the project: epidemiological investigative phase (1992-1998); analytical systemic phase focusing on the link between social, ecological, and health variables in an ecosystem approach to health (1998-2001); and a synthesis phase employing a variety of systemic, narrative, and participatory research tools (2001). With funding from IDRC, the National Zoonoses and Food Hygiene Research Centre (NZFHRC) conducted the research study. The research has been used to influence policy in Nepal, resulting in the new Animal Slaughtering and Meat Inspection Act, modification of the Nepal Food Act, modification of the Infectious Disease and Public Act, revision of the Kathmandu valley housing plan, and revision of the Nepal Drinking Water and Sewerage Plan. The Nepal Butchers' Association and Nepal Meat Marketing Association are helping to change present animal slaughtering practices and improve their communities not only in and around the Kathmandu valley but also in other parts of the Kingdom of Nepal. The second phase of the project (2003-2006) was started with the overall objectives


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to further enhance the ability of community groups and ward authorities in Kathmandu City to disseminate and share research findings from the first phase of the project, as well as to set in place sustainable processes to better understand and improve the management of socio-ecological system and ultimately human health.

**Results**

The key outputs of project activities included:

1. a systemic description of the urban socio-ecological system, including a detailed description of the communities, activities, major concerns and needs,
2. stakeholder-specific action plans,
3. development of ecosystem health indicators, and
4. implementation of collective action plans for improving the situation.

Baseline research for this project indicated that approximately 36% of meat vendors worked in very poor sanitary conditions. In 43% of slaughtering sites, slaughtering was carried out in open areas. This project has assisted in the formulation and implementation of new laws and regulations, in coordination with the state government responsible for controlling and maintaining food hygiene standards, meat slaughtering, sales and handling standards to reduce the effects of food borne and water borne diseases on human health. The local government also banned open-air slaughtering practices, which was an important source of the environmental problem. Now slaughtering practices have moved to closed courtyards and the disposal of waste in the river is prohibited.

Reflection classes, health education training, mass awareness programs in the community, drinking water quality management training, stakeholders training, butchers and meat sellers training, and hotel and restaurant staff training have been carried out. The butchers no longer keep their water buffaloes outside their houses or along the riverside. There is a buffalo, sheep and goat-marketing centre where butchers buy and slaughter according to their needs. One of the impacts of the urban ecosystem health project has been the reduction of disease in KMC due to the enclosure of slaughter yards, the provision of clean drinking water and the proper management of garbage.

In addition to the policy influence outlined above, other project outcomes include positive impacts in wards 19 and 20 and improved stakeholder capacity from training. The results of the research have started to be communicated to a larger audience but more effort needs to be made in this area. The results have also been used by the commercial sector to innovate in the meat-processing field.

**Outcomes**

The major outcomes of the project in improving ecosystem health include:
Riverside cleanup - a fence was built along the river and different plants were planted inside the fence, and a beautiful garden was made at the corner of Bishnumati Bridge.

Public toilets - with the help of the ward office two public toilets have been constructed in order to lower the incidence of public defecation.

Garbage management training - community members have been provided with garbage management training, learning how to sort garbage before collection, and separate organic waste which is being collected by local clubs to make compost.

Cleanliness - awareness was raised among the community regarding cleanliness. Notice boards have been put up around some of the water taps that advise people not to bathe or wash clothes there, since these are very important sources of drinking water.

Butchering practices - a number of training and awareness programs have been conducted with local butchers. The local government also banned open-air slaughtering practices, which was an important source of the environmental problem. With slaughtering practices moved to closed courtyards, and the disposal of waste in the river prohibited, previous slaughtering sites have now been converted into beautiful roadside.

Public health training and equipment - public health clinic personnel have been provided with training for the examination of stool and urine samples. The urban health clinics were provided the basic laboratory equipment necessary to test stool and urine samples, as well as drinking water.

Rabies vaccinations - dogs in the community, both pets and stray have been vaccinated against rabies.

Drinking water quality - community members have been trained to monitor and manage drinking water quality. They test different water sources in the community and disseminate the results to the rest of the community. With this increased awareness of drinking water quality, the incidence of water borne diseases has decreased.

Parasitic diseases - all environmental factors related to parasitic diseases transmission in the community have improved and people are more aware of their health, taking care to prevent disease transmission. The stool and urine test training means that there is technical know-how, as well as a lab in the health centre.

Disease awareness - through reflection classes, health education training, a mass awareness program in the community, drinking water quality management training, stakeholders training, butcher and meat-sellers training, hotel and restaurant staff training, there is improved knowledge on various diseases and their transmission.
Meat sector training - one-day specific training on meat borne diseases, animal slaughtering and the Meat Inspection Act was organized, which helped, raise awareness among the businessmen related to the particular field.

Livestock zone - none of the butchers keep their water buffaloes outside the house nor do they keep along the riverside any more. There is now a contractor, who keeps all the buffaloes as well as sheep and goats outside the Kalanki side ring road where the butchers buy and slaughter according to their needs.

Hygiene and sanitation training - there are now well-maintained, small-scale teashops, hotels and restaurants in these wards where meat snacks and fast foods are available for consumers. Although most remain along the roadside, they have also received hygiene and sanitation training as well as information on how to protect, preserve and store prepared food materials.

**Impact Assessment Results of the Project**

The influence on policy of the different activities is worth noting since changes have been made both on the municipal (anti-dumping policy to protect the Bishnumati River) and national (changes underway to the Nepal Food Act and Meat Inspection Act) levels.

Impacts can also be seen at the community or regional level, both in terms of physical improvements such as the relocation of slaughtering sites, and in terms of research and capacity building through a number of training and awareness programs.

**Reach of Research**

The reach of the research extends from local community members to consumers to policy makers with changes made to practices and habits, to physical installations and to public policy.

**Acknowledgements**

We are most grateful to International Development Research Centre (IDRC) Ottawa, Canada for their kind financial and technical support for this project.

**Bibliographic References**


**Power Point Presentation**

An Urban Ecosystem Health Approach to Make a Cleaner City and Better Health in Kathmandu, Nepal

Dr. Durga Datt Joshi
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The full presentation of Durga Datt Joshi in PDF format in its original language (English) at:
Panelist 3 – Marcelo Korc, “Urban Ecological Challenges in Latin America and the Caribbean. The Healthy Housing Initiative: Linking Research to Policy”

Marcelo Korc, from the Pan American Health Organization in Caracas, Venezuela presented his work on “Urban Ecological Challenges in Latin America and the Caribbean. The Healthy Housing Initiative: Linking Research to Policy”. His presentation abstract and the link to his presentation are found below.

Marcelo E. Korc - Pan American Health Organization, Caracas, Venezuela.

For several years, human settlements have been acknowledged as one of the main determinants of health. Human settlements can either support or limit the physical, mental, and social health of their residents. Although these effects are broadly accepted, the concrete relationship between the quality of the settlements and the health of its residents has not been fully understood so far. One of the most challenging housing and urban development issues in the Latin American and Caribbean countries are the conditions of the urban precarious settlements or urban slums. Approximately 130 million people in the urban areas of the region live in precarious conditions. In Haiti, Nicaragua, Peru, Belize, Guatemala and Bolivia more than 50% of the urban population lives in slums. The authorities have not yet properly recognized the magnitude of the problem. In several countries in the region, housing and urban development policies have focused primarily on the physical structure of the dwelling and financial issues without taking into consideration the ecological conditions of the settlements and the potential effect on the health of the residents. Nor have they integrated the meaning of home and community. In addition, these policies have been implemented without collecting and analyzing the information...
needed to assess their potential effect on the health of the residents, with limited participation of the residents, and with no respect for local cultures and customs. The healthy housing strategy promotes and protects the health of the population from the hazards that it is exposed to in slums. It is the implementation of a regional initiative that links research to policy using an integrated approach. The strategy requires strong political commitment, solid technical and intercultural experience, permanent intersectoral collaboration, a multidisciplinary focus, and a high degree of community participation.

This paper discusses the relationships between the physical, ecological, and social conditions of urban slums and the health of its residents in three cities of the region. In addition, it presents the approach of the healthy housing strategy in implementing housing and urban development policies that promote health and empower the communities from the very beginning of the process.

**Power Point Presentation**

Marcelo Korc’s presentation is available in PDF format in its original language (Spanish) at: [http://www.idrc.ca/uploads/user-S/11555858291korc_presentacion.pdf](http://www.idrc.ca/uploads/user-S/11555858291korc_presentacion.pdf)

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Chapter 4

Panel 4 - Extending Social Protection in Health in LAC: five case studies

This panel took place on August 23rd from 2:30 to 4:00 pm in the Room E of Pavilion 5. The purpose of this panel was to present the results of five research projects, funded by IDRC or PAHO, directed towards the discussion of problems related to social exclusion in health services and the formulation and implementation of proposals which aim to overcome this unequal situation.

The four panelists presented their work from Jamaica, Colombia, and Brazil under the coordination of Ernesto Bascolo from the Juan Lazarte Institute in Rosario, Argentina.

Panelist 1 - Ana Luiza Viana, “Universal Health System And The Territorial Dimension: Analysis And Subsidies To Develop A Regional Policy For Legal Amazonia”

Ana Luiza Viana from the Department of Preventative Medicine at the University of Sao Paulo in Brazil was the first to present. The abstract of her presentation and the link to her full presentation are found below along with a short paper on her project.

Ana Luiza d’Ávila Viana - DMPr/Faculdade de Medicina da Universidade de São Paulo, Brasil; Cristiani Vieira Machado, Luciana Dias de Lima, Maria Helena Magalhães de Mendonça, Tatiana Wargas de Faria Baptista - Escola Nacional de Saúde Pública ENSP/ Fundação Oswaldo Cruz FIOCRUZ, Rio de Janeiro, Brasil; Jorge Kayano, Luiza S. Heimann, Virgínia Junqueira - Instituto de Saúde Sao Paulo (IS)/Secretaria da Saúde do Estado de São Paulo (SES-SP), Brasil; Mariana Vercesi de Albuquerque, Samuel Frederico, Pablo Ibanez – Faculdade de Filosofia, Letras e Ciências Humanas, Universidade de Sao Paulo, FFLCH/USP, Brasil; Fabiola Lana Iozzi e Virna Carvalho David – Inst. de Geociências, Unicamp, Brasil

Introduction

Overcoming the inequity patterns framing the health system is one of the main challenges in expanding social protection in Brazil. Socio-economic and sanitary inequalities have a strong territorial expression which points to the relevance of cross-regional public policies, especially in the field of health. The goal of research is health policy in Legal Amazonia (LA), a region featuring several unfavorable peculiarities and social indicators.
Objectives

To analyze federal health policy for the LA region from 2003 to 2005 and provide subsidies for the development of cross-regional policies in health.

Methodology

1. Analysis of federal health policy construction process for LA through analysis of documents, interviews, and participatory observation;
2. elaboration of a database of socio-economic, sanitary and management indicators for the health system; and
3. definition of different existing geographic situations in LA on the grounds of a theoretical, documentary review and 15 case studies in selected municipalities.

Results and conclusions

Evident mobilization was observed at the Ministry of Health to elaborate an LA policy, as a result, in part, of the influence of the federal government project. Meanwhile, there was low institutionalization regarding the health policy for LA given structural difficulties (characteristics of federalism, decentralization model, limited integration across public policies), institutional difficulties (little tradition in connecting health with regional policies, distance between planning, funding and execution of strategy) and political difficulties (context and priority in the agendas of managers). The identification of six geographic situations--corporate use of the land, frontier for the dissemination of corporate uses of the land, espacios opacos, conservative uses, international border areas, metropolization--was useful to systematize the differences and similarities found in the uses of the land that have repercussions on health and need to be considered in the implementation of public policies. There is a gap between the actions of the State and the territorial dynamics and this is evident in the divide between the current federal policy and its recognition by local managers. In addition to the elaboration of a regional policy for the LA, the need for differentiated policies within the LA was also evident.

SHORT PAPER

The Challenges For Social Protection In Health In A Context Of Inequity In Brazil

Research Team
General Coordination
Ana Luiza d’Ávila Viana – Preventive Medicine Department/Faculty of Medicine/University of São Paulo (DMP/FM/USP)

Groups of Researchers
Escuela Nacional de Salud Pública/ Fundación Oswaldo Cruz (ENSP/FIOCRUZ)
Cristiani Vieira Machado
Executive Summary

The project on "Challenges for social protection in health in a context of inequity in Brazil" was developed in association by three Brazilian research institutes and the Ministry of Health, funded by a joint initiative of the International Development Research Centre (IDRC) of Canada and the Pan-American Health Organization (PAHO), with the support of AcademyHealth as part of the Research Programme on "Building and Bridging Health Services Research and Health Policy in the Americas: Extension of Social Protection in Health", co-funded by the Ministry of Health itself. The overall objective of the research conducted was to analyse the federal policies in health for the Legal Amazonia region in the period 2003-2005, under the leadership of the Brazilian Ministry of Health, as part of a broader agenda of the Federal Government.

The relevance of the issues chosen stems, in the first place, from the understanding that overcoming inequity patterns framing the current system, represents one of the main challenges to expand social protection in Brazil. Socio-economic and sanitary inequities in the country have a strong territorial coverage, which points to the importance of cross-region public policies in the different areas, including health.

Defining the specific research object—health policies for Legal Amazonia—was related to the fact that such region is marked by peculiar socio-spatial dynamics and unfavourable social indicators. These peculiarities bring forth tremendous challenges in terms of the national integration and of the integration of Brazil with other countries, given the broad international border areas and the multiple interests and organizations present in the region. Furthermore, the complexity of the social fabric, characterized by immense inequity and social exclusion, poses challenges in terms of reducing inequalities promoting equity in health.

Research conducted was geared by the following questions: Why is the territory important in terms of defining public policies? What are the possibilities and difficulties in terms of formulating a health-related policy in Legal Amazonia? How to address the complexity and diversity of socio-spatial situations present in Legal
Amazonia? How to develop regional policies in a national strategy to fight inequity in health?

The attempt to answer these questions called for new theoretical contributions to support the research, apart from those that traditionally inform the field of Collective Health, in particular, the area of policies, planning and health management. Accordingly, approaching the theoretical field of geography and incorporating a group of geography consultants to the original team, was essential. Thus, the theoretical framework of the research was originated with a more encompassing discussion on the relations existing between globalization, territory and public policies, and it incorporated concepts obtained in the field of geography, such as that of the geographic situation for a deeper understanding of territorial dynamics and their interface with health policies.

The research methodology involved a great number of strategies and methods, including, *inter alia*, interviews with different stakeholders, document and financial analyses, statistical analysis and processing of secondary databases, visits to municipal governments in Legal Amazonia.

The outcomes of the study can be summarized in two main areas. The first relates to the analysis of the public policy institutionalization for Legal Amazonia in the period under study (2003-2005), estimated with the help of variables such as: characteristics of the regional policy planning process; expansion and appropriation of the regional rationale by the Ministry of Health; consistency between formulation, planning, funding and regulation of policies in a regional rationale; and, policy outputs and outcomes and solid grounds on which to support the policy. Regarding the last item, apart from the institutional analysis in the framework of the Ministry of Health, it was necessary to extend field research to cover the other areas of the Federal Government, managers from other government quarters, Science and Technology institutes and the Legislative in the region.

In that branch of action, a fragile health-policy institutionalization was perceived in the case of Amazonia during the period, due to structural, institutional and political difficulties. Structural difficulties are the ones most likely to explain the institutional status given the following factors: the characteristics of Brazilian federalism and the prevailing decentralization model at the level of taxes and in public policies, that less favour the development of regional policies; the limited integration between public policies; the complexity of the region (large geographic distances, difficult access, population isolation and diversity, social inequity, conflict of interests); and, the low articulation capacity of regional stakeholders involved in public policies. It must be highlighted that managers of states, despite their sense of regional identity, acknowledged difficulties in terms of their mutual articulation and urged the Federal Government to promote regional policies. The role of the Legislative in health still seems to be rather restricted to the submittal of parliamentary amendments to the
federal budget; this is of a punctual and limited nature vis-à-vis the perspective of establishing regional systems.

In short, as regards the first area of research one can say that, somehow, the difficulties observed in the formulation of a health policy for Legal Amazonia are the expression of more general difficulties relative to development of regional policies in the country. During the period under study there was a certain distance between federal actions and the territorial dynamics, expressed in the separation between the ongoing policy and its recognition by local managers, among other factors. Even so, important efforts and initiatives were undertaken for internal articulation in the Ministry of Health, as well as more adequate or better coordinated proposals for regional strategies, namely, the establishment of a cooperation network of Science and Technology institutions, with the support of the Ministry of Health. Given the adverse structural and institutional conditions the establishment of a policy of regional nature in health would necessarily be a long-term process.

In relation to the second branch of action in the research, an attempt was made to analyse the complexity, diversity and internal inequity of Legal Amazonia, from the standpoint of three main approaches: the economic-financial and funding of health in Legal Amazonia; the existing geographic situations in Legal Amazonia; and, the characterization of municipalities in Legal Amazonia, according to secondary data that provided subsidies for the understanding of the different territorial dynamics in the region.

The financial analysis showed that the majority of regional municipalities are highly dependent on federal transfers, though such degree of dependency varies according to the relevance and, mostly, to the municipal economic dynamism. This profile highlights even more the relevance that federal policies have for the region.

The definition of geographic situations in Amazonia stems from the perspective of making the existing territorial dynamics more visible and in order to illustrate the different uses of the land in the region, allowing for an all-embracing consideration of the manager and the search for actions that are more appropriate to each different reality. The identification and analysis of six geographic situations--corporate use of the land, frontier for the dissemination of corporate uses of the land, metropolization, international borders, conservative uses and dull spaces--was useful to systematize the differences in land uses that have an impact on health and must be accounted for when implementing public policies.

On the basis of secondary data, an attempt was made later on to characterize the 761 municipalities in some variables that were important to define the geographic situations, in particular productive specialization, territorial flows and population mobility. Productive specialization was estimated by analysing the contribution of different productive activities in the municipalities to the Gross Domestic Product, measured by the "values added" to the Gross Domestic Product. Following that
methodology, five groups of municipalities were identified according to the types of prevailing economic activities. The territorial flows was determined after analysing the territorial distribution of highways, waterways and the intensity of air passengers and cargo flows. This analysis allowed for the identification of dynamic focuses and the large amounts of territory that are far from the regional nodes of economic fluidity and dynamism, revealing a regional heterogeneity. In the population mobility field there were limitations relative to the use of official data that, in general, did not match the intensity in the flow of people.

Given the different analysis branches and strategies some large groups of challenges were identified in the development of health policies that take into account the regional complexity, peculiarities and dynamics. These challenges are related to the following aspects: information for the formulation of policies; health conditions; supply of services and public-private relations; health funding and spending; infrastructure (in general and in health); intensity of population mobility, urbanization and metropolization; and, federal relations and territorial heritage.

Apart from creating a regional policy for Amazonia, research revealed the need for differentiated policies within the region. The national health policy must add the territorial dimension stemming from a series of important variables, in order to understand the dynamics of different places, some of which were registered by the research. In the case of health, the main contribution of this type of approach is to introduce a dynamic and singular perspective for the territory in the process of policy planning, with emphasis on the differences and peculiarities of each case. For the federal manager, this new approach means to go beyond the vertical organization rules of the national system and to work more on in-depth strategies that envisage greater integration with other policies and other spheres of government dealing with planning.

Finally, giving thought to a regional policy for Legal Amazonia may help strengthen the regional perspective while implementing national policies, with a view to reducing inequities and building on the social protection in health.

**Power Point Presentation**

![Sistema de saúde universal e dimensão territorial: desafios para o desenvolvimento de uma política regional para a Amazônia Legal](image)

Congresso ABRAISCO
21 a 25 de outubro de 2006
Rio de Janeiro
Panelist 2 – Amparo Hernández, “Improvement of the effectiveness of social protection policy in health for a population forcibly displaced by Violence in Bogotá, Colombia”

Amparo Hernández, from the Universidad Javeriana in Bogotá, Colombia presented her work on “Improvement of the effectiveness of social protection policy in health for a population forcibly displaced by Violence in Bogotá, Colombia.” Her presentation abstract, short paper and the link to her full presentation are found below.

Abstract

Amparo Hernández Bello, Román Vega Romero, Ofelia Restrepo Vélez, Marta Lucía Gutiérrez y Luigi Conversa – Pontificia Universidad Javeriana, Bogota, Colombia
Luis Jorge Hernández y John Ariza Montoya – Secretaría Distrital de Salud de Bogotá, Colombia

Colombia has the second highest proportion of displaced people in the world after Sudan. Over three million people have been affected since 1985, of which approximately 450,000 live in the Capital District. Forcibly displaced people constitute one of the most vulnerable groups in the country. Most of them are women and children and one in four is indigenous or Afro-Colombian. They repeatedly suffer from the violation of international humanitarian law principles, are excluded from basic social rights and experience social, political and cultural discrimination. They have a greater exposure to health risk factors than other poor and marginalized populations in the country and the State’s response to their needs is still insufficient.

With a systemic, multi-method and participatory methodological approach, the objective of the study is to identify factors that hinder equitable access to, and use of,
health services for populations displaced by violence and to strengthen the capacity of health authorities and services to effectively intervene in the determinants and priority risk factors that affect them. Up until now available evidence shows that many of displaced people’s health problems are a direct consequence of the displacement itself, that material and emotional deprivation increases their susceptibility to risks and that, although the State acknowledges victims’ rights, in practice their possibilities for exercising them are remote because there are barriers to access, both outside and inside the health sector, which worsen the already appalling situation of exclusion. With regards to social protection in health, policy decisions initiated more than a year ago by the city health authorities have increased the demand for services, but the response is still limited in terms of resources and organization: barriers persist against insurance affiliation and access to, and use of, services; inter-sectorial work is incipient; there is no information system to identify the needs of different populations to support decision-making and neither has an appropriate differential approach to healthcare been developed. The intervention’s objective is to contribute to the broadening of social protection in health by ensuring increased access with greater equity, reduced user costs and more dignified care, through the strengthening of health system management, insurance and service provision.

Short Paper

Improvement of the effectiveness of social protection policy in health for a population forcibly displaced by violence in Bogotá, Colombia, 2004-2006

(Amparo Hernández Bello1, Ofelia Restrepo Vélez2, Luigi Conversa3, Marta Lucía Gutiérrez Bonilla4, Román Vega Romero5, Luis Jorge Hernández Flórez6, John Ariza Montoya7

Introduction

In Colombia over three and a half million people have been forcibly displaced by violence in the last decade.1 Colombia has the second largest internally displaced population in the world, after Sudan,2 and Bogotá is the primary receptor community, with over 250,000 displaced people.

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2 Facultad de Medicina, Universidad Javeriana.
3 Sociologist, MSc. Co-researcher.
4 Facultad de Ciencias Políticas y Relaciones Internacionales, Universidad Javeriana.
5 Facultad de Ciencias Económicas y Administrativas, Universidad Javeriana.
6 Specialist, Dirección de Salud Pública, Secretaría Distrital de Salud.
7 Specialist, authority on the issue of displacement, Dirección de Salud Pública, Secretaría Distrital de Salud.
Internally displaced people are victims of the systematic violation of the principles of international law; they are denied basic social rights, and face social, political and cultural discrimination. Many of the serious and frequent health problems suffered by the displaced population are a consequence of their displacement, which exposes them more than other poor and vulnerable populations to risk factors resulting from material and affective deprivations, the deepening of social disparities, and limitations in the official response to the situation.\textsuperscript{3, 4}

To respond to some of these problems, the objectives of this research project are to study the health profile of the displaced population, the determining and risk factors involved, the factors that condition access to and use of services, and the differences in this regard between the displaced population and the receptor community population; to analyze the services-related factors that hinder an effective response to health problems and access to those services; to define potential interventions in these factors and explore the kinds of decisions needed to remedy them. It is aimed at improving the quality of existing evidence and supporting decision-makers in the process of formulating policies to respond to a complex situation from a perspective of equity.

\section*{Methodology}

The general approach of the research is systemic, multi-method and participatory, establishing direct dialogue between researchers and decision-makers in the health sector at different levels. It is composed of three stages: the gathering and analysis of information for the construction of baselines; the joint design of processes for the change and rethinking of policies; and follow-up and formulation of recommendations. As of now, the baseline stage has been completed, and work is underway on the analysis of interventions.

The first stage, concluded in December 2005, combined qualitative and quantitative techniques for the gathering and analysis of information from primary and secondary sources. A cross-cutting study was conducted which included a sample of 2092 internally displaced persons and 1705 non-displaced persons from 800 households in the six neighbourhoods where more than 60% of the city’s displaced population is concentrated. This stage comprised a description of the health situation, an analysis of the factors that condition access to and use of services, a comparison of the rates of prevalence of different characteristics in the two populations, and the exploration of a number of associations through the calculation of indirect relative risks.

Through workshops, focal groups, in-depth interviews and ethnographies, the qualitative study of the population and other groups involved (public hospital networks, subsidized health insurance providers and other stakeholders) was aimed at exploring and delving deeper into aspects that are difficult to address through quantitative methods. The overall analysis was carried out in successive stages through the triangulation of data, sources and researchers based on six categories
(demography, displacement, living conditions and institutional response, provision of and access to services, and participation) and four analysis axes (before and after displacement, gender, ethnicity and generation).

Results

The evidence provided by the baseline stage of research concluded in 2005 revealed that the displaced population is primarily made up of women, children and adolescents. There is a greater prevalence of female-headed households in the displaced population than in the poor population of the receptor communities (37% vs. 30%) and the proportion of indigenous and African-Colombians is 10 times greater. They are victims of uprooting, discrimination and stigmatization. They live in precarious conditions, in high-risk areas, and suffer overcrowding and less access to public services (Table 1). Compared to the receptor community population, they have high rates of unemployment and poor quality employment, low educational levels and high school dropout rates (Table 2). They have a higher proportional degree of perception of poor health and a greater prevalence of infant, maternal and violent deaths (Table 3). Close to 40% receive no state assistance. Although they have higher levels of coverage under the subsidized insurance regime than they did in their places of origin, they receive less extensive and poorer quality benefits than those who belong to contributory schemes, and face greater geographical, administrative, cultural and economic barriers in access to services (Graph 1), and the medical care model, particularly for psychosocial problems, is ineffective in meeting the actual need.

The evaluations of different stakeholders and the testimonies and demands of the population indicate that the policy for the comprehensive management of forced displacement has been insufficient in the framework of the current social protection and assistance policies. What has predominated up until now is an assistentialist and targeted approach in which coverage and assistance are dependent on labour market performance and economic growth, and there are serious difficulties in accessing the services guaranteed, and a failure to recognize the need for compensatory action in view of the damages suffered and preventive action against the effects of the associated risks in the deterioration of quality of life and well-being.

To move towards the construction and coordination of a comprehensive approach and proposals for intervention, the series of problems identified in the baseline phase were submitted for the consideration and analysis of the affected population, particularly the leaders of organizations of the displaced, as well as officials from the department of health, the institutions and social sectors involved or obliged to provide assistance, and representatives of international agencies and human rights organizations, in different scenarios for dialogue and exercises for information exchange, reflection and complementation, drawing on qualitative and consensual techniques, leading to their reinterpretation, validation (and assimilation) by the different stakeholders and a relatively complete vision of the phenomenon in the city.
The first agreements have made it possible to establish that there is a need for a new perspective in response to the causes and problems that will lead to an end to forced displacement as a result of violence, that the victims should be compensated for the losses and damages to their material property and social rights and for the loss of future opportunities, and that they should be included in a comprehensive system of social rights as established by the principles of international human rights and the general treaties on human rights, and as demanded by the rulings of the Constitutional Court of Colombia.

The proposal for improving social protection in health should be based on the following elements: A determinant approach that allows for analysis of and intervention in the social and environmental factors that influence health. The recognition of health as a basic right in the framework of interdependent economic, social and cultural rights that go beyond the right to health care services. A social protection approach emphasizing universal, contributory and citizens’ rights and a social protection approach in universal, comprehensive health care guided by the achievement of results in the health of individuals, families and the population. An equity-based approach geared to reducing or eliminating inequalities in social strata and opportunities for access to services and to the full realization of social rights, including the right to health. Recognition of diversity (ethnic groups, genders, generations) and of the circumstances of displacement that differentially affect the displaced population – and the different groups it comprises – and require affirmative action.

On the basis of these minimal agreements, the researchers have distanced themselves from the different stakeholders to elaborate a proposal to be widely discussed with the district health department – with the Secretary of Health, the directors, officials, and the network of public hospitals – prior to engaging in consultation and consensus with the affected population. To support a proposal that goes beyond actions focussed on the health sector, yet must clearly define them, this process has entailed an exhaustive review of the institutional services offered and an interpretation of the new legislation, of the reports on the national and district policy for the internally displaced population, monitoring and analysis of the national and district political scenarios, and the assessment and discussion of approaches to social protection, assistance and insurance.

It is hoped that the upcoming process will result in the formulation of guidelines for a policy aimed at rethinking the current scheme of social protection (and social protection in health) and its principles, values and sustainability in the framework of a participatory process; the definition of concrete changes in the management of the health sector, in the health care model and in the design, implementation and evaluation of programmes sensitive to the particular conditions and risks of the displaced population; and the generation of spaces for participation, discussion and active intervention by the displaced population in decisions that affect their well-being and health. This will require ample discussion with the district authorities to overcome...
the current regulatory and financial resource limitations and to achieve a clear interpretation of the role of the health sector and the commitment of the health authorities to the changes needed in terms of insurance, a differential approach, public health, primary care and intersectoral work.

**Discussion and conclusions**

Generally speaking, the evidence provided by the research project shows that internal displacement exacerbates health risks and social exclusion and heightens inequalities in material living conditions, health outcomes and access to social and health services.

The internally displaced population is more vulnerable than other Colombians because the risks that existed prior to displacement (generally poverty and exclusion) are superimposed by the risks of displacement itself (the loss of quality of life, material property, rights and social quality), those generated by state and societal disregard (loss of capacities and future opportunities and the worsening of the social consequences of displacement) and those resulting from discrimination and the lack of recognition of the circumstances of displacement, the cultural diversity of the displaced population and the need for a rights-based, differential and affirmative approach, all of which add up to a quadruple burden of risks, differential exposure and inequality.

Given the nature of the problems, the main challenge for the project is to define an approach through which the improvement of the health of the displaced population is the result of improvements in their well-being and quality of life and not mere treatment of diseases. This is consistent with a regime of social protection (and social protection in health) that is universal, comprehensive and based on affirmative action and a differential approach that guarantees social and political rights in order to neutralize the impact of social risks on health, guarantee attention to individual and collective needs, and reduce the greater social inequality. However, such an approach will require a rethinking of the Colombian state model of intervention in the social area, which is why the leadership of the health authorities to oversee the changes over a long-term horizon is an essential task in the formulation of a policy that responds to the demands, expectations and needs of the population.

**Acknowledgements**

This research was funded under Building and Bridging Health Services Research and Health Policy in the Americas: Extension of Social Protection in Health, a joint initiative of the International Development Research Center (IDRC/Canada) and the Pan American Health Organization (PAHO).

The authors wish to thank everyone who participated and contributed their experiences and knowledge to the construction of this complex panorama of problems and challenges, including Fernando De La Hoz and Nelsy Rodríguez for their statistical and
epidemiological assistance; Claudia Naranjo, Julia Álvarez and Gloria Jiménez, who participated as research assistants; Martín Rondón for his work in processing the household surveys; Álvaro Suárez for his contributions to the design and analysis of the surveys; Andrés Guzmán, Jenny Russi and Maryory Pizza, practicum students; the directors and officials at the hospitals and the District Health Department; and especially, the individuals and families forcibly displaced by violence and the regular residents of the neighbourhoods of Usme, Bosa, Ciudad Bolívar, Rafael Uribe, Kennedy and Suba and their community leaders.

Table 1. Displaced and non-displaced populations in receptor communities by housing characteristics and access to public services

<table>
<thead>
<tr>
<th>Housing characteristics</th>
<th>Displaced population</th>
<th>Receptor population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td><strong>Type of housing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>House or apartment</td>
<td>26</td>
<td>6.5</td>
</tr>
<tr>
<td>Rooms in tenement buildings</td>
<td>192</td>
<td>48.0</td>
</tr>
<tr>
<td>Rooms in other types of structure</td>
<td>174</td>
<td>43.5</td>
</tr>
<tr>
<td>Other type of housing</td>
<td>8</td>
<td>2.0</td>
</tr>
<tr>
<td><strong>Access to public services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water supply system</td>
<td>306</td>
<td>76.5</td>
</tr>
<tr>
<td>Sewerage system</td>
<td>278</td>
<td>69.5</td>
</tr>
<tr>
<td>Electricity</td>
<td>385</td>
<td>96.2</td>
</tr>
<tr>
<td>Gas</td>
<td>154</td>
<td>38.5</td>
</tr>
<tr>
<td>Telephone</td>
<td>165</td>
<td>41.2</td>
</tr>
<tr>
<td><strong>Avg. number of household members</strong></td>
<td>5.2</td>
<td></td>
</tr>
<tr>
<td><strong>Number of rooms in home</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>194</td>
<td>48.5</td>
</tr>
<tr>
<td>2</td>
<td>129</td>
<td>32.2</td>
</tr>
<tr>
<td>3 or more</td>
<td>77</td>
<td>19.1</td>
</tr>
<tr>
<td><strong>Number of bedrooms</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>235</td>
<td>58.7</td>
</tr>
<tr>
<td>2</td>
<td>143</td>
<td>35.7</td>
</tr>
<tr>
<td>3 or more</td>
<td>22</td>
<td>5.5</td>
</tr>
</tbody>
</table>

Table 2. Displaced and non-displaced populations in receptor communities by education and employment (%)

<table>
<thead>
<tr>
<th>Education and employment</th>
<th>Displaced population</th>
<th>Receptor population</th>
</tr>
</thead>
<tbody>
<tr>
<td>No formal education (over 5 years old)</td>
<td>22.8</td>
<td>3.8</td>
</tr>
<tr>
<td>Out of school (over 5 years old)</td>
<td>69.3</td>
<td>65.7</td>
</tr>
<tr>
<td>Work-employment</td>
<td>24.1</td>
<td>32.6</td>
</tr>
<tr>
<td>Informal or poor quality employment</td>
<td>69.6</td>
<td>52.7</td>
</tr>
</tbody>
</table>


Table 3. Displaced and non-displaced populations in receptor communities by conditions of health-illness (%)

<table>
<thead>
<tr>
<th>Conditions of health-illness</th>
<th>Displaced households and people</th>
<th>Receptor households and people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health events in household</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant, maternal or violent death</td>
<td>2.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Disability</td>
<td>10.3</td>
<td>12.8</td>
</tr>
<tr>
<td>Current pregnancy</td>
<td>7.7</td>
<td>4.7</td>
</tr>
<tr>
<td>Pregnancy ended by abortion</td>
<td>29.0</td>
<td>25.0</td>
</tr>
<tr>
<td>Perception of health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good or very good</td>
<td>72.4</td>
<td>81.0</td>
</tr>
<tr>
<td>Poor or very poor (OR=1.6 IC95% 1.3 1.8)</td>
<td>27.5</td>
<td>18.8</td>
</tr>
<tr>
<td>Illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic illness</td>
<td>9.4</td>
<td>9.4</td>
</tr>
<tr>
<td>Illness in the last 30 days (OR=1.29 IC95% 1.03 1.61)</td>
<td>10.4</td>
<td>8.2</td>
</tr>
<tr>
<td>Disability due to illness</td>
<td>69.2</td>
<td>59.6</td>
</tr>
</tbody>
</table>

Graph 1. Displaced and non-displaced populations in receptor communities by use of health services


References


6. Sentencia T-025. Por la cual se declara la situación de los desplazados en el país como un “estado de cosas inconstitucional” y se imparten órdenes específicas para la protección de los derechos de los desplazados y se fijan plazos breves para que se remedie la vulneración de sus derechos fundamentales. Corte Constitucional, Sala Tercera de Revisión, República de Colombia 2004; febrero 6.


Power Point Presentation

Panelist 3 – Álvaro Cardona, “Strategy for a Reimbursable Subsidy and Credit Fund to expand the health insurance scheme and help protect the cultural heritage of unemployed workers in Colombia”

Álvaro Cardona, from the School of Public Health in Medellín, Colombia presented his work on a “Strategy for a Reimbursable Subsidy and Credit Fund to expand the health insurance scheme and help protect the cultural heritage of unemployed workers in Colombia.” His presentation abstract, short paper and the link to his full presentation are listed below.

Abstract

Álvaro Cardona, Emmanuel Nieto L, Román Restrepo V, Oscar Sierra R Facultad Nacional de Salud Pública, Universidad de Antioquia, Colombia
Carlos Enrique Cárdenas R. Secretaría de Salud de Medellín, Colombia
Felipe Aguirre A. Dirección de Salud de Antioquia, Colombia

In Colombia, governance and social well-being are fundamentally affected by the diverse consequences of unemployment. These include a lack of health insurance and the economic risks that temporarily unemployed workers and their families are exposed to in the event of major health problems. This work proposes an alternative ensuring sustainable health insurance for temporarily unemployed workers. It demonstrates the benefits of cooperation between researchers and policy decision-makers in the design of creative strategies for responding to the problem of health insurance exclusion in vulnerable populations.

The project’s principal objective has been to design, validate and construct an intervention strategy to guarantee health insurance sustainability for temporarily unemployed workers and their families in the form of a Subsidy and Repayable Credit
Fund jointly established by them and the Municipality of Medellín. The research applied a descriptive, retrospective and cross-cutting methodology to characterize temporarily unemployed workers and their willingness to participate in the proposed fund. It was based on secondary sources, complemented by a survey of a representative sample of temporarily unemployed workers in Medellín and its metropolitan area. The principal secondary sources used were:


The results provide a social and occupational characterization of temporarily unemployed workers in the seven main metropolitan areas of Colombia and of their employment-unemployment cycles. The project presents the administrative and financial design of a Subsidy and Repayable Credit Fund to facilitate continuity in affiliation to the Subsidized Health and Social Security Regime for workers who become unemployed.

**Short Paper**

Álvaro Cardona, Emmanuel Nieto L, Román Orlando Restrepo V, Oscar Sierra R
Facultad Nacional de Salud Pública, Universidad de Antioquia, Colombia
Carlos Enrique Cárdenas R. Secretario de Salud. Municipio de Medellín, Colombia
Felipe Aguirre A. Director de Salud. Departamento de Antioquia, Colombia

**Summary**

This paper presents the research process carried out jointly by academic researchers and policy-makers on the socio-economic conditions, health insurance characteristics and employment-unemployment cycles of temporarily unemployed workers in Medellín, Colombia. Based on its results, an intervention proposal was formulated for the development of a local public policy to guarantee sustainable health insurance for these workers and their families, and was submitted to the local government for their consideration.

The study’s findings are presented along with an analysis of the project’s achievements and the difficulties encountered in applying research results to local public policy-making on this issue.

**Introduction**
This research was carried out in the context of the international social science community’s efforts to achieve the following objectives:

i. That the results of public health and social protection research are used in public policy-making for the purpose of solving problems of inequity and lack of health coverage in vulnerable sectors of the population;\textsuperscript{1,2,3,4}

ii. That public policy-making is based on evidence obtained by scientific research.\textsuperscript{1,2,3}

This is just one of many research initiatives that will have to be undertaken in different social realities in order to clarify the confusion surrounding some aspects of the use and dissemination of scientific research results in these areas of knowledge.\textsuperscript{5,1,2,3}

This document presents the results of work jointly undertaken by academic researchers and policy-makers in Medellín, Colombia, on the socio-economic conditions and employment-unemployment cycle characteristics of temporarily unemployed workers. Lessons learned from the process are described and difficulties in translating research findings into public policy are analyzed.

The context of this study was defined by the regulatory framework of social security in the Colombian health system, established through Law 100 in 1993, and by the results of that reform.

One of the traits of this regulatory framework is that it defines two distinct types of health insurance, depending on a person’s link to the work market,\textsuperscript{1,2,3} as a result of which two regimes were established for participants in the system:

i. The Contributory Regime, for those who have a link to the labour market or sufficient income to pay the system contributions;

ii. The Subsidized Regime, which provides insurance for the poorest population sector with no link to the labour market.\textsuperscript{1,2}

In 2004 this health insurance covered 59.1% of the population, 30.5% through the Contributory Regime and 28.6% through the Subsidized Regime.\textsuperscript{1} In the same year, the unemployment rate in the seven main metropolitan areas was 16.7%. The rate was 15.4% in the Medellín metropolitan area - some 219,000 people without work. Out of this total, 80.2% were temporarily unemployed, that is, workers with a past link to the labour market.\textsuperscript{1}

Objectives

The research had the following objectives in regard to temporarily unemployed workers in Medellín:

- To determine their socio-economic conditions
- To characterize their employment-unemployment cycles
• To determine the characteristics of their health insurance
• To design, and present to the city government, an intervention proposal that would guarantee health insurance sustainability for these workers and their families

Methodology

The methodological characteristics of the study are:

• Descriptive, retrospective and cross-cutting research.
• A temporarily unemployed worker is considered as one who is unemployed but has previously been linked to the work market.
• The scope of the study covered workers who became unemployed between 1st August 2003 and 31st October 2004, as reported by the National Training Service (Servicio Nacional de Aprendizaje – SENA) and by three of the Health Promotion Entities (Entidades Promotoras de Salud – EPS) with the greatest number of affiliates in the city. This limited scope was adopted due to the refusal of the other Health Promotion Entities to provide information (citing confidentiality reasons), thus making it impossible to determine the total number of workers who became unemployed during the research period.
• A sample of 569 people was used selected by simple random procedure. The calculation of results assumed a 5% random error factor, a 95% reliability level and losses of 10%.
• Information was collected through an individual survey applied to each worker in his or her home.
• In depth qualitative information was obtained through eight focal groups.

Results

Socio-economic conditions

An analysis of information collected from the sample of temporarily unemployed workers produced the following results:

Distribution by sex: no significant difference was registered, 48.2% were men and 51.8% were women.

Distribution by age: the great majority were aged between 12 and 44, 50.4% being between 12 and 28, 38.8% between 29 and 44 and 10.8% over 44.

Distribution by education: 21.4% had 5 years or less of primary education, 58.2% had secondary or technical education and 20.4% technological, pre-graduate, graduate or postgraduate education.
Distribution by socio-economic level: 57.6% of workers in the sample registered a low socio-economic level, 40.8% a medium level and 1.6% a high level.

Distribution by economic sector in which the last employment occurred: 49.7% in the service sector, 27.1% in the commercial sector, 21.6% in the industrial manufacturing sector and 1.6% in the agricultural and mining sectors.

Distribution by type of company in which the last employment occurred: 66.8% in micro-companies and 33.2% in companies with more than 10 workers.

Distribution by salary level: The average salary for the last employment was 1.2 Minimum Legal Salaries (Salario Mínimo Legal Vigente - SMLV). In 2004 one SMLV was 358,000 Colombian pesos, equivalent to USD 149.8 at that time. Of the sample, 34.5% received less than one SMLV, 54.9% between one and two SMLVs and 10.6% more than two SMLVs.

Characteristics of the employment-unemployment cycle

At the time of becoming unemployed the temporarily unemployed workers of the sample had on average been working for 21.7 months. During the period of the survey the average time needed for finding new employment was 6.3 months. So the average complete employment-unemployment cycle lasted for 28.0 months.

The duration of the complete employment-unemployment cycle classified by socio-occupational profile included: 31.2 months for men; 68.4 months for those aged over 45; 38.4 months for those with only primary education; 66.1 months for those in the agricultural and mining sectors; 30.9 months for the self-employed and 30 months for those previously employed in micro-enterprises.

Of the temporarily unemployed workers in the sample 13.8% found employment within the first two months of search, thus generating for that period an 86.2% probability of remaining unemployed. For the first four and six months of search, the accumulated probabilities of remaining unemployed reduced to 73.8% and 67.3% respectively. (See Figure 1)
Figure 1. Probability of remaining unemployed in relation to duration of employment search. Medellín 2004

<table>
<thead>
<tr>
<th>Months of employment search</th>
<th>Accumulated probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>86.2</td>
</tr>
<tr>
<td>4</td>
<td>73.8</td>
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<tr>
<td>6</td>
<td>67.3</td>
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<td>47.9</td>
</tr>
<tr>
<td>14</td>
<td>42.1</td>
</tr>
<tr>
<td>16</td>
<td>38.2</td>
</tr>
</tbody>
</table>

Accumulated probability of remaining unemployed
Source: Survey of temporarily unemployed workers sample applied by the researchers.

Health insurance characteristics

- 37.0% of workers in the sample had no health insurance.
- Of the temporarily unemployed workers without health insurance, 92.3% indicated that they would make use of the intervention proposed by the research team, i.e. the creation by the Municipal Administration of a Subsidy and Repayable Credit Fund, through which they could receive a subsidy equivalent to a third (1/3) of the contribution to the Contributory Regime and simultaneously a credit equivalent to the other two thirds (2/3) to complete the contribution, thus ensuring health coverage for their whole family through the Contributory Regime.

Intervention Proposal

A sustainability study on the economics and financing of the proposed Subsidy and Repayable Credit Fund was undertaken, out of which an administrative design for the proposed fund was formulated and submitted for consideration to the Municipal Administration.
To date there has not been a positive response from the Municipal Administration to the presentation of this proposal. Some of the possible reasons for this are:

- The political agenda of the Mayor and the Municipal Council has been focused on strategic commercial decisions regarding telecommunications systems for public companies in Medellin and on the demobilization of paramilitary organizations.
- The Mayor of Medellin has maintained his stance that there must be participation by private organizations in the financing of the proposed fund, especially for the Family Compensation Fund. However there has been no positive response from such organizations.
- There are no temporarily unemployed workers’ organizations in the city to facilitate an organic and systematic expression of their views.

Conclusions

The interaction between researchers and policy-makers made it possible to identify a significant problem that was not covered by the municipal policy agenda. This is what some academics call “a window of opportunity” or timing. Also, the research team could identify a specific area of public policy in which it is possible to make use of research results as a basis for public policy-making at a local level.

Because policy-makers have a greater proximity to daily problems and detailed information on the flow of public administration budgetary resources the interaction with them proved beneficial, in that it generated a greater precision in the formulation of relevant research questions and the intervention proposal. This process also facilitated discussion on the transition that is taking place from the concept of “Social Security” to that of “Social Protection”. Some members of the group are observing growing restrictions on efforts to achieve equity and social justice.

To that part of the scientific community concerned with unemployment the group has presented a new approach for this issue based on an analysis of the quality of life experienced by temporarily unemployed workers during their period of unemployment.

Finally, we have verified that social protection in health still occupies a secondary place in the policy agendas of our local institutions and is easily relegated in favour of issues related with the market economy’s more modern sectors or national political priorities.

Recommendations

We present the following two recommendations:
That the municipal administration of Medellín directs its attention to the standard of living of temporarily unemployed workers during their periods of unemployment.

That organizational structures are set up through which unemployed workers can express their needs and proposals related to their own and their families’ standard of living.

Bibliographic References

Panelist 4 - Wilma Bailey, “The Impact of User Fees For Preventative Care on the Health Seeking and Coping Behaviour of Patients in Jamaica”

Wilma Bailey from the University of West Indies in Kingston, Jamaica presented her work on “The Impact of User Fees For Preventative Care on the Health Seeking and Coping Behaviour of Patients in Jamaica.” The abstract, short paper and link to her presentation are found below.
Abstract


New user fee schedules for preventive care were introduced into the health sector in Jamaica between 1984 and 1999 and the objectives of the project were to identify the factors leading to the new policy; to analyse the impact of the fees on utilization and coping strategies: to develop a working mechanism to bridge the activities of researchers and policy makers and to identify policy options which could generate the revenue currently sought through fees for preventive services.

A mixed methodology was adopted including a cohort study involving a questionnaire survey of patients seeking family planning, antenatal and immunization services, as well as services for diabetes and hypertension which are major causes of morbidity among the elderly. These are being followed over a period of one year. A qualitative component comprised focus group discussions, observation by Mystery Clients and expert interviews.

Expert interviews revealed that persistent economic difficulties have constrained the ability of the Government to fund publicly provided health services. Inflation and an expansion in the range of services offered had resulted a gap between what was budgeted and what was needed and the Ministry of Health had no choice but to raise fee levels.

The cohort of 1117 respondents captured the most vulnerable members of society. A high proportion of household heads (almost 50 percent) was female; only had primary education (39 percent) and was unemployed (47 percent). Those who were employed were mainly service and shop and market workers. There was general agreement that public sector fees were reasonable but nevertheless, at times, they were prohibitive and for various reasons respondents were not benefiting from the exemptions and safety net programmes. The results of the cohort study were supported by the focus group discussions as well as Mystery Client observations. As a result, the participants reported a number of coping strategies such as delaying seeking care, postponing visits, purchasing less food and not purchasing all drugs prescribed. Some negative outcomes have been observed during the life of the project. There has been regular consultation with officers in the Ministry of Health as well as in the safety net programmes and new directions are being taken which should have an impact on access.

Short Paper

User fee for Preventive Care, Jamaica: Research to Policy in Public Health
Wilma Bailey\textsuperscript{1}, Stanley Lalta\textsuperscript{2}, Georgiana Gordon-Strachan\textsuperscript{3}, Aldrie Henry-Lee\textsuperscript{1}, Jasper Barnett\textsuperscript{3}, Dillon Alleyne\textsuperscript{1}, Elizabeth Ward\textsuperscript{3}

Background And Context

Our project was conceived against the background of increases in user fees for health care in 1993 and 1999 and the extension of fees to preventive care in the face of high levels of poverty and high tax rates to support public health services in Jamaica. Given the broad consensus internationally among health planners and policy advisors that user fees adversely affect health and health seeking behaviour, we set out to provide research-based evidence on the effect of these fee increases on utilization of family planning, antenatal and immunization services. We included diabetes and hypertension because they are leading causes of ill health among the middle age and elderly population in Jamaica.

Methodology

A mixed methodology was adopted comprising a cohort study of 500 households and 1017 clients seeking family planning, antenatal and immunization services as well as services for diabetes and hypertension. These consumers were selected from low income communities in the capital, Kingston, a market town, Linstead, and Hopewell, a rural community in the parish of Hanover, and were followed for a period of 12 months. An ordered logit model was employed to determine the conditions associated with the degree of difficulty in meeting costs of care. A qualitative component comprised focus group discussions with a subset of the sample and observations of service delivery in health centres by mystery clients. Data on utilization of public sector services were also analysed.

Achievements And Challenges

We report on the research stage of a two-phase process. The first laid the groundwork for collaboration between researchers and policy makers and we determined to build on this by creating a learning platform for both groups.

Outcome mapping

We were assisted by the adoption of the Outcome Mapping strategy, which, through its emphasis on influencing and monitoring change in boundary partners, stimulates effective communication - one of the most important factors facilitating the role of research in policy formulation. We carefully selected policy advisors within institutions who were able to influence, though not necessarily, make the final determination of

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\textsuperscript{2} National Insurance Board, Blue Hill Road, Nassau, The Bahamas
\textsuperscript{3} Ministry of Health, Kings Street, Kingston Jamaica
the direction and intensity of change. We also set up a Project Advisory Committee comprising some boundary partners and this could be seen as a model for future activities as operational, policy makers and researchers found a forum to ventilate issues. We used workshops, letters and presentations to keep our partners, committee members and the Directors of Regional Health Authorities abreast of our findings.

However, there was a top-heavy quality to the membership of the groups with which we interacted. In spite of all our efforts we could not persuade health providers to attend our workshops and our results have shown that change at this level is crucial.

Mistrust

We faced mistrust during the research stage, both of the research agenda and the research process.

i) the research agenda
In the absence of the Permanent Secretary, we had extensive interviews with the Acting Permanent Secretary during the first phase of the project. The Permanent Secretary was sent a copy of the proposal on her return and gave ethical approval to the project. But a relatively long period had elapsed between the two phases and when we approached her at the start of Phase 2, there was an irate response to our claims of collaboration. She was suspicious of our research agenda and perhaps we should have been more sensitive to the need for renewing high-level collaboration once she was in office. We had to go through a delicate process of wooing and brought her around to the extent that she made recommendations for membership of our Advisory Committee and asked to be kept informed of our progress and findings.

ii) the research process
We found that we also had to dispel misunderstanding of the research process among our boundary partners. There was concern about the ‘science’ that is, the scientific process of selecting survey sites which allowed, we were told, one of the ‘worst’ rural areas to be selected. It was a defensive posture, a reaction to the problems of access revealed. We found that patients with chronic clients, in particular, were extremely sensitive to the increases in fees (Figure 1). For example, there was a 23% decline in attendance the year following the 1993 fee increase while in 2000 the decline was of the order of 15%. But the extent of the problem is obscured by the entry of new patients. For example, in 1999 the number attending was 218,570. This declined to 184,919 in 2000. But in that year, there were 41,868 new cases. In effect, the actual loss was 75,519. Rural clients proved to be more vulnerable than urban for they also had to meet high transportation costs. They therefore employed a number of avoidant coping strategies by delaying consultations and tests, for example.
We had to convince our partners that while the problems were more acute for rural clients, the poor in the three areas selected for the study were also experiencing the same problems. Our partners came to appreciate the fact that especially in view of our concern about social protection, the most vulnerable could not be deliberately excluded.

**Making Change**

We claim success if our findings stimulate/precipitate change in policy and/or in the attitude of our boundary partners in terms of the extent to which they were more appreciative of the need for evidence based research findings.

i) **Policy**

The Ministry of Social Services administers several welfare programmes that could help to reduce the cost of drugs to beneficiaries. The National Health Fund (NHF) and Jamaica Drugs for the Elderly (JADEP) are drug programmes designed to assist patients with specified chronic conditions as well as the elderly. However, our focus group moderators found that few of the participants knew of them and those who did reported numerous problems in gaining access. These findings were confirmed by the analysis of the first round of the survey data. In view of this, we increased the number of boundary partners bringing on board directors of two of the social protection programmes. Interaction with these two proved to be most stimulating and rewarding and we would like to believe that these discussions hastened the decision to institute two important modifications –registration at all health centres rather than at the offices of the institutions involved and a streamlining of the beneficiary system. We saw the
effect of these changes in the second round of our interviews. Enrolment in the welfare programmes had increased from 11 to 174.

ii) Attitude
In our meetings we saw ideas flowing between the research team and the boundary partners and from one boundary partner to the other. There was general acceptance that the national formalized system of exemption was not working. Patients seeking care are required to pay the gazetted registration fee at the first and each subsequent visit. The amount varies depending on the type of service requested and certain personnel are exempt. Fee waivers are supposed to be extended to those who cannot meet these costs. Decisions as to who should benefit from fee waivers are made at the point of service. We reported some dissatisfaction among the focus group participants over the fact that no discretion was exercised at the health centres; that the criteria for exemption were subjective and requests for fee waivers discouraged by loud, embarrassing, aggressive behaviour by staff not trained to make assessments. Moreover, the fees quoted were in excess of those gazetted. These claims were backed up most forcefully by the experiences of the mystery clients. The position was strongly put forward at a meeting with our boundary partners that such decisions should not be made within the MOH but the Ministry of Social Security. There was general agreement with this point of view and we look to see whether the MOH would give up this function.

We also put forward the possibility of exemption of the chronic elderly at our last meeting. We were concerned about this group because in the second round of interviews we found that of the 97 clients who had medical problems in the intervening period, 34% were in the 60 and over age-group. Table 2 shows the distribution of those affected. Almost 70% of those reporting illness represented costs as a major or minor burden and their coping strategies were predominantly avoidant. The complaints of those in the chronic group were serious complications of the diseases – neuropathy causing loss of feeling in the feet, foot ulcers, stroke. Two diabetic patients had nervous breakdowns.

Table 2. Clients reporting illness

<table>
<thead>
<tr>
<th>Health Service</th>
<th>Total Ill</th>
<th>Percentage in Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>16</td>
<td>22.2</td>
</tr>
<tr>
<td>Hypertension</td>
<td>44</td>
<td>14.9</td>
</tr>
<tr>
<td>Diabetes &amp; Hypertension</td>
<td>30</td>
<td>28.3</td>
</tr>
<tr>
<td>Rest</td>
<td>7</td>
<td>0.8</td>
</tr>
</tbody>
</table>

Moreover, 11 clients, all with chronic illnesses, had been admitted to hospital. One of these was hospitalized on three occasions for progressive amputations spending a total of 87 days in hospital. Seven of these were in the 60 and over age group. The logit model applied to determine the specific factors associated with hardship in
meeting costs revealed that age and chronic conditions were significantly associated with hardship. There was, in effect, research-based evidence of stress among this group.

Our boundary partners cautiously said that they would await the final document before committing themselves on the need for exemption.

Project Impact

There was recognition of the role of independent researchers and of well-designed research studies. Policy makers have more respect for researchers and may call on their expertise on other occasions. The reports generated will form a part of the essential database for future policy action.

Working Together

There were also disappointments. Our research team comprised policy makers in the Ministry of Health and academics at the University of the West Indies. We deliberately included policy makers at the Directors level because we argued that they were more likely to get the attention of those who make decisions. And we were right. We could not have secured the participation of personnel of such high status were it not for the relationship which existed between them and those on the research team. However, the policy makers on the team had a research function to carry out. They were also selected for their expertise. Those at the Directors level, however, were too busy; they had too many responsibilities and the job of coordinating the study was extremely taxing.

We lost our Health Economist and although he retained an avid interest and was generous with his encouragement and advice, and although we had an able replacement, we missed his expertise.

Conclusions

Our findings suggest that those with diabetes and hypertension have difficulties in meeting the cost of health care. We advocate the removal of fees from this segment of the population. However, fees are not the only deterrent to care. Transport costs are prohibitive when patients are required to access health care as well as pharmaceuticals and we suggest three possibilities. Firstly, groups needing transport assistance could be provided with travel vouchers. Pharmacies are too far from rural communities. Pharmacies at the clinics could be stocked at least with those drugs that are essential to the health of the elderly or itinerant pharmacists could rotate monthly through health centres offering services for chronic patients. The third possibility of overcoming the transportation problem is a revival of the Community Health Aide (CHA) programme. CHAs could work closely with social workers and the Programme of Advancement through Health
and Education (PATH) to ensure that those needing treatment/drugs are able to gain access to these services.

Some of the most intransigent attitudes to changing the policy of user fees are to be found among providers and special efforts must be made to expose them to research findings.

Special efforts must be made to expose the front line workers to research findings for some of the most intransigent attitudes to the poor and to changing the policy on user fees are to be found at this level.

Policy makers included in these long-term projects must be able to commit their time.

The assessment of results as the investigation proceeds and immediately communicating problems to partners in a sensitive, non-confrontational manner can bring about change during the life of projects.

**Power Point Presentation**

[Power Point Presentation]

Wilma Bailey’s full presentation in PDF format is available in English at: [http://www.idrc.ca/uploads/user-S/11555799661bailey.pdf](http://www.idrc.ca/uploads/user-S/11555799661bailey.pdf)

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Chapter 5

Panel 5 - Ecosystems Approaches to Communicable and Emerging Diseases

On August 24th from 9:30 to 11:00 am, 4 panelists presented this topic in the Auditorium of Pavilion 4.

Ecosystem Approaches to Human Health are encouraged to promote a holistic view of human health, social determinants and environmental sustainability. This framework relies on methodologies that are participatory, transdisciplinary, and that integrate social and gender concerns to generate a better understanding of ecosystem determinants of human health. Findings can then be used to identify sustainable, preventive interventions to improve human health, the ecosystem, to monitor environmental sustainability and, thereby complement conventional health activities. This panel discussed lessons learned from research projects using this framework in the prevention and control of communicable diseases.

The panel was coordinated by Roberto Bazzani, Senior Program Specialist, IDRC and consisted of 4 speakers from 4 different countries.

Panelist 1 - Clifford Mutero, “Ecosystem Approach to Malaria Research and Control: Perspectives from pioneering projects in sub-Saharan Africa”

Clifford Mutero is a Senior Researcher at the International Water Management Institute (IWMI) in Pretoria, South Africa and the Coordinator of the Systemwide Initiative on Malaria and Agriculture (SIMA). The abstract for his presentation on the “Ecosystem Approach to Malaria Research and Control: Perspectives from pioneering projects in sub-Saharan Africa” is copied below. A link to his full presentation is also provided.

Abstract

Clifford M. Mutero -International Water Management Institute (IWMI), Pretoria, South Africa

The Systemwide Initiative on Malaria and Agriculture (SIMA) initiated its first project in Kenya in 2001, with the objective of applying an ecosystem approach to malaria research and control. This was followed in 2002 by a regional capacity-building workshop for multidisciplinary research teams interested in developing projects on
ecosystem approaches to malaria in several other African countries. Subsequently, similar ‘eco-health’ projects were initiated in Uganda, Zimbabwe and Tanzania. A second phase of the Kenyan project commenced in 2004 to follow up on pertinent issues, jointly identified by the target community and researchers as warranting further research and action. Using a more conventional approach to research, three other projects aimed at understanding linkages between malaria and agriculture were initiated in Ghana, Ethiopia and Mozambique between 2003 and 2004. In these latter projects, relatively less emphasis was placed on transdisciplinarity and the participation of communities and other relevant stakeholders. Overall, SIMA coordinated eight projects in seven countries between 2002 and 2006. SIMA’s first objective was to understand how common farming systems and associated natural resource management influence malaria transmission in representative countries of sub-Saharan Africa. Its second objective was to contribute to holistic approaches to malaria control, by integrating improved agroecosystem management with existing health-sector anti-malaria interventions. Results from the various projects revealed important differences in the ecological and social-economic determinants of malaria in different agricultural settings. On this basis, future actions were proposed related to further research or the implementation of targeted interventions. Important lessons were also learned in connection with the advantages and limitations of forging transdisciplinary research teams. Furthermore, the relevance of community and stakeholder participation in concretely identifying future engagements in malaria control activities was evident among SIMA projects emphasizing an ecohealth approach. The ecohealth approach was generally found to raise expectations among communities and other stakeholders, due to its inherent capacity for greater involvement and participation compared to the more conventional, but less-participatory approaches. The provision of donor support for projects beyond an initial 2-year phase of characterizing social-ecological systems, to a second phase that simultaneously deals with research and the actual implementation of anti-malaria interventions in the community, was found to be a mutually-agreeable way of addressing the expectations of researchers, communities and other stakeholders.

Power Point Presentation
Clifford Mutero’s full presentation in PDF format is available at:

**Contact Data**

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**Panelist 2 - Johannes Sommerfeld, “Eco-Bio-Social Research on Dengue: TDR/IDRC Research Initiatives in Latin America and Asia”**

Johannes Sommerfeld is the Project Leader of the TDR/IDRC research initiative on “Eco-Bio-Social Research on Dengue in Asia” at the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR), World Health Organization, Geneva, Switzerland. The abstract for his presentation on “Eco-Bio-Social Research on Dengue: TDR/IDRC Research Initiatives in Latin America and Asia” is available below along with a short paper on his work and the link to his full presentation.

**Abstract**

Johannes Sommerfeld, Axel Kroeger
Special Programme for Research and Training in Tropical Diseases
World Health Organization, Geneva, Switzerland

Recent attempts to understand the resurgence of dengue acknowledge the importance of ecological, social, economic, political, health systems and other contextual variables, but fail to explicitly incorporate them into integrative models or consider how they evolve in relation to one another. At the same time, global guidelines for the prevention and control of dengue play an important role in policy-making at national (central government) and regional levels. However, these guidelines offer only generic recommendations. More specific insights relevant to specific ecosystems on the transmission dynamics and feasibility of intersectoral community development...
programmes for dengue prevention and control are needed. These insights can have a crucial function in defining locally relevant and appropriate interventions. This presentation will provide an overview of the rationale, conceptual framework and methodological challenges of this type of research, making reference to ongoing TDR/IDRC joint research initiatives in Latin America and Asia. The Latin America initiative focused on two studies in Colombia and Brazil. The presentation will report on preliminary findings of both studies. The Asia initiative is focusing on high burden/hyperendemic countries in South Asia and South-East Asia and is under preparation. In that region, strategic trans-disciplinary research on eco-bio-social dynamics of dengue transmission will be conducted in selected ecosystems, with technical assistance provided to increase local capacities. The projects will then develop viable ecosystem management interventions based on inter-sectoral interaction between communities at risk of dengue epidemics and public services and proceed to test and evaluate them through implementation research. Finally, the write-up and dissemination of funded studies will be supported and research-to-policy linkages will be strengthened. Both research initiatives were designed to contribute to improved dengue prevention by better understanding, through multilevel/multi-scale and trans-disciplinary analysis, its ecosystem-related, biological and social ("eco-bio-social") determinants. The initiatives were also aimed at developing and evaluating community-centered ecosystem management interventions targeting dengue vector larval habitats, embracing intersectoral actions.

**Short Paper**

Johannes Sommerfeld - Special Programme for Research and Training in Tropical Diseases (TDR), World Health Organization (WHO), Geneva, Switzerland

**A Rationale for Eco-Bio-Social Research**

This write-up of a presentation given at the 11th World Congress for Public Health provides a short overview of an emerging research collaboration between the Special Programme for Research and Training in Tropical Diseases (TDR) and the International Development Research Centre (IDRC) on dengue fever. This collaboration focuses on what is conceptualized as "eco-bio-social research," i.e., trans-disciplinary research combining the perspectives of IDRC's Eco-health Programme with social science research in order to define improved dengue vector interventions in specific ecosystems. Since 2003, TDR and IDRC have collaborated on this effort, first on a pilot programme in Latin America and most recently on a major extension of the research initiative into Asian countries.

Dengue infection, which manifests clinically as dengue fever (DF) or more severely as dengue hemorrhagic fever and dengue shock syndrome (DHF/DSS), is one of the most important contemporary public health problems in the developing world. The disease is resurgent at an alarming rate: an estimated 50 million dengue infections
each year, including 250,000-500,000 cases of DHF/DSS and some 25,000 deaths and with 2.5 billion people at risk worldwide.

The incidence of the disease is reportedly increasing in a number of countries particularly those in South–East Asia, the Western Pacific and the Americas. More and more dengue epidemics are being reported, with these epidemics becoming larger and more frequent in their appearance. The main vector of dengue, Aedes aegypti, is spreading throughout the tropics. The secondary vector, Aedes albopictus whose presence used to be restricted mostly to Asia is now also spreading into Latin American countries.

A variety of inter-linked environmental, economic, political and social factors are known or suspected causes for the resurgence of dengue. They include factors at the global, national and community levels.

Global level factors include the following:

1. Global environmental change, including climate change, for example leading to increased rainfall, humidity and temperature;
2. The impact of economic and political globalization on ecology such as shipping trade of used tires and increased global air-travel;
3. Demographic changes such as population growth in developing countries; and
4. Ineffectiveness of ultra-low volume space sprays for insecticides in Aedes aegypti control

The main national/regional level factors include:

1. Deterioration of health systems, including fragmented mosquito control programmes;
2. Rapid and unplanned urbanization resulting in substandard housing, inadequate water supply and waste management systems;
3. Increased population mobility and travel, including rural-urban migration; and
4. Clearing of forest and development of human settlements

Finally, local level factors include:

1. Poor sanitary conditions of vulnerable social groups at risk for dengue leading to breeding sites in water tanks and other precarious reservoirs for drinking water;
2. Increased use of non-biodegradable disposable recipients such as bottles, drums, cans and tires leading to increased vector breeding opportunities at household level;
3. Vector breeding in areas which are usually left-alone such as construction sites, cemeteries, parks or sewage systems;
4. Inadequate public/municipal services leading to irregular water supply/sewage and substandard public garbage collection; and
5. Poor participation and ability/willingness of communities to contribute to vector control measures.

Recent attempts to understand the resurgence of dengue acknowledge the importance of social, economic, political and other contextual variables, but fail to explicitly incorporate them into models or consider how they evolve in relation to one another. Consequently, Gubler, a leading scholar in dengue research, concluded that: “[t]he reasons for the dramatic global emergence of DF/DHF as a major public health problem in the waning years of the twentieth century are complex and not fully understood.” (Gubler 1997: 17).

While dengue could be controlled in the Americas from 1945 until the late 1970s, it was never successfully contained in Asia. Control measures in the Americas were expensive “top-down” approaches focusing on larval control and DDT use, and did little to involve the community in the process. The 1980s saw a shift to more "bottom-up" approaches focusing on integrated community-based methods to mosquito control and environmental management interventions. These methods not only target larval habitats mainly in domestic and peri-domestic water containers but also in public spaces (Spiegel et al. 2005).

In a recent article in Eco-Health, Spiegel et al. (2005) present six critical elements for successful dengue vector control:

- *Immature Mosquito Control* with a focus on larval habitats through integrated approaches;
- *Community ownership*: Community-based programs need to mobilize communities and ensure not only participation but ownership of the Programme by the community;
- *Partnership with Government*: Local and regional government agencies play a critical role in coordinating control efforts and ensuring that the level of participation at the community level is maintained;
- *Local leadership*: Formal and informal local leaders are important drivers of local change, and they need to be enrolled into ecosystem management approaches as they know the breeding sites and can enrol the community;
- *Scalability*: Extending the local level scale of successful mosquito control to a regional, national or cross-border levels; and
- *Adaptability*: Control strategies need to be able to adapt themselves to changing epidemiological patterns and control challenges resulting from the interaction of social and ecological systems.

Clearly all six elements need to be supported by intersectoral collaboration and transdisciplinarity.
Spiegel and colleagues conclude that "while new and more effective approaches to prevention and control are urgently required..., our scientific understanding of the factors that influence success in this domain remains minimal" (Spiegel et al. 2005: 274).

Dengue control remains a major challenge and until a vaccine becomes available for public health use, primary prevention remains solely dependent upon dengue vector control, for which the following elements are of critical importance:

- Environmental management modifying ecosystem conditions that favor larval habitats and vector proliferation;
- Inter-sectoral interventions (partnerships among donors, the public sector, civil society, non-governmental organizations and the private and commercial sectors);
- Sustainable social participatory involvement in vector control programs;
- Improvement of public health infrastructure and vector control programs;
- Implementation of integrated surveillance systems (environmental, entomological and epidemiological surveillance) instead of acting in response to epidemics;
- Reinforcement of health legislation; and
- Political will (financial support, human resources).

On the basis of the above, dengue as a public health problem can be conceptualized as "eco-bio-social" in nature and origin, with ecological, biological and social factors overlapping and reinforcing each other in feedback loops. "Eco"-logical factors refer to climate (rainfall, humidity, temperature, etc.) and the natural and human-made ecological setting (including the urban and agricultural environment, etc.). "Bio"-logical factors relate to the behaviour of the vector, Aedes aegypti, and transmission dynamics of the disease. Both the ecological and the biological domains are linked by the ecology of the vector population. Social factors incorporate a series of determinants relating to health systems, including vector control and health services, and their political context (health sector reforms, for example), public and private services such as sanitation and sewage, garbage collection and water supply, "macro-social" events such as demographic growth and urbanization and community and household based practices, knowledge and attitudes and how these are shaped by large-scale forces such as poverty, social inequality and community dynamics. Such a generic conceptual framework can inform the development of eco-system specific frameworks which again could be investigated in actual research and substantiated in models originating from that research.
The TDR/IDRC Collaboration

The Special Programme for Research and Training in Tropical Diseases (TDR), which forms part of the Communicable Diseases Cluster of the World Health Organization, is an independent global programme of scientific collaboration, co-sponsored by UNICEF, UNDP, the World Bank and the World Health Organization. The TDR Programme was established over 30 years ago, in 1975, with the aim to help coordinate, support and influence global efforts to combat a portfolio of ten tropical diseases. Dengue fever was added to the TDR portfolio in 1999 only.

In 2003, TDR and IDRC’s Ecosystem to Human Health Program Initiative embarked on a major collaboration. A Pilot Programme began in Latin America with two studies in Brazil and Colombia to strengthen eco-systems research capacity.

One study at Ceará State University (Universidade Estadual do Ceará), Brazil (Caprara et al. 2005), elucidated eco-bio-social factors responsible for the re-emergence and persistence of dengue fever in the Brazilian city of Fortaleza, through a combination of survey research, entomological assessments and ethnographic research. A multiple-case study was carried out in six purposively selected study units, (city blocks or quarteirão). The study highlighted important gender aspects of the disease: Women play a central role in water use, water storage and garbage management and need to be specifically targeted in interventions. Differential access to water between higher-class neighbourhoods and poorer ones was found a critical determinant in dengue control. In households from under-privileged neighbourhoods, the high need for water containers due to the irregular water supply creates the environmental conditions that allow for a greater number of breeding areas. The research team concluded that public policies that guarantee poor people’s right to regular potable water, access to sewage systems, education and work, will have great impact on dengue control and its eradication.

Another study, carried out in Colombia at the Fundacion Santa Fé de Bogota (Carraquilla 2005), in collaboration with the Universidad de los Andes, the Universidad del Valle and the Colombian National Institute of Health, investigated the dengue problem in two endemic cities on the Magdalena basin river, Melgar and Girardot. Both qualitative and quantitative approaches to data collection were used to identify variables that may explain dengue vector indices. A Knowledge, Attitudes and Practices (KAP) survey in randomly sampled households was combined with direct observation of potential breeding sites. The eco-social context was explored through ethnography, direct observation, interviews, and focus groups. Multivariate analysis and ethnographic techniques were used for the analysis. Using information of 213 weekly reports of cases of dengue (January 1999 to January 2003) as well as information on climate variables, autoregressive models (ARIMA) were built to find relationships between dengue cases and climate variations. It was found that dengue cases were preceded by a peak of rainfall 14-16 weeks before the outbreak. The households where interviewees had at least one year of schooling showed a significant
lower risk of having vector forms than those with no formal education. It was also found that water tanks located on the ground were the most common breeding sites in the study area. Most informants considered dengue a minor affection not falling into the category of illness. However, once hemorrhagic symptoms emerge, a different meaning is given to the disease episode, with a high level of perceived severity and vulnerability. Displaced populations and tourists are not concerned with dengue nor with water storage, water use and adequate environmental management. Targeted interventions focussing on the cleanliness of low tanks are not well understood.

The pilot programme in Latin America is now extended into a major research initiative entitled "Eco-bio-social research on Dengue in Asia" which will take place over five years, from late 2005 to 2010.

The overall objectives of the study are to:

1. contribute to improved dengue prevention by better understanding its ecosystem-related, biological and social ("eco-bio-social") determinants; and to
2. develop and evaluate community-centered ecosystem management interventions directed at reducing dengue vector larval habitats, embracing intersectoral actions.

In October 2005, TDR issued an internationally advertised call for letters of intent. The various letters-of-intent were systematically screened and evaluated by an external expert panel. Selected research teams were invited to a proposal development workshop in Bangkok, Thailand, in May at which a core conceptual framework was developed. Teams submitted full proposals in July 2006 and the external committee is now in the process of reviewing them. We expect that six studies will be part of this research initiative, to begin research in early 2007. The studies will take at least two years, so that analysis, write-up and dissemination can be pursued in 2008-09.

A common framework was developed at the recent proposal development workshop which considers dengue vector density as the dependent variable. In Phase I, case studies of specific ecosystems will be carried out focusing on vector ecology, the social and ecological context and vector control program functioning. The association of these factors with varying levels of vector density, measured through pupal surveys, will be established. These will then serve as a basis for identifying, through participatory processes, appropriate interventions that could impact on vector density.

Studies in selected eco-systems will have two phases: A research phase in the first year to understand the eco-bio-social dimensions of dengue transmission, followed by the design of a dengue-related ecosystem management intervention. The intervention will be carried out in year 2. The first phase will enrol researchers from a wide variety of disciplinary backgrounds, from entomologists to virologists, and various social scientists, including anthropologists and policy analysts.
Overall, it is expected that the research and the intervention will lead to locally and ecosystem-specific relevant practices for dengue prevention, a new framework for improved ecosystem-related dengue interventions, a community of research practice and that the sites will have measurable impacts on vector density and transmission. Strategic research and implementation research, both accompanied by appropriate capability strengthening efforts and networking through a "community of practice," are integral components of the basic concept underlying this activity.

References


Power Point Presentation

The full presentation of Johannes Sommerfeld is available in PDF format at: http://www.idrc.ca/uploads/user-S/11570345371Sommerfeld_Presentation.pdf

Contact Data

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Panelist 3 - Carlota Monroy, “Ecosystem and housing risk factors for the control of *Triatoma dimidiata* in Guatemala”

Carlota Monroy, from the Universidad San Carlos de Guatemala, Guatemala presented on “Ecosystem and housing risk factors for the control of *Triatoma dimidiata* in Guatemala”. The abstract of her presentation is found below along with the link to her full presentation (PDF format) in Spanish.

**Abstract**

Carlota Monroy, Antonieta Rodas, Sandy Pineda, Xochilt Castro. Virgilio Ayala, Bárbara Moguel, Dulce María Bustamante, Laboratorio de Entomología Aplicada y Parasitología, Universidad de San Carlos de Guatemala, Guatemala

Chagas disease vectors in Guatemala and Central America are being reduced in number through a national campaign that employs insecticides as its main tool. However, one vector species, *Triatoma dimidiata* reappears a few months after spraying. Because of this we began research on risk factors in regions where this native vector persists, in spite of repeated spraying, occupying various ecosystems (tropical forest, peri-domestic and domestic). One of the most significant risk factors detected is the deterioration in the condition of walls such as cracks in them. To counteract this we initiated a study on the local availability of materials needed for wall covering, and the location of complementary materials not available locally, in this case river sand. The inhabitants themselves undertook the improvement work with 79% of houses being covered in one village and 95% in the other. We compared these villages with ones in which this work was not undertaken and the difference in vector infestation was significant. The covering of walls is a protection factor against the presence of these vectors.

Another detected risk factor is the peri-domestic presence of left over construction material, such as adobe, floor and roof tiles or stones. Vectors can be found among this material which is often situated very close to the house. To counteract this, a campaign to raise public awareness was initiated and suggestions were offered about how to use these left over construction materials in order to avoid facilitating the presence of insects. Poverty conditions such as human overcrowding and beds situated
next to walls are risk factors that are difficult to counteract. In connection with this we are working on the development of fruit tree nurseries and the technification of non-stinging (Melliponas) bee-keeping. Deforestation and the intensive use of encino (Quercus) for firewood seem to be factors to be considered. Unplastered adobe chicken houses with more than 10 birds are another risk factor.

Studies of insect mobility between peri-domestic and domestic areas and of the relationship between tree cover and vector presence are necessary. The control of Triatoma dimidiata involves taking a series of risk factors into account in order to avoid proliferation.

**Power Point Presentation**

[Image of presentation slide]

Carlota Monroy’s full presentation in its original language (Spanish) is available in PDF format from http://www.idrc.ca/uploads/user-S/11556742201monroy_presentation.pdf

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Panelist 4 - Mariano Bonet, “An ecohealth approach for the prevention of Dengue at a local level. Municipality of Havana, Cuba”

Mariano Bonet from the Cuban Hygiene and Epidemiology Institute (Instituto de Higiene y Epidemiología de Cuba - INHEM) in Havana, Cuba. His presentation abstract on “An ecohealth approach for the prevention of Dengue at a local level. Municipality of Havana, Cuba” is found below with a link to his full presentation.

Abstract

Mariano Bonet, Ana María Ibarra, Miriam Concepción Rojas, Lilian Cuellar, Instituto Nacional de Higiene, Epidemiología y Microbiología, Cuba
Angel Alvarez, Instituto de Medicina Tropical IPK, Cuba
Jerry Spiegel, University of British Columbia, Canada

Experience gained from the “Ecosystem Health in Central Havana” (Salud del Ecosistema en Centro Habana) project enabled the authorities and community of Cayo Hueso to utilize an ecohealth approach for the prevention and control of dengue risk factors during the 2002 epidemic in Havana. Subsequently it was possible to extend its use to all Popular Councils (Consejos Populares) in the Municipality of Central Havana. The objective was to implement and evaluate a dengue transmission prevention strategy at a local level employing an integral and participatory ecohealth approach. This municipality is an urban area of 3.5 square km with the highest population density in the country. The monitoring system applied is comprised of three sub-systems: environmental monitoring to identify and stratify risks at the Popular Council level; entomological surveillance, including active monitoring to identify areas at risk of infestation and concentration points as they appear; and clinical-epidemiological surveillance with the serological testing of people at probable or confirmed risk. The system provides for an integral analysis, involving community participation, of information coming from the three sub-systems. The exposure of the population to insecticide, both larvicide and adulticide, was evaluated using gas chromatography techniques. To promote community involvement in ecosystem management a model of social participation was developed based on the principle of co-management in health as a contribution to the creation of a healthy ecosystem. The work of determining the needs and risks of the municipality’s population took place in two phases. In the first, information was gathered on the perceived needs of the population and on the risks that they face and in the second, a questionnaire was used to evaluate their perception of the risk. A case study and monitoring were used to identify risk factors for the occurrence of Aedes aegypti breeding grounds in the home. The results of this study provide guidelines for complementary interventions. In conclusion, we emphasize the success, in terms of viability and achievements, of this integrated system based on an ecosystem approach to human health.
Power Point Presentation

Mariano Bonet’s full presentation is available in PDF format at:
http://www.idrc.ca/uploads/user-S/11564474971bonet.ppt

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Chapter 6

Panel 6 - Extension of social protection in health and universal access to healthcare: challenges for policy-makers

This panel took place on Thursday, August 24th from 14:30 to 16:00 pm in Room E of Pavilion 5.

The purpose of this panel was to discuss the issue of extension of social protection in health in the framework of universality of healthcare. It focused fundamentally on the challenges faced by decision-makers in the implementation of policies with this perspective - these challenges being caused by the innumerable restrictions related to political-ideological, financial or technical problems, which exist in the current Latin American context.

The panel included 4 speakers from Argentina, Brazil and Colombia and was coordinated by Christina Zarowsky, Program Manager of IDRC’s GEH program.

Panelist 1 – Celia Almeida, “Extension of social protection in health in Latin America and the Caribbean: the challenge of universality”

Celia Almeida is currently researcher and lecturer in Health Policy and Health Systems and Services Organization, in the Dept. of Health Administration and Planning, in the National School of Public Health, Oswaldo Cruz Foundation. The abstract for her presentation on “Extension of social protection in health in Latin America and the Caribbean: the challenge of universality” is found below along with a link to her full presentation.

Abstract

Celia Almeida
Escola Nacional de Saúde Pública Sergio Arauca
Fundação Oswaldo Cruz, Rio de Janeiro, Brazil

In recent decades health sector reform has been an important issue in the political agenda of most Latin American and Caribbean countries, as part of a broad program
of structural transformation. These processes, involving changes to health service systems, have been influenced by various simultaneous phenomena, both endogenous and exogenous. Although the discourse on health service system reform had the overcoming of inequalities and the achievement of equity as its guiding principles, the models implemented and available evidence suggest that these objectives were not achieved. Today the extension of health protection is an important element in the health policy agendas of countries in the region and has been raised by some international agencies operating in this field. This presentation discusses the concept of universalization of access to health services, evaluating it in comparison with focalization, as guiding principles for specific forms of health system organization that, depending on the way in which they are institutionalized in the practices of health systems and services, lead to different results for social protection in health. Evidence is presented to show that contemporary reforms have not been able to extend this protection and that abandoning the basis of healthcare universalization has worsened inequalities in access to services. Overcoming these difficulties represents a significant challenge for policy-makers, with reform models often tending to limit the possibility of implementing more inclusive alternatives with a greater potential for the promotion of equity.

Power Point Presentation

EXTENSIÓN DE LA PROTECCIÓN SOCIAL EN SALUD Y ACCESO UNIVERSAL A LA ASISTENCIA: DESAFÍOS PARA LOS FORMULADORES DE POLÍTICAS

Celia Almeida
Escola Nacional de Saúde Pública “Sergio Arouca”
Fundação Oswaldo Cruz
Rio de Janeiro, Brasil
11º Congresso Mundial de Saúde Pública
8º Congresso Brasileiro de Saúde Coletiva
Rio de Janeiro, Brasil
Agosto, 2006

A full copy of Celia Almeida’s presentation in PDF format is available at: http://www.idrc.ca/uploads/user-S/11586833261almeida_presentacion.pdf

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Panelist 2 – Monica Fein, “Health in Rosario – Everyone’s Right”

Monica Fein from the Municipal Secretary of Health in Rosario, Argentina was unable to attend the event to give her presentation on “Health in Rosario – Everyone’s Right” however her abstract is included below. Her colleague, Deborah Ferrandini, Rosario’s Coordinator of Public Health Services.

Abstract

Dra. Mónica Fein - Secretaria de Salud, Municipalidad de Rosario, Argentina

For more than a decade closer links have been promoted in Rosario between its citizens, its government, the government administration and decision-making processes. To this end, in 1995 a process of decentralisation began with the aim of generating a more effective and efficient government less distant from the inhabitants of the city and promoting harmonic democratic development. An essentially political process of decentralisation and division into districts was established as part of an integral reform of the Municipal State, with the aim of bringing decision-making capacity into the local context where problems arise, are defined, prioritized and, most importantly, are experienced and suffered.

Within the framework of general municipal policies, we are working on the construction of sanitary districts that reflect in the healthcare network the same territorial idea upon which municipal administration is based. Each district management team will have decision-making autonomy, integrating the community as leading protagonist in their work proposals, in the definition of priorities and the strategies for addressing them, as well as in the evaluation of actions. The guiding principles for this process are equity, the community as protagonist, social effectiveness and the contextualization of health worker practices.

In terms of policy, a Primary Health Care strategy implies focusing the organization of services on the needs of the population. This involves ensuring the participation of both the community and health workers, inter-sectorial action, availability of appropriate technology and, principally, that decision-making takes place as close as possible to the context in which problems are experienced. This way of understanding and solving the population’s health problems reflects an integral vision of health care, disease prevention, health promotion and rehabilitation. The healthcare network plays a leading role in the decentralized management of public health. Healthcare centers and zone hospitals are located in the six districts of the city, facilitating improved interaction between health centers and hospitals in each district and thus bringing health teams closer to the community. In this way, general and maternity hospitals can concentrate on their intended function, i.e. the care of people needing more complex services.
Panelist 3 - Roman Vega Romero, “Challenges and implementation of PHC strategy in the context of social security in health in Bogotá, Colombia”

Roman Vega Romero from the Universidad Javeriana in Bogotá, Colombia presented his work on the “Challenges and implementation of PHC strategy in the context of social security in health in Bogotá, Colombia.” The abstract of his presentation and a short paper on his work, as well as the link to his full presentation are found below.

Abstract

Román Vega Romero, Universidad Javeriana, Bogotá, Colombia
Alex García Sarria, Grupo Guillermo Fergusson, Colombia

Introduction

This work shows the challenges and opportunities faced by decision-makers in the Bogotá District Health Department in implementing “Health to your Home” (“Salud a su Hogar”), a Primary Health Care (PHC) strategy, within the framework of Colombia’s System of Social Security in Health (Sistema General de Seguridad Social en Salud de Colombia - SGSSS). It began in 2004 as part of “A Bogotá without Indifference, a Social Commitment against Poverty and Exclusion”, a development plan initiated by the capital city government. It was implemented to guarantee the right to health and to reduce inequities in this field, particularly those related to access to integral healthcare services. Beginning in the poorest and most marginalized areas of the city it covered more than 2 million poor people whether or not they were affiliated to SGSSS.

Objectives

To show the challenges facing decision-makers in the implementation of the Bogotá project “Health to your home”, in the framework of Colombia’s SGSSS. To demonstrate some health outcomes in aspects sensitive to the strategy and organizational changes in territories and populations where it is implemented.

Methods

A documentary analysis of “Health to your Home” design, implementation, follow up and public debates was carried out, as well as semi-structured interviews with the main decision-makers from the Bogotá Health Department in 2004 and 2005.
Results

Implementation has resulted in improvements in health indicators sensitive to PHC, access to and use of services, and in greater scope of healthcare. However, organizational limitations have emerged relating to SGSSS market rationale, the content of social protection in health policy and the interests and practices of some SGSSS stakeholders and institutions that require regulatory and organizational transformations throughout SGSSS.

Conclusion

A successful implementation of a PHC strategy, with a renewed approach, will depend on the degree of commitment on the part of government and all SGSSS stakeholders. However, making progress in guaranteeing the right to health and in reducing inequity in healthcare will require changes to the SGSSS regulatory framework and to Colombia’s current social protection in health policy.

Short Paper

Román Vega-Romero & Janeth Carrillo-Franco, Universidad Javeriana, Bogotá, Colombia

Introduction

This study demonstrates the outcomes, challenges and opportunities faced by decision makers from the District Health Department of Bogotá (Secretaría Distrital de Salud de Bogotá - SDS) in the implementation of the Primary Health Care (PHC) strategy in the framework of the Social Security in Health System (Sistema General de Seguridad Social en Salud de Colombia - SGSSS) of Colombia between late 2004 and 2005. The strategy was adopted to improve accessibility and comprehensive health care services in the poorest and most marginalized areas of the city. The initial results indicate that PHC can serve as a complement to the SGSSS insurance model by increasing access and contributing to improved health results.

Objectives

To demonstrate the experiences and challenges for decision makers in the implementation of the “Salud a su Hogar” (Health in your Home) program in Bogotá and some of the health results and organizational changes impacted by the strategy.

Methods

Documentary analysis of the design, implementation, follow-up and public debate on “Health in Your Home”, and semi-structured interviews with some of the main decision makers between 2004 and 2005.
Problem

While the SGSSS insurance model in Colombia has improved access to health services, it has still not achieved universal coverage, nor has it corrected the inequities between the rich and poor. In Bogotá there are still enormous difficulties hindering the use of health services, particularly among sectors who do not have the ability to pay but do not qualify for the health plan membership subsidy, and among the health plan members with the lowest incomes.

The advances made in insurance coverage have also not remedied the individualistic and curative emphasis of the health system, instead accentuating it. The market approach and the continued existence of different insurance schemes and benefit plans have segmented and fragmented health care, made resource allocation inefficient, hampered the financial protection of households and created serious doubts over the financial sustainability of the system. It has been demonstrated that in order to enhance the effectiveness of social protection it is not enough to strengthen the health care network from an administrative and financial perspective unless the predominantly curative focus of service provision is also corrected.

Justification for implementation

Although remediating the problems of accessibility, use, segmentation and fragmentation of health care will require structural changes in the insurance model, other changes are needed in the service provision system to help universalize access, increase equity and promote a more comprehensive approach to health care. With regard to these aspects, PHC can make important contributions to the SGSSS program as a complement to insurance coverage.

PHC is recognized as an effective strategy for improving accessibility and equity in the use of services and in health results. Therefore, taking into account the national regulatory restrictions, and in the framework of the “Bogotá without Indifference” (Bogotá Sin Indiferencia) Development Plan, the decision was made to implement the PHC strategy to improve social protection and guarantee the right to health.

Model in implementation

The PHC model has a family and community focus, articulated with a quality-of-life promotion approach and the expansion of insurance coverage, aimed at improving access for the insured and non-insured population through primary contact, continuity of care, strengthening the coordination of sectoral and intersectoral action and community participation. The strategy is being gradually promoted in three population groups: first, 390,000 poor and vulnerable families who are not members of the SGSSS scheme and whose health care is the responsibility of the District Health Department and the public hospital network; second, members of the subsidized health plan scheme whose care is guaranteed by contracts between the public
hospitals and the subsidized scheme insurers; and third, members of other plans with both subsidized and contributory scheme insurers but with contracts with other service providers.

The model includes articulated sectoral and intersectoral components. There are two sectoral components. The first is individual, and pertains to the mandatory health plans of contributory and subsidized insurance. The other is collective, and corresponds to the public health Basic Health Care Plan. The first is limited in its application to the contents of the contracts and agreements between the SDS, public and private service providers and insurers. The second is universal and applies to the entire population. The quality-of-life promotion approach fosters coordination with other sectors and different actors in the health sector. The model under the responsibility of public hospitals operates in “micro-territories” defined in accordance with geographical areas granted priority because of the population’s precarious living conditions. The model under the responsibility of other service providers functions freely within the framework of the contracts with insurers, or as part of strategies of integrated care networks encompassing various levels of complexity.

The provision of services by the public hospitals is undertaken with multidisciplinary teams who are assigned 800 to 1200 families per micro-territory. Their work begins with the characterization of the access, state and health conditions of individuals, families, housing and environment. In accordance with SGSSS membership status and the health care needs identified, sectoral and multisectoral responsibilities and activities are planned and defined. Planning and design include the reorganization and reallocation of the available financial resources in such a way as to prevent duplication of expenditures, and the adaptation of human resources, information systems and management capacities in accordance with sectoral and trans-sectoral needs. The main role of the SDS is that of overseeing the process and regulating the service providers and insurers.

The PHC strategy should contribute to the achievement of the following goals: contribute to the entry of 300,000 people into the subsidized insurance regime; achieve useful rates of vaccination coverage; decrease infant mortality to less than 15.1 per 1000 live births; decrease deaths from acute diarrheal disease to 6.1 per 100,000 children under the age of five; decrease deaths from pneumonia to 17.5 cases per 100,000 children under the age of five; decrease the number of teenage births by 17%; increase Pap smear coverage by 50%; and maintain the prevalence of HIV-AIDS at 0.5 per 1000 or less.

Results

According to the information sources consulted, between late 2004 and November 2005, over 100,000 families had been characterized, of whom 43.3% were members of the subsidized insurance scheme, 32.2% were covered by contributory schemes, 0.7% were covered by other schemes, and 23.7% had no
insurance coverage. Of these, 24% faced economic barriers to access, and 51% faced geographic barriers.

In Bogotá in 2005, the infant mortality rate was 14.5 per 1000 live births; the rate of death from pneumonia was 20 per 100,000 children under five years of age; and the rate of death from acute diarrheal disease was 2.6 per 100,000 children under five. In addition, the strategy has contributed to the 95% achievement of the goal for subsidized insurance scheme membership; 100% of the pregnant women identified were provided with prenatal care; Pap smears were performed on 64% of the women aged between 24 and 69 who had not had Pap smears over the previous year; useful rates of vaccination coverage were achieved, with the vaccination of 66% of the previously unvaccinated children under five; 100% of TB cases identified were entered into the chemotherapy treatment program; 3700 families had access to home oral care health plans; 36% of disabled people were referred to community or specialized rehabilitation programs; 100% of domestic abuse cases were given comprehensive attention through social and family welfare programs; 50% of people with nutritional deficiencies were referred to the “Bogotá Sin Hambre” (Bogotá without Hunger) program; and 88% of children out of school were channelled into Education Department programs.

This characterization process has made it possible to create the rudiments of a community information system that serves the purposes of both planning and programming primary care and public health activities and of the advisory, monitoring, follow-up and evaluation activities of the regional health authorities. The Basic Health Care Plan’s operation has been reorganized through a comprehensive intervention approach that has given rise to Comprehensive Plans for the areas and micro-territories under the responsibility of the public health service network and the District Health Department, which are supported by the activities of other social sectors and community participation. An agreement has been signed between the District Health Department and 14 insurance companies to overcome the barriers to access and provide health promotion services and preventive care to the pregnant women, newborns, children under five, disabled people, people with chronic diseases and older adults identified in the areas where the strategy is in operation.

Training in family and community health has been provided to 740 health sector employees, who make up 185 health care teams (there are currently 141 teams operating) and to 400 community leaders to support the strategy. However, the ways in which employees are contracted and paid do not provide sufficient incentives and contribute to high turnover rates in health personnel. The permanent (staff) personnel in the health sector have remained somewhat resistant to the new mode of health care. More than 67 public assemblies and 1122 community meetings have been held, and 27 community management groups have been created. The mayor of Bogotá has become involved in the issue, closely following the activities and reporting to the public. Technical and political discussions have been held with local government authorities in Bogotá, where some sectors are opposed to the strategy, or fear that its
implementation is a threat to the advances in insurance coverage and the financial sustainability of the public health service network, since it presumably leads to a duplication of expenditures. However, hospitals continue to run with surpluses, particularly primary care hospitals, and there is no indication that their sustainability could be affected by the PHC strategy.\textsuperscript{32}

**Conclusions, discussion and challenges for decision makers**

Although there has not been a rigorous and systematic evaluation of the short, medium and long-term results of the PHC strategy, the outcomes demonstrated indicate that it is not a parallel system to the SGSSS and on the contrary can effectively complement it as a good alternative to deal with the problems of accessibility and comprehensiveness of health care that the SGSSS has yet to completely resolve. Although there is legislation on health promotion and preventive care activities (Resolutions 412 and 3384 of 2000) that obligate insurers to address these areas, their coverage and impact have been inadequate.\textsuperscript{32} PHC can serve as a strategy that articulates the activities of health promotion, prevention, healing and rehabilitation and contributes to the effective fulfillment of the established norms. Within a market-approach insurance system like the one in Colombia, different models of primary care can coexist – a community model in the public sector and a professional model in the private sector – but this will require strong national and territorial guidance, coordination and leadership to develop. The lack of legislation that obliges all stakeholders to commit to primary care and the liberality of the recent National Policy on the Provision of Services in this sector\textsuperscript{34} make it difficult to remedy the lack of commitment on the part of insurers and service providers to cost-effective models of primary health care.

The quality and effectiveness of the strategy is threatened by high personnel turnover and the lack of incentives for trained functionaries. There is a need to further strengthen community participation in the definition of budgets and the formulation of public policies. There is also a need to increase the articulation and strengthening of the information and communication system, both within PHC services and between these and other levels of health care, and to improve the formulation of comprehensive public policies and the development of a trans-sectoral management approach, to make these policies less technocratic and more participatory and inter-institutional. The criticism regarding duplication of expenditures appears to be a fallacious argument on the part of the political opposition, but nevertheless, there should be an evaluation on the financial and cost impacts of the strategy on the payers, service providers and households.

**References**


26. Interviews conducted between July 19 and 26, 2006, with Dr. Mario Hernández, Director of Planning at the District Health Department (2004 – 2005) and Department Secretary (February-June 2005); Dr. Nancy Molina, Director of Public Health at the District Health Department (2004 – 2005); and Libia Forero, PHC operational coordinator at the District Health Department (currently).


Power Point Presentation
Román Vega’s full presentation in PDF format is available at:

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**Panelist 4 – Eduardo Levcovitz**

Eduardo Levcovitz, Chief of the Health Systems and Policies Unit, Area of Health Systems Strengthening at the Pan American Health Organization (PAHO) presented his work last in the panel.
Chapter 7

Panel 7 – Ecosystem Approach, the Heralded Complexity for Public Health

On Friday, August 25th at 9:30 am, the joint IDRC-ABRASCO panel took place on the “Ecosystem Approach, the Heralded Complexity for Public Health” in Room D8 of Pavilion 5.

The panel was held with the purpose of discussing the use of the Ecohealth approach in public health research and projects. Three of the four panelists presented on projects in Brazil, while the remaining panelist – an IDRC partner – presented on the Community of Practice on Ecosystem Health Approaches to Reduce Toxics in Latin America and the Caribbean and Improve Collective Health (CoPEH-TLAC).

The panel was coordinated by Ary Carvalho de Miranda from the Oswaldo Cruz Foundation in Brazil and included the participation of 2 IDRC partners – Donna Mergler and Frédéric Mertens.

Panelist 1 – Rodrigo Victor, Instituto Florestal de Sao Paulo, Brazil.

Panelist 2 – Lia Girandlo da Silva Augusto from the Oswaldo Cruz Foundation.

Panelist 3 – Frédéric Mertens, “Community networks and Solution building to reduce mercury exposure in the Brazilian Amazon”

Frédéric Mertens is a visiting professor at the Centre of Sustainable Development (Centro de Desenvolvimento Sustentável), Universidade de Brasília, Brasília, Brazil. His presentation abstract on “Community networks and Solution building to reduce
mercury exposure in the Brazilian Amazon” is found below along with a short paper on his work. The link to his full presentation is also provided.

**Abstract**

Frédéric Mertens, Kátia Demeda, Mauro de Castro, Centro de Desenvolvimento Sustentável, Universidade de Brasília, Brazil
Johanne Saint-Charles, Donna Mergler, Carlos José Sousa Passos, Marc Lucotte, Université du Québec à Montréal, Canada
Jean Rémy Davée Guimarães, Universidade Federal do Rio de Janeiro, Brazil

The Caruso Project (1994 to present) is a participatory research project based on the ecosystem approach to human health that shows that deforestation resulting from "slash-and-burn" agricultural practices leads to widespread mercury contamination of aquatic ecosystems, affecting the health of a large number of fish-eating communities in the Tapajós region, Brazilian Amazon. Social network analysis is used to investigate information exchange processes on mercury issues between the villagers in four communities selected on the basis of their social, economic, cultural, ethnic and environmental diversity. The structural characteristics of mercury discussion networks are investigated based on three properties that are especially relevant for assessing the ability of individuals to communicate with each other:

- the degree of fragmentation of the network which is associated with the existence of distinct disconnected subgroups,
- the distribution of the discussion partners and,
- the communication distances between individuals.

Analysis of the relationships between the structural properties of discussion networks and participation and change processes to reduce mercury exposure reveals distinct information and involvement levels between men and women, as well as among key actors such as health workers, church leaders, school teachers, fishermen and farmers in each community. These results prompted us to propose network interventions adapted to the social diversity of the populations in order to promote information exchange within and between communities and to ensure the equitable involvement of all villagers in the construction of solutions to mercury contamination at both the local and regional levels.

**Short Paper**

Community Network Analysis For Addressing Gender, Equity And Participation In Ecohealth Research
Frédéric Mertens,1,2 Johanne Saint-Charles,2,3 Kátia Demeda,1 Mauro de Castro,1 Carlos José Sousa Passos,2 Marc Lucotte,4 Jean Rémy Davée Guimarães,5 and Donna Mergler2

Abstract

Transdisciplinarity, gender analysis, social equity and participation are the methodological pillars of the Ecohealth approach, whose main goal is to improve human health and well-being while simultaneously maintaining a healthy ecosystem. In the present study, social network analysis is presented as an innovative tool to address gender, equity and community participation in Ecohealth research, by drawing upon experiences and results from the Caruso project which studies environmental dynamics and health effects of mercury in the Brazilian Amazon with the objective of reducing mercury exposure. As a participatory research tool, social network analysis is used to examine the relationships between community action to reduce mercury exposure and 1. the distinctive roles of men and women; 2. involvement of the different social groups and 3. patterns of community participation. As a participatory development tool, social network analysis can contribute to the promotion of gender and social equity as well as local participation.

Introduction

The main goal of the Ecohealth approach is to improve human health and well-being while simultaneously maintaining a healthy ecosystem.1,2 Transdisciplinarity, gender analysis, social equity and participation are the essential methodological pillars of the approach, which focuses on the analysis of the complex relationships between environmental, economic, social and cultural factors and human health.3

Gender analysis takes into account that the tasks and responsibilities of men and women in the community and the family result in men and women using environmental resources differently, and having different exposure risks. The equity pillar acknowledges the importance of working with various social groups to ensure that the development outcomes are shared between different community members. The participation of the communities in the research process is essential. It ensures local ownership of research results and makes communities responsible for building...

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4 Université du Québec à Montréal, GEOTOP, Institut des Sciences de l’Environnement, Montréal, Québec, Canada
5 Universidade Federal do Rio de Janeiro, Laboratório de Traçadores, Instituto de Biofísica Carlos Chagas Filho, Rio de Janeiro, Brazil
solutions adapted to their socio-cultural contexts, which meet the population’s needs and are effective in the long-term.

In the present article, social network analysis is presented as an innovative tool to address gender, equity and participation in transdisciplinary Ecohealth research, by drawing upon experiences and results from the Caruso project whose main objective is to study the environmental dynamics and the health effects of mercury in the Brazilian Amazon and to build solutions with the communities to reduce mercury exposure.

Social network analysis and transdisciplinarity in the Caruso project

Results from the first phase of the Caruso project (1994-1997) showed that deforestation resulting from "slash-and-burn" agricultural practices leads to the widespread mercury contamination of aquatic ecosystems, affecting the health of a large number of fish-eating communities in the Tapajos region, Brazilian Amazon. In the second phase of the study (1998-2001) participatory actions carried out in the Brasilia Legal community were successful in reducing human exposure and improving well-being by promoting diet behaviour change towards the consumption of fish species with low mercury levels. These results have been achieved through transdisciplinary research involving communities, decision-makers and specialists in the fields of biogeochemistry, aquatic ecology, toxicology, agriculture, human health, nutrition, anthropology and communication. In the third phase of the project (2002-2005) participatory research activities were scaled up to the regional level and included a new approach, known as social network analysis, to study the relationships between the pattern of social interactions among people and individual behaviour.

The network approach allowed us to map the discussion networks on mercury issues in several communities in order to answer key questions regarding gender, equity and participation in the Caruso project. How is diet behaviour change to reduce mercury exposure affected by communication within and across gender? Is there equity in the involvement of different social groups regarding mercury issues? What are the relationships between the participation patterns in the discussion networks and community action to reduce mercury exposure?

Material and methods

The study was carried out in three communities that are situated on the banks of the Tapajos River, which is a major tributary of the Amazon River in Brazil. The Brasilia Legal community has been involved in the Caruso project since 1994, while the Mussum and Açaituba communities have become involved much more recently in 2003. (A map of the study region is available on the CARUSO project web site: http://www.unites.uqam.ca/gmf/caruso/caruso.htm.) Data were collected in 2001 (Brasilia Legal) and 2005 (Mussum and Açaituba), using semi-structured face-to-face interviews that captured information on standard demographic characteristics, the
adoption of new diet behaviour to reduce mercury exposure, and network questions. (The strategy to maximize the size of our sample in Brasilia Legal (n=158) is presented in Mertens et al, 2005.) All the villagers over the age of 14 who were present at the time of field trip were interviewed in the Mussum (n=130) and Açaítuba (n=63) communities.

IN order to assess interpersonal communication regarding mercury issues, respondents were asked to name the individuals with whom they usually discuss mercury issues. Network data were stored in an actor-by-actor matrix using the UCINET software and then exported to the Netdraw software to visualize the structure of the discussion networks.

Adoption of new diet behaviour was measured as a dichotomous variable according to whether the respondent said that he/she has modified his/her fish consumption toward fish species with low mercury levels, with the objective of reducing mercury exposure and was able to explain how this change has been achieved.

**Results**

**Gender: the role of men and women in mercury discussion networks**

Figure 1 presents the distribution of men and women in the discussion network about mercury in the Brasília Legal village. Two individuals are considered to be discussion partners (and connected by a line in the figure) if one or both reported discussing mercury issues with the other. A series of logistic regression models was used to look for whether relationships exist between the number of men and/or women an individual is discussing mercury issues with and whether or not this individual has adopted new diet behaviour to reduce mercury exposure. The percentage of individuals who adopted a new fish diet was not significantly different between men (54%) and women (58%). Although most of the discussion about mercury occurs within same gender groups - respectively 76% of the men and 81% of the women discuss mercury issues with same sex members – discussion across gender was identified as key to promoting the adoption of new diet behaviours. At the community level, preferential consumption of less-contaminated fish was associated (for both men and women) with discussion with other women, but not with other men. At the household level, men who considered their wife to be a discussion partner were much more likely to change their behaviour than those who did not.

**Equity: the involvement of social groups in mercury discussion networks**

Equity in community involvement regarding mercury issues was addressed by performing a disaggregated analysis of the discussion patterns between the various social groups in the Brasilia Legal community. Figure 2 illustrates how social groups can be differentiated in the mercury discussion network, using for example, subsistence activities to characterize the villagers. By calculating the mean number of discussion
partners of social groups differentiated according to age, religious affiliation, education, socio-economical status and subsistence activities, it was possible to map the social factors that may facilitate or act as a barrier to the involvement of the various social groups in discussions about mercury. Results are summarized in Table 1.

Participation: community involvement patterns in mercury discussion networks

A higher level of adoption of new diet behaviour is observed in the Açaituba (29%) compared to the Mussum (20%) community. In order to inquire into a possible relationship between adoption levels and community participation patterns in the discussions about mercury issues, we compared the networks of the two communities based on four structural properties.

Three of these properties exhibit similar characteristics in the discussion networks of the two communities. The mean number of discussion partners, which reveals the average level of participation in the communication process, is similar in the discussion networks of Açaituba (3.9) and Mussum (3.5). The degree of fragmentation of the network, which is associated with the existence of distinct disconnected subgroups, follows the same pattern in the two communities with the majority of the respondents belonging to one main and relatively dense component comprising 87% and 84% of the individuals for Açaituba and Mussum, respectively. The mean distance between individuals, which is especially relevant for assessing the ability of people to communicate with each other, is similar in the main component of the discussion networks of Açaituba (3.0) and Mussum (3.3).

However a fourth network property, the frequency distribution of the number of discussion partners, shows a different pattern in the two communities (Figure 3). The discussion network in Mussum exhibits a heterogeneous distribution revealing that the majority of individuals have none or a small number of discussion partners (64% of the individuals have 0 to 3 discussion partners), while some individuals discuss mercury issues with a very high number of villagers and can be considered opinion leaders in the community. A homogeneous distribution characterizes the discussion network in Açaituba, indicating that the majority of the individuals has a number of discussion partners close to the mean value (61% of the individuals have 2 to 5 discussion partners) and consequently only a few individuals do not discuss mercury issues and no individual has a very high number of discussion partners.

Discussion

Results demonstrate the importance of interpersonal communication between community members regarding the adoption of new diet behaviours to reduce mercury exposure. By sharing these results with communities, adapted actions can be carried out in order to achieve higher levels of adoption and improved health.
Promoting discussion across gender

The analysis of the distinctive roles of men and women in the Brasilia Legal mercury discussion network illustrates the key role that women play in promoting healthy changes in dietary habits and reveals the importance of stimulating discussion across gender both at the community and the family level. For example, promoting discussion between spouses is one of the guidelines we have adopted in the workshops, (carried out in 2005 in Brasilia Legal), where young couples were invited to debate health risks of mercury exposure for foetuses and young children.

Promoting equity of involvement between social groups

The results on differential involvement of social groups in the Brasilia Legal community, allowed us to develop specific participatory activities to address the low level of participation of some groups and to promote equity by stimulating a balanced participation between the various segments of the village. In 2005, targeted activities involving farmers, people under the age of 30, school teachers and evangelical church members have been carried out in Brasilia Legal to promote debates centered around the specific role of each group in the building of solutions to reduce the environmental and social impacts of mercury contamination.

Promoting horizontal participation

Although no causal relationship can be inferred between a higher level of diet adoption and a more homogeneous distribution in the frequency of discussion partners in Açaituba, compared to Mussum, the observed association suggests that involving most of the villagers in an inclusive and equitable discussion process is efficient in promoting social change. Results also suggest that researchers should not rely exclusively on community opinion leaders to stimulate the process of change in communities and should place emphasis on strengthening the horizontal process of participation, which may facilitate the emergence of cooperation and consensus-building.

Conclusion

It is a challenge for Ecohealth projects to develop methods that take gender issues into consideration, which analyse and promote social equity, and which evaluate and stimulate participation. Social networks analysis is a promising methodological tool, which could be included in the Ecohealth approach to achieve these goals. It is a way of developing a better understanding of the role of social structure in order to facilitate the promotion of environmental awareness, and improve health.

Transdisciplinarity in the Ecohealth approach aims to achieve not only the participation of researchers and communities, but also of decision-makers from the regional and national levels. In the next phase of the Caruso project, social network
analysis will be used to map dialogue, collaboration and confidence networks between villagers of communities at the local level and between communities and stakeholders from government and civil society at the regional, state and federal levels. Analysing how community and multi-scale networks spread into and take advantage of the existing spaces for dialogue and channels for representation, will allow better understanding of how the pilot activities at the community level might be scaled up spatially to the entire Amazon region and temporally to continue over the longer-term after the end of the project.

Acknowledgements

We express our deep gratitude to the population of Brasília Legal, Açaituba and Mussum for their welcome and their participation and collaboration in the accomplishment of this work. We gratefully acknowledge all the researchers who participated in the Caruso studies from 1994 up to now, for their invaluable conversations and comments. This work was financially supported by the International Development Research Centre (IDRC) and the Social Sciences and Humanities Research Council (SSHRC) of Canada.

References

Figure 1
Gender is used to differentiate between the villagers in the mercury discussion network from the Brasília Legal community. The network is composed of one main component of 130 individuals, one small component of three individuals and 25 isolates.

Figure 2
Subsistence activities are used to differentiate between the villagers in the mercury discussion network from the Brasília Legal community. The network is composed of one main component of 130 individuals, one small component of three individuals and 25 isolates.
Figure 3
Frequency distributions of the number of discussion partners in the Açaituba and Mussum communities.
Table 1

Participation in the mercury discussion network

<table>
<thead>
<tr>
<th>Social factors used to differentiate between the villagers</th>
<th>High</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>31-50 years old</td>
<td>14-30 and 51-88 years old</td>
</tr>
<tr>
<td>Religious affiliation</td>
<td>Catholics</td>
<td>Evangelical or none</td>
</tr>
<tr>
<td>Education</td>
<td>More than 8 years of schooling, only for women</td>
<td>No difference between groups</td>
</tr>
<tr>
<td>Socio-economical status</td>
<td>No difference between groups</td>
<td>No difference between groups</td>
</tr>
<tr>
<td>Subsistence activities</td>
<td>Health workers, fishermen, school teachers</td>
<td>Farmers, housewives</td>
</tr>
</tbody>
</table>

Power Point Presentation

The full PDF presentation presented by Frédéric Mertens is available at: http://www.idrc.ca/uploads/user-S/11556736891mertenz_presentacion.pdf

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Panelist 4 – Donna Mergler, “Community of Practice on Ecosystem Health Approaches to Reduce Toxics in Latin America and the Caribbean and Improve Collective Health (CoPEH-TLAC)”

Donna Mergler from the University of Quebec in Montreal, Canada presented on “Community of Practice on Ecosystem Health Approaches to Reduce Toxics in Latin America and the Caribbean and Improve Collective Health (CoPEH-TLAC)”. Her abstract can be found below.

Abstract

Donna Mergler- CINBIOSE, University of Quebec at Montreal, Canada

As we increase our understanding of the complex links between environmental degradation and human health, different approaches, which go beyond traditional environmental health paradigms, are being put forward to capture this complexity.

The World Health Organization has proposed the Multiple Exposures/Multiple Effects (MEME) model, which takes into account bi-directional interactions between social, economic and environmental factors for understanding children’s environmental health. The Millennium Ecosystem Assessment recently published a synthesis of the relations between ecosystems and human well-being. The Ecosystem Approach to Human Health (Ecohealth) provides a framework for studying the complex relations between the physical and social environment and human health, integrating gender, social equity and community participation, with a view to proposing viable and durable solutions. Researchers in Ecohealth have demonstrated its usefulness for understanding and abating toxic exposures and their detrimental effects to human health. A Community of Practice on Ecohealth was recently established in Latin America and the Caribbean with Canadian collaboration, to further develop and support Ecohealth research and better integrate these activities into public policies and interventions. The CoPEH-TLAC has a nodal structure, with regional centres strongly rooted in existing institutions that have demonstrated their capacity for interdisciplinary, intervention-oriented research in Canada, Mexico, Central America and the Caribbean, the Southern Cone, the Andean Region and Brazil. Transversal themes cover vector-borne diseases, pesticide use in agriculture, mining and metals, economic restructure and up-scaling the ecosystem approach. This presentation will examine the usefulness of CoPEH-TLAC for advancing public and collective health concerns.

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Chapter 8

Panel 8 - Governance in Health. A Conceptual and Analytical Approach to Research in Health Policy

This panel also took place from 9:30 to 11:00 am on Friday, August 25th, but in room E of Pavilion 5.

This panel intended to clear up the confusion around the concepts and uses of the term governance when used in the analysis of the political processes linked to the health sector. In Latin America there is notable conceptual confusion caused by the indiscriminate use of different words or phrases as equivalents to the word "governance" in English. For our purposes, governance is applied as an analytical research tool in the thematic area of policy and health systems. The use of an analytical governance framework in research projects was discussed, in contrast to its normative use promoted by various international agencies. Examples of its application to health policy were presented which allowed the panel to describe, explain and understand the interactions of actors, processes and rules linked to behaviour and decision-making in society.

Luiza Heimann, from the Institute of Health in Sao Paulo Brazil, coordinated this panel, which included presentations from 4 different countries.

Panelist 1 - Roberto Bazzani, “Analytical Proposal for Governance in Health Research in Latin America and the Caribbean”

Roberto Bazzani from the Regional Office for Latin America and the Caribbean, Montevideo, Uruguay of the International Development Research Centre (IDRC) presented an “Analytical Proposal for Governance in Health Research in Latin America and the Caribbean.” The abstract of his presentation is copied below, along with a short paper on the subject. A link to his full presentation is also provided below.

Abstract

Roberto Bazzani, International Development Research Centre (IDRC), Montevideo, Uruguay
Marc Hufty, Graduate Institute of Development Studies (IUED), Geneva, Switzerland
Ernesto Báscolo, Instituto Juan Lazarte, Rosario, Argentina
Luz Helena Sánchez, ASSALUD, Bogota, Colombia

The capacity for research on health policies and systems is still at an incipient phase in many Latin America countries. It is proposed that methodologies be developed with a view to improving analytical capacities in the field of research on health policies and systems with a perspective geared to strengthening the role of public policies and promoting social equity in health. Through the work of a multidisciplinary team it is intended to make a contribution to clarifying the concept and use of the term “governance” as used in the analysis of policy-making processes linked to the health sector. In Latin America there is notable conceptual confusion caused by the indiscriminate use of different words as equivalent to the English word “governance”. The category “governance” will be applied as an analytical research tool in the thematic area of health policies and systems. The development of this analytical tool is in contrast to the normative use of the term governance in a generalized way, mostly employed by international agencies.

A survey of different academic and policy-making stakeholders related to the health sector revealed considerable ignorance and widespread confusion in regard to the terms governance and governability. Governance is understood here as a framework and analytical tool for understanding factors that determine the organization of stakeholder interaction, process dynamics and rules of the game (informal and formal) with which a society makes and implements its decisions. In health systems research its proposed use is as an analytical category, in contrast with its normative or prescriptive use. Factors that influence these dynamics, processes and rules of the game will be researched in order to understand how they condition the performance of health systems. The concept of governability on the other hand, is understood as the capacity of a socio-political system to implement a policy or a program.

Short Paper

Roberto Bazzani – International Development Research Centre

Introduction

The development of a governance analytical framework and its application to the field of collective health research in Latin America and the Caribbean represent a regional priority for the Governance, Equity and Health Program Initiative (GEH) of the International Development Research Centre of Canada (IDRC). Within the framework of research into health policies and systems, the analysis of health sector governance processes is currently a challenge of great relevance that warrants the creation of new reflection spaces and methodological contributions. This is congruent with the objectives of the GEH Programs Initiative, which gives priority to health system research and the subsequent use and exchange of knowledge.
GEH provides financial and technical support to research projects led by teams from developing countries. The development of research methodologies, such as the one proposed by this panel, potentially represents a significant contribution to the strengthening of institutional research capacities in the region. GEH aims to strengthen regional capacities for health policy and systems research, as part of a process geared towards promoting regional evidence in support of health policy-making that will strengthen health systems, the role of public policy in health and progress towards greater equity in health. This academic field is developing out of a growing awareness of the more favourable environment surrounding issues related to health systems, equity in health and evidence-based health public policies, both at an international level and within countries of the region.

GEH has therefore established three priority areas for the support of applied research projects: health sector governance processes, health system functioning and the development of new financing approaches. In this context GEH regards the development of methodological instruments for the analysis of governance processes as a key element.

**Governance or Governability?**

This panel presents a synopsis of an academic exercise aimed at the development and validation of a methodology for the analysis of health governance processes. Part of this exercise is an endeavour to clarify definitions, concepts and uses of the term governance in the analysis of social and political processes in Latin America and the Caribbean, with special emphasis on the health sector. This is particularly relevant in our region due to the conceptual confusion that exists as a result of an indiscriminate and undifferentiated use of several words as equivalents to the English word “governance”. Firstly the indiscriminate and ambiguous use of the terms governance (in Spanish “gobernanza” and “gobernancia” are variously employed) and governability is acknowledged. The specific scope of the term governance is then delimited and differentiated from that of governability, a word more often heard in our region. To resolve the confusion in Spanish between the use of “gobernanza” and “gobernancia” to mean governance, the exclusive use of “gobernanza” is proposed as this word is recognized by the Royal Spanish Academy.

This proposal aims to define the concept of governance, to promote its use and application in the area of health policies and systems and to show its utility as an analytical research tool for better understanding and transforming health system policy-making and management processes. More specifically, it focuses on the building of a health governance conceptual and analytical framework that is distinct from its normative use currently in vogue and employed mostly by international agencies.
Background

This academic exercise resulted from concerns raised by a group of researchers from various Latin American countries who perceived the ambiguity and heterogeneity in the use and application of the terms governance (“gobernanza” and “gobernancia”) and governability. They agreed on the need to initiate a process that would lead to a consensual proposal for the use of a health governance conceptual framework in our region. In response to this need and within the framework of the Governance, Equity and Health (GEH) Initiative, IDRC called a first workshop in October 2004 in Montevideo, Uruguay, with the objectives of agreeing on a conceptual and methodological proposal for common use and establishing a work agenda. The workshop participants were Armando Arredondo - National Institute of Public Health, Mexico (Instituto Nacional de Salud Pública de México); Ernesto Báscolo - Instituto Juan Lazarte, Rosario, Argentina; Roberto Bazzani – IDRC; Luiza Heimann - São Paulo Health Institute, Brazil; Marc Hufty - Graduate Institute of Development Studies, IUED, Geneva, Switzerland; Andrés Rius – IDRC; Ana Luiza Viana - São Paulo University, Brazil. As well as agreeing on the basis of a common analytical and conceptual framework this meeting significantly provided a platform for launching subsequent activities related to this theme in the region.

As part of the analytical process an initial review of literature was made and a series of interviews with researchers and decision-makers were undertaken to determine the knowledge, understanding and use of the terms governance and governability on the part of researchers and decision-makers in the health sectors of Argentina, Brazil, Colombia and Mexico.

In the workshop it was decided to elaborate the concept of governance as an analytical category as opposed to its normative use. This normative use is based on a value and implies a postulate and social prescription, that is, in the examination or evaluation of a policy or program it proposes a certainty of what is good or bad and therefore compares the case in question with predetermined values. Whereas its analytical use facilitates the description, explanation and understanding of stakeholder interactions, processes and rules of the game related to behaviours and decision-making in society.

The following definition of governance was adopted: “the collective action processes that organize the interaction between stakeholders, process dynamics and rules of the game (informal and formal) with which a society makes and implements its decisions and determines its behaviour” (October 2004 Workshop Team, Montevideo, Uruguay).

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8 The norm is a socially prescribed value (Hufty, 2005).
The following definition of governability was adopted: “the capacity of a socio-political system to govern itself in the context of other larger systems of which it forms a part” (Kooiman, 1993).

While governance refers to processes, governability refers to capacities, which are to a large degree affected by governance processes.

The problem being studied

Even though the governance analytical framework represents an extremely valuable tool for the study of factors that condition health policies and management, it is necessary to overcome some obstacles that exist in our region for its use to become feasible. These obstacles became evident through the above mentioned literature review and knowledge and uses survey carried out through interviews with decision-makers and researchers.

In this region there is a notable lack of conceptual coherence in the use of the terms governability and governance, both in their application in social and political sciences and in the field of health. In relation to governance, this translates into different understandings of the term amongst researchers, contradictory and heterogeneous uses of the concept, a lack of knowledge regarding the term on the part of decision-makers and great confusion in its use by both groups. To all this may be added the frequent indiscriminate use of governance and governability as synonyms or to indicate varying meanings.

The considerable ignorance of the term governance amongst decision-makers, which was clearly evident in the interviews, also implies the challenge of building a research agenda that would promote continuous interaction from an early stage between academic actors and decision-makers. This is essential in the design and implementation of strategies for the use of research results.

In our region the concept of governance has been introduced quite recently to the field of health. However it is increasingly used in other fields, as can be seen in many academic and policy publications produced by national and international institutions during the last decades. The indiscriminate use of governance (“gobernanza” and “gobernañcia”) and/or governability in such publications has not favoured a conceptual clarification of the terms and constitutes an additional confusion factor.

Interviews with researchers and decision-makers

The preceding arguments aim to demonstrate the lack of an analytical use of governance in our region. This was corroborated by the survey of knowledge and uses of the term.
We now present the conclusions drawn from the survey of knowledge, understanding and use of the terms governance and governability. A total of 36 interviews were carried out in Argentina, Brazil, Colombia and Mexico: 19 with researchers from different disciplines linked to the field of health but excluding those from political sciences, and 17 with decision-makers from different health system levels. The same questions were put to researchers and decision-makers employing the following format and contents:

<table>
<thead>
<tr>
<th>Questions</th>
<th>Governance (Gobernanza or Gobernancia)</th>
<th>Governability</th>
</tr>
</thead>
<tbody>
<tr>
<td>1- Do you know the term?</td>
<td>Yes/No</td>
<td>Yes/No</td>
</tr>
<tr>
<td></td>
<td>Specify which of the two</td>
<td></td>
</tr>
<tr>
<td>2- What do you understand by the term?</td>
<td>Concept of the respondent</td>
<td>Idem</td>
</tr>
<tr>
<td>3- Do you use it?</td>
<td>Frequently, sporadically, not at all</td>
<td>Idem</td>
</tr>
<tr>
<td>4- What do you use it for?</td>
<td>Respondent explanation</td>
<td>Idem</td>
</tr>
</tbody>
</table>

The questionnaire for each respondent comprised his or her name, occupation and position, discipline/profession profile and the table with answers. For the analysis of answers to the question on the understanding of the terms governance and governability they were compared with the above-mentioned definitions used in this proposal (Governance - 2004 Workshop and Governability - Kooiman, 1993).

Conclusions drawn from interviews with researchers

- Significant levels of confusion were found in the understanding and use of both terms.
- Knowledge, understanding and usage levels for the term governance (“gobernanza” or “gobernancia”) were lower than those corresponding to the term governability.
- The great majority of researchers indicated that they had a better knowledge and understanding of the term governability than governance (this is probably due to the fact that the term governance was introduced later in Latin America, in the 1990s).
- Even though there was less variation in the understanding and use of the term governability there was some heterogeneity in the answers (which can be explained in part by the different academic disciplines that the researchers being interviewed came from).
- In spite of most researchers indicating that they knew of the term governance, and in some cases claiming to understand its meaning, the degree of compatibility with the proposal’s definition was predominantly low.
As expected, the lack of knowledge of the term governance was less in those researchers directly or indirectly linked to GEH-IDRC projects. However, even amongst them there was a significant variation in the understanding.

In most cases the researchers associated governance with concepts that only partially correspond to the proposal’s definition, such as: social participation, consensus generation and dialogue capacity between stakeholders, as well as concepts closer to governability, such as policy implementation capacity resulting from the functioning of a socio-political system.

Governance was frequently used in its normative sense (good or bad governance) as opposed to its use as an analytical category.

Apart from those directly or indirectly involved in GEH-IDRC projects, most researchers do not use the term governance.

Conclusions drawn from interviews with decision-makers

- Decision-makers’ knowledge and understanding levels for the term governance were extremely low, for the most part they did not know its meaning or the difference between it and governability.
- With one exception, they claimed to know the term governability and understand its meaning but there was a significant variance among their answers, and the degree of compatibility with the proposal’s definition varied.
- With two exceptions, the decision-makers did not use the term governance, whereas most of them said that they do use the term governability (although with varying meanings).
- As with the researchers, significant levels of confusion were found in their understanding of the difference between governance and governability.
- The variance in the understanding of the meaning of governance was much greater than in the case of governability (probably because governability is a more familiar term for decision-makers).
- In short, the term and the concept of governance are not well known or understood by most decision-makers who were interviewed and almost none of them use the term. This was anticipated and is related with the fact that the term has only recently been introduced in Latin America.

The results of this survey confirm some of our previous findings from the review of literature: a) there is limited knowledge and use of the term governance, whereas in the case of governability recognition and use are more widespread; b) in both actor categories the meanings attributed to the term governance were highly ambiguous and varied, which was also the case, but to a lesser degree, with governability.

These results corroborate the existence of a need and opportunity for the development of the proposed conceptual methodological framework as a contribution to bridging a gap in health policies and systems research in the region. The creation of analytical tools for the analysis of health sector rules of the game generation and
implementation will contribute to a better understanding of decision-making processes and generate evidence needed to support the design of appropriate interventions, which in turn will contribute to the strengthening of public health policies in the region.

References


Power Point Presentation

Roberto Bazzani’s full presentation is available in PDF format (in Spanish) at: http://www.idrc.ca/uploads/user-S/11570373771bazzani_presentation.pdf
Panelist 2 - Marc Hufty, “The conceptual and analytical framework of governance”

Marc Hufty, from the Graduate Institute of Development Studies in Geneva, Switzerland presented his work on “The conceptual and analytical framework of governance”. His abstract and the link to his presentation are found below.

Abstract

Marc Hufty
Graduate Institute of Development Studies (IUED), Geneva, Switzerland

This communication presents the results of a theoretical and empirical reflection on governance, which began in 2004 within the framework of the Swiss project NCCR-North-South (FNS-SDC) in association with teams from Argentina and Bolivia, and with IDRC. Governance is a polysemic term, that is used in several ways. We have identified at least five different groups of meanings, which generate a lot of confusion and prevent the scientific use of this concept. The greatest challenge that we have met here is to move from a confusing word to a useful operational concept. The first stage was an examination of its various contrasting uses in scientific literature (political science, political sociology, international relations) and evaluate them with some basic scientific criteria (axiological neutrality, cumulativeness, reproductiveness, internal and external coherence, and empirical validation). The second stage, based on its occurrence in literature, was to delimit the object and the third was to design an observation methodology appropriate to it. At this point an in depth epistemological reflection, something specific to social sciences, was necessary in order to clarify our theoretical position. After two years, the first result is an analytical framework (toolkit) applicable to various subjects and types of issues. In this communication its application in the field of public health is presented. This methodology aims to explain and intervene in situations where governance constitutes a decisive factor in the application of public health programs or policies. That is, where the process of interaction between stakeholders causes, for example, inequity in access to health services in spite of the law and the resources invested. The methodology presented is based on a non-normative, interdisciplinary and multi-level posture. The principal elements that it analyzes are stakes, stakeholders (power and characteristics), nodal points (physical or virtual spaces of interaction), norms and institutions (formal and informal rules of the game), and processes (successive states of the system over time).

Short Paper

The “Governance Analytical Framework”: A Powerful Tool For The Analysis Of Health Policies
A central factor in the provision of public health, especially regarding the equity of access to health services, is how policies are being formulated and implemented. Policy formulation and implementation itself depends on legal and social norms, and on the concrete interactions of actors and the distribution of power. In a word, it depends on the governance processes in public health.

In this paper I present the “Governance Analytical Framework” (GAF), a pragmatic methodology whose aim is to demonstrate the potential of the concept “governance” with regards to the analysis of collective issues, such as public health. Some basic assumptions of the GAF are that governance processes can be found in any society, whenever there is a public issue at stake. These processes can be observed and analysed from a non-normative and non-prescriptive perspective. Contrary to many approaches based on ex-ante solutions (ex. World Bank’s “good governance”), my proposal is that governance can be a tool for diagnosing “the collective processes that determine, in a given society, how decisions are made and how social norms are elaborated, in relation to public affairs.”

This diagnosis, very similar to a medical doctor’s, seeks to find out “what is”, and not “what ought to be”. It uses the tools and methods of social sciences. Since it is oriented towards a pragmatic understanding of social problems, it is based on an interdisciplinary perspective (law, political science, sociology, anthropology, economics, social psychology, history, geography, etc.). This methodology is deliberately jargon-free and can be used by non-specialists.

Based on several research programs (NCCR North-South, IDRC GEH), the GAF proposes a set of five main analytical tools: defining the problem, analysing the actors dynamics, observing nodal points, analysing norms formulation and understanding processes of governance in a time perspective. These tools constitute a coherent and logically articulated methodology.

The first tool, “defining the problem” is based on the assumptions that, whenever an issue is at stake and being disputed among individuals and groups, each actor has its own understanding of what is at stake. This also includes the observer (the person or group who uses the GAF for a diagnosis). Hence, a first step is to “deconstruct” and “reconstruct” the issue.

Different actors have different histories, cultures, constraints, objectives and discourses. These are called “universes of signification”. When undertaking a study with the GAF, we first have to admit the plurality of visions, including ours. Any social interaction, or conflict, is an encounter of these universes. Defining the issue at stake implies the understanding of these universes, how each actor perceives the issue from
his/her standing point. This is a fundamental step towards a realistic analysis and a possible solution. With the help of discussions with stakeholders, a literature review, and a transformation of identified social problems (“My children are sick and I can’t buy medication”) to sociological ones (“Access to medication is unequal”), the issue can be “reconstructed”.

The definition of the issue is itself at stake. It is obvious that any social relation entails power relations and that the definition of the problem at stake can be imposed by force or persuasion. The person who holds more power can influence the definition of the issue, albeit with a high probability of generating discontent and leading to passive or active forms of resistance. A more subtle way of imposing one’s will is symbolic violence⁶, convincing the other actors that the dominant’s preferences are his, like in patron-client relationships. In unequal relationships, the definition of the problem will most probably incorporate these schemes. Whether the observer goes a step beyond what is presented as a problem by the actors and transforms it into a sociological problem depends very much on the political context.

As an example, equity in access to health services is a problem for those who are denied access. However, they might not even realise that theirs is a collective problem and that things could improve through a collective reflection and action process. One will say “my child is ill” or “I did not get attention in the public hospital because I had no money to bribe the personal”. For the people that take advantage of this situation, it is of course not a problem. Behaving according to the prevalent norms (political manipulation of health resources or bribery), they might not even be conscious of their participation in mechanisms that introduce inequity, and attribute to it fatality. External intervention (most probably by political authorities and external observers) and a wide reflection process will be needed to relate this to a governance problem. Here, governance can be considered an independent variable.

The second tool, much related to the first one, is “analysing the actors dynamics”. The assumption here is that all stakeholders (individuals or groups) must be considered in the definition of the issue and for the analysis, including those who are “informal” or “invisible”, such as social networks for example. Of course, not all actors have the same influence on an issue. That is why we propose a sub-set of tools aimed at analysing the resources available to and the ways of influencing all actors on the considered issue. One is a descriptive grid, which makes clear each actors’ characteristics (status, references, controlled resources, discourses, means of action, etc.). A second tool is an interaction grid where actors’ relationships are detailed. This can also be illustrated by actors mapping.
Types of interactions: structural (kinship, economical, legal, common history, community...), strategic (of negotiation, direction, distribution, reciprocity, conflict, alliance...).

The third tool is called “nodal points”\(^7\). Just like when railways converge in a given place, actors’ trajectories meet at certain points around certain issues. At these points, located in time and space, the actors’ dynamics and the issues can be observed. It can be for example a negotiation table. However it does not need to be a physical space: a network could also be a nodal point. As well, it is a place for the convergence of several “second-row” nodal points. A group or an organisation participating in a negotiation table will present one unified position, but it is the product of an internal debate where several positions might have been in competition. These internal debates are also nodal points that can be observed. In a nodal point, there is cooperation and competition in relation to the issue at stake. And finally, this is the place where norms are being elaborated.

The “elaboration of norms” is my fourth tool\(^8\). Norms are defined as collective expectations related to what is considered to be appropriate behaviour under given circumstances. Norms always include a value or a belief (the sense of what is good and wrong) and a prescription (what one has to do or not). They influence the actor’s behaviour and are modified by collective action. Norms have to be understood in a sociological sense. At this stage, there is no distinction between formal-legal norms
(produced by legal authorities) and informal-social norms (produced by the practices of actors). In any situation, a pluralism of norms can be observed. In fact, norms are the main stake in a dispute. The actors objectives are to determine what the norms will be, who will have the right to formulate norms, what the norms defining the rules-of-the-game between the actors will be and who has the right to formulate them. When norms are recurrent, they transform into social institutions.

I distinguish three broad categories of norms. Meta-norms are principles that orient in a general sense the social contract in a given society - for example universal access to health care, or sustainable development. Constitutive norms define organisational principles and roles. This includes who has the right to command, formulate rules and make decisions in an organisation or a society, for example the hierarchical structure of a firm or a group. Regulative norms are rules of conduct. They specify what can be done (has to be done) and what cannot be done, and provide positive (approval, reward) and negative (disapproval, punishment) sanctions.

Norms also express the multilevel aspect of governance. They can be formulated at various levels and transferred to others. This has a huge importance in international relations or in development. Norms are often elaborated at a national level, transferred at the international level and again to other countries, where they are transferred to the local level. At each level, there is a process of reaction, rejection or internalisation. The participation in the cost of health care or participation of local people in the management of protected areas can be used as examples. This process is illustrated by the following graph.

<table>
<thead>
<tr>
<th>Multilevel analysis of norms</th>
<th>Steps</th>
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<tbody>
<tr>
<td></td>
<td>Elaboration</td>
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<tr>
<td>Levels</td>
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<td>International</td>
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<td>National</td>
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<td>Local</td>
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The last tool is the “understanding of governance processes over time”. Issues, actors, nodal points, norms and the context convene in these processes. Actors interact among themselves, and over time they will adjust their expectations, objectives and even identity. Several nodal points might appear, disappear, interact and get transformed on the same issue. Norms are being formulated, transformed, and institutionalised. The context changes. It is only with regard to these elements that the governance process can be fully understood.

References


5. Governance, Equity and Health, a programme of the International Center for Research on development


Power Point Presentation

His full presentation in PDF format can be found at the following link: http://www.idrc.ca/uploads/user-S/11555827401hufty_presentacion.pdf

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Panelist 3 - Ernesto Báscolo, “Application of the analytical perspective of governance in public health insurance research in the Province of Buenos Aires”

Ernesto Báscolo, from the Juan Lazarte Institute in Rosario Argentina presented his work on the “Application of the analytical perspective of governance in public health insurance research in the Province of Buenos Aires”. His presentation abstract and short paper are found below along with the link to his full presentation in Spanish.

Abstract

Ernesto Pablo Báscolo & Natalia Yavich
Instituto de la Salud “Juan Lazarte”, Rosario, Argentina

Introduction

This research project analyses the Public Health Insurance (Seguro Público de Salud - SPS) implementation process in the Province of Buenos Aires and its implications for the organization of primary health care services. The growing academic development of the conceptual framework of governance has provided a methodological basis for analyzing institutional and political processes that condition the implementation modality of a policy under analysis.

Objective

To discuss conceptual categories of the governance conceptual framework and apply them to evaluation research on public health insurance in the province of Buenos Aires.

Methodology

Firstly, the analytical conceptual perspective of governance in the context of research on SPS is discussed focusing on the following methodological criteria: transdisciplinarity, realism, comparativeness, multi-level and reflexivity. Secondly, the analysis framework variables are identified and elaborated, considering governance as an intermediate variable. Finally, governance conceptual categories (rules of the
game, stakeholder interaction and processes) and their use in the framework of research are elaborated.

Results

The discussion on methodological criteria focuses on the modality of integration between researchers and different stakeholders involved in the process of public insurance implementation, as a knowledge producing strategy. In the analysis framework, governance is considered to be an intermediate variable, conditioned by the organizational and institutional characteristics of the health system and the local economic and social context (independent variables) and conditioning certain service performance results (dependent variables), in particular accessibility conditions for the population. Finally, the nodal points are used as a central element of governance, characterized by the different levels of analysis, the stakeholders involved (and their interactions) and the associated norms and rules of the game in each case.

Conclusions

The application of the analytic perspective of governance, as a methodological and theoretical basis for the evaluation of public insurance in the province of Buenos Aires, facilitated a transdisciplinary production of knowledge and an articulation of the research process within the decision-making process of implementation, through the identification, characterization and evaluation of institutional spaces impacting on the policy-making process of the analyzed intervention and on health service performance.

Short Paper

Ernesto Pablo Báscolo & Natalia Yavich
Instituto de la Salud “Juan Lazarte”, Rosario, Argentina.

Introduction

The governance analytical framework is used as the basis for analyzing processes related to the extension of social protection in health in Latin America, and in particular, the case of the Public Health Insurance (Seguro Público de Salud - SPS) implementation process in the Province of Buenos Aires.

The SPS is a program developed by the Ministry of Health of the Province of Buenos Aires as a strategy for strengthening the governing capacity of the provincial health ministry, transforming the model of medical care and improving access to health services for the population living in poverty, through institutional changes at different administrative levels (central, regional and municipal) and in the relations between
organizations and institutions in the health sector and the social sector. The most relevant innovations include changes in the modalities for financing services, the treatment model and the management of health services.

Methodology

The notion of governance adopted in this project falls under the framework of the analytical perspective of governance. The conceptual categories of governance are: stakeholder interaction, nodal points, critical social interfaces, stakes in the game, rules of the game and processes of change.

Under the governance analytical framework (GAF), the SPS implementation process is understood as the analysis of the political and institutional process of the production and implementation of norms as a result of the interaction of the stakeholders involved.

The application of the GAF implies considering governance as an intermediate variable that conditions the governability of the public health insurance implementation process and health service performance (dependent variables) and is conditioned by the characteristics of the system and the local context (independent variables). The independent variables are represented by the economic, social and epidemiological factors of the population, and particularly the institutional structure of the health system in the province.

The conditioning factors were studied through secondary information sources. Health service performance at the primary care level was analyzed through the use of population surveys, while governance and governability were analyzed through interviews with local decision-makers, the authorities responsible for the implementation of SPS at the local and central level, and SPS providers.

Analytical categories

The “stakeholders” involved are analyzed through the construction of a “stakeholder map” in which they are characterized by i) their positioning and relative place in SPS implementation, ii) stakeholder perceptions of those with strategic power, iii) the spaces (formal or informal) in which they operate, their participation at different levels (provincial, municipal or local) and the modalities of interaction (cooperation, competition) among them. The analysis of the positioning of the stakeholders requires recognizing not only their respective interests and values, but also the particular issues that are resolved in each interaction space. The use and application of “norms” is analyzed from the perspective of the political and organizational process triggered by the reforms promoted by the SPS program.

The social interfaces are considered spaces for critical exchange, marked by “stakes in the game” or power struggles with the capacity to provoke changes in the
governability of the implementation process (sustainability of the political process) and the organization and accessibility of SPS health services.

The “nodal points” constitute spaces for observation of stakeholder interaction with the capacity to produce norms associated with the public health insurance implementation process.

The identification of the “process” of change in SPS implementation requires observing and analyzing the transformations in the rules of the game associated with the changes in the critical social interfaces.

Results

This section describes the way in which the conceptual and analytical categories of the GAF were applied to the different levels of organization and interfaces identified. At the provincial level, two social interfaces were identified. The first corresponds to the relationship between the medical professional associations and the SPS program. The stakes in the game relate to the distribution of the financial resources allocated for the payment of the professionals (political economy). The nodal points are the formal spaces for negotiations between the representatives of the professional associations and the SPS agency. The norms derived from this interaction are generated by the agreements between the SPS program and the associations, which establish the forms of contracting, the amount of per capita payments and the details of the corresponding services.

The second social interface corresponds to the relations between the structure of the Ministry and the SPS agency, where the stakes relate to the tensions associated with the direction of the reform. In this context, the points of conflict in the struggle are the definition of the role, scope and autonomy of the agency responsible for managing the health system reform (the change team) and substantive aspects of the reform itself. This interface significantly influences the SPS formalization process, through the generation of different norms (the SPS resolution, decree and law) and its political sustainability.

At the intermediate level (provincial-municipal), two social interfaces were identified. One refers to the relationship between the SPS agency, the provincial health regions and the municipal health departments, and the other to the relationship between those responsible for the SPS program at the provincial level and those responsible for its administration at the local level (stakeholders from the Municipal Health and Development Departments and Municipal Professional Associations, as well as others from public welfare organizations).

The first interface represents the formal spaces for coordination of the network of services in the territory covered by the study. The second represents the tension between the search for strengthening provincial regulation of the functioning of local
health systems and the maintenance of municipal autonomy. The most important nodal points in the first interface are the institutional spaces of the regional units, while in the second they are the spaces for political negotiation and the different training activities promoted by the Provincial Executor Unit (Unidad Ejecutora Provincial - UEP), with the participation of different stakeholders linked to the local administration of SPS, aimed at improving the conditions of local planning and the adaptation (and production) of SPS organizational norms in accordance with local conditions.

At the municipal level, the social interfaces correspond to the relationships between officials and technical teams from the municipal departments of health and development and representatives of the professional associations and non-governmental organizations. What is at stake is the definition of who is responsible for managing the SPS resources and how this is done. The most visible nodal point is that of the local coordination units, which decide upon the selection of professionals, the location of the office, the definition of neighbourhoods or areas with the highest priority, and the articulation between the social development sector and the municipal services management teams.

Lastly, at the local level, the interfaces arise from the relationships between the community, the SPS service providers and the professionals at the municipal health centres. The nodal points are the meetings between the neighbourhood workers and beneficiaries, the neighbourhood workers and the public health insurance doctors, the health centres, etc. These spaces are characterized by greater informality and express the struggle between the population’s demands for health services versus the limitations, availability and capacity for response of the professionals.

The analysis of the processes of change in SPS implementation between 2001 and 2005 allows for the definition of different stages in governance conditions generated in the SPS implementation process by virtue of the different levels of autonomy of the SPS agency – as a strategic stakeholder in the political and technical construction of reforms in primary health care at the provincial level – and the different degrees of “entrenchment” of the SPS agency, with diverse civil society entities both at the macro level (private sector providers) and the local level (the network of social workers), through new interfaces with stakeholders from the state structure, at the macro level (Ministry of Social Development) and the local level (municipal secretaries of health and development).

Discusión

To further advance the development of the analytical framework of governance in health, its conceptual categories have been applied to a particular case of research for the analysis of the implementation of a policy to extend social protection in health (the SPS program).
The governance conditions of the SPS implementation process orient the identification and analysis of political and technical aspects. Reassessing the social interfaces encompassed by the SPS agency highlights the complexity of the process. Also generated at the same time are: i) higher degrees of freedom (technical and political) with a wide field of action in new interfaces that support a course that modifies traditional institutional relations, and ii) growing conflictive tension with the formal and functional structure of the Ministry of Health in conducting the reforms.

From this perspective, it is possible to recognize how the new governance conditions have facilitated the adaptation of the reform process to the particular conditions of the primary health care system in each scenario, with greater integration of local community stakeholders. On the other hand, the same strategies have met with greater limitations for using regional coordination spaces, integrating the services offered by SPS with secondary health care services (which are under provincial jurisdiction). This problem is explained by the political tension in the conduction of the reforms and the need to integrate technical and political levels of the ministerial structure to consolidate a strategy for the integration of the health system.4

Conclusions

The application of the GAF in the analysis of the public health insurance implementation process was aimed at demonstrating its explanatory capacity with a greater understanding of the political, social and institutional processes that determine the sustainability and results of such policies.

In the analysis of SPS implementation, the analytical categories of the GAF served as a basis for understanding the relationship between governance conditions and the political governability and health service performance of the SPS program.

This analysis highlights the need to consider the specificities produced in the relations between the institutional political process associated with implementation processes and the changes in the organization of health services and their implications for the accessibility of services from the perspective of the population.

Recommendations

Although some contributions can be documented from a long course of theoretical and methodological reflection, in order to complete the interpretive framework it will be necessary to seek greater development and articulation between the analysis of the specificities of the political and institutional aspects of health policies and the evaluation of their results through the application of the GAF on a wider variety of national and local initiatives.
References


Power Point Presentation

Ernesto Bascolo’s full presentation in Spanish can be found in PDF format at the link below: http://www.idrc.ca/uploads/user-S/11570379011bascolo_presentacion.pdf

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Panelist 4 - Luz Helena Sánchez, “Governance and research on public health”

Luz Helena Sánchez from the Colombian Health Association (Asociación Colombiana de la Salud - ASSALUD) in Bogotá, Colombia presented on her work on “Governance and research on public health”.

135
Abstract

Luz Helena Sánchez, Francisco J. Yepes, Asociación Colombiana de la Salud ASSALUD, Bogota, Colombia
Manuel Ramírez, Facultad de Economía de la Universidad de Rosario, Argentina

Introduction

Research to action as a contribution to governance (governability) in health through health policy-making based on evidence and with social participation.

Objectives

The evaluation of health reform performance during its first decade through a civil society participation process, with technical support and the use of available evidence, to formulate health policy proposals leading to the solution of identified problems.

Method

The convening of two stakeholder groups, one comprising health professionals with experience in directive positions and another comprising social organizations and community leaders. The technical group provided information, organized work meetings, promoted forums to validate the results in different towns and also got parliamentary members involved in the process. Parallel to this stakeholder mapping was carried out using Policy Maker.

Results

An analysis of the policy-making process; the reform’s losses and gains balance; validation with technical, community and political stakeholders; the articulation of stakeholders with policy-making.

Conclusion

Social stakeholders who are not aligned with economic or political interest or power groups, have access to few participation spaces in policy-making. Researchers need to develop communication, training and technical assistance tools in order to strengthen governance in health.

Short Paper

Luz Helena Sánchez Gómez, Francisco J. Yepes, Manuel Ramírez

Governance as an analytical category and governance as an outcome to be pursued
In the research project “Governance and Evidence-Based Decision Making: a participatory formation process of health policies - A comprehensive evaluation of the first ten years of health reform”, jointly undertaken by the Colombian Health Association (Asociación Colombiana de la Salud –ASSALUD) and the School of Economics of the University of Rosario, we are considering governance as both an analytical category and an outcome to be pursued; in the latter case, we view it as synonymous with governability.

As an analytical category, we address governance as an interface between research and public policy-making that comprises decision makers, common citizens and their organizations (civil society) and different stakeholder groups – in our case, health professionals and their organizations, insurers, public and private hospitals, territorial entities, political parties, etc. The IDRC working group proposal refers to governance as the processes of collective action that organize the interactions of actors and social rules through which a society determines its behaviour.

In this framework, governance leads us to an analysis of the interactions of the different stakeholders and a critical reflection on the role of researchers in the task of explicitly contributing to the process of public policy-making.

In other words, it allows us or helps us to understand the “why” and “how”.

As an outcome, it is something we pursue by promoting public policy-making based on evidence and involving the informed participation of different social actors.

In this case, the use of evidence by the different stakeholders in policy-making takes on greater importance. It is not enough to understand the “why” and “how”; it is also necessary to advance towards the achievement of results.

**Generation of evidence**

In promoting policy-making based on evidence and informed participation, we must ask ourselves a number of questions:

- **How do we identify the available evidence?**

  This implies identifying, gathering, systematizing and analyzing the evidence already available, while generating new evidence as well. It is further necessary to rate the available evidence: to what extent can the evidence available be considered reliable or hard evidence?

- **How can the evidence be disseminated to influence decision making? What strategies should be used?**
In addition to the identification of evidence, which is part of the usual work of researchers, the dissemination of this evidence is a new task within our work, and opens up a series of questions on the best way to achieve it.

This makes it necessary to identify the best means to transmit the evidence found to the different social actors and to adapt the language used to their level. It is quite likely that the means chosen and the language required will vary in accordance with the kind of actors we are attempting to reach.

This gives rise to another series of questions that we researchers must resolve. Should we establish direct contacts with decision makers? With which decision makers? How can we know and understand the interests at stake behind the decisions being made? Should we generate mechanisms to generate social pressure? Through the media? By mobilizing social organizations?

Social participation

This component also gives rise to a series of questions.

- How do we define civil society?
  - Social organizations
  - Ad hoc groups
  - Grassroots communities
  - Mass media
  - Specialized communications
  - Specific training

- How can civil society be incorporated in an effective way? Does this require the development of special strategies, tools and educational materials?

Obviously, “civil society” is not a homogenous entity, and is composed of various groups with different interests and different degrees of participation, power, understanding, etc. An analysis of governance aimed at pursuing an outcome from our actions requires the identification of those groups which have the greatest influence and can have a greater impact on policy-making. On the other hand, it is also necessary to consider the short-term interests (effect on policy) versus the long-term interests (sustainability of civil society involvement).

Involvement of decision makers

- How can we understand the interests at stake and the balance of powers in order to achieve equitable policy-making?
• How can we involve decision makers from the executive branch?
  o Ministry of Social Protection
  o National Board on Social Security in Health
  o Superintendency of Health
  o National Planning Department

• How can we involve decision makers from the legislative branch?
  o Senate
  o House of Representatives

Policy-making

• How can the evidence be translated into policy-making?
• How can allies be sought and identified?

Final Reflections

This is a relatively new field of explicit action for researchers, and consequently implies a learning process on our part.

It requires the building of multidisciplinary teams and the incorporation of different methodologies to help identify the different knowledge levels of the stakeholders, their different interests, the diversity of perspectives and times for action.

It also demands an explicit process of learning about the identification and formulation of action strategies, the building of alliances, the neutralization of opposition, social mobilization, and so on.

Power Point Presentation

Luz Helena Sanchez’s full presentation in PDF format is available in its original language at:
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Chapter 9

Other Congress Presentations by IDRC Partners

Several IDRC partners presented their work in panels which were not officially organized by IDRC. The abstracts and presentations of some of these partners can be found below.

Douglas Barraza, “An ecosystem approach to pesticide exposure and children’s health in communities living in the vicinity of banana plantations”

Douglas Barraza, from the Regional Institute on Toxic Substance Studies at the National University (Instituto Regional de Estudios en Sustancias Tóxicas Universidad Nacional IRET’UNA) presented “An ecosystem approach to pesticide exposure and children’s health in communities living in the vicinity of banana plantations”. The abstract for his presentation is found below.

Abstract

Douglas Barraza, Berna van Wendel de Joode, Elba de la Cruz, Catharina Wesseling, IRET, Universidad Nacional, Heredia, Costa Rica
Hans Kromhout, IRAS, Utrecht University, The Netherlands
Kees Jansen, TAO, Wageningen University and Research Center, The Netherlands
Donna Mergler CINBIOSE, Université du Québec à Montréal, Canada

A pilot project is being performed in Costa Rica that aims to study pathways of children’s pesticide exposure, its health effects and social consequences in communities adjacent to banana plantations, integrating natural, social and health sciences using an holistic, ecosystem health approach. The study population includes a community, which has a primary school with 40-80 pupils, and is situated near plantations with extensive pesticide use. Pesticide exposure pathways are studied both qualitatively and quantitatively within a social, cultural and gender context. Community participation is assured throughout this entire pilot study. One low-exposure community is included in the study. To evaluate children’s health, a neurobehavioral test-battery was developed by a multi-disciplinary group of experts from Canada, Latin America and the United States and will be verified during this pilot in 30 exposed and 30 low-exposed children living in the selected communities. We will present results from focus groups and interviews with different stakeholders (such as parents, teachers, company-owners, and government employees) on their risk perception of pesticides and their view on exposure routes. We will discuss results from observations at multiple locations such as play areas, schools, parents’ work-sites and at home (storage, indoor use) giving insight into possible exposure routes.
Preliminary data on measured pesticide exposure levels in air, dust and soil will be presented. Samples of drinking water and locally grown vegetables will also be analyzed for pesticide content and personal exposure measurements (air, dermal, and urinary metabolites) will be performed on 4 children on two occasions. Environmental conditions such as air velocity, humidity, temperature and spraying activities of the banana companies will also be documented. The results will be used in the design of a future project on pesticides and children’s health in communities living in the vicinity of banana plantations using an ecosystem approach to human health. The future project will integrate risk identification with risk reduction. Our results will give insight into different aspects of environmental pesticide exposure in children for one of Costa Rica’s most important cash crops. It will also identify agricultural, social and cultural practices, and gender-dependent variables that influence this exposure. The community, local government and researchers will use this information to promote changes at a local level that reduce main pesticide routes and children’s exposure.

Contact Data

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Ruth Arroyo, “Environmental and Human Health Impacts in the Rimac River Basin, Peru”

Ruth Arroyo, from the Institute of Health and Work (Instituto de Salud y Trabajo – ISAT) in Lima, Peru presented her work on “Environmental and Human Health Impacts in the Rimac River Basin, Peru”. The abstract of her presentation as well as a link to her presentation are found below.

Abstract

Impacts On The Environment And Human Health In The Rimac River Basin, Peru

Ruth Arroyo, Hugo Villa, Walter Chamochumbi, Eng. Haidé Acuña, Dr. Luis Yupanqui, Dr. Judith Herrera, B.Sc. H. Villa Pavel, Patricia Ynoñan, Instituto Salud y Trabajo -ISAT (Health & Labour Institute)
In Peru, the Rimac River basin is considered to be one the most polluted basins in the country given the large volumes of solid and liquid waste discharged mostly by mining activities.

Research is conducted in order to obtain deeper knowledge on mining pollutants in the ecosystem and their effects on human health and the environment. Two ecosystems were studied. The Higher Basin where the highest amount of mining liabilities are to be found and the Medium Basin. The overall objective was to determine the presence and impact of heavy metals (lead and arsenic). In each of the ecosystems a survey was conducted and irrigation and consumption water was studied (for solids in suspension), soils (total particles in suspension, minor particles at 10 microns (MP10) and air. The health study included taking biological samples (blood and urine), as well as tests for psychological evaluation. Qualitative techniques were also applied such as focal groups, in-depth interviews and participatory observation. The ecosystem approach used in this research allowed for the integration of a gender approach, bio-geo-physics sciences and community participation.

It was found that the districts of the Higher Basin are the ones with the highest levels of heavy metals in water (lead and arsenic), though no significant values were found in soil and air. In the children examined, the levels of lead and arsenic detected exceed the Safe Limits established by the CDC and WHO. In all locations, the population under study presented a high percentage of children with chronic malnutrition disorders and varying levels of visual and motor immaturity.

In terms of popular perception, adults recognize the pollution issue as a historical problem while women recognize more the effects of environmental pollution on human health, flora, fauna, nutrition and changes in lifestyles.

The progressive deterioration in the use of natural resources - in terms of quantity and quality - versus the development of extraction activities, and the case of medium and small-scale mining in the medium and high basins, must be evaluated in a comprehensive, permanent, multi-sectoral way. The above must also be evaluated from a holistic approach in order to understand the environmental, social and economic role and mechanics of the basin and the strategic importance of preserving its natural stock to guarantee the best living conditions to the populations that traditionally use these resources, by harmonizing their development with the other mining activities.
Power Point Presentation

Ruth Arroyo’s full presentation in PDF format in its original language (Spanish) can be found at: http://www.idrc.ca/uploads/user-S/11591966311arroyo_presentacion.pdf

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Francisco Yepes, “Health reforms from 1993’s Law 100 – the achievements, the failures, the problems and recommendations for action”

Francisco Yepes from the Colombian Health Association (ASSALUD) made a presentation on “Health reforms from 1993’s Law 100 – the achievements, the failures, the problems and recommendations for action”.
Las reformas de la salud a partir de la ley 100 de 1993
Los logros, las pérdidas, los problemas, acciones a recomendar

ASSALUD
Universidad del Rosario - Facultad de Economía

Rio de Janeiro, 22 de agosto de 2000

The full presentation is available in PDF format in its original language (Spanish) at: http://www.idrc.ca/uploads/user-S/11571375731yepes_presentacion.pdf

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Chapter 10 - Llamado a Presentación de Notas Conceptuales en América Latina y el Caribe

Enfermedades Transmisibles en América Latina y el Caribe: Investigación de Ecosalud para las Políticas y la Acción

Agosto de 2006

El Centro Internacional de Investigaciones para el Desarrollo (IDRC) de Canadá se complace en anunciar un llamado a la presentación de notas conceptuales para la investigación sobre el uso de enfoques ecosistémicos para la salud humana (Ecosalud) en la prevención y control del mal de Chagas, el dengue y la malaria; enfermedades contagiosas de transmisión por vectores que son prioridad en la salud pública de toda América Latina, tanto en entornos rurales como urbanos.

Coordinada por el Programa ‘Enfoques Ecosistémicos para la Salud Humana’ del IDRC, ésta es una colaboración con el Banco Interamericano de Desarrollo (BID), la Organización de Estados Americanos (OEA) y la Organización Panamericana de la Salud (OPS).

Características clave:

Enfoque transdisciplinario: el enfoque Ecosalud apuesta a los aportes de una variedad de expertos para entender más plenamente los factores que se originan en la sociedad y el ambiente y pueden determinar la vulnerabilidad de un individuo a una enfermedad o padecimiento determinado. Los equipos de investigación deben incluir integrantes provenientes de varias disciplinas.

Análisis social y de género: las enfermedades transmisibles como el mal de Chagas, el dengue y la malaria afectan a los pobres de los países en desarrollo en forma desproporcionada. Además, las mujeres y los niños a menudo se enfrentan a factores de riesgo distintos a los que enfrentan los hombres. Las notas conceptuales deben prestarle especial atención a los temas de equidad para asegurar el desarrollo de intervenciones más sustentables e inclusivas.

Investigación participativa con multiplicidad de actores: la inclusión de la mayor cantidad posible de actores clave en la investigación y desarrollo de intervenciones aumenta las probabilidades de obtener mejoras sostenidas y de largo plazo en la salud individual y de
la comunidad. Las presentaciones deben incluir pruebas de una amplia colaboración comunitaria.

Áreas geográficas de interés:

**Mal de Chagas:** América Central, la región del “Gran Chaco” (incluyendo zonas endémicas de Bolivia, Paraguay y el Norte de Argentina) y la Cuenca del Amazonas.

**Dengue:** Zonas hiperendémicas de América Central, la Región Andina y el Noreste de Brasil.

**Malaria:** La Cuenca del Amazonas

**Valor de las donaciones:**
Cuatro donaciones de hasta CAD $220.000 (unos USD200.000).

**Duración del proyecto:** 2 años.

**Elegibilidad:** Esta iniciativa va dirigida a equipos multidisciplinarios de investigación de América Latina y el Caribe interesados en desarrollar investigaciones orientadas a la acción que usen un enfoque ecosistémico para prevenir y controlar enfermedades transmisibles. Los equipos de investigación deben incluir investigadores de distintas disciplinas (ciencias sociales y ciencias relacionadas con la salud y el ambiente). Los investigadores han de estar afiliados a una organización sin fines de lucro, incluyendo instituciones académicas, ONGs u organizaciones gubernamentales.

Las notas conceptuales pueden presentarse en inglés, francés o español.

**Plazo para las presentaciones:**
31 de octubre de 2006

Enviar las notas conceptuales completas a: IDRC-Ecohealth CD-Americas Call Coordinator, cd-americas@idrc.ca

Se puede obtener más información en: http://www.idrc.ca/ecohealth/
Convocação para a apresentação de Notas Conceituais na América Latina e o Caribe

Doenças Transmissíveis na América Latina e o Caribe: Pesquisa de Ecossalúde para as Políticas e a Ação

Agosto de 2006

O Centro Internacional de Pesquisas para el Desenvolvimento (IDRC) do Canadá tem prazer em anunciar uma convocação para a apresentação de notas conceituais para a pesquisa sobre o uso de enfoques ecossistêmicos para a saúde humana (Ecossaúde) na prevenção e controle do mal de Chagas, a dengue e a malária; doenças contagiosas de transmissão por vetores que são prioritárias na saúde pública de toda a América Latina, tanto em ambientes rurais quanto urbanos.

Coordenada pelo Programa “Enfoques Ecossistêmicos para a Saúde Humana” do IDRC, esta é uma colaboração com o Banco Interamericano de Desenvolvimento (BID), a Organização dos Estados Americanos (O.E.A.) e a Organização Panamericana da Saúde (OPAS).

Características-chave:

Enfoque transdisciplinar: o enfoque Ecossaúde aposta nas contribuições de uma variedade de peritos para entender mais plenamente os fatores gerados na sociedade e no ambiente, e que podem determinar a vulnerabilidade de um indivíduo a uma doença ou padecimento determinado. As equipes de pesquisa devem incluir integrantes provenientes de várias disciplinas.

Análise social e de gênero: as doenças transmissíveis, como o mal de Chagas, a dengue e a malária, atingem desproporcionalmente os pobres dos países em desenvolvimento. Além disso, as mulheres e as crianças com frequência enfrentam fatores de risco diferentes aos enfrentados pelos homens. As notas conceituais devem prestar especial atenção aos temas de equidade para assegurar o desenvolvimento de intervenções mais sustentáveis e inclusivas.

Pesquisa participativa com multiplicidade de atores: a inclusão da maior quantidade possível de atores-chave na pesquisa e desenvolvimento de intervenções aumenta as probabilidades de obter melhoramentos sustentáveis e de longo prazo na saúde individual e da comunidade. As apresentações devem incluir provas de uma colaboração comunitária ampla.

Áreas geográficas de interesse:

Mal de Chagas: América Central, a região do “Grande Chaco” (inclusive zonas endêmicas da Bolívia, do Paraguai e do Norte da Argentina) e a Bacia do Amazonas.
Dengue: Zonas de grande ônus ou hiperendêmicas da América Central, a Região Andina e o Nordeste do Brasil.

Malária: A Bacia do Amazonas

Valor das doações:
Quatro doações de até CAD $220.000 (cerca de USD200.000).

Duração do projeto: 2 anos.

Elegibilidade: Esta iniciativa está dirigida a equipes multidisciplinares de pesquisa da América Latina e o Caribe interessadas em desenvolver pesquisas orientadas à ação, que se utilizem de um enfoque ecossistêmico para prevenir e controlar doenças transmissíveis. As equipes de pesquisa devem incluir pesquisadores de diferentes disciplinas (ciências sociais e ciências relacionadas com a saúde e o ambiente). Os pesquisadores devem estar afiliados a uma organização sem finalidade de lucro, inclusive instituições acadêmicas, ONGs ou organizações governamentais.

As notas conceituais podem ser apresentadas em inglês, francês ou espanhol.

Prazo para as apresentações:
31 de outubro de 2006

Deve-se enviar as notas conceituais completas a: IDRC-Ecohealth CD-Americas Call Coordinator, cd-americas@idrc.ca

Pode-se obter mais informação em: http://www.idrc.ca/ecohealth/
SECTION 2

Proceedings of IDRC-PAHO-REDE Workshop
“Research to Policy in Public Health – Analytical Frameworks for Action”

August 19 & 20, 2006
Rio de Janeiro, Brazil
Chapter 1- Workshop Background

Information and Objectives

Background

The workshop on “Research to Policy in Public Health: Analytical Frameworks for Action” was held in the Intercontinental Hotel in Rio de Janeiro on August 19th and 20th.

Over sixty researchers, policy-makers and other partners were invited to the event, of which 58 attended (predominantly from Latin America and the Caribbean but also including participants from Canada, USA, Africa, Asia and Europe). A list of participants is available is found below in Chapter 6.

The workshop was devoted to strengthening a research to policy analytical perspective in public health. The approach and contents were based on three key inputs:

a) The Policy Influence Study developed by IDRC’s Evaluation Unit
b) Lessons Learned from the project Social Protection in Health (IDRC-PAHO) and the special issue of the Journal Cadernos de Saude Publica de Fiocruz devoted to research to policy linkages
c) A rapid assessment of research to policy outcomes in three IDRC-Ecohealth projects in Ecuador.

Workshop presentations and discussions examined how research results have been translated into action and policy planning in different social and ecological contexts, and analyzed the main factors that have facilitated or hindered the policy influence potential of research studies.

Three main analytical categories were proposed for the workshop, based on IDRC’s Policy Influence Study:

- Team capacities to undertake research that has policy relevance, including the capacity to understand the policy context and ability to design and implement bridging strategies from research to policy and action (policy capacities);
- Knowledge generation and sharing across stakeholders boundaries, multi-stakeholder networking strategies and partnership development (broadening horizons), and
- Potential, extent and role of research in preparing the ground for policy change and action (affecting policy regimes)

This approach was not limited to the analysis of elements affecting formal public policy influence. The intent was to assess and strengthen the potential for knowledge utilization
and policy change among all relevant stakeholders since the analysis of policy influence is understood here in its broader sense and not limited to the assessment of direct policy impacts.

**Workshop Objectives**

The overall objective of the workshop was to strengthen the capacities of scientists and policymakers to build bridges between research, policy and practice in public health and sustainable development.

**Specific Objectives:**
- To promote an in-depth reflection on research to policy influence in public health and sustainable development, discuss and suggest appropriate mechanisms and strategies for linking academics, decision makers and civil society.
- To contribute to the development of networking linkages between public health stakeholders and those from other key development sectors.
- To encourage the development of communities of practice in the fields of ecohealth research (and related health and sustainable development thematic areas) and governance, equity and health research (and related health policies and systems thematic areas), and promote cross-fertilization exchanges between both communities.
- To discuss research to policy conceptual frameworks and lessons learned from a diverse set of experiences.

**Format**

On both days of the workshop plenary sessions took place where conceptual frameworks, case studies and the views of decision makers were presented and discussed.

Four working groups also analyzed core issues and made presentations of their recommendations on how to strengthen future research to policy strategies.
Chapter 2 – Workshop Agenda

Saturday August 19th

08:30 – 08:45  WELCOMING REMARKS

_Federico Burone_, Regional Director, Office for Latin America and the Caribbean, International Development Research Centre (IDRC)
_Eduardo Levcovitz_, Unit Chief, Health Policies and Systems Development, Pan American Health Organization (PAHO)
_Ligia Giovanella_, Executive Secretary, Network for Health Systems and Services Research in the Southern Cone (REDE)

08:45 – 09:00  OBJECTIVES AND AGENDA – _Roberto Bazzani & Lucy Gray-Donald_, IDRC

09:00 – 10:30  RESEARCH TO POLICY FRAMEWORKS – Coordinator: _Roberto Bazzani_, IDRC

(30 minute presentation + 15 minutes for discussion for each presentation)

09:00 - 09:45  _Roberto Briceño-León_, Laboratorio de Ciencias Sociales (LACSO), Venezuela - A research to policy conceptual framework for Ecohealth projects

09:45 – 10:30  _Celia Almeida_, Escola Nacional de Saúde Pública Sergio Arauca – Bridging Research to Policy in Health Services Research

10:30 – 11:00  Coffee break

11:00 – 12:30  PANEL ON CASE STUDIES – Coordinator: _Ligia Giovanella_, REDE

11:00 – 11:20  _Francisco Yepes_, ASSALUD - Participatory Evidence-based Health Policy Formulation, Governability & Decision-Making in Colombia


11:40 - 12:00  _Robert Fincham_, Centre for Environment, Agriculture and Development, South Africa – Integrative Framework for Policy Formulation: the case of health and housing in South Africa

12:00 - 12:30  Questions and Discussion

12:30 – 14:00  Buffet Lunch

14:00 – 15:30  ROUNDTABLE: THE DECISION-MAKER’S PERSPECTIVE - Coordinator: _Héctor Zambrano_, Secretary of Health, Bogotá, Colombia
14:00 - 14:30  Sergio Vélez Castaño, Sub-Secretary of Health, Municipality of Medellin, Colombia
14:30 - 15:00  Jorge Méndez, Director Vector-Borne Diseases, CENAVECE, Secretary of Health, Mexico
15:00 – 15:30  Questions and Discussion

15:30 – 15:45  INTRODUCTION TO WORKING GROUPS
Ana Boischio & Roberto Bazzani, IDRC

15:45 – 16:00  Coffee break

16:00 – 18:30  WORKING GROUPS ON CHALLENGES AND OPPORTUNITIES FOR EVIDENCE-BASED POLICYMAKING: RECOMMENDATIONS FOR RESEARCH PLANNING AND IMPLEMENTATION
The group will split into 4 working groups of 10-15 people.

19:00  Toast with workshop participants followed by a buffet dinner

Sunday August 20th

08:30 – 10:30  ROUNDTABLE: LESSONS LEARNED IN RESEARCH TO POLICY
Coordinator: Carlos Agudelo, Andean and Caribbean Health Policy and System Research Network

Health Systems Research

08:30 – 09:00  Celia Almeida, ENSP-FIOCRUZ & Eduardo Levcovitz, PAHO
Research to Policy in Social Protection in Health
09:00 – 09:15  Discussant: Román Vega, Universidad Javeriana, Colombia
09:15 – 09:30  Questions and Discussion

Ecohealth
09:30 – 10:00  Roberto Briceño-Leon, LACSO & Jean Remy Guimarães, Universidad Federal do Rio de Janeiro - Research to Policy Findings in Ecohealth projects in LAC
10:00 – 10:15  Discussant: Donna Mergler, University of Quebec at Montreal, Canada
10:15 – 10:30  Questions and Discussion

10:30 – 10:45  Coffee break

10:45 – 11:45  PRESENTATION OF WORKING GROUP RESULTS
Moderator: Ana Boischio, IDRC
Each working group will have 10 minutes to present the results of their group work from the day before. This will be followed by 5 minutes for questions.

10:45 – 11:00  Group 1
11:00 – 11:15  Group 2
11:15 – 11:30  Group 3
11:30 - 11:45  Group 4

11:45 – 12:45  PLENARY DISCUSSION (45 minutes) & SUMMARY (15 minutes)
Commentator: Roberto Bazzani, IDRC
12:45 – 13:00  **Closing Remarks**  
*Federico Burone, IDRC & Eduardo Lev covitz, PAHO*

13:00 – 14:00  Buffet lunch
Chapter 3 - Short Papers

From Research To Policy: A Conceptual Framework For Ecohealth Projects

Roberto Briceño-León
Laboratorio de Ciencias Sociales, LACSO
Caracas, Venezuela

In 1919 German sociologist Max Weber published two essays now considered classic works for understanding the relationship between science and politics: Wissenschaft als Beruf and Politik als Beruf. These two works address the differences between the ways in which scientists and politicians carry out their activities, or in other words, between the ways that science and politics are practiced. To a certain extent, the essays sought to reflect two dimensions of these activities, yet the manner in which the German term “Beruf” has been translated into Spanish and French has tended to refer to science and politics as “vocations” or callings, without granting much importance to the other dimension of the German word’s meaning, which is that of science and politics as professions. But the fact remains that science and politics are different from one another both in terms of being different vocations and because they entail different practices and ways of acting and of conceiving ideas and plans. And this is what leads to the difficulties in reconciling the interests and outcomes of the two activities.

In his influential 1788 treatise on practical reason, Kant posited that the key question guiding one’s acts should be - What can I do? This is a different question from the one that scientists ask themselves, which would be - What can I know? In response to the question of what one can do, Kant states that man should act as if he were free, and be guided by his conscience, by a categorical imperative based on values and good will, and not on circumstance. But for Weber, the problem lay elsewhere, because what mattered most was not the intention of the actor, but rather the consequences of his acts, since any actions can lead to results that are different from or even contrary to the desired results, a fact that has given rise to contemporary theories of “perverse effects” in the human sciences. For Weber, therefore, the difference between scientists and politicians corresponds to the existence of two different “ethics”. On the one hand, scientists are guided by what he called the “ethic of conviction”, which can be summed up by the idea of “I do what I think is right, and I tell the truth, regardless of the consequences.” On the other hand, politicians should be guided by the “ethic of responsibility” and the premise that “I am responsible for the consequences of my actions.” In the first case, scientists would feel that they are under the obligation (and this is something that all of us who work in science have experienced) to always tell the truth, no matter what the ultimate consequences may be. In the second case, politicians may consider that at a given
moment, it is their responsibility not to tell the truth, and that this is the most ethical way to act, in view of the impacts that telling the truth could have.

These two classic stances are complicated by the search for another position that responds to the need to reconcile research and policy in research-action projects. This “research to policy” orientation entails the encounter of two different practices with their own distinct vocations and professions, two different ethics, and two different kinds of outcomes: knowledge and decisions.

Now then, why has this issue become so important? Changes have taken place in modern society that have granted extreme importance to knowledge. These changes involve both the usefulness of knowledge and the differences that have emerged among generations. In traditional society, knowledge was possessed by the elders. Since very few changes in knowledge took place, it was those with the greatest age and experience who had generally accumulated the largest store of information, and as a result, people learned from their grandparents. However, in a society marked by constant innovation and change, where new scientific outcomes are generated almost every instant, the knowledge of older generations is not sufficient for all of the new technologies developed. Moreover, it can be difficult to reconcile the knowledge of the past with new practices and procedures. Consequently, it is now the young who know the most, and today we are constantly learning from our children. The new outcomes generated are the result of knowledge, science and technology, and the impact of knowledge on industry has been tremendous. However, the same cannot be said for other areas of society, such as the impact on public policies. The vast knowledge that currently exists and is recorded daily in scientific texts is not used by politicians when it comes to making decisions. How can this be remedied?

The science market

One way of attempting to overcome this divide is the authoritarian approach, through which all research activity is controlled by and geared towards political needs, meaning that the only research undertaken would be that required by the state (or by a private company, as the case may be) while all other research would be excluded or prohibited.

There is another possibility, however, which is expressed in the interpretation of phenomena used in the well-known “push and pull” models to graphically illustrate the factors that push the supply of knowledge or pull towards certain needs and questions. I believe it is simpler to adopt a market model (without necessarily endorsing liberalism by doing so) in order to understand the relationship between society’s demand for knowledge and the knowledge that can be supplied by the scientific community. For the case in point here, the demand would be constituted by the knowledge requirements of decision makers or executors of public policies. The supply would be constituted by the results of the research undertaken by scientists, which may or may not coincide with the demand. And the market itself would comprise the corresponding rules, language and real or virtual spaces where the demanders and suppliers come together.
In order for this relationship to work, there are three conditions that must be met. In the first place, research results must be useable. In other words, on the one hand, they must possess qualities that allow them to be used, and on the other hand, they must be presented in a language that is comprehensible and acceptable to the decision makers. Scientific material must be translated into a “user friendly” language, but in addition, in order to be truly attractive, its own inherent qualities must allow for its use.

Secondly, within this process, politicians must be prepared to take advantage of the outcomes of science, which implies knowing how to interpret the results of scientific research in order to determine if they are useful to them or not. And thirdly, there is the need to foster this relationship by creating spaces where the two sides can meet, since it is rare to find scientists and politicians together in the same room, and if they do not see each other, they will not be able to interrelate. Not only are there few places where the two come together, but it is also unlikely that they read the same publications, or visit the same websites. This leads to the need to create real or virtual meeting spaces. But these spaces also require certain rules of functioning, norms to regulate the ties made and the expectations of both sides. There is also a need for a common language, which means that apart from using the same signifiers, these must signify the same thing for everyone involved.

The methodological framework

To study this relationship, the IDRC Evaluation Unit has established three categories: Enhancing policy capacities, Broadening horizons and Affecting policy regimes. Each of these categories can be interpreted in light of the different components of the relationship. The first relates primarily to researchers, the third to the users or decision makers, and the second to the meeting places. These dimensions help make it possible to evaluate the changes that have taken place in the different components that make research useful for public policies.

Enhancing policy capacities. For researchers, the aim is to see how their capacity has increased to formulate research projects in such a way that they are relevant to the definition or implementation of policies that serve to mitigate or remedy a given problem. For this goal to be met, researchers need to have enhanced their capacity to understand the context for policy formulation in their given society, as well as their capacity to present their research in this context, in other words, by communicating their message effectively when the receptors are not other researchers, but rather society as a whole: the community, the private sector, and public officials.

Affecting policy regimes. Directed at potential users – those responsible for public policies – this approach is aimed at enhancing their capacity to understand and assimilate the results of research, but also their capacity to construct questions that are relevant to their needs and can be communicated to the researchers. The goal is to enhance their capacity for using research results, in other words, for translating relevant results into policy
proposals, as well as being able to demonstrate their pertinence to other political stakeholders within society.

Broadening horizons. The aim here is to open up common spaces to bring together decision makers, politicians and researchers through the creation of networks, partnerships, associations or joint ventures involving the different stakeholders. It also implies strengthening civil society as a whole, and increasing its capacity to promote the discussion of issues that are relevant to society, and suited to being studied by researchers and used by politicians.

In order to study how this has been achieved in the projects carried out, we propose a methodology that begins by reconstructing these processes and subsequently analyzing each of the intervening factors.

In order to reconstruct the processes it is first necessary to identify the stakeholders who took part in the process and establish the relations that were formed among them. The next steps would be to establish what was done, what activities were undertaken, and finally what the outcomes of each of these activities were (see Table 1).

Table 1
Study Methodology: Reconstruction

<table>
<thead>
<tr>
<th>Dimensions of the reconstruction of the process</th>
<th>Stakeholders and their relationship</th>
<th>Processes and activities</th>
<th>Outcomes</th>
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<tr>
<td>Enhancing policy capacities</td>
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<td>Broadening Horizons</td>
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<td>Affecting policy regimes</td>
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Once the processes have been reconstructed, the next step would be the analysis of each of the intervening factors, which can be of two types: those which facilitated the research process and its relation to policies, and those which hindered or disturbed the achievement of the objectives. These facilitating or disturbing factors may pertain to the stakeholders or institutions involved, but they may also be related to societal or natural conditions that interfere with the planning and execution of the project and the dissemination and implementation of the results.

This analysis is undertaken for each individual project, but when several projects are assessed, we can then ask ourselves, what do they have in common? They may all be unique, but it is possible to find certain regularities or similarities that can be established regardless of the singularity of each project as a social and human process. Establishing these common patterns is of particular importance, and it is from this aspect that we can extract the most important, or at least the most useful conclusions, and therefore the best practical consequences.

However, our understanding of the processes cannot be complete without considering the unexpected events of nature or society which are referred to in scientific language as “serendipity”\(^{12,13}\) and which may be related to either actual events or unexpected data that can change the course of research. This factor demonstrates the other side of the coin, the other face of regularity, developments that were not expected or planned for in the project but which affected the course of research and its results.

These components of the analysis can be summed up in a chart (see Table 2) in which for each of the components constructed, we can analyze the factors involved, establish common patterns, and identify, when they occur, the extraordinary or serendipitous events. The purpose of this model is not only to evaluate the course taken by the processes, the role of the stakeholders or the relevance of the results, but also to learn how a new model for the relationship between science and politics is being shaped and invented.
Table 2: Study methodology: evaluation

<table>
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<tr>
<th>Facilitating Factors</th>
<th>Disturbing factors</th>
<th>Regularities or common patterns</th>
<th>Serendipity</th>
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<tbody>
<tr>
<td>Enhancing policy capacities</td>
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*Sapere Aude!*

In a brief 1784 essay, Kant declared that enlightenment comes when people leave behind a state of intellectual immaturity and dependence and the inability to use their own powers of reflection without guidance from others, and decide to think for themselves. Thus enlightenment can be summed up as *Sapere Aude*, dare to think!

This current of thought has led discussion toward the autonomy of knowledge, which has been interpreted in different ways: by some, as autonomy from teachers; by others, as autonomy and independence from higher powers, religion or government (giving rise to the secularism and autonomy of universities); and finally, as the separation of science and politics. As a result, many academics are opposed to mixing science and politics.

It must be recognized that the relationship between science and politics is highly conflictive and should always take place in a context of freedom. The attempt to define science through politics is very complex and dangerous, because it can lead to the aberrations seen in the last century, such as the attempt to impose “Aryan mathematics” in Germany or to have physics directed by “historical materialism” in the Soviet Union.

It is an accepted principle that researchers must not lose their autonomy with regard to thought or to choosing lines of research or ways to ask or answer questions. At the same time, however, researchers must increase their social responsibility and understand the
importance for society of their skills and knowledge. For their part, politicians can call for research that serves to improve government programs on any scale, but they cannot impose the approaches used or the means of solving the problems. In line with the ethic of responsibility, politicians have the option of not using the results of research, but we believe that they should never ignore them.

Therefore, the contemporary proposal of linking research and policy is a matter of constructing an ethic that synthesizes both conviction and responsibility. Achieving this goal requires a special effort to modify the vocation and profession of scientists and politicians. Obviously, changes in vocation are not easy to bring about, nor or they necessarily desirable. There are, however, aspects of the two professions that can and should be transformed to achieve greater interaction between these practices and skills sets, so that science can have a greater impact on the construction of a better world.

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Cross-Sector Learning: New Strategies To Enable Use Of Research

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Background

Despite the conceptualization of health services research as an applied area of study, the challenge of making research relevant to the policy process continues to preoccupy the field and its funders. It is the hypothesis of this paper that this may be, at least in part, a function of the research funding mechanisms that is most often employed. Grants typically begin with a researcher-defined proposal, even when the general topic is predefined in a Request for Proposals, and they tend to end with the submission of a paper to a peer reviewed journal. Most requests for proposals include no funding that would obligate, or even allow, researchers to interact with those whom they wish to influence with their findings.

In this paper we analyze preliminary results of a new research program strategy developed by the International Development Research Centre (IDRC) and the Pan American Health Organization (PAHO) with the support of AcademyHealth that experiments with the structure and process of research. The initiative’s goal is to spur innovation in the expansion of social protection in health in Latin American and the Caribbean. Its strategy was to require partnerships among researchers and decision-makers (DM) from the start of the research design. Five projects were funded from a pool of over sixty applicants. The assessment of these partnerships as they evolved during the first and second phases of the projects are included in this special issue.

The underlying assumption of the partnership strategy is two-fold. First, research results are more likely to be used if there is interaction with decision makers throughout the design and implementation of a study. Second, the process of negotiation of inquiry itself creates and enriches knowledge for both sides.

The first assumption reflects an instrumental goal and is fueled by the notion that research findings should be “transferred” to DMs. It builds on the idea that research questions
are more likely to be relevant to policy if the two groups talk to each other early on and that if interaction continues throughout the research process, a relationship of personal trust will emerge. Trust will, in turn, ensure that the DM is a) exposed to the findings and b) is more likely to view them as legitimate.

The second level moves beyond instrumental use and reflects a paradigm shift away from the linear construction of “theory – knowledge – practice”. It acknowledges that there is knowledge everywhere and that research is a socially constructed practice like any other.ix The objective in this case is to promote interaction between two or more worlds such that learning is advanced for all involved. The content of that learning is spurred by the different perspectives that researchers and DMs bring to the table.

Research on the use of research, however, suggests that there is another factor that strongly predicts successful uptake: the level of interaction between researchers and DM throughout the research process. x xi Landry describes the interaction as a series of disorderly interactions between researchers and users, rather than a linear sequence that begins with the needs of researchers or the needs of users. Lomas, Lavis and others in Canada call this Linkages and suggest that, in addition to push and pull activities, there needs to be repeated situations of contact (personal or otherwise) from the start .xii In an idea that reckons back to Action Science, and to a lesser extent Participatory Research, they believe that more sustained and intense interaction will result in a greater likelihood of uptake. xiii xiv

While there is growing consensus on the importance of linkages, it is an umbrella concept and little is known about how and why it improves research uptake. What are the conditions of successful linkages? Are there always pre-existing political or personal ties that facilitate relations? If so, is it reasonable for funders to try and prompt such interactions? Are there certain kinds of health policy research that can not, or should not engage in linkages? In short, is linkages a sound strategy for research funders to explicitly pursue, and if so, how can it be promoted?

New Funding Arrangements

The initiative was conceived as a two-part process that began with a research for proposal (RFP) that required a formal agreement between the researchers and a DM group that could be either public or private. Selection criteria emphasized the importance of a solid working agreement with a DM body that could potentially use the research to spur change in the health system. At Phase I, less importance was placed on the clarity of the research question, which we anticipated could be improved during the planning period. DMs were loosely defined as any governmental or non-governmental group that could use the research results to raise awareness or take action that seeks to extend social protection in health.xv
The Research Projects

The five projects selected for Phase II addressed different issues and research questions, but they shared a common interest in identifying innovative ways to improve access to health care of their countries’ most disadvantaged groups. We begin by summarizing their original research questions.

Bascolo et al. proposed to evaluate the design and implementation of a public sector maternal and child health insurance in the Province of Buenos Aires. In the original proposal they formulated the following research questions: how do different dynamics of governance at the municipal and provincial levels affect the management and outcome of the Maternal-Child Health Insurance Program?

Viana et al., initially proposed to analyze the challenges of social protection in health in the context of inequities in the Brazilian Unified Health System (SUS–Sistema Único de Saúde), and their research questions focused on the nature of the relationships among different levels of government.

Gordon-Strachan et al., proposed to evaluate user fees for preventive care services and to examine impact on health seeking and coping behaviors. They asked what the impact of user fees was for preventive services, as measured by utilization and outcomes. They also proposed to explore alternative financing mechanisms.

Hernández Bello et al., proposed to improve the effectiveness of social protection policies for populations displaced by violence in Bogotá, Colombia. Their central questions were: how can access and quality of healthcare for refugees living in Bogotá be improved, and what is the contribution of a “differential” policy towards the special needs of refugees?

Finally, Cardona et al., proposed to analyze alternative organizational and financial designs to guarantee the sustainability of public health insurance for unemployed workers in Medellin, Colombia. They asked: how can municipalities and states work together to create an insurance program for the unemployed? This project included the design, pilot and evaluation of such an insurance experiment in Medellin.

The range of topics explored under the rubric of social protection in health included the relationship of governance to equity, public insurance targeting priority populations, and barriers to access. Researchers were all based in universities and research institutions. DMS were all governmental, although two were federal, one provincial, and two municipal.

Phase I Developments

Consistent with the premise of the program design, we expected that the introduction of this pre-research period of funding (Phase I) would result in protocols that were more relevant and more rigorous than if we had not had the pre-research funding phase. We also expected the DMs involved in the project to be more sensitive to the challenges of
research and more interested in its potential contributions to policy than they would otherwise be.

So what did happen over the course the six months planning period? As with any intervention there were both expected and unexpected results. Our assessment was based on the teams’ self-reported accounts of the interaction between researchers and (a required deliverable of Phase I), and on a questionnaire that we jointly developed at the beginning of Phase II that focused in on some of the common themes that had emerged and would facilitate comparison across the five experiences.

Factors at play during the formation of partnerships

The story began in every case with the researchers learning of the call for proposals through local PAHO offices, regional research networks or universities. Researchers then sought out DMs with whom they wanted to form an alliance. This defined a certain level of ownership by the researchers from the start that may not only be inevitable, but perhaps even positive. The inevitability stems from the fact that it is the researchers, not the DMs that will be generating revenues from the research, and so it is, therefore, their “job” to seek out new research opportunities. The potential positive effects concern the balancing of power between the researchers and DMS as discussed in the next section.

Regardless of the merits, researchers were in fact the active partner in search of a DM body with whom to form an alliance. Having prior contact or not did not appear to be clearly advantageous in either case.

Interactions shape research question(s)

In the two cases with broad research topics, Argentina and Brazil, the interaction with the DM helped to define and narrow the scope of the topic and the research questions, and to include an evaluative component in the research.

In the other three cases, the DMs played a similar role in pushing the researchers not only to evaluate policies, but also to propose and test policy alternatives.

In search of clearly delineated roles

All of the teams agreed that over the course of the Phase I the relationships between the two groups had changed. The tensions regarding respective roles, and with that the distribution and use of power, was explicitly addressed in several cases. On the one hand, researchers empathized with DMs, yet they also struggled to avoid feeling “captured by the other’s logic”.

As mentioned above, the relationship began with the researchers having a certain quota of power due to that fact that they had initiated the proposal and “chosen” the DMs. As Phase I evolved, however, DMs’ power was established as a result of the researchers need for their approval. Researchers reported that in their eagerness to obtain buy-in and
establish trust, they were “tempted” to reduce their own autonomy and to assume the DMs’ viewpoints as their own.

Other elements also played into the process of delineating the respective roles. The case of Brazil 4 was notable in that at the beginning of the relationship, the DMs, who had themselves been researchers at one time, wanted to take over and define the research project themselves. Similarly, as the interactions continued and researchers became more familiar with the political challenges being faced by the DMs, they also reported having become excited about designing policy. At times they indicated that they felt as though they had overstepped the boundary and tried to advise the DMs on how to maneuver politically. After this blurring of roles occurred on both sides, the team was able to discuss what was happening and eventually agreed that it was important to explicitly differentiate roles in order to maximize the usefulness of the alliance. Similar dynamics were reported by the other teams 3, 5, 6, 7 and all agreed that the differentiation of roles was key to establishing a relationship of trust and mutual respect.

This is interesting both as a difference with participatory research, which includes research subjects and researchers. It is also germane to the age-old debate over researcher as “objective” observer, versus researcher as advocate that often plays out in discussions between researchers in the North and the South. xvi In a sense, the kinds of alliances established in these projects fall in a middle ground. The teams recognize the importance of autonomy of researchers without going so far as to affirm that “objectivity” is possible or desirable.

There was also a clear appreciation of the special knowledge and skills of each side.

**Additional determinants**

In assessing the factors that strengthened or weakened the relationships, during a workshop held at the end of Phase I the teams summarized the factors that seemed to have contributed to and to have detracted from successful partnerships. These factors were as follows:

- Having clearly expressed the needs and role of each side.
- Having clearly defined the place and time of meeting with DM, such that focus was exclusively on the research project.
- Having selected a timely and relevant topic that interests the DM.

Factors that were viewed as having weakened the relationships were:

- Geographic distance between researchers and DMs in the case of Brazil 4 and Argentina 3.
- The time pressure faced by DMs to provide policy answers, especially in Jamaica 5 and Argentina 3.
- In some cases, the very preliminary stage of the policy process in which DMs were engaged slowed down the researchers, as in Brazil 4, Bogotá 6 and Medellín 7.
- Government turnover of officials in Brazil 4, Bogotá 6 and Medellín 7.
• The uncertainty of not knowing if the proposal would be funded in Phase II.

DM involvement

Researchers expressed concern that the slow pace of the selection process and the funding flow, in addition to the time required to carry out the research, could result in a loss of commitment. Indications are that the commitment of the DMs to the projects has been strong to date. They have attended two week long regional meetings and participated actively. They have spent time discussing protocols with researchers. They have allocated funding and in some case altered policy already. Yet by their own account, the DMs are atypical in their willingness to do this. They insisted that not all DMs are not the same and that any consolidation of a program design like this in the future should consider this variation.

Theories of knowledge diffusion are premised on the idea that early adaptors and opinion leaders are strategic to the process of change.Apparently the researchers in this initiative have selected DMs that are early adaptors, and this may well be a concept that would be worth elaborating in a future call for proposals.

Phase II Developments

The implementation phase of these projects began in October 2004 and they are still ongoing at the time of this writing. The primary findings of the five experiences tend to validate the model. However, significant problems have emerged as a result of the institutional instability among the DMs, the complexity of the research topic in some cases, and the difficulties in guaranteeing a steady funding flow for the projects.

The impact of DM turn-over on buy-in

The issue of DM turn-over is a reality in all countries, especially in Latin America, and is a likelihood that needs to be considered in the design of such programs. The Brazilian, the two Colombian \(^6,^7\) and the Jamaican’s teams \(^5\) faced significant difficulties as a result of changes. In all four cases with DMs departing, the commitment of the new DMs to the research was significantly diminished. Researchers have had to spend time once again trying to obtain DM buy-in, rather than using the project resources to deepen the dialogue with DM. In all four cases, to their credit, the researchers have, however, managed to keep the projects alive by expanding their contacts to mid level officials and pursuing relationship with the new authorities.

Difficulties in the funding flow

In several cases there was a lag between the funding of Phases I and II, which was problematic for the country teams.
The Complexity of Topics as an Impediment

Bogotá ⁶, Medellin ⁷ and Brazil ⁴ have confronted an additional challenge as a result of the complexity of the social problems they set out to tackle. There are no quick policy fixes to increase access to care for the displaced in Bogotá, for the unemployed in Medellin or for the poor in the Amazon. Moreover, the legal implications of the two Colombian projects bump up against the social security laws. Reforming those laws, however, is a highly political endeavor that is clearly beyond the scope of these projects. In addition, changes in government policies were also critical, as referred by the Jamaica ⁵ and Brazilian ⁴ teams.

In synthesis, the object of analysis evolved in these projects not only as the relationship between researchers and DMs occurs, but also as contextual developments unfolded. The challenge for the country teams, then, is to adjust to these two levels of change in ways that maintain a focus on producing research results that can be used to inform decisions.³ This requires significant flexibility and a dynamic perspective, competencies that are not developed in the context of formal research training.

Final Reflections

There were a number of benefits to the program design that emerged from these five experiences, and while they are not generalizable, they do provide lessons worth sharing and building upon.

The first was that both the program leadership and the participants strongly agreed that the pre-research phase improved the policy relevance of the research proposal. Since relevance is assessed primarily by the DMs, and they played a role in defining the research question this comes as no surprise, but it is an important confirmation of this design.

A second benefit was that the DMs played a positive role in helping to focus the research question. Researchers reported that they gained detailed operational knowledge through discussions with DMs that helped them tighten their methods and sharpen their focus. They were also pushed to include evaluative components in the research that would not otherwise have been considered. As noted in a recent review of research on health sector reform in Latin America and the Caribbean carried out by PAHO and IDRC, there is a dearth of this kind of public research. xvii Creating partnerships with DMs, then, appears to be one way to stimulate more evaluative research.

In keeping with this finding, all but one team considered the scientific rigor of the projects to have improved as a result of the extended planning and interaction with DMs as well. In looking across these experiences, the question arose as to what was gained by insisting on differentiated roles and responsibilities. The types of DMs and the types of relationships with researchers present in this initiative were far more varied than have thus far been
contemplated on the literature. Yet in all of the projects there was a concern that by blurring distinctions, both researchers and DMs run to the risk of being “captured” by the other group’s interests and logic. Each of the teams found it critical to explicitly differentiate roles in order to establish a balanced and effective partnership.

The notion of developing a social contract between the two sides was discussed as a challenge for the future. Teams drew on their experiences to identify the following elements as components of that contract:

1. Clearly defined professional roles.
   - Explicitly expressing fears and expectations.
   - Emphasis on the DMs role in helping to define the problem and facilitating access to data.
   - Emphasis on the researchers’ role in defining research strategy and in retaining autonomy in the analysis of results.
   - Formalizing alliances, such that if there is DM turnover, the project can continue.

2. Commitment to the overall principals of the health system, such as equity, participation, efficiency, effectiveness, etc.

3. Cooperative attitudes that include such as being:
   - Reciprocal
   - Respectful
   - Trusting
   - Transparent

The analysis of the cases presented in this issue also reconfirms the notion that “windows of opportunity”, determined by specific historic and contextual circumstances, are critical determinant of research uptake.xviii. Such windows create visibility and interest in gaining new knowledge around a specific topic.

A side commentary on how this experience relates to Research Action and Participatory Research. The above mentioned attributes identified by the teams do resonate with both methodologies. However, there also seem to be differences. The first is that Research Action and Participatory Research are usually focused on the direct beneficiaries of change at the community level (as in the case of Bogotá project 6), rather than the policymakers. The second is that in this experience the researchers and the DM have chosen to clearly differentiate their roles; the DMs, not the researchers, are the agents of change, and the DM does not participate in the research, they simply influence certain aspects of it, in particular the framing of the research question.

There were also weaknesses to this program design that emerged from the group analysis. The first was the difficulties in providing DMs incentives to remain active in the project, when their timelines tend to be more short term. Although none of the DMs withdrew from their alliance of their own accord, both sides reported frustration. A second limitation was
that, while Bogotá was able to establish participatory dynamic with non governmental actors, most of the projects focused their energies on constructing the relationships with a single DM which was governmental. Expanding alliances beyond government would appear to be a key lesson to protect against the devastating effects that political turn over can have on a research project.

The real possibility, if not probability, of turn-over among high level DMs in governments is a serious threat to this research program funding model. While the Argentine team escaped change in their team composition and, as a result, has been able to consolidate and deepen their partnerships, this was indeed the exception not the rule. While the other teams have continued to move ahead, they have quite wisely chosen to expand the stakeholders involved and to include mid level officials that are less likely to be caught up in political strife.

The five projects also reconfirm the notion of scientific knowledge as a source of power. "As a resource of power knowledge plays innumerable roles, which change with place, time and circumstances. Also each concrete case involves different explanatory variables for the change in policy, and each variable implies that the research played a specific role. Some of these variables are particularly important" xx (p. 10).

The Brazilian case illustrated how important research can be to policy makers as they search for legitimization of a given policy or program. The research offers visibility for a programmatic area considered a priority for a new government. A similar situation exists in Argentina, although in that case the program is well underway, while in Brazilian it is still in its infancy and its implementation is still somewhat tenuous.

The question of power, then, is closely tied to the uptake of research, and it is likely that, as Bowen et. al, have suggested, “the way in which research evidence is combined with other forms of information is key to understanding the meaning and use of evidence in policy development and practice. (...) A major challenge to contextualizing evidence for policymaking is recognition that a broad information base is required [and] (...) considering the evidence within the context in which it will be used is critical for effective policymaking and practice”.

Brown, Weiss and Majone emphasize this point is affirming that “the support that research can give to the decision-making process has less to do with offering definitive solutions to the problematic issues in debate and more with improving the quality of the terms of the debate. That being the case, the ability to change the nature of public debate on a given issue is an important form of power, because bringing ideas, proposals and interests into confrontation is an important force in changing the balance of power among the various contesting groups” (p. 12).

A final assessment of whether and to what extent this type of research design will have an impact on innovation in social protection in health will, of course, need to be addressed upon completion of the initiative. The methodological challenges of measuring research
impact are well known, and there will undoubtedly be limits to our ability to answer this question. Similarly, a serious assessment of this research funding strategy would evaluate the cost opportunity of the investment. While the amount of the grants could be reduced in the future, it remains a significant additional cost, and a valid question is whether the same amount of resources would be better spent on push or pull strategies. While the both the final impact of this strategy on research use, and the cost opportunity of Phase I are beyond the scope of this paper, the difficulty in answering such questions points the need to begin a program of study that will seriously assess the many strategies funders are now using to increase research uptake.

References

Research to Policy and Ecohealth Projects – Lessons Learned

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Below we share some thoughts on bridging research and policy-making based on our involvement with some Ecohealth projects and the evaluation of many others. These projects applied the principles of multidisciplinarity, stakeholder participation, consideration of equity and gender issues and reached their main objectives, although with very different balances between scientific outputs, intervention and impacts on policy-making.

The projects covered a wide range of subjects and geographical areas and also presented different socio-economic and environmental settings. At one extreme of this range were projects in purely urban, densely populated areas; while at the other extreme projects also took place in rural, agricultural areas with very little infrastructure. Mid-range projects were those in mixed urban/rural sites where the impact of environmental changes was very complex. As outliers, some projects were carried out by governance structures themselves. These different points along a continuum represent complementary strategies, each with its own costs and benefits in terms of parameters such as success and reach of interventions, potential for up and outscaling, flexibility, scientific output, sustainability, impact on policy.

The projects carried out in isolated areas had few partners, interacted directly with the project beneficiaries, and carried out very successful and sometimes massive interventions, but had little or no immediate impact on policy-making. One could say that before thinking of lobbying the authorities, you must find them. Although several constraints could have impaired the development of such projects, their adaptability and strong community participation promoted visible, positive changes in attitudes and practices, and the impact of these changes on health, well being and environmental sustainability was documented with hard data. The success story projects relied on well-known and usually low-tech approaches or methods such as intercropping, crop residue burial, integrated pest management, and diet diversity. It was the existence of properly skilled teams, their affirmative attitudes and high level of commitment that made a difference. Community and stakeholder-specific workshops and practical demonstrations such as farmer field schools were common elements of these projects. Also, social and anthropological work supported the study and intervention design and developed better-focused communication. Working with few partners allows more control over budget, team composition and timetables and this helps make transdisciplinary interventions and knowledge empowerment successful. The negative impact of external factors is lower, and the scientific output is high. However, these projects act on a limited geographical scale, and once the projects phase out the sustainability of the induced positive changes may become uncertain unless the project message resonates in official institutions that...
incorporate its main goals and methods in their agenda and programs, thereby outscaling it.

Other projects aimed at making changes in policy, placed themselves in the eye of the hurricane, dealing with constellations of stakeholders with mixed results, including institutional partners, universities, NGOs, private companies. After the initial conflicts, better dialogue was established among institutions, agendas were harmonized, some regulations were changed or created at local or regional levels, and beneficiaries were empowered and increased their organization levels. Many professionals were trained, and the national infrastructures of official institutions offered great potential for outscaling the projects. However, this potential is under constant menace due to the inherent instability of political and administrative structures, and the low motivation of their members – who often occupying volatile functions and positions dictated by political conveniences. It is also threatened by unfavorable inclinations in institutional cultures and traditions towards transdisciplinarity and gender/equity issues, as well as participatory approaches, which may sound subversive to some decision-makers. These structures are slow to move and change, and setting up programs to deal with an emergent environmental health problems may take as long as phasing it out after the problem is controlled. Many countries resist setting up programs to control pesticide exposure, despite eloquent scientific and practical evidence in their favour, while other health problems like goiter, long ago controlled, still deserve elaborated notification systems.

In contrast, the beneficiaries of multi-stakeholder projects (including official institutions) clearly perceived the difference in speed and efficiency between these projects and their “enemies”, which moved fast to impair or overcome any positive change that was promoted by applying Ecohealth principles and practices, or even worse, adopted these practices in benefit of their own agendas.

The coexistence of scientists and decision-makers in multi-stakeholder projects is prone to a number of conflicts or misunderstandings as they are evaluated by society using different criteria, but both fear becoming oblivious. Scientists try to escape this fate through publications, while decision-makers fight for reelection. A decision-maker wants results within four years, while these may take much longer to come. He/she may start seeing the scientists as potential allies and end up seeing them as troublemakers. Researchers in turn, may expect to interact with a statesman/woman and find themselves dealing with an interim manager of a political power structure.

Despite their numerous limitations, public institutions are sensitive to pressure. From above they are pressured by multilateral and or donor agencies and from the sides by fellow institutions which were successful and visible using Ecohealth tools. Additionally, they receive pressure from below from project beneficiaries who develop higher expectations after witnessing practical examples of their feasibility. In this respect, we feel that there is a need for more cost-benefit analysis of the solutions advocated by the projects, to share with current and potential beneficiaries, authorities and other stakeholders and for better documentation of the project development.
Irrespective of their type, a common challenge in all projects was the decision regarding the balance between research and intervention. Projects have finite resources and build on an equally finite initial “community confidence capital” that can be spent too quickly if too much effort is initially invested in research at the expense of interventions.

One of the most powerful, dynamic and ubiquitous actors in some projects is often not even mentioned in the project proposals - the market. Consumer movements and NGO’s campaigns for cleaner and more equitable food production add market value to organic products and seem more efficient in reducing pesticide use in agriculture globally than many years of projects painstakingly developed in specific regions. Although these market forces drive the overexploitation and degradation of resources and health that we are increasingly witnessing, they can still be positive for many elements of the Ecohealth agenda and should be considered.
Governance And Research In Public Health
Participatory Evidence-based Health Policy Formulation in Colombia

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Introduction

The relation between research and decision-making is an issue raised with ever increasing intensity and is today found in the agendas of financing entities and scientific societies. How can research transcend being merely of academic interest and play a role in decision-making when the frameworks, timing and interests of academics and decision-makers do not usually converge?

Colombia initiated two very significant reforms in the health sector during the 1990s: the decentralization and reform of health social security. A decade after these reforms began intense debate on the issue arose in the country with extreme positions being taken for and against them. How can research contribute to a participatory decision-making process in which all stakeholders have access to scientific information and civil society is equipped for active and informed participation?

This project was jointly initiated in February 2004 by the Colombian Health Association (Asociación Colombiana de la Salud – ASSALUD) and the Economics Faculty of Rosario University (Facultad de Economía, Universidad del Rosario). It was set up as a research-action project with the explicit objective of promoting evidence-based health policy-making that involves civil society participation.

Criteria for the design of project elements were therefore based on the achievement of this objective.

Objectives

The study proposed two general objectives and four specific ones.

General Objectives

To evaluate the reformed health sector’s performance during its first ten years, identifying its strengths, weaknesses and problems through a broad civil society participatory process, with technical support and using available evidence.

To formulate concrete health policy proposals for the solution of identified problems.
Specific Objectives

a) To create spaces for the informed analysis of health policy by civil society.
b) To form and consolidate dialogue spaces in which both organized stakeholders and government level decision-makers participate.
c) To develop and elaborate public health policies on the basis of available evidence and with civil society participation.
d) To evaluate the efficiency of this process in terms of:
   - Acceptability to participants from civil society and government.
   - Usefulness of the technical tools employed.
   - Relevance and significance of formulated and adopted policies.

Pillars

To achieve these objectives the study has been based on three central pillars: evidence, civil society and decision-makers.

Evidence

The study has identified and used existent evidence as well as generated new evidence.

a) Existent evidence: Identification, consolidation and analysis.

Various publications on Colombian health reform since 1997 were identified through searches of both the internet (MEDLINE, LILACS, WHOLIS) and selected libraries of research centres in Bogotá: ASSALUD, Foundation for High Education and Development (FEDESARROLLO), Center for Development Projects (CENDEX), Corona Foundation (Fundación Corona), Colombian Academy of Medicine (Academia Colombiana de Medicina), Javeriana University (Universidad Javeriana), National University (Universidad Nacional), Center for Competence Studies (CEDE), Center for Research in Development (CID), etc. From 340 identified publications, up to now 200 have been selected for inclusion in an Access database.

b) New evidence: Complementary studies and the development of analytical tools.

To date three types of activity have been undertaken:

- An analysis of the policy-making process involved in the first attempt to reform Act 100 through the use of Policy Maker during 2004 and 2005. A working paper on this experience is being prepared.

- The study, from a health perspective, of the National Quality of Life Surveys’ (Encuestas Nacionales de Calidad de Vida) 1997 and 2003 databases. This study’s results are published in a draft report on the research (http://www.urosario.edu.co/FASE1/economia/documentos/pdf/bi72.pdf) and in
two articles submitted to one Colombian and one international scientific publication.

- The development of a computable general equilibrium model for the Colombian economy and the social security in health sector, through which different financing scenarios for the sector are being run. Amongst these scenarios are those currently being proposed in the policy debate.

As a partial product of the above, “An accounting of losses and gains from health reforms” (Balance de pérdidas y ganancias de las reformas de salud) was generated.

**Civil society**

During the course of the project various civil society organizations have become involved in it. There have been seven regional forums and one national forum involving the participation of the community, academics, insurers and service providers. A phase of dissemination through the media has been initiated to present “An accounting of losses and gains from health reforms”.

**Decision-makers**

From the beginning the project team had links with the Congress of the Republic and were invited to sessions of an ad hoc commission for the analysis of health system reforms (first six months of 2004), to participate in the round table on Public Health organized by this commission and in sessions of the Seventh Commission.

“An accounting of losses and gains from health reforms” was presented to the technical and health vice-ministers of the Social Protection Ministry (Ministerio de Protección Social) and their respective technical teams. An executive summary was sent to all members of Congress on the Constitutional Seventh Commission in charge of social security and to presidential candidates in the last elections. In addition, new Congress members from the Seventh Commission that deals with social security were invited to a working breakfast. An audience has been requested with the Social Security in Health National Council (Consejo Nacional de Seguridad Social en Salud) and a media strategy is currently being developed.

**Achievements**

The formulation for the first time of an objective, evidence-based accounting of losses and gains from the health reforms in Colombia and the development of a tool to simulate financing policies for the system.

The participation of a group of Congress members and their receptivity. The invitation to participate in commission sessions and task groups.
The incorporation of a substantial number of recommendations in at least one of the reform projects.

**Difficulties**

The limited receptivity of the Social Protection Ministry.

The vested interests in the reform process (of insurance companies, hospitals and health professionals) and the limited presence of community spokespeople.
Chapter 4 - Presentations

Saturday, August 19th, 9:00 – 10:30, Research to Policy Frameworks

Roberto Briceño-León, “A research to policy conceptual framework for Ecohealth projects” is available at:


Celia Almeida, “Bridging Research to Policy in Health Services Research” is available at:


Saturday, August 20th, 11:00 – 12:30, Panel on Case Studies

Francisco Yepe’s presentation on “Participatory Evidence-based Health Policy Formulation, Governability, & Decision-making in Colombia” is available at:

Carlos Dora’s presentation on “Health and Environmental Linkages (HELI), WHO – A Twofold Challenge: Linking Research and Policy, Integrating Health and Environment” is available at:


Robert Fincham’s presentation “Integrative Framework for Policy Formulation: the case of health and housing in South Africa” is available at the following link:


Saturday, August 20th 14:00 – 15:30, Roundtable: The Decision-Maker’s Perspective

The presentation of Sergio Vélez on the perspective of decision makers in the Municipality of Medellin, Colombia is available at:

The presentation made by Jorge Méndez on “Malaria Control Program in Mexico: can it be eliminated?” is available at:


Sunday, August 20th, Roundtable: Lessons Learned in Research to Policy

The presentation made by Celia Almeida on “Lessons Learned in Research to Policy: Health Systems Research” is available at:


The presentation made by Eduardo Levcovitz on “Reflections on a Research Agenda in Health Policy” can be accessed at:

Roberto Briceño-León’s presentation on “Lessons Learned in Research to Policy in Ecohealth Projects” is available at:


Jean Remy Guimaraes’ presentation on “Bridging Research and Policy-making” is available at:

Chapter 5 - Working Groups

Working Group Guidelines

Justification

The group discussions should revolve around questions that connect the individual experience of the researchers with the general topic and in this way facilitate participation, allow participants to get to know each other better, and permit general reflection on the workshop theme without having had previous knowledge or theories about the topic. On the other hand, these questions must be concrete, since there is little time assigned to this activity and must allow for a pause in the middle of the 2.5 hours designated to this activity.

Methodology

Part 1:

Two questions will be asked to the participants:

1) According to your knowledge and experience, what factors do you believe have limited or impeded the use or application of the results of your research project (in public policy)?

2) According to your knowledge and experience what factors do you believe have facilitated the use of your project’s research results (in public policy)?

Each participant must respond. Coordinators can ask participants at random, voluntarily, or by going clockwise around the group, or both by first asking for volunteers and then going in order in order for all participants to participate. If each participant speaks for 5 minutes, this portion of the discussion will last 50 to 75 minutes.

Part 2:

Once the above questions have made it around the group, another question will be asked:

Taking into account what the group has already heard, what suggestions or proposals can the group offer on how to improve, help or facilitate the use of research results?

In this portion of the activity the discussion will be open and not all participants necessarily need to participate. Rather the discussion should be open and should try to stay on the topic, with the hope of developing further some of the proposals. For this portion of the discussion, there will be 1 – 1.5 hours available.
### General Aspects

- Between the first and second part of the discussion period, the coordinator should make a summary of the common themes without going into too great of detail and without repeating too much what was just heard.
- When there are 15 minutes left in the discussion period, the moderator should try to begin to look for conclusions and summaries the proposals in order to achieve group consensus on the group’s results.

### Taller: Grupo N 1

**Integrantes:**

The discussion results presented by Group 1 are available at:


### Grupo 2

**Los vínculos entre investigación y políticas en salud colectiva: bases analíticas para la acción**

Grupo 2

Rio de Janeiro, Agosto 19, 2008

The discussion results of Group 2 can be accessed at:


### Presentación - Grupo 3

**Limitaciones y obstáculos:**
- Revisar el concepto de “producto” y con el, el impacto que produce la lógica de mercado aplicada a la investigación.
- La relación entre investigación y toma de decisiones debe ser analizada estratégicamente. Puede aparecer oposición de múltiples actores (ejemplo de ONG y otros investigadores).
- Otra limitación son las diferencias valorativas (ej. derecho a la salud vs. focalización)

Group 3’s presentation is available at:

The framework presented by Group 4 can be viewed at:

Chapter 6 - List of Participants

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