SOCIAL PROTECTION *in* HEALTH SCHEMES *for* MOTHER, NEWBORN *and* CHILD POPULATIONS:

Lessons Learned from the Latin American Region

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"The primary determinants of disease are mainly economic and social, and therefore its remedies must also be economic and social. Medicine and politics cannot and should not be kept apart".

Geoffrey Rose
"The strategy of preventive medicine", 1992.

"Health is the result of fair socio-economic development"

Sergio Arouca, 2003

PRESENTATION

Due to the wide variety of interventions in place, the task of identifying and describing social protection in health schemes (SPHS) for mother, newborn and child populations in the Latin American and Caribbean (LAC) region is an arduous one. While nearly all Latin American countries have implemented immunization and nutrition programs that are standardized according to a global consensus based on worldwide experience on what works best, health protection schemes aimed at guaranteeing access to health care to mothers and children are heterogeneous and have achieved varying degrees of success. Along with those factors within the health sector that hinder the timely delivery and quality of health services, a number of conditions outside the health sector play a key role in determining access to care and health outcomes in LAC countries. The political situation and social determinants of health are of paramount importance in the performance of SPHS in the region, given the fact that political instability and inequity shape the social landscape of many countries.

The availability of comprehensive reproductive and child health care remains an unrealized goal in most of the world, and some countries have actually experienced stagnation or even reversals in their maternal and child health indicators (World Health Organization -WHO-, 2005). This reality has prompted policymakers and international cooperation agencies to focus on the implementation of different mother, newborn and child health protection schemes in order to improve access to care for these populations. Although the impact of many of these interventions on health processes and outcomes is well-documented in the LAC Region, further comparative analysis is needed to identify lessons learned and to understand the role these interventions play in the broader institutional setting of existing health systems and their relationship with social determinants of health such as socio-economic status, gender, and ethnicity.

In the context of this need, the Pan American Health Organization (PAHO) has partnered with three international cooperation agencies to study the best methods for redressing exclusion from health care among the maternal, newborn and child population.

- PAHO and the Swedish International Development Agency (SIDA) have been working together since 2000 to support the efforts of LAC countries to address social exclusion in health and to develop strategies to extend social protection in health. PAHO/SIDA have focused on characterizing exclusion

from health care and increasing awareness of the problem through support for social and policy dialogues between social and political actors. These dialogues are aimed at implementing Plans of Action to reduce exclusion and expand protection in health.

- The PAHO-USAID (United Satetes Agency for International Development) three-year agreement, signed in June 2004, also places a strong emphasis on maternal and neonatal health. This component of the agreement consists of two main activities:

1. Identify, describe and document different models of and experiences with SPHS in LAC as they relate to Maternal, Neonatal and Child Health (MNCH).[1]
2. Based on the different models/experiences identified, develop a comparative analysis of the strengths and weaknesses of different social health protection schemes for mother, newborn and child populations.

- The third component of the 11th Joint Action Plan (PAC-XI), subscribed to by PAHO/WHO and the Spanish International Cooperation Agency (AECI), concentrates on developing actions that will extend social protection in health to the mother, newborn and child population, in line with Millennium Development Goals (MDGs) 4 and 5 (to reduce infant mortality and improve maternal health). PAHO and AECI seek to support countries in their efforts to develop their institutional capacity to extend social protection in health, with a focus on mothers, newborns, and children.

This analysis is the first step in a process aimed at increasing knowledge about the dynamics of health access for mothers, newborns, and children. We hope this effort will contribute to the goal of extending social protection in health to these populations in the LAC Region.

Pedro Brito
Area Manager
Health Systems and Servicies

1. Typically, most organizations, including WHO, refer to mother and child health as MCH. But in its 2005 World Health Report, WHO specifically highlights the importance of tackling the health needs of newborns. Hence in this document we will use the acronym MNCH which stands for maternal, neonatal, and child health.

ACKNOWLEDGMENT

This report is the product of a joint initiative between PAHO/WHO, USAID, SIDA and AECI, initiated in 2004/05 to identify options for extending social protection in health to mothers, newborns, and children in LAC. It relies strongly on concepts and methodologies developed since 2000 by PAHO and SIDA and on the conceptual developments of the ILO(Intenational Labour Organization)-PAHO Joint Initiative on Extension of Social Protection in Health.

Two teams, one from the Health Policies and Systems Unit (HSS-HP) and the other from the Women and Reproductive Health Unit (FCH-CLAP/WR) and Child and Adolescent Unit (FCH-CA), within the Areas of Health Systems and Servicies and Family and Community Health, respectively, worked together on the publication of this paper, under the supervision of Eduardo Levcovitz and Gina Tambini.

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LIST OF ACRONYMS

AECI: Agencia Española de Cooperación Internacional *(Spanish International Cooperation Agency)*
ARI: Acute Respiratory Infections
AUGE: Acceso Universal con Garantías Explícitas *(Universal Access with Explicit Guarantees)*
BE: Bono Escolar *(School Voucher)*
BMI: Bono Materno Infantil *(Mother and Child Voucher)*
CDC: Centers for Disease Control and Prevention
CONAMU: Consejo Nacional de las Mujeres *(National Women Council)*
CSDH: Commission on Social Determinants of Health
DHS: Demographic and Health Survey
DILOS: Directorio Local de Salud *(Local Health Directory)*
ECLAC: Economic Commission for Latin America and the Caribbean
ENDSA: Encuesta Nacional de Demografía y Salud *(National Demographic and Health Survey-DHS)*
ESSALUD: Seguro Social de Salud de Perú *(Peru's Social Security Institute)*
FONASA: Fondo Nacional de Salud *(National Health Fund)*
FONNIN: Fondo Nacional de Nutrición Infantil *(National Fund for Nutrition)*
GDI: Gross Domestic Income
GDP: Gross Domestic Product
GNI: Gross National Income
GRADE: Grupo de Análisis para el Desarrollo *(Analysis for Development Group)*
HIPC: Heavily Indebted Poor Countries
IBGE: Instituto Brasileiro de Geografia e Estatística *(Brazilian Institute of Geography and Statistics)*
IDB: Inter-American Development Bank *(IADB)*
ICU: Intensive Care Units
IESS: Instituto Ecuatoriano de Seguridad Social *(Ecuadorian Social Security Institute)*
IHSS: Instituto Hondureño de Seguridad Social *(Honduran Social Security Institute)*

ILO:	International Labour Organization
	(OIT)
IMCI:	Integrated Management of Childhood Illness
IMR:	Infant Mortality Rate
IMSS:	Instituto Mexicano del Seguro Social
	(Mexican Social Security Institute)
INEC:	Instituto Nacional de Estadísticas y Censos de Ecuador
	(Ecuador National Institute of Statistics and Censuses)
INEI:	Instituto Nacional de Estadística e Informática
	(National Institute of Statistics and Information Technology)
ISAPRE:	Instituciones de Salud Previsional
	(Private Health Insurance Funds)
ISSSTE:	Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado
	(Institute of Social Security and Services for State Workers)
LAC:	Latin America and the Caribbean
LACHSR:	Latin America and the Caribbean Regional Health Sector Reform Initiative
LMGYAI:	Ley de Maternidad Gratuita y Atención a la Infancia
	(Free Maternity and Child Care Law)
MCH:	Mother and Child Health
MNCH:	Mother, Newborn and Child health
MCHSHPP:	Mother and Child Social Health Protection Policy
MINSAL:	Ministerio de Salud de Chile
	(Chilean Ministry of Health)
MMR:	Maternal Mortality Ratio
MDG's:	Millennium Development Goals
MIDEPLAN:	Ministerio de Planificación y Cooperación de Chile
	(Chilean Ministry of Planning and Cooperation)
MSP:	Ministerio de Salud Publica
	(Ministry of Health)
OECD:	Organization for Economic Cooperation and Development
PACS:	Programa de Agentes Comunitários de Saúde
	(Community Health Agents Program)
PAE:	Programa de Alimentación Escolar
	(School Feeding Program)
PAHO:	Pan American Health Organization
	(OPS)
PEN:	Peruvian Nuevo Sol
PNAC:	Programa Nacional de Alimentación Complementaria
	(National Complementary Feeding Program)
PPP:	Purchasing Power Parity

PRAF:	Programa de Asignación Familiar *(Family Allowance Program)*
PROGRESA:	Programa de Educación, Salud y Alimentación *(Education, Health and Nutrition Program)*
PSF:	Programa Saúde da Família (Brazil) *(Family Health Program)*
PSF:	Plan de Salud Familiar (Chile) *(Family Health Plan)*
SAP:	Structural Adjustment Programs
SBS:	Seguro Básico de Salud *(Basic Health Insurance)*
SEG:	Seguro Escolar Gratuito (Free School Insurance)
SPHS:	Social Protection in Health Scheme
SIDA:	Swedish International Development Agency *(ASDI)*
SIS:	Seguro Integral de Salud *(Integrated Health Insurance)*
SMI:	Seguro Materno Infantil (Mother and Child Insurance)
SNMN:	Seguro Nacional de Maternidad y Niñez *(National Mother and Child Insurance)*
SUMI:	Seguro Universal Materno Infantil *(Universal Mother & Child Insurance)*
SUS:	Sistema Único de Saúde *(Unified Health System)*
TGN:	Tesoro General de la Nación *(National General Treasury)*
UN:	United Nation *(ONU)*
UNDP:	United Nations Development Fund
UNFPA:	United Nations Fund for Population Activities
UNICEF:	United Nations Children's Fund
USAID:	United States Agency for International Development
WB:	World Bank *(BM)*
WHO:	World Health Organization *(OMS)*

CONTENTS

Executive Summary -1-

1. Introduction -5-

2. Background -11-

3. Conceptual Framework -19-
   - 3.1) Description of the Social Protection in Health Schemes (SPHS) currently in place in the region -19-
   - 3.2) Analysis of the strengths and weaknesses of the SPHS -27-

4. Analytical Framework -42-
   - 4.1) Objectives -42-
   - 4.2) Methods -43-
   - 4.3) Conducting the Analysis -48-
   - 4.4) Information Sources -49-
   - 4.5) Limitations of the analysis -50-

5. Case Studies -51-
   - 5.1) Universal Mother & Child Insurance (Bolivia) -51-
   - 5.2) The Family Health Program (Brazil) -62-
   - 5.3) Mother & Child Social Health Protection Policy (Chile) -72-
   - 5.4) Free Maternity and Child Care Law (Ecuador) -82-
   - 5.5) Mother and Child Voucher (Honduras) -96-
   - 5.6) OPORTUNIDADES Program (Mexico) -107-
   - 5.7) Integrated Health Insurance (Peru) -118-

6. Results -131-

7. Discussion and Lessons Learned -137-

References -149-

EXECUTIVE SUMMARY

In the context of current PAHO/WHO agreements with USAID, SIDA, and AECI, research was carried out to gather information on social protection in health schemes (SPHS) aimed at mothers, newborns, and children in the Latin American (LA) Region. In order to do so, a cross-sectional descriptive analysis based on a literature/internet review and secondary sources was carried out.

For the purposes of this study, SPHS were defined as public interventions directed at allowing groups and individuals to meet their health needs and demands through access to health care goods and services in adequate conditions of quality, opportunity, and dignity, regardless of their ability to pay.[1]

The information gathered during the research process served as the knowledge base for a comparative analysis with two objectives:

a) Identify, describe, and document different models of/experiences with SPHS in LA as they relate to Maternal, Neonatal, and Child Health (MNCH);
b) Based on the different models/experiences identified, develop a comparative analysis of the strengths and weaknesses of different SPHS for mother, newborn, and child populations in terms of their ability to expand coverage of health services, increase equity in the access to care and offset social determinants that negatively effect health status and/or the demand for health care.

a) Description of SPHS currently in place in the region

A typology of SPHS was developed based on the work of the Organization for Economic Cooperation and Development (OECD) Development Centre and OECD Health Project (Drechsler D., Johannes J., 2005; Colombo F., Tapay N., 2004) as well as on Wouter van Ginneken's and Bonilla and Gruat's work for ILO (Van Ginneken, 1996; Bonilla and Gruat, 2003) and on our own observations.

1. This definition is derived from the PAHO-WHO Resolution CSP26.R.19 of September 2002, which defines Extension of Social Protection in Health -ESPH as the "society's guarantee, through the different public authorities, that individuals or groups of individuals can meet their needs and demands in health through adequate access to the services of the system or to those of any of the existing health subsystems in the country, regardless of their ability to pay."

b) Analysis of strengths and weaknesses

A multi-country cross sectional analysis based on literature/internet review and secondary sources was conducted. We based our analysis of strengths and weaknesses on four principles, selected both for their well-documented importance on MNCH and because they serve as points of consensus among experts in maternal, newborn, and child health (WHO, 2005; United Nations -UN- Millennium Development Project, 2005; Interagency Strategic Consensus for Latin America and the Caribbean, 2003). The following principles were selected:

I. Equity is central to MNCH;
II. MNCH is strongly linked to larger social determinants of health;
III. Improving coverage of and access to technically appropriate interventions is crucial to achieving better outcomes in MNCH;
IV. Context matters in the performance of SPHS. Any analysis of SPHS must be rooted in their social, political, and economic context.

According to these principles, three performance parameters were defined:

i. The ability of the SPHS to increase equity in the access to care and/or in the utilization of health services;
ii. The extent to which the SPHS contributes to offsetting social determinants that affect health status and/or hinder the demand for health care - i.e. the role the SPHS plays in shaping the social environment in ways that contribute to better health;
iii. The ability of the SPHS to expand coverage of and increase access to technically appropriate health interventions by eliminating one or more causes of exclusion from health care.

Seven SPHS were selected and characterized using this framework: Bolivia's Mother and Child Universal Insurance (Seguro Universal Materno Infantil, SUMI), Brazil's Family Health Program (Programa Saúde da Família, PSF), Chile's Mother and Child Social Health Protection Policy (MCHSHPP), Ecuador's Free Maternity Law (Ley de Maternidad Gratuita y Atención a la Infancia, LMGYAI), Honduras's Mother and Child Voucher (Bono Materno-Infantil, BMI), Mexico's OPORTUNIDADES Program and Peru's Integrated Health Insurance (Seguro Integral de Salud, SIS).

The selection was based on the availability of reliable information and the scheme's importance in the country, as measured by the resources allocated to it as well as its priority on the public agenda. The strengths and weaknesses of the selected SPHS were analyzed according to the schemes' compliance with the three performance parameters established above.

Additionally, acknowledging the importance of social and political context on the performance of health interventions (Commission on Social Determinants of Health- CSDH 2005, UN Millennium Development Project, 2005), the general setting in which each SPHS operates was also examined. The elements used to describe the general situation included the country's poverty level, per capita income, education level, percentage of population living in rural dwellings or remote settlements, population's ethnic background, access to water/sanitation/electricity, and employment condition (level of unemployment and share of formal vs. informal workers). Where information was available, women's status, institutional strength, distribution of power, and governance were also included in the analysis.[2]

Our main findings from the analysis of the seven SPHS were the following:

a) Four of the seven schemes under analysis - Bolivia's SUMI, Brazil's PSF, Chile's MCHSHPP, and Mexico's OPORTUNIDADES - have increased equity in the access to and/or utilization of health services. Three schemes, Ecuador's LMGYAI, Honduras's BMI, and Peru's SIS, show mixed results, and, in some cases, have increased inequity in the access to and/or utilization of health services.

b) All of the schemes under consideration helped to offset at least one of the negative social determinants of health, most frequently poverty, but only four of the analyzed schemes - Bolivia's SUMI, Brazil's PSF, Chile's MCHSHPP, and Mexico's OPORTUNIDADES - had a clear and unambiguous effect. The amount of investment in the program, the degree of coverage, continuity over time, the improvement of women's social status within the family, and the explicit promotion of the right to

2. For the purposes of the analysis we adopted the United Nations Development Fund (UNDP) definition of governance (UNDP, 1997) as "the exercise of political, economic and administrative authority in the management of a country's affairs at all levels". The definition comprises the complex mechanisms, processes, relationships, and institutions through which citizens and groups articulate their interests, exercise their rights and obligations and mediate their differences.

health appear to be crucial factors in the ability of the SPHS to tackle negative social determinants.

c) All seven schemes under analysis contributed to reducing the impact of at least one cause of exclusion from health care. Most of the schemes removed economic barriers to health care. However, the analysis of Bolivia's SUMI, Honduras's BMI and Peru's SIS shows that in ethnically diverse countries and/or countries with geographically dispersed human settlements, removing economic barriers alone does not guarantee access to health care.

d) Only two schemes - Brazil's PSF and Chile's MCHSHPP - have increased coverage of technically appropriate health interventions. Three schemes - Bolivia's SUMI, Ecuador's LMGYAI and Peru's SIS - have placed additional constraints on the health system by increasing the demand for health services without expanding provision, resources, and infrastructure accordingly.

e) Only in two cases - those of Chile's MCHSHPP and Bolivia's SUMI - have schemes achieved more than 60% coverage of the eligible population. Along with continuity over time and investments in resources and infrastructure, institutional capacity and decentralization of the scheme's management seem to play an important role in achieving the expected coverage.

f) Although not enough data has been collected regarding financial sustainability, three of the seven schemes - Bolivia's SUMI, Ecuador's LMGYAI, and Honduras's BMI - reportedly face financial shortages that threaten their sustainability.

This report argues that the improvement of mother, newborn, and child health can only be achieved through a holistic approach, combining interventions that address social, economic, cultural, age related and ethnic barriers to accessing health care. This multifaceted approach must be based on a long-term societal and political agreement.

1 INTRODUCTION

The health of mothers, newborns, and children is currently at the center of the agendas of multilateral organizations, international cooperation agencies, and governments around the world. This importance is mirrored in the MDGs (Millennium Development Goals), which express the historic consensus of the international community as to which high-priority challenges must be faced to improve the quality of life of people around the world and achieve sustainable development (PAHO/WHO, 2004). All eight MDGs are directly or indirectly related to health, particularly the health of mothers and children, as shown in table 1.

Table 1: Millennium Development Goals

Goals and targets	Indicators
Goal 1: Eradicate extreme poverty and hunger	
Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day	• Proportion of population whose income is below $1 (PPP) a day • Poverty gap ratio (incidence x depth of poverty) • Share of poorest quintile in national consumption
Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	• Prevalence of underweight children (under five years of age) • Proportion of the population below minimum level of dietary energy consumption
Goal 2: Achieve universal primary education	
Target 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	• Net enrollment ratio in primary education • Proportion of pupils starting grade 1 who reach grade 5 • Literacy rate of 15 to 24-year-olds

Goal 3: Promote gender equality and empower women	
Target 4: Eliminate gender disparity in primary and secondary education preferably by 2005 and in all levels of education no later than 2015	• Ratio of girls to boys in primary, secondary, and tertiary education • Ratio of literate women to men ages 15 to 24 • Share of women in wage employment in the nonagricultural sector • Proportion of seats held by women in national parliament
Goal 4: Reduce Child Mortality	
Target 5: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate	• Under-five mortality rate • Infant mortality rate • Proportion of one-year-old children immunized against measles
Goal 5: Improve Maternal Health	
Target 6: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	• Maternal mortality ratio • Proportion of births attended by skilled health personnel
Goal 6: Combat HIV/AIDS, Malaria, and other diseases	
Target 7: Have halted and begun to reverse the spread of HIV/AIDS by 2015	• HIV/AIDS prevalence, both sexes • Contraceptive use rate • Ratio of school attendance of orphans to school attendance of non-orphans ages 10-14
Target 8: Have halted and begun to reverse the incidence of malaria and other major diseases by 2015	• Prevalence and death rates associated with malaria • Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures • Prevalence and death rates associated with tuberculosis • Proportion of tuberculosis cases detected and cured under directly observed treatment short course (DOTS)
Goal 7: Ensure Environmental Sustainability	
Target 9: Integrate the principles of sustainable development into country policies and programs, and reverse the loss of environmental resources	• Proportion of land area covered by forests • Ratio of area protected to maintain biological diversity to surface area • Energy use (kilograms of oil equivalent) per $1 GDP (PPP) • Carbon dioxide emissions (per capita) and consumption of ozone-depleting chlorofluorocarbons (ODP tons) • Proportion of population using solid fuels
Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	• Proportion of population with sustainable access to an improved water source, urban and rural • Proportion of population with access to improved sanitation, urban and rural
Target 11: Have achieved, by 2020, a significant improvement in the lives of at least 100 million slum dwellers	• Proportion of households with access to secure tenure

Goal 8: Develop a Global Partnership for Development
Target 12: Develop further an open, rule-based, predictable, nondiscriminatory trading and financial system (includes a commitment to good governance, development, and poverty reduction – both nationally and internationally)
Target 13: Address the special needs of the least developed countries (includes tariff-and quota-free access for exports enhanced program of debt relief for HIPC (Heavily Indebted Poor Countries) and cancellation of official bilateral debt, and more generous ODA for countries committed to poverty reduction)
Target 14: Address the special needs of landlocked countries and small island developing states (through the Program of Action for the Sustainable Development of Small Island Developing States and 22nd General Assembly provisions)
Target 15: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term
Target 16: In cooperation with developing countries, develop and implement strategies for decent and productive work for youth
Target 17: In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries
Target 18: In cooperation with the private sector, make the benefits of new technologies available, especially information and communications

SOURCE: "The Millennium Development Goals: a Latin American and Caribbean perspective" ECLAC, 2005

In this context, maternal, neonatal and child health has ceased to be the object of merely technical consideration and has become one ethical and political imperative. This is due to the fact that despite impressive advances made since the 1950s in the fight against maternal and child mortality, inequality between countries and among different population groups within countries - especially the gap between rich and poor - has increased in the past twenty years, producing stagnation and, in some cases, a relapse in the progress achieved in maternal and child health (WHO, 2005). Moreover, three factors have negatively affected the patterns of maternal and child morbidity and mortality in the LAC Region: (i) the economic crises of the 1980s and late 1990s, which resulted in slow and volatile economic growth, high levels of inflation and unemployment and a decrease in the capacity of the public sector to provide essential health services; (ii) the social crises produced by increasing unemployment and informal economic activity, highly unequal income distribution, and the reduced presence of the State in areas such as education and health; and (iii) the HIV/AIDS pandemic (WHO, 2005; Levcovitz E, Acuña C, 2003; Economic Commission for Latin America and the Caribbean- ECLAC, 2005).

Every year, around 23,000 women die of complications during pregnancy and childbirth in LAC. In twelve countries of the Region, the maternal mortality ratio remains over 100 per 100,000 live births (PAHO/WHO, 2004). Most of these deaths are preventable (Regional Interagency Task Force Strategic Consensus for the Reduction of Maternal Mortality, 2003). Two of the key determinants of high maternal mortality ratios are the delay in access to health care when danger signs go unrecognized, and the lack of access to prompt and quality attention by skilled personnel, both during childbirth and postpartum (PAHO/WHO-USAID, 2004). Most of the women who die are poor, of indigenous origin, uneducated, and from rural areas (PAHO/WHO, 2004; WHO, 2005). These deaths have enormous social, economic, and emotional repercussions for families and communities, and are a determining factor in the generational transmission of poverty.

In 2004, eleven countries in the Americas had an under-five mortality rate of over 40 per 1,000 live births. As a whole, these countries are responsible for approximately 274,000 deaths of children under five years old, which is equivalent to 60.6% of all the deaths for this age group in LAC (PAHO/WHO-USAID, 2004 ECLAC, 2005). Meanwhile, eight countries had under-five mortality rates of fewer than 20 per 1,000 live births. This fact highlights the wide disparities prevailing among countries in the region. Nevertheless, the national averages do not reflect the existing gaps within countries. Ethnicity, income level, and area of residence seem to be the variables most strongly correlated with under-five mortality rate disparities within at least seven countries in the region - Bolivia, Brazil, Colombia, Guatemala, Haiti, Peru, and the Dominican Republic. In the region as a whole, however, access to sanitation and potable water, household income, and the mother's education level remain the most important determinants of under-five mortality. Lack of access to health care is an increasingly important cause of infant and neonatal mortality (PAHO/WHO-USAID, 2004; WHO, 2005).

Rising inequalities in the access to health care explain the stagnation in maternal, neonatal, and infant mortality rates observed in a number of LAC countries, despite of the existence of effective interventions to prevent or to treat the main causes of maternal and child death (WHO, 2005). Exclusion in health - defined as the lack of access of some groups or individuals to the health goods, services, and opportunities that other members of society enjoy (PAHO/WHO, 2003) - remains a challenge that requires urgent attention in most countries of the region.

To address this situation, many governments, multilateral financial institutions, and international technical cooperation agencies have concentrated their efforts on promoting and implementing SPHS for mother, newborn, and child populations. Their goal is to improve access to and quality of MNCH interventions, in turn helping to reach the Millennium Development Goals by the year 2015 (WHO, 2005).

PAHO/WHO has made supporting the countries in their efforts to eliminate exclusion in health, through the extension of social protection in health, a priority for its technical cooperation efforts. Social protection is here understood as the guarantee, granted by society through the State, that an individual or group of individuals can meet its needs and demands for health care through adequate and timely access to health services, without the ability to pay, nor cultural, social, or personal attributes, serving as restrictive factors.[3]

In addition, the reduction of maternal, neonatal and child mortality is a key component of PAHO/WHO's agenda. Recognizing the importance of this issue and its impact in the international context, Member States approved three key resolutions during the 2002 Pan American Sanitary Conference: Resolution CSP26.R.19, Resolution CSP26.R 13-14 and Resolution CSP26.R 10. The first Resolution called for PAHO/WHO and ILO to support and strengthen the extension of social protection in health in Member States as part of their technical cooperation activities. The second resolution urged Member States to make a full commitment to reduce maternal mortality by approving a new regional strategy. And the third Resolution encouraged Member States to support further implementation and strengthening of Integrated Management of Childhood Illness (IMCI) activities in order to improve child health and reduce child mortality in the region. Furthermore, in 2004 PAHO/WHO's 45th Directive Council adopted Resolution CD45.R3, urging Members States to strengthen their political commitment to the Millennium Declaration by developing and implementing national plans to achieve the MDGs.

PAHO/WHO and AECI have agreed to work together to strengthen LAC countries' political, institutional, organizational, and human capacities so that they can extend social protection in health and reduce inequities in the access to health care, in the utilization and financing of health

3. Op. Cit 1

services, and in health outcomes (PAHO-AECI Agreement 2005-2007). At the same time, since 1986, USAID and PAHO/WHO have worked together in areas of common interest - among them health systems strengthening and maternal and child health. Similarly, PAHO and SIDA have been working together since 2000 to support the efforts of LAC countries to address social exclusion in health and to develop strategies to extend social protection in health.

Within this framework of cooperation, and eight years from the deadline established for the achievement of the MDGs, it is important to examine how the implementation of health protection schemes and other strategies to extend social protection in health has affected the health of mothers and children. The purpose of this document is to analyze these schemes comparatively, with the goal of understanding why certain strategies perform better than others in guaranteeing access to maternal, neonatal, and child health services. Through this analysis we hope to identify the best mechanisms for achieving universal social protection in health for mothers, newborns, and children.

2 BACKGROUND

The protection of the health of mothers and children is not a new topic in the public policy sphere. It has been a priority on the social agenda of many countries since the nineteenth century, which in large part explains the drastic reduction in maternal and child mortality seen around the world during the 20th century. The creation of public health programs to improve the health of women and children became a priority after the Second World War, as seen in the 1948 Universal Declaration of Human Rights, which stated the obligation of all countries to provide special care and assistance for mothers and children.

In order to examine social protection schemes in LAC, it is important to understand the context in which they came to be. Health systems in the region were created based on a mix of European models of social protection. However, unlike in most European countries, health systems in LAC were comprised of subsystems focused on the different health needs of specific segments of the population, grouped according to income, nationality, occupation, or social class (Acuña C., 2000 and 2005).

This development mirrored the highly unequal societal arrangements inherited from the Spanish/Portuguese colonization process, which created a set of institutions benefiting the Spanish/Portuguese settlers and allowing them to extract wealth from the indigenous population (The World Bank, 2006, 2:111-113; Inter American Development Bank, 2004 4:23-26). Thus, the public/MoH managed subsystem undertook the health care provision for the poor, sometimes inheriting private and public assistance programs; the social security subsystem focused on workers in the formal sector and sometimes their families and dependents; and the private subsystem specialized on the groups with higher incomes (Acuña C.,

2000; Rosenberg H. and Andersson B., 2000; PAHO/WHO, 2003; The World Bank, 2006, 7:147). This segmented institutional arrangement still persists in most of the countries of the region with the exception of Brazil, Canada, Colombia, Costa Rica, Cuba, and several English speaking Caribbean countries.

Fragmentation is also a characteristic of health systems in the region, where multiple agents operate without coordination and often in competition with each other. The structural segmentation mentioned above; weak governance; lack of integrated planning; often inadequate state and non-state interactions; and inefficient referral mechanisms all lead to the fragmentation of health systems (PAHO/WHO, 2003, ECLAC, 2005). Fragmented systems create obstacles to the efficient use of resources and the development of adequate standards of quality. Transaction costs increase, and it becomes difficult to guarantee the same level of attention to populations affiliated to different SPHS. Health System's segmentation and fragmentation lead to inequity as well as inefficiency.

In addition, during the 1980s and 1990s, structural adjustment policies (SAPs), combined with the international oil crisis, the deterioration of terms of trade, and civil wars, had a deep impact on the region's social and economic landscape. According to Milanovic (Milanovic B., 2005), the period from 1980 to 2002 was a time of uneven global development. The average annual rate of growth for all countries, unweighted by population, was only 0.7 percent per year, 2 percentage points less than during the previous twenty years (1960-1980). Looking at individual countries, this means that many failed to grow at all, or even experienced negative growth, as the table below shows.[4]

4. According to the same author, the average unweighted decrease in real per capita GDI between 1980 and 2002 among countries that have a lower income in 2002 than in 1980 is 20 percent.

Table 2: Winners and losers during the globalization era in LAC, 1980-2002

2002 real per capita GDI in relation to 1980 real per capita GDI	Country
More than 58% gain	Chile Dominican Republic
Gain between 0 and 58%	Bahamas Barbados Brazil Colombia Costa Rica El Salvador Guyana Jamaica México Panamá Trinidad & Tobago
Loss between 0 and 20%	Argentina Bolivia Ecuador Guatemala Honduras Paraguay Peru Uruguay
Loss over 20%	Haiti Nicaragua Venezuela

SOURCE: Adapted from Milanovic B. "Why did the poorest countries fail to catch up?" Carnegie papers. Carnegie Endowment for International Peace, N° 62, November 2005. Appendix 1, Page 30.

SAPs usually followed a set of prescriptions that were believed at the time to be the best formula for economic growth. These policies encouraged governments in the region to liberalize employment regulations, privatize State-owned enterprises, decentralize services and budgets, deregulate capital markets, and cut public expenditures. Facing strong pressure from international financial institutions to reduce expenses, most governments in the region reduced budgets for social programs. Franco-Giraldo et al. (2006) analyzed the impact of SAPs on health indicators in LAC from 1980-2000 and found that the adoption of SAPs in the 1980s is linked to a negative impact on social indicators, in the region, particularly those related to the health situation. Furthermore, they conclude that the negative effects lasted into the next decade.

The decline in public expenditure on social programs was accompanied by a decrease in per capita income and an increase in unemployment and informal economic activity. As a result, SPHS provided both by the

Ministry of Health-managed subsystem and the Social Security institutions became insufficient, leaving millions of people excluded from access to health goods and services (Levcovitz E., Acuña C., 2003; ILO, 2003). This translated into the high out-of-pocket expenditure on health that reaches around 50% of total expenditure on health in several countries in the region (PAHO/WHO, 2003). Studies show that when out-of-pocket expenses are high, the ability to pay becomes the most important determining factor in whether or not an individual will seek health care (WHO, 2000 5:96-99; World Bank, 1993).

Table 3: Out-of pocket expenditure in health in the Americas, 2003

Country	ISO3	Private expenditure on health as percentage of total expenditure on health	Out-of-pocket expenditure as percentage of private expenditure on health	Latest Year	Out of pocket expenditure as a percentage of total expenditure on health
Antigua and Barbuda	ATG	29.4	100	2003	29.40
Argentina	ARG	51.4	55.6	2003	28.58
Bahamas	BHS	52.5	40.5	2003	21.26
Barbados	BRB	30.6	77.2	2003	23.62
Belize	BLZ	50.7	100	2003	50.70*
Bolivia	BOL	36	79.3	2003	28.55
Brazil	BRA	54.7	64.2	2003	35.12
Canada	CAN	30.1	49.6	2003	14.93
Chile	CHL	51.2	46.2	2003	23.65
Colombia	COL	15.9	47.2	2003	7.50
Costa Rica	CRI	21.2	88.7	2003	18.80
Cuba	CUB	13.2	75.2	2003	9.93
Dominica	DMA	28.7	100	2003	28.70
Dominican Republic	DOM	66.8	70.8	2003	47.29
Ecuador	ECU	61.4	88.1	2003	54.09*
El Salvador	SLV	53.9	93.5	2003	50.40*
Grenada	GRD	26.4	100	2003	26.40
Guatemala	GTM	60.3	91.9	2003	55.42*
Guyana	GUY	17.4	100	2003	17.40
Haiti	HTI	61.9	69.5	2003	43.02
Honduras	HND	43.5	85.8	2003	37.32
Jamaica	JAM	49.4	64.7	2003	31.96

Mexico	MEX	53.6	94.2	2003	50.49*
Nicaragua	NIC	51.6	95.7	2003	49.38*
Panama	PAN	33.6	82.2	2003	27.62
Paraguay	PRY	68.5	74.6	2003	51.10*
Peru	PER	51.7	79	2003	40.84
Saint Kitts and Nevis	KNA	36.2	100	2003	36.20
Saint Lucia	LCA	31.8	100	2003	31.80
Saint Vincent and the Grenadines	VCT	32.5	100	2003	32.50
Suriname	SUR	54.2	51.8	2003	28.08
Trinidad and Tobago	TTO	62.2	88.6	2003	55.11*
United States of America	USA	55.4	24.3	2003	13.46
Uruguay	URY	72.8	25	2003	18.20
Venezuela (Bolivarian Republic of)	VEN	55.7	95.5	2003	53.19*

* Out of pocket expenditure around or over 50% of total expenditure in health

SOURCES: Own computation based on data provided by WHO, including 'World Health Statistics 2006' and 'The World Health Report 2006 Edition'.

By the mid 1990s, the idea that it was important to protect the poor from the shocks and adversities associated with a globalized economy began to gain momentum.[5] Many governments in the region implemented a series of health and education programs aimed at protecting vulnerable populations. In addition, nearly all LAC countries had established the right to universal and free health care in their Constitutions, even though the transition from constitutional right to practice is still incomplete in most countries. (Mesa-Lago, 2005).

5. According to recent studies, globalization (understood as exposure to international markets) has been negatively correlated with the allocation of resources to social programs. See Avelino et al. *Globalization, Democracy, and Social Spending in Latin America*, 1980-1997, and Kaufman & Segura-Ubiergo, *Globalization, Domestic Politics, and Social Spending in Latin America: A Time-Series Cross-Section Analysis, 1973–97.*

Table 4: Years when LAC governments enacted universal health care

Country	Constitutional Right to Health	Specific Law
Argentina	none	Law N°23.661 of 1989
Bolivia	Constitution of 1967	Presidential Decree N°25.265 of 1998
Brazil	Constitution of 1988	Law N°8.080 of 1990
Chile	Constitution of 1980	Law N°19.966 of 2005
Colombia	Constitution of 1991	Law N°100 of 1993
Costa Rica	none	General Health's Law N°5395 of 1973
Cuba	Constitution of 1976	Law N°41 of 1983
Dominican Republic	none	Law N°87 of 2001
Ecuador	Constitution of 1996	Law N°80 RO 670 of 2002
El Salvador	Constitution of 1983	Legislative Decree 775 of 2005
Guatemala	Constitution of 1985	Social Development Law, Decree N°42 of 2001
Guyana	Constitution of 1980	none
Haiti	Constitution of 1987	none
Honduras	Constitution of 1982	Health Code of 1991
Mexico	Constitution of 1917	General Health's Law of 2003
Nicaragua	Constitution of 1987	General Health's Law N°423 of 2002
Panama	Constitution of 1972	Law N°27 of 1998
Paraguay	Constitution of 1967	Law N°836 of 1980
Peru	Constitution of 1993	Law N°27.812 of 2002
Uruguay	none	Law No. 18.211 of 2007
Venezuela	Constitution of 1999	Degree 2944 of 1998

SOURCE: Own compilation based on the countries' legal documents and secondary sources.

Countries in the region also adopted a series of health sector reforms (HSR) with a strong emphasis on cost-effectiveness and financial sustainability and an increased role for the private sector. However, the reforms did not achieve the expected results, and there is now a renewed focus on the role of the state in guaranteeing social protection and equitable access to health care (FLACSO-World Bank, 2002; Levcovitz E., Acuña C., 2003; ILO, 2003).

Table 5: HSR in the 80's and 90's in LAC countries

Changes associated with HSR	Shortcomings
Separation of health system functions (steering role, provision, financing, insurance) occurred in many countries. The private sector took on an increased role in the provision of insurance and health care.	The creation, promotion, and deregulation of health insurance and provision markets led to the proliferation of intermediate agents, all competing among each other, as well as weak or non-existent regulatory mechanisms, in turn increasing fragmentation within the system, raising transaction costs and weakening the Ministry of Health's steering role in many countries.
Fiscal discipline was introduced in the public health sector. The importance of sustainable health financing was emphasized. New sources of financing were sought.	Public expenditure on health was drastically reduced in most countries. The introduction of user fees and other payment mechanisms at the point of service increased out-of-pocket expenditure in health in most countries.
Management of health facilities was improved in many countries, in some cases through management contracts. Efficiency and effectiveness criteria were applied to the provision of health services.	Increasing competition among insurers and/or providers, without effective state regulation, deepened segmentation within the system. The introduction of economic incentives related to the provision of individual health services led to a prioritization of curative care over preventive actions.
Targeting mechanisms to expand coverage and reach underserved populations were implemented.	The introduction of basic health packages for the poor or specific population groups deepened segmentation of health systems. The creation of separate funds for those who can contribute and those who cannot led to a loss of solidarity within the system and increased inequity in access to health care as well as in health outcomes. Coverage did not improve as expected.
Accountability in the management of health facilities, quality of service, responsiveness to user's needs, and freedom of choice were recognized as central to the performance of health systems. Patients'/users' rights were made explicit in many countries	Increasing demand for health services induced by the promotion of users/patients' rights was not accompanied by interventions to improve health services provision.
Decentralization of health management was implemented in most countries to increase local participation.	Incomplete decentralization processes increased lack of governance and geographic inequity in the provision of health services.

SOURCE: Own compilation based on: Fleury, S. 2003; ILO, 2003; Levcovitz E., Acuña C., 2003; Levcovitz, 2006; Mesa-Lago, 2006; Sojo, A. 2001; World Bank, 2006; World Health Organization, 2006; ECLAC, 2005; LAC Region countries Health Systems Profiles 2000-2006 PAHO/WHO

Although several countries in the region have long implemented SPHS that aim at or include mothers and children, only recently have most governments, largely influenced by the adoption of the MDGs, shown a strong commitment to addressing the needs of these populations. Some of them have done so in the context of wider social and economic initiatives as a part of the World Bank's Poverty Reduction Strategy Programs (PRSPs), the International Monetary Fund-IMF's Highly Indebted Poor Countries-HIPC strategy or other initiatives carried out along with the international community. This commitment has been translated into the creation or improvement of a series of social protection in health schemes in the region. While some countries have developed targeted programs, as is the case in Bolivia, Ecuador, Peru, and Argentina, other countries, such as Brazil and Chile, have strengthened their maternal and child protection strategies within the broader setting of universal SPHS. It is noteworthy that many countries have a mix of different interventions aimed at protecting the health of mothers, newborns, and children.

3 CONCEPTUAL FRAMEWORK

3.1 DESCRIPTION OF SOCIAL PROTECTION IN HEALTH SCHEMES (SPHS) CURRENTLY IN PLACE IN THE REGION

3.1.1 WHAT IS A SOCIAL PROTECTION IN HEALTH SCHEME (SPHS)?

For the purposes of this study, a SPHS was defined as a public intervention aimed at allowing groups and/or individuals to meet their health needs and demands through access to health care and/or other goods, services or opportunities in adequate conditions of quality, opportunity, and dignity, regardless of their ability to pay. This definition draws from the PAHO/WHO-ILO's 'Extension of Social Protection in Health' framework, which defines Extension of Social Protection in Health as "society's guarantee, through the different public authorities, that all individuals or groups of individuals can meet their needs and demands in health through adequate access to the services of any of the existing health subsystems in the country, regardless of their ability to pay" (ILO-PAHO, 2005(6):40).[6]

What lies at the center of both definitions is the idea of securing access to adequate health care –i.e. in adequate conditions of quality, opportunity, and dignity - for all, without the economic situation of the individual or his/her family being a barrier to access health care. According to Carrin and James (Carrin G. and James C., 2004) this idea incorporates two

6. PAHO-WHO Resolution CSP26.R.19 of September 2002.

different coverage dimensions: health care coverage (*adequate* health care) and population coverage (health care *for all*). This idea also brings into play a third dimension: financial protection (*regardless of ability to pay*) through solidarity in financing.
The concept of social protection has changed over time. It first comprised the notion of 'safety nets,[7] understood as "minimalist social assistance in countries too poor and administratively weak to introduce comprehensive social welfare programs" (World Bank, 1993). Safety nets aimed at providing public assistance to those who could not manage otherwise, so as to keep people out of poverty by guaranteeing a minimum income to meet basic needs (Bonilla and Gruat, 2003; Interamerican Development Bank- IDB, 2001). In this context, safety nets function as a temporary cushion against specific shocks, mainly through an income transfer mechanism. As Unger et al. note, residual welfare - not solidarity – is the value behind the concept of safety nets (Unger et al., 2006). This approach also envisioned a limited role for government, usually favoring solutions coming from civil society and the private sector.

Concerns for equity and human rights in the access to health care and the magnitude and sustained character of poverty in some countries forced a re-conceptualization of the notion of social protection in health. Although the safety net approach is still widely applied, it fails to address the structural determinants that generate vulnerability in the first place. It also fails to recognize that the State can play an important role in managing mechanisms to increase and improve access to health care for vulnerable populations (ILO, 2003).

With the expansion of wage labor in the late 19th and early 20th centuries, labor-related social protection schemes began to take shape to cover a wider range of risks, such as unemployment, invalidity due to age, workplace accidents or injury. Thus, social protection evolved from having a primary safety net function, to a dual aim of protection against and prevention of risks in the workplace. Over time, mechanisms for resource redistribution and pooling were introduced and consequently, the concept of individual risk evolved into a collective approach to risk. Thus, solidarity among the insured became a central aspect of social protection. Two models of social protection, one based on solidarity among actors in the labor realm (Bismarkian) and the other based on solidarity among the entire population (Beveridgian) would later be applied, in different versions, all over Europe and also in the developing world.

7. The idea of social protection as a safety net can be tracked back to the English Poor Law, which was in place from 1598 to 1948.

In the 1990s, the World Bank developed a new approach to social protection called 'risk management' (World Bank 1999; IDB 2000). It focused on assisting individuals, households, and communities to manage risk, such as the risk of falling into poverty. Its health components involved both reducing exposure to risks through targeted interventions and alleviating their consequences through risk pooling in private or informal insurance schemes. This approach relied on individual capacity to manage risk and its goal was individual wellbeing. It did not view interpersonal redistribution of income as necessary to improve wellbeing (Doryan et al. 2001 p.11).

Today, the growth of informal labor, the demographic changes associated with higher life expectancy, and greater mobility linked to migratory movements have compelled many countries in the industrialized and developing world to re-examine their systems of social protection. To better meet changing needs and to adapt to increasing vulnerability in a global world, the concept of social protection in health needs to be broadened (Bonilla and Gruat, 2003), to go beyond the 'safety net' and "risk management" approaches - which rely solely on economic protection to cope with specific shocks - to address those factors, imbedded in the social structure, that generate exclusion and inequity in the access to health care (PAHO/WHO 2003; Levcovitz E., Acuña C. 2003; Jordan B. 1996).

3.1.2 WHY ARE SPHS IMPORTANT?

Social Protection in health schemes matter. They play an important role in improving access to health care. Although the existence of SPHS is neither necessary nor sufficient to guarantee access to health care, they remain one of the most important factors in improved access. Industrialized countries halved their maternal mortality in the early 20th century by providing professional midwifery care at childbirth. They further reduced it to current low figures by improving access to health care through the implementation of Bismarkian or Beveridgian social protection schemes (ILO, 2003). A number of developing countries have followed the same path in the last few decades (WHO, 2005).

The Committee on the Consequences of Uninsurance in the USA found that children without insurance are three times as likely as children with coverage to have no regular source of care (Institute of Medicine, 2001). One of the main roles of SPH Scheme is financial protection. As table 3 shows, in LAC countries with weak SPHS, out-of-pocket payments usually account for more than 50% of the total health expenditure. In these countries, out of pocket expenses are much higher in the poorest quintile and function as a main barrier to access health care (PAHO/WHO, 2003).

Gender also seems to play a role in out-of-pocket health expenditure: household surveys that include individual health spending information show that women's out-of-pocket expenses are systematically higher than men's in Brazil (1996-1997), the Dominican Republic (1996), Ecuador (1998), Paraguay (1996) and Peru (2000) (United Nations, 2005; ECLAC, 2005). Lowering out-of–pocket expenditure, especially among the poor, is a stated goal of many interventions and is seen as a way to eliminate the economic barrier to accessing health care and improving health outcomes (WHO 2005, PAHO/WHO-ILO 2005, PAHO/WHO 2003).

3.1.3 BUILDING A TYPOLOGY OF SPHS AIMED AT OR INCLUDING MOTHER, NEWBORN, AND CHILD POPULATIONS CURRENTLY IN PLACE IN LAC COUNTRIES

Acknowledging the diversity of SPHS that aim at or include mothers, newborns and children in the region, we grouped them into different types according to the three dimensions that arise from the definition of SPHS:

a. Health care coverage
b. Population coverage
c. Financial protection/Solidarity in financing

For each dimension several benchmarks, drawn from the literature and relevant to the analysis of SPHS in the region, were selected. The report drew especially on the work of D. Drechsler and J. Johannes (2005) and F. Colombo and N. Tapay (2004) for the OECD on health insurance schemes, as well as on the studies carried out by van Ginneken (1996) and Bonilla and Gruat (2003) for the ILO in the field of social protection.

For the first dimension, health coverage, the following parameters were selected:

1. Degree of coverage - i.e. whether the benefits/services portfolio is comprehensive, complementary, or supplementary[8]
2. Existence of a portfolio of entitlements
3. Type of provision

8. According to Mossialos and Thomsom, a *complementary* insurance package provides services excluded or not fully covered by the state through regular channels whereas a *supplementary or substitutive* insurance package provides faster access and increased consumer choice to services that are already covered by the state. See Elias Mossialos and Sarah Thomsom "Voluntary health insurance in the European Union: a critical assessment" on the International Journal of Health Services 2002; 32 (1):19-88. A *comprehensive* insurance package is one that provides full coverage.

For the second, population coverage, the following parameters were chosen:

1. Degree of selectivity, i.e. whether the SPHS is universal or targets a specific group;
2. Population entitled to coverage
3. Conditions for access
4. Size of the risk pool

Concerning the third dimension financial protection/ solidarity in financing, the following parameters were used:

1. Mode of financing
2. Source of funding
3. Type of risk pooling arrangement[9]
4. Resources management and management level - who manages the resources and at what government level the resource management is carried out.

9. According to Sekhri and Savedoff, risk pooling arrangements may be *community-rated* – ie. transfers between healthy and sick-; *income-based* –i.e. transfers between higher income and lower income individuals; -or *individual risk-rated* –i.e. minimal risk transfer between individuals-. See N. Sekhri and W. Savedoff "*Private health insurance: implications for developing countries*" WHO Bulletin 2005; 83 (2):127-34.

Table 6: Typology of SPHS aimed at or including Mother, Newborn, and Child populations

Type	Mode of financing	Source of funds	Risk pooling arrangement	Management and manage-ment level	Degree of selectivity	Who is entitled to coverage	Condition for access	Extent of risk pooling	Explicit portfolio	Degree of coverage	Type of Provision
Public Health Insurance	Contribution-based insurance scheme	-General taxes -Individual mandatory contribution -Individual voluntary contribution -Co-payments	-Community-rated -Income-based	National Ministry of Health (MoH)	Universal	Individual	Citizenship	Large pool	Explicit	Comprehensive	Public Private
Social Health insurance		-General taxes -Social security contributions (payroll tax) -Co-payments	-Community-rated -Income-based	National -Public Agency -Unions -Tripartite: Gov-employers- em-ployees	Formal work-ers and their families	Individual / Dependants	Employment status (Labor contract)	Large pool	Variable (Explicit / Not explicit)	Comprehensive	Public Private
Mother and child health Insurance		-General taxes -Users' fees -Co-payments -Premiums	Income-based	National Sub-national Public Agency MoH Provincial govern-ments	Targeted: -Reproductive age or preg-nant women -Children under five years old	Individual	-Age -Proof of pregnancy -Proof of delivery -Means test	Small pool	Explicit	Complementary	Public
Extension of social securi-ty to informal workers		-General taxes -Informal work-ers' voluntary contribution -Social security contributions	Income-based	National Sub-national - Public Agency - Social Security Institution	Targeted: -Informal workers and in some cases their families	Individual / Dependants	Employment status	Large pool	Explicit	Complementary	Public Private
National Health Insur-ance	Tax-financed insurance	General taxes	-Community-rated -Income-based	National Sub-national -Provincial governments	Universal	Individual	Residence	Large pool	Explicit	Comprehensive	Public Private

Type	Mode of financing	Source of funds	Risk pooling arrangement	Management and manage-ment level	Degree of selectivity	Who is entitled to coverage	Condition for access	Extent of risk pooling	Explicit portfolio	Degree of coverage	Type of Provision
National Health system	Tax-financed health system	General taxes	-Community-rated -Income-based	National Sub-national Local MoH Local gov.	Universal	Individual	Citizenship	Large pool	Not explicit	Comprehensive	Public Private
Free primary health care	Publicly funded health programs	General taxes	-Community-rated	National Sub-national Local MoH Local gov.	Universal	Individual Family	Citizenship Residence	Large pool	Not explicit	Comprehensive	Public
Free mater-nal and child care		-General taxes -Other rev-enues (IDB/WB loans)	-Income-based	National Sub-national Local MoH Local gov.	Targeted: Re-productive age or pregnant women Children under five years old	Individual	Age Proof of pregnancy Proof of delivery	Small pool	Explicit	Complementary	Public
Conditioned cash transfer	Publicly funded social assistance	-General taxes -Other rev-enues (IDB/WB loans)	-Income-based	Local Local gov.	Targeted: Pregnant or Lactating mothers Children under 5 years old Disabled children under 12 years old Poor house-holds	Family	Age Proof of pregnancy Means test	Small pool	Explicit	Complementary	Public
Conditioned in-kind transfer		-General taxes	-Income-based	Local MoH Local gov.	Targeted: Pregnant women Lactating mothers Children under 6 or 5 years old	Family	Means test Place of residence	Small pool	Explicit	Complementary	Public

SOURCE: Own compilation based on categories proposed by Drechsler D., Johannes J., (2005); and Colombo F., Tapay N., (2004) for the Organization for Economic Cooperation and Development-OECD and by W. van Ginneken (1996); and Bonilla and Gruat (2003) for the International Labour Office-ILO.

According to the typology, some of the SPHS currently in place in the region can be classified as follows:

Table 7: Social Protection in Health Schemes (SPHS) aimed at or including mothers, neonates and children in the Americas

Type	Example	Country
Public Health Insurance	-Fondo Nacional de Salud -Seguro Popular de Salud	Chile Mexico
Social Health Insurance	-Caja Costarricense de Seguridad Social -Instituto Guatemalteco de Seguridad Social -Instituto Mexicano de Seguridad Social -MEDICARE	Costa Rica Guatemala Mexico USA
Extension of social security to informal workers	-Seguro Social Campesino -IMSS (Instituto Mexicano de Seguridad Social)-Solidaridad	Ecuador Mexico
National Health Insurance	-National Health Insurance	Aruba, Bahamas, Canada
National Health System	-Sistema Único de Saúde -Ministry of Health(*)	Brazil Barbados, Belice, Cuba, Nicaragua, Venezuela
Free primary health care	-Programa Saúde da Família -Programa de Salud Familiar -Programa Barrio Adentro	Brazil Chile Venezuela
Free maternal and child care	-Ley de Maternidad Gratuita y Atención a la Infancia -Seguro Universal Materno-Infantil -Seguro Provincial Materno-Infantil -Seguro Integral de Salud	Ecuador Bolivia Argentina Peru
Conditioned cash transfer	-Bono materno-infantil -OPORTUNIDADES Program -Bono Solidario -Bolsa Familia	Honduras Mexico Ecuador Brazil
Conditioned in kind transfer	-Plan Nacional Alimentación Complementaria -Plan Nacional Alimentación Complementaria -Vaso de Leche Program	Chile Argentina Peru

SOURCE: Own compilation based on secondary sources
(*) Most of Latin American countries have a National Health System run by the Ministry of Health

3.2 ANALYSIS OF THE STRENGTHS AND WEAKNESSES OF THE SPHS

3.2.1 THE CHALLENGE OF MEASURING SPHS PERFORMANCE

The assessment of public health interventions that provide social protection in health is intrinsically difficult due to the various factors involved in their design, implementation, and outcomes. Moreover, there is no standard method to evaluate the impact of public health interventions in general - let alone public interventions focused on extending protection in health to mothers, newborns, and children- other than approaches used within the cost-benefit analysis framework (Kelly M., McDaid D., Ludbrook A., Powell J., 2005). Some of the challenges posed by the performance analysis of SPHS are:

1. SEPARATING CAUSE AND EFFECT. Unlike drug-based and other clinical interventions, public health interventions such as SPHS use different strategies and mechanisms to tackle multi-causal and complex problems, making it difficult to identify which elements of the scheme are responsible for which, if any, changes. The effects of mediating or confounding factors at the point of implementation in real-word settings need to be considered. Kelly et al. state that the variable effectiveness and success of interventions are filtered through two sets of mediating factors which are, to some extent, independent of the mechanisms of the intervention itself. These are the enthusiasm, expertise, and engagement of the staff carrying out the intervention and the local delivery infrastructure (Kelly M., McDaid D., Ludbrook A., Powell J., 2005). Even when interventions are well defined and highly circumscribed their performance and outcomes strongly depend on institutional and other contextual factors, as it can be observed when comparing the impact of almost identical mother and child health and nutrition programs in two relatively similar countries, Chile and Argentina, along the same period of time (Idiart A., 2004).

2. ASSESSING THE INFLUENCE OF THE SOCIAL, POLITICAL AND INSTITUTIONAL CONTEXT ON PERFORMANCE. The context in which SPHS are implemented may be highly influential to their achievements and shortcomings. As Travis et al. note, the overall policy environment, political instability, and the quality of governance are some of the factors outside the health system that may impact health service delivery. Some findings suggest that in certain countries these broad policy and institutional constraints pose greater barriers than resource constraints (Travis P et al., 2004). Furthermore, the socioeconomic context has implications for how public health interventions are designed and evaluated and must be taken into account in the analysis (Levcovitz E., Acuña C., 2003; Kelly M., McDaid D., Ludbrook A., Powell J., 2005).

3. IDENTIFYING WHICH ASPECTS SHOULD BE EXAMINED WHEN ASSESSING SPHS. The ultimate target of SPHS - securing access to adequate health care for all regardless of ability to pay - is often a long term goal, posing the need for identifying indicators that may be used as proxies of progress in the short, intermediate, and long term. Any assessment of SPHS aimed at or including mother, neonatal, and child health must examine a) the impact of the SPHS on the main health determinants of the target populations; b) the mechanisms for addressing inequities in the access to and the utilization of health services, and c) the extent to which the SPHS improves the provision and quality of specific interventions highly correlated with MNCH, such as care during delivery by skilled personnel.

4. MAKING CROSS-COUNTRY COMPARATIVE ANALYSIS. If assessing the performance of a given SPHS is difficult, undertaking a comparative analysis among several SPHS in different countries poses huge methodological challenges. As Travis et al. point out, cross-country comparative analysis is one of the most contentious issues in health systems and services research, since health systems operate in such different contexts (Travis P. et al., 2004). In addition, SPHS in different countries are in different stages of maturity, further complicating cross-country comparisons since the effectiveness of a given scheme may be influenced by its evolution over time.

3.2.2 TOWARDS A BASELINE FOR THE ANALYSIS OF SPHS AIMED AT OR INCLUDING MOTHER, NEWBORN, AND CHILD POPULATIONS

3.2.2.1 LAYING OUT THE FOUNDATIONS

Despite the constraints mentioned above, there is an urgent need to learn which SPHS, and under what conditions, perform best in protecting the health of mothers, newborns, and children, in order to inform and support the policymaking process in the countries of the region. Currently, there is no analysis of lessons learned in the area of SPHS for mother, newborn, and child populations in Latin America, and it is therefore necessary to build a baseline for assessing SPHS.

A good starting point is a descriptive analysis of strengths and weaknesses, taking into account the socio-political context as well as key environmental factors that affect MNCH. The analysis will be based on four principles, selected for their well-documented importance for SPHS performance as well as MNCH (ECLAC, 2005; Interagency Strategic Consensus for Latin America and the Caribbean, 2003; WHO, 2005; UN Millennium Project, 2005). The principles are:

I. Equity is central to MNCH, as well as to achieving the goal of "health for all." Improving equity in the access to and/or the utilization of health services, as well as in health outcomes, should be one of the goals of any SPHS focusing on MNCH.
II. MNCH is strongly linked to social determinants of health, which also have a deep impact on the performance of SPHS. Social determinants may help to reduce disparities in health or be a source of inequity in health, since mothers and children that are poor, socially excluded, malnourished, and lacking adequate access to food, water, and sanitation are more likely to suffer from disease and less likely to have the resources to seek - and obtain - timely health care. SPHS should be instrumental in offsetting social determinants that damage health and/or hinder the demand for health care.
III. Improving quality and coverage of technically appropriate interventions is crucial to achieving better outcomes in MNCH. There is a growing consensus that for this to be possible, health systems must be strengthened and their capabilities in key areas such as the health workforce, drug supply, health financing, and information systems must be increased. SPHS can play a role in strengthening health systems by implementing comprehensive and integrated strategies to improve quality and coverage of technically appropriate interventions highly related to maternal, neonatal, and child health.
IV. Context matters in the performance of SPHS. The analysis of SPHS must be rooted in their social, political, and economic context.

I. EQUITY IS A CENTRAL ISSUE FOR MNCH

The concepts of equity/inequity in health are rooted in the framework of Rawls's (1971) Theory of Distributive Justice, which develops the idea that all social primary goods - liberty and opportunity, income and wealth, and the bases of self-respect - are to be distributed equally, unless an unequal distribution of any or all of these goods is to the advantage of the least favored.

From the idea mentioned above, it follows that there are at least three principles of equity in health that need to be achieved (Oliver and Mossialos 2004):

1. Equal access to health care for those in equal need of health care
2. Equal utilization of health services for those in equal need of them
3. Equitable health outcomes

Each of these three principles requires the satisfaction of different conditions which make them more or less suitable for operational policy objectives within the scope of the health sector.

1. Equal access for equal need is related to the *supply side* of heath care and requires conditions whereby:

a) Those with equal needs - for example, all the people who need treatment for diabetes - have *equal opportunities to access health care* (this is called "horizontal equity"); and

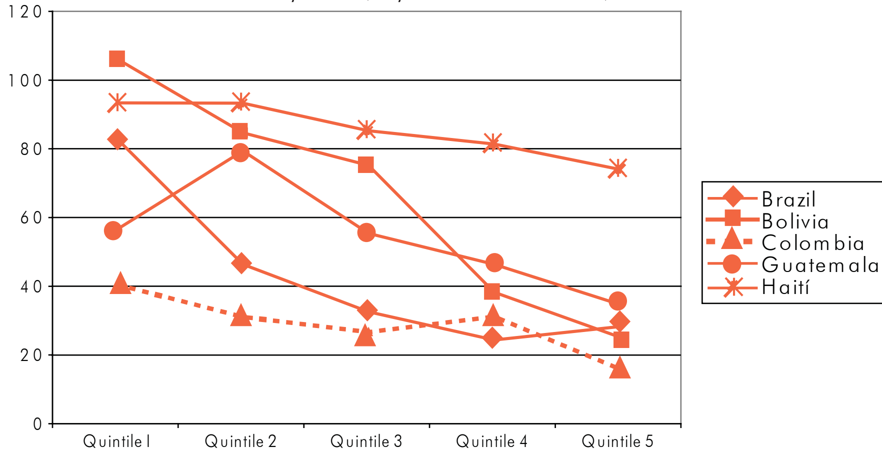
b) Those with unequal or different needs - for example all the diabetic women who are also pregnant - have *appropriately unequal opportunities to access health care* (this is called "vertical equity").

2. Equal utilization for equal need is related to the *demand side* of health care and requires that those who have an equal need for health services make equal use of those services. It is worth noting that satisfying this principle may require that potentially acceptable reasons for unequal use of health services by those in equal need - for example, differences in lifestyle, beliefs, or levels of risk aversion - be overridden.

3. Achieving equitable health outcomes requires not only the satisfaction of the first two principles but also the active participation of other areas of fiscal and social policy that impinge upon income, employment, education, housing, nutrition and other social macro determinants of health.

Although there are different methods for measuring inequities in health, the measurement of socioeconomic inequities, using income as the ranking variable for individuals and groups is the most widely used, perhaps because of the importance of poverty and income distribution as determinants of inequity in health. Comparing the health outcomes of the richest and the poorest quintiles provides strong evidence to support the statement that the health of mothers and children is strongly linked to equity (Wagstaff 2004; Bergman L, Kawachi I, 2000; Shen C., Williamson J., 1999; Daniels N., Kennedy B., Kawachi I., 2000).

Graph N. 1
Latin America and the Caribbean (Selected Countries):
Infant Mortality Rates, By Income Quintiles, 1999



SOURCE: D.R. Gwatkin and others, Socio-Economic Differences in Health, Nutrition and Population in Selected Countries, Washington, D.C., World Bank, quoted in Pan American Health Organization (PAHO), Health in the Americas, 2002 edition, Washington, D.C., 2002.

Rising inequalities in the access of mother, newborn, and child populations to health care explain the slow progress, the stagnation and, in some cases, the backward trend in maternal, neonatal, and infant mortality rates registered throughout the world, despite the existence of effective interventions to prevent or to treat the main causes of maternal and child deaths (WHO, 2005). In the LAC region, for example, despite advances in the reduction of infant mortality, the trends in neonatal mortality have shown practically no improvement over the past ten years in a number of countries. This stagnation has brought increasing attention to the plight of newborns and calls for greater efforts to reduce these unnecessary deaths (Interagency Strategic Consensus for Latin America and the Caribbean, 2007).

Approximately 11,624,300 children are born in LAC every year, of which 348,729 die before reaching their first year of age. About 174,364 deaths occur during the neonatal period, and 60% of neonatal deaths occur during the first week of life. The newborns mainly die from infections (32%), asphyxia at birth (29%), prematurity, and low birth-weight (24%). About 10% die from congenital anomalies. Infant mortality (deaths between 0-11 months) is a sensitive indicator of the general health conditions in a given country and is therefore often used as a measure of inequity (Royston and Armstrong 1989; WHO 1996; Shen and Williamson 1999).

Moreover, maternal death rates are also higher in the poorest countries than in the richest, and within countries they are significantly higher among the disadvantaged, the poor, the indigenous, and those who live in rural areas (PAHO/WHO 2004; WHO 2005). Maternal ill health is the largest contributor to the disease burden affecting women in developing countries (Castro and Camacho 2004). Furthermore, rates of maternal mortality show a greater disparity between rich and poor nations than any other public health indicator (Shen and Williamson, 1999). In Bolivia, for example, coverage of institutional births in 1998 was only 39 percent in the poorest quintile, compared with 95 percent in the richest quintile (IADB, 2004).

It has been estimated that more than half of global under-five deaths are attributable to five conditions, namely diarrhea, pneumonia, measles, HIV-AIDS, and malaria (Caulfield and Black 2002). Malnutrition is associated with 60% of these deaths. These conditions disproportionately affect the poor. The under–five mortality rate currently averages 6 per 1000 live births in the industrialized countries, but is as high as 274 in the developing world, and 119 in LAC (WHO, 2005). Moreover, the gap in under-five mortality rates between the rich and the poor within countries has widened in at least four LAC countries between 1986 and 2000 (WHO, 2005).

II. MNCH IS STRONGLY LINKED TO SOCIAL DETERMINANTS OF HEALTH

Since the seminal work of Marmot and Wilkinson in the eighties, the importance of social determinants of health - defined as all the non-genetic and non-biological influences on health - to the health status of population has come to be widely recognized, especially as a source of disparities between the disadvantaged and the better-off in society (Marmot and Wilkinson, 1999; Berkman and Kawachi, 2000). The concept of social determinants of health comprises individual risk factors - such as risky behaviors - and also the so-called "wider determinants" that in turn include social, cultural, and environmental factors, such as social position, education, gender, ethnicity, income, employment, housing, and social exclusion (WHO, 2003; Wanless, 2004; Graham, 2004).

The importance of social and economic conditions to maternal and child health has long been acknowledged. Infant mortality reduction over the last fifty years has been mostly related to improvements in socio-economic circumstances and in living conditions (Rashad H., 1994). During the 1970s, socioeconomic development and improved basic living conditions - namely access to clean water, sanitation, and nutrition - started to be seen as the keys to improving child health (WHO, 2005 p. 103).

There is also a sound body of information indicating that child health largely depends on the health status and education of the mother and on family income (Marmot M, Wilkinson R., 1999; Save the Children, 2005; Holmes J., 2002; Wamami et al, 2004). Regarding maternal health, Shen and Williamson (1999) found that women's status, as measured by indicators such as level of education relative to men, age at first marriage, and reproductive autonomy, is a strong predictor of maternal mortality.

Table 8: The social context of raised risk to health in early life

• Poverty
• Income inequality
• High rates of unemployment of both parents
• High degree of family discord
• Gender-biased and generally restricted opportunities for education, and low levels of literacy, especially for women
• Low levels of contraceptive use and/or breast feeding
• Isolation of women from the mainstream of social participation, and from legal and social security

SOURCE: "Social determinants of health" edited by Michael Marmot and William Wilkinson. Oxford University Press, 1999, Chapter 3, pages 44-57.

In 1998, UNICEF (United Nations Children's Fund) devised a conceptual model for understanding child morbidity and mortality. It states that, amongst other factors, the political, social, and economic systems that determine how resources are used and controlled need to be considered so as to determine the number and distribution of children who do not have enough access to food, child care, clean water and sanitation, and health services. This model is also applicable to maternal health and highlights how the distribution of power, political influence, and economic resources shape the pattern of health globally (Global Health Watch, 2005). The model identifies the quantity, quality and allocation of resources as basic causes of child malnutrition, death and disability at societal level and insufficient access to food, inadequate maternal and child care, poor water/sanitation and inadequate health services as underlying causes at household/family levels.

Graham (2004) also proposes a model of how key health determinants connect to each other. In his conception, health care and social services act as intermediary determinants of good health, due to their role in preventive care as well as their contribution to reducing the impact of

illness and injury and providing care and support to those with disabling conditions. On the other hand, when the costs associated with health care services push people into poverty or deepen already existing poverty, the health system itself becomes a cause of poverty and, therefore a determinant of ill health (WHO-EURO, 2003, p.13).

Health interventions may also offset or reduce the negative effects of other determinants of health. For example, Holmes argues that access to and quality of community health facilities tend to substitute for household wealth and mother's education in the production of child health and that public health infrastructure, such as piped water and sanitation, tends to complement mother's education in the production of child health (Holmes J., 2004). Along the same lines, Barros et al. propose that well designed health interventions can reduce the damaging effect of poverty on child health (Barros et al., 2005).

Thus, it can be argued that in order to achieve their goals, SPHS must be able to offset social determinants that worsen health status and/or hinder the demand for health care.

III. IMPROVING QUALITY AND COVERAGE OF TECHNICALLY APPROPRIATE INTERVENTIONS IS CRUCIAL TO ACHIEVING BETTER OUTCOMES IN MNCH

While maternal and child *health* is to a great extent determined by factors outside health sector, timely access to and the quality of health services play a crucial role in maternal, child, and neonatal *mortality* (Iunes R., 2001; PAHO/WHO, 2003; Interagency Strategic Consensus for Latin America and the Caribbean, 2003; WHO, 2005). Several studies show that the main determinant of maternal and neonatal mortality is the delay in accessing adequate care provided by trained personnel during childbirth and postpartum (Interagency Strategic Consensus for Latin America and the Caribbean, 2003; PAHO/WHO, 2004; WHO, 2005).

Social exclusion in health refers to the lack of *access* of certain groups or people to various goods, services, and opportunities that improve or maintain their health status and that other individuals and groups in the society enjoy (PAHO/WHO, 2003). It is a multi-causal phenomenon affected by causes within and outside the health system. *Access* - understood as the capacity of the individual who has the health need to come into contact with the mechanisms aimed to satisfy his/her health needs - is to a great extent determined by *coverage* - defined as the provider's ability to supply the adequate health goods and services to those who need them. Thus, in order for access to occur, two conditions are required:

a) The individual who has the health need should possess the means for coming into contact with the provider of the goods/ services aimed at satisfying that need (*demand side*).
b) The provider should be able to make available the service or good required (*supply side*).

There are several factors inside and outside the health system that affect the availability of health goods and services in the Region. Within health systems, these factors lie:

a) In the health systems' architecture, namely the degree of segmentation and fragmentation;[10]
b) In the way that interventions are organized and resources allocated;
c) In the geographical distribution of the service delivery network.

a) Health system's segmentation and fragmentation.

In segmented systems, the coverage and quality of health interventions are higher for population groups with higher income and social position (PAHO/WHO-SIDA, 2003; Behrman, Gaviria and Székely, 2003; Acuña C., 2005). Improvement in economic status does not alter this situation; data show that in highly segmented health systems, as countries move from a pattern of massive deprivation toward one of marginalization, the poor-rich gap in health servicies coverage and utilization grows in size, to diminish only when universal access is within reach. Unless specific measures are implemented to extend coverage and promote utilization across all population groups simultaneously, improvement of aggregate population coverage will go through a phase of increasing inequality (WHO, 2005 2:29-30).

Fragmentation hinders coverage and quality of health services because the existence of various agents operating without coordination makes it difficult to standardize the quality, content, cost, and application of interventions and prevents building effective referral mechanisms. Studies in Bolivia, Brazil, El Salvador, Honduras, and Nicaragua show that one of the main problems in implementing successful interventions to reduce maternal mortality is the difficulty of applying them at different territorial levels due to the fragmentation within the public subsystem (PAHO/ WHO-USAID, 2004).

10. The following definitions were adopted for segmentation and fragmentation: Segmentation is the coexistence of various health subsystems with distinct financing, affiliation, and provision arrangements "specialized" for different segments of the population according to their income level and social position. Fragmentation is the existence of many non-integrated entities and/or agents within the whole system or in a subsystem that operate without synergy and often competing among each other.

Segmentation and fragmentation largely influence the way interventions are organized, resources are allocated, and the service delivery network is geographically distributed.

b) Resource allocation and organization of health interventions.

Health systems in most LAC countries face serious problems of scarcity and poor distribution of resources. The greatest shortcomings lie in the allocation, distribution, and training of human resources and in the amount and distribution of public spending (ECLAC, 2005 V: 157-71). The latter also account for the lack of adequate drug supply and information systems.

There is ample evidence that the size and quality of the health workforce are positively associated with immunization coverage, outreach of primary care, and child, neonatal, and maternal survival (WHO, 2006). However, few countries in the Americas have succeeded in implementing appropriate human resources policies, and countries have demonstrated enormous diversity in the skill mix of health teams. Again, segmentation and fragmentation of health systems has led to persistent imbalances in human resources distribution and asymmetrical growth in personnel supply and demand across the public subsystem, social security organizations and the private sub sector. Inequality exists between regions inside the countries, as well, with the health workforce concentrated in rich urban areas (PAHO/WHO, 2003).

The public subsystem offer few incentives to trained professionals to work in poor or rural communities where the rates of maternal mortality are the highest. Moreover, the skills of personnel attending births vary greatly, and many do not have the expertise necessary to provide adequate treatment for obstetric emergencies (Interagency Strategic Consensus for Latin America and the Caribbean, 2003 2: 28-33). A sizable number of countries in the Region do not have the necessary workforce to provide minimum coverage.[11] In countries with a low density of health personnel, under-five mortality rate is around 43 per 1,000; maternal mortality ratio reaches 148 per 100,000 and deliveries attended by skilled personnel do not exceed 74% (PAHO/WHO, 2006).

Overall public spending in health is lower in LAC countries than in the developed world. Moreover, in LAC countries with highly segmented health systems, public spending in health is regressive, leading to higher out-of-pocket spending in the poorest households (PAHO/WHO, 2003; ECLAC, 2005 V:160-61; PAHO/WHO: Basic Indicators 2005). Only

11. 25 professionals per 10,000 population, according to WHO's Joint Learning Initiative.

Costa Rica, Chile, and Uruguay show a progressive pattern of public spending that benefits lower income groups (ECLAC 2005 V: 160-61). When public spending is low and regressive, it is difficult to assure sustainable financial support for maternal and child care to low-income populations.

c) The geographical distribution of the service delivery network and health infrastructure.

The concentration of infrastructure for health care delivery in the wealthiest urban areas in many LAC countries leads to lack of coverage in poor, rural, and isolated territories. For example, basic Essential Obstetric Care (EOC) facilities are often unavailable in these areas, thus leaving those living in them - often poor people and of indigenous origin- excluded from access to health care (Interagency Strategic Consensus for Latin America and the Caribbean, 2003 2: 28-33).

Thus, women are faced with few choices for perinatal care and childbirth. They can either deliver at home or travel to a distant hospital. For women living in rural areas, traveling is often expensive, both in terms of transportation costs and of time away from their families and work. The imbalance that results from the concentration of the service delivery network and medical care in the richest regions is a main cause of maternal and/or child mortality in Bolivia, Brazil, Ecuador, El Salvador, Honduras, Guatemala, and Mexico (PAHO/WHO, 2003; Flores W., 2005; Schwartzman S., 2006[12]; World Bank, 2006 7:142-48).

IV. CONTEXT MATTERS IN THE PERFORMANCE OF SPHS

As mentioned in section 3.2.a, SPHS are neither created nor function in a vacuum. The social, political, and economic context in which the schemes are designed and implemented, including factors such as institutional capacity, governance, and gender and ethnic issues, may have a strong influence on the overall performance of the scheme. Furthermore, it is important to bear in mind that to be sustainable, a given SPHS must take into account how society conceives of the State and its welfare function.

Governance can be defined as the exercise of political, economic and administrative authority in the management of a country's affairs at all levels (UNDP, 1997),[13] and as the art of steering societies and organizations, including the process whereby, within accepted traditions and

12. Simon Schwartzman. Presentation made at the Conference "The Struggle for Social Inclusion in Brazil. Policies to Combat Poverty and Inequality" at the Wilson Center, Brazil Program in Washington, DC February, 2006
13. Op. Cit. 3

institutional frameworks, interests are articulated by different sectors of society, decisions are made, and decision makers are held accountable (Plumptre and Graham, 2000). By either definition, governance is key to shaping SPHS in an organic way by establishing public agreement on what must be done, bringing stakeholders together for structured negotiations, providing the institutional framework for the SPHS to function, and promoting solidarity in society. Weak governance capacity prevents SPHS from fulfilling their potential and undermines their sustainability over time.

The organization and functioning of SPHS requires solid public institutions, at all levels, that can be held accountable for the decision making process and are responsive to the population's needs. This includes parliamentary oversight, a fair and transparent judiciary system, and strong and clear administrative rules to ensure that public resources are allocated and spent to achieve maximum impact on health outcomes and not lost through corruption or mismanagement (DFID, 2005). Lack of accountability, monitoring, and/or evaluation of social protection in health policies limits the possibilities of feedback and obstructs results-based management of resources, causing inefficient spending in programs that are not accomplishing their stated goals.

Table 9: Causes of exclusion in health

Dimension	Cause	Area	Category
Internal to health system	Segmentation, Fragmentation	Architecture of the system	a. Health system is divided into subsystems specialized for population groups according to income and social position b. Agents within the system operate without integration in a non-synergistic fashion
	Poor regulation/enforcement	Organization of the system	Inability to enforce compliance with rules and regulations
	Deficit of infrastructure	Health goods and/or services provision	Lack/ shortage of health facilities
	Inadequate resource allocation/distribution	Health goods and/or services provision	Lack/ shortage of human and/or technological resources, drugs, medical devices, equipment
	Low quality of care, leading to self exclusion	a. Technical quality b. Contact at the point of service	a. Errors in diagnosis and/or treatment that result in lack of access to needed care b. Disrespectful treatment of the public, discrimination, untidy facilities
External to health system	Barriers that prevent access to health care	Geographical	Geographical isolation
		Economic	Inability to purchase health care
		Cultural/ethnic	Health care is delivered in a language or in a modality that is not understood by the user or that is in conflict with his/her beliefs
		Gender	Health care is delivered without proper consideration of specific gender needs
		Employment status	Underemployment, informal employment, unemployment
		Public infrastructure other than health sector's	Lack/shortage of drinkable water, sewerage systems, roads, transportation
		Provision of goods and/or services that affect health status	Lack/ shortage of refuse collection

SOURCE: Adapted from "Exclusion on health in Latin America and the Caribbean" PAHO/WHO, 2003

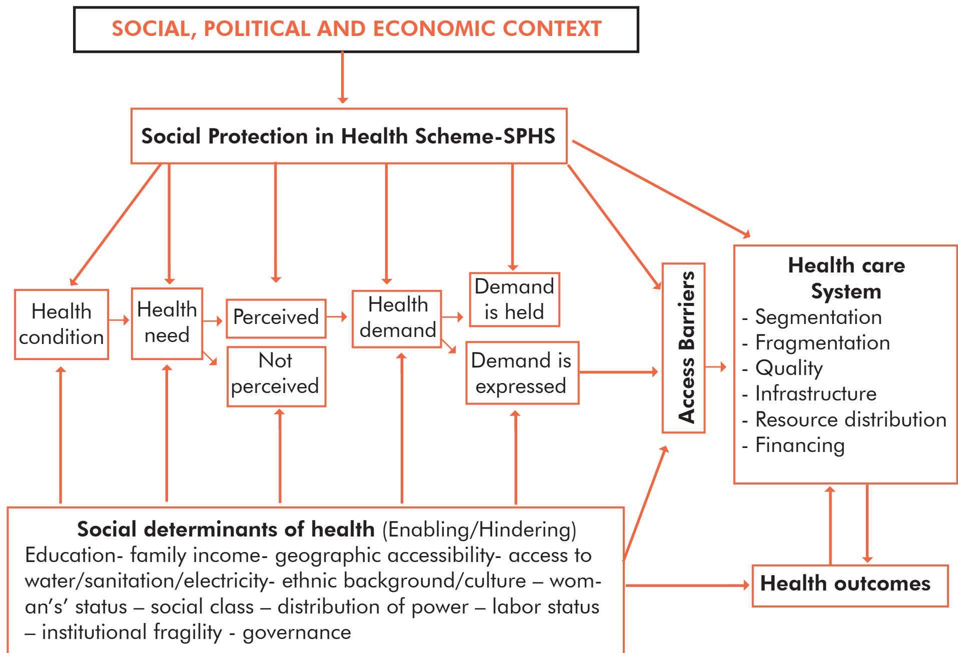
Gender and ethnicity are also important in the implementation of social protection policies. Women, as caretakers and head of households, are more likely to be affected by changes in social policies, since they can dramatically alter the balance between paid labor and domestic labor (Research on Poverty Alleviation-REPOA, 2006). In addition, in ethnically diverse countries such as those in Latin America, the SPHS not only has to devise mechanisms to tackle discrimination, but must also adapt the provisions of health care to various cultural preferences and beliefs.

Economic context - namely, the level of public spending, the ability to collect tax revenues, the degree of economic growth and macroeconomic stability, and most importantly the poverty level - certainly shapes social policies and especially social protection policy in the Region. The growing trend of collecting revenues through indirect cumulative taxes (sales taxes) with low distributive impact, and the failure to implement fiscal reforms, has left many countries of the Region with a weak capacity for redistribution and a highly regressive system of taxation (ECLAC, 2005).

3.2.2.2 HOW THESE PRINCIPLES INTERACT

To achieve the goal of guaranteeing "that all individuals and groups of individuals can meet their needs and demands in health trough adequate access to services… regardless of their ability to pay," the SPHS must be able to increase equity in the access to and utilization of health services, thwarting social determinants that may determinate status and/or deter the demand for health care for the disadvantaged groups in society. It must also have the ability to improve quality and coverage of technically appropriate interventions, confronting the factors that restrict the provision of health care for those who need it. To a great extent, the social and institutional context determines the ability of the SPHS to achieve those goals, posing constraints to their performance and defining how the SPHS are designed and evaluated.

The interaction of the key elements described can be diagrammed as follows:


SOCIAL, POLITICAL AND ECONOMIC CONTEXT
Social Protection in Health Scheme-SPHS
Health condition
Health need
Perceived
Not perceived
Health demand
Demand is held
Demand is expressed
Access Barriers
Health care System
- Segmentation
- Fragmentation
- Quality
- Infrastructure
- Resource distribution
- Financing
Social determinants of health (Enabling/Hindering)
Education- family income- geographic accessibility- access to water/sanitation/electricity- ethnic background/culture – woman's' status – social class – distribution of power – labor status – institutional fragility - governance
Health outcomes

4 ANALYTICAL FRAMEWORK

4.1 OBJECTIVE

The objective of the analysis is to identify and describe different SPHS currently in place in LAC countries as they relate to MNCH, and to develop a comparative analysis of their strengths and weaknesses, based on the conceptual framework developed on Chapter 3. The steps included in the analysis are:

1. Characterization of the SPHS
2. Characterization of the general setting in which the SPHS is implemented
3. Analysis of the strengths and weaknesses of the SPHS based on its compliance with the following parameters:

    a) Increase equity in the access to and/or utilization of health services;
    b) Offset social determinants that deteriorate health status and/or hinder the demand for health care; and
    c) Extend coverage of and increase access to technically appropriate health interventions by reducing or eliminating one or more causes of exclusion.

4.2 METHOD

A cross-sectional descriptive analysis based on a literature/internet review and secondary sources was conducted. Seven SPHS were selected for analysis based on availability of reliable information and the scheme's relative importance within the country, as measured by the resources allocated to it as well as its priority on the public agenda.

4.2.1. CHARACTERIZATION OF THE SPHS

Each of the seven SPHS under analysis was characterized according to the criteria listed in Table 6 and the typology developed in section 3.1 of this document.

4.2.2 CHARACTERIZATION OF THE GENERAL SETTING IN WHICH THE SPHS IS IMPLEMENTED

A matrix was created to analyze the conditions surrounding the SPHS. The matrix was based on Marmot and Wilkinson's Social Determinants of Health framework - which was explained in the previous chapter - and on the contextual/political factors most frequently associated with health conditions, namely institutional fragility/strength and governance as related to political stability/instability. The analysis is qualitative and therefore does not intend to provide a quantitative measure of how the selected social determinants affect health status and demand for health care. To build the matrix, the following criteria were used:

Table 10: Criteria to examine the effect of context on health status and demand for health care

Contextual factor	Situation	Health Status	Demand for health care
Poverty: people living under the poverty line % of total population	High >= 30%	deteriorates	hinders
	Low < 30%	improves	promotes
Education level: literacy rate %	High >= 70%	improves	promotes
	Low < 70%	deteriorates	hinders
N° of rural dwelling/remote settlements	Numerous >= 30% total population living in rural/remote dwelling	deteriorates	hinders
	Few < 30% total population living in rural/remote dwelling	improves	promotes
Access to tap water, sanitation, and electricity	Full >= 70% total population covered	improves	hinders
	Scarce < 70% total population covered	deteriorates	hinders
Government institutions	strong	improves	promotes
	fragile	deteriorates	hinders
Country's governance	Politically stable	improves	promotes
	Politically instable	deteriorates	hinders
Unemployment	High >=25% of total working population	deteriorates	hinders
	Low < 25% of total working population	improves	promotes
Labor informality	High > 50% of total jobs	deteriorates	hinders
	Low < 50% of total jobs	improves	promotes

Therefore, the country's general situation matrix - as shown in table 11 - must be interpreted based on the criteria selected on table 10.

Table 11: Country's general setting (context)

Contextual factor	Health status		Demand for health care	
	deteriorates	**improves**	**hinders**	**promotes**
Poverty level				
Education level				
No. in rural dwelling/remote settle-ments				
Access to tap water/sanitation/elec-tricity				
Government's institutions				
Country's governance				
Unemployment rate				
Labor informality rate				

4.2.3 ANALYSIS OF THE STRENGTHS AND WEAKNESSES OF THE SPHS

Each SPHS was analyzed according to their ability to comply with the parameters proposed in the conceptual framework and shown in Table 12.

Table 12: Strengths and weaknesses of the SPHS

Parameter	Performance	
	yes	**no**
Increases equity in the access to and/or utilization of health services		
Offsets social determinants that deteriorate health status and/or hinder the demand for health care		
Extends coverage of and/or increases access to technically appropriate interventions by reducing or eliminating one or more causes of exclusion		

The three parameters were broken down into smaller categories in order to facilitate the analysis, as shown in tables 13, 14 and 15.

4.2.3.1 EQUITY

Table 13: Performance of the SPHS: Equity

Category	Performance	
	yes	**no**
Increases equity in the access to health services		
Increases equity in the utilization of health services		

4.2.3.2 SOCIAL DETERMINANTS

The same criteria used to examine the effect of context on health status and demand for health care (Table 8) were used to analyze whether the SPHS was able to offset social determinants. The social determinants selected were those widely recognized as having effects on health, as discussed on the conceptual framework, section 3.2.2.1.

Table 14: Performance of the SPHS: social determinants

Category	Performance	
	yes	**no**
Offsets poverty by eliminating or reducing economic barrier		
Fosters women's social status		
Fosters health rights through Right Charts, explicit guarantees, etc.		
Offsets unemployment/informal labor by eliminating or reducing economic barrier		
Offsets women's lack of education by fostering demand for health care		

4.2.3.3 COVERAGE AND ACCESS

To analyze whether the SPHS expands coverage of and increases access to technically appropriate health interventions, a matrix was built based on the categories established in the conceptual framework, section 3.2.2.1. The matrix was divided into two components: coverage and access. Each component was measured by specific parameters: the number of people covered by the scheme as a % of eligible population (coverage) and the number of people with access to health goods or services provided by the scheme (access). Additionally, each component was broken down into their corresponding subcomponents to help explain the reason for the recorded increase, if any.

Table 15: SPHS Performance: Increase coverage of and access to technically appropriate health interventions by eliminating one or more causes of exclusion in health

Category	SPHS	
	yes	**no**
Increases coverage (rise in number of people covered as a % of eligible population)		
Establishes a single guaranteed portfolio of entitlements with the same quality, content, and delivery conditions for all socioeconomic groups as to avoid segmentation		
Increases coordination/integration within the system so as to avoid fragmentation		
Improves resource allocation and organization of health interventions by increasing number and capabilities of human resources in previously underserved areas		
Improves resource allocation and organization of health interventions by increasing the amount of public spending allocated to the scheme		
Public spending allocated to the scheme is progressive		
Improves geographical distribution of the service delivery network and health infrastructure by increasing number/amount of health facilities, equipment, medical devices, and drugs in previously underserved areas		
Increases information system's coverage		
Increases access by eliminating or reducing barriers to access (rise in number of people with access to health goods or services provided by the scheme)		
Eliminates/reduces geographic barrier		
Eliminates/reduces economic barrier		
Eliminates/reduces gender barrier		
Eliminates/reduces employment status barrier		
Improves access to drinkable water, sewerage, roads, and/or transportation		
Improves refuse collection		

4.3 CONDUCTING THE ANALYSIS

A questionnaire was developed in order to conduct the analysis. For each intervention, the following queries were made:

Table 16: Questionnaire

1.	What type of social protection scheme or intervention has been implemented?
2.	Is it universal or targeted?
3.	What type of targeting is used? (geographic-age-income-health condition)
4.	What is its scope? (national/sub-national/local)?
5.	How long has it been in place?
6.	Does it build on previous programs/interventions?
7.	Does it have explicit guarantees and/or benefits plan?
8.	Who is entitled to the right of coverage?
9.	Who are the beneficiaries among the country's total MNCH population?
10.	What goods and services does it cover?
11.	Who is excluded?
12.	How does it relate to the health system?
13.	Who manages it (the public sector-private for profit-NGO-donor-international cooperation agency)?
14.	Is it subject to regulation? Who regulates it?
15.	Has public spending increased to finance the SPHS?
16.	Has out-of pocket spending decreased within the eligible population since the SPHS started?
17.	How is it financed (budgetary/extra budgetary source; taxes; affiliates contributions; donors, other)?
18.	Are there any legal mechanisms that frame the operation of the social protection scheme?
19.	Were there any changes in health outcomes after the implementation of the SPHS?
20.	Were there any changes in health processes after the implementation of the SPHS?
21.	Have there been any changes in access to health services after the implementation of the SPHS?
22.	Has the social protection scheme brought more equity into the system?
23.	Has the situation of exclusion in health improved with the implementation of the scheme?

Health results indicators were used to guide the analysis and, in some cases, as a measure of equity according to the conceptual framework in 3.2.b.1 I. Not all of the indicators listed below were used to analyze every SPHS. Specific indicators were selected based on the availability of data and on their relevance to the analysis of each SPHS.

Table 17: Set of indicators

Category	Indicator
Health Results	-Maternal mortality ratio -Infant Mortality Rate (IMR)
Health Processes	-% of coverage institutional delivery -% of women with 4 antenatal controls -Number of antenatal controls -% of women with one antenatal control before the 4th month of pregnancy -% of women tested for syphilis during antenatal control, following specific standards -% of women of indigenous origins or afro descendants using modern contraceptive methods -Number of cases of neonatal tetanus diagnosed in newborns with less than 28 days -% of children 12-23 months with complete immunization coverage (DPT, measles, polio, BCG)
Exclusion	-% of women with access to institutional delivery -% of women with complete antenatal control -% of children with complete immunization coverage -% coverage for Acute Respiratory Infections (ARI) for children under 5 years old
Equity	-% of women with access to institutional delivery by quintiles of income/ethnic origin/geographic location (urban-rural), type of provider -Waiting time for women by quintiles income/ethnic origin/place of residence -Waiting time for children under 5 years by quintile income/ethnic origin/gender/place -Utilization of M-I services by income quintiles -Gap between measles and BCG immunizations by quintiles of gender and income

4.4 INFORMATION SOURCES

a. Secondary sources: data from DHS (Demographic and Health Survey) , CDC (Center for Disease Control and Prevention), Ministries of Health, National Statistics Systems, National Health Accounts, PAHO/WHO, and household surveys were used.

b. Literature review: articles in peer reviewed journals as well as publications and reports from universities, international cooperation agencies, development banks, and academic institutions in English, Portuguese and Spanish, were used.

c. Internet search: documents from the institutions listed below:

- Economic Commission for Latin America and the Caribbean (ECLAC)
- Global Watch
- ILO
- Inter-American Development Bank (IDB)
- Partners for Health Reform Plus (PHR*plus*)
- Panamerican Health Organization- PAHO
- The World Bank
- The Millennium Development Project
- United Nations Children's Fund (UNICEF)
- United Nations Population Fund (UNPFA)
- United States Agency for International Development (USAID)
- World Health Organization - WHO

4.5 LIMITATIONS OF THE ANALYSIS

The variability of the data, as well as the multiplicity of SPHS in place, the different stages of maturity of each scheme, and the wide range of social determinants involved in each case made it very difficult to draw conclusions on the direct effects of the SPHS on the health of MNCH population. The method for analyzing SPHS used in this study yields information that allows for a general overview on how different SPHS have performed, given their features and the general setting in which they were implemented. However, neither association nor direct effect can be established between the performance of the SPHS and MNCH outcomes.

5 CASE STUDIES

5.1 Mother & Child Universal Insurance (SUMI) - BOLIVIA-

1). CHARACTERIZATION OF THE SPHS

Bolivia's health system, established in 1979, consists of a public health sector, a social security system, and the private sector. In 1996, the Ministry of Health and Social Welfare launched the "To Live Better" Health Plan, designed to strengthen the Bolivian health system and ensure universal access to individual, family, and community primary health care. Three successive SPHS aimed at the mother and child population have been implemented under the aegis of the Health Plan. They are the National Maternal and Childhood Insurance (SNMN), the Basic Health Insurance (SBS), and the Mother and Child Universal Insurance (SUMI). Despite their names, they are not insurance schemes, but rather slightly differing forms of free maternal and child care.

The SNMN was created in 1996 with the goal of reducing the number of maternal deaths by 50% and halving the deaths of children under five from pneumonia or diarrhea. The program's creation was based on the belief that reducing economic barriers to health would improve access and increase utilization of health services. To this end, it focused on providing services, free of charge, to children under five, as well as to pregnant women. The SNMN was financed with municipal funds and resources from the National Treasury (Tesoro General de la Nación- TGN) and from international cooperation. It originally covered 26 services,

later expanded to 32 services, to be provided in public health facilities, as well as those of the Social Security, and in the facilities of churches and NGOs that had signed agreements with local municipalities. The package included prenatal care; labor and delivery; postpartum care; Caesarian-section; pre-eclampsia; eclampsia, and other obstetrical emergencies; newborn care; neonatal asphyxia; pneumonia; sepsis, and diarrhea, among others (UDAPE/UNICEF, 2006).

In 1998, the SNMN was replaced by the SBS, which increased the number of health interventions provided to 92, covering complications of the newborn, sexually transmitted diseases, post-abortion care, and some services directed at the general population and financed by national programs (malaria, tuberculosis and cholera). Besides health interventions, the SBS included selected laboratory tests, transfer of patients referred as a result of obstetric emergencies, and health personnel visits to rural communities without health facilities. The SBS not only expanded the package of services; it also extended participation to all women of reproductive age, as well as including Social Security and non-profit providers in its provision.

Although the SUMI, created in 2003, retained the goal of reducing maternal and child mortality by increasing health services utilization through the elimination of economic barriers, it also introduced substantial changes in the system. It included higher complexity care for mothers and children in the provided benefits, thus distinguishing itself from previous programs which primarily focused on basic care. In order to provide such high-level care, the program extended its benefits package to all institutionalized health services and made it available to women, through pregnancy and up to six months after childbirth, and to children under 5 years old. This group received care in all three sub-systems: the public system, Social Security, and certain private establishments assigned as providers, all of them organized into municipal health networks. But the SUMI also restricted coverage, removing the general population and reproductive age women.[14]

14. The government has recently sought to extend coverage under the free insurance, first to all Bolivians over 60 (Seguro de Vejez) secondly to Bolivians under 21, and finally to all citizens (Seguro Universal de Salud). But legislative ratification of the universal insurance, and the implementation of the old-age insurance, has been blocked by disagreements between central and municipal governments over funding for the programs.

Table 18: The evolution of the mother and child universal insurance in Bolivia

	SNMN	SBS	SUMI
Target population	Pregnant women and children under 5 years	Pregnant women, children under 5 years and general population for specific interventions	Pregnant women until 6 months after childbirth and children under 5 years
Package (risks covered)	32 interventions corresponding to the first and second levels of care	92 interventions corresponding to the first and second levels of care	Comprehensive, with few exceptions. Includes complex care and dental care
Financing	2.7% of central tax transfers to municipalities (3.2% of 85% of "co-participation" funds)	5.4% of central tax transfers to municipalities (6.4% of 85% of "co-participation" funds)	10% of central tax transfers plus 10% of the National Dialogue Account[1] for the National Redistribution Fund (Fondo Solidario Nacional, or FSN)
Distribution of funds	Per capita distribution to municipalities	Per capita distribution to municipalities	Per capita distribution of central tax transfers plus demand-based access to FSN to cover deficits
Payment Mechanism	Fee-for-service reimbursement; Fees set centrally	Fee-for-service reimbursement; Fees set centrally	Fee-for-service reimbursement; Fees set centrally
Management	Municipality reimburses health facilities	Municipality pays health district, which consolidates information from facilities	Municipality pays Management of health network after approval by Local Health Directories
Reimbursement fees	Based on variable costs (drugs and other inputs) + incentives for deliveries and other priority services	Based on variable costs (drugs and other inputs) + incentives for deliveries and other priority services	Based on variable costs and estimated frequency of cases; differentiated by level of complexity of facilities
Use of excess funds	Forbidden; specific one-time exceptions were granted	Forbidden; specific one-time exceptions were granted	Regular use granted for health investments

1. The National Dialogue Account was established in Bolivia as a frame of the HIPC iniciative aimed at alleviating the burden of the external debt.

SOURCE: The World Bank, 2003

The SUMI also seeks:

i) to strengthen the processes of decentralization and the participation of civic organizations in health management through the implementation of Local Health Directories (DILOS) and social networks
ii) to strengthen municipal participation in the financing of drugs, supplies, and laboratory tests as well as the Municipal government's responsibility for paying participating health providers for drugs, supplies, and hospitalizations,

iii) to provide incentives to providers through a mechanism based on fee-for-service payments.

The SUMI not only doubled the resources earmarked at the municipal level (to 10% of the central tax transfers distributed to the municipalities on a per capita basis), but also created a National Redistribution Fund, financed with 10% of the Special National Dialogue Account. These additional funds are not distributed to municipalities on a per capita basis but are available for municipalities whose own resources are insufficient to cover needs. Therefore, the financial resources for the program derive from three sources:

- National Treasury (TGN): finances the human resources of the public health subsystem, while Social Security or other facilities enlisted in the SPHS cover human resources with their own funds.
- Taxes: a percentage of co-participation funds (7% in 2003, 8% in 2004, and 10% in 2005) from each municipality is used for benefit payments.
- National Redistribution Fund

The estimated beneficiary population by 2004 was 1,600,000 - around 74% of the target population. 1,279,000 children under 5 years of age and 328,000 women (either pregnant or within 6 months of pregnancy) were covered.

Table 19:. SUMI's main features

Feature	Category
Type	Free maternal and child health care
Mode of financing	Publicly funded
Source of funds	General taxes Other revenues: extra budgetary source (HIPC II)
Risk pooling arrangement	Income-based
Management and management level	National/Sub-national/Local MoH Local government
Degree of selectivity	Targeted: Pregnant women until 6 month after childbirth and children under five years old
Who is entitled to coverage	Individual
Condition for access	Specific attribute: age/proof of childbirth/proof of pregnancy
Extent of risk pooling	Small pool
Explicit portfolio?	Not explicit
Degree of coverage	Complementary
Provision	Mainly public

2). CHARACTERIZATION OF THE GENERAL SETTING IN WHICH THE SPHS IS IMPLEMENTED

Basic Information - Bolivia is a low income country located in the Andean Region of South America. It has a population of approximately 9.1 million, with 37% living in rural areas, (as of 2002). More than 80% of the population is under 50 years of age, 13% is under five years old and 48% is of childbearing age (15-49 years old) (UDAPE-PAHO/WHO, 2004). Bolivia is a republic, with an elected president and bicameral legislature. Evo Morales, the current president and Bolivia's first chief of state from an indigenous background, took office in January 2006. He has made social protection in health a priority, pushing to expand the SUMI into a Universal Health insurance.

Ethnicity - Bolivia is a multiethnic country, with 36 different indigenous groups making up 52.3% of the total population. The main indigenous groups are the Aymara (30%) and the Quechua (30%), and many members of these groups do not speak Spanish fluently. The indigenous population suffers from political and social exclusion, and the poverty rate among the indigenous population (78%) is much higher than among those of European descent (less than 50%) (UDAPE-PAHO/WHO, 2004). According to 2002 figures, 91.25% of the indigenous population is covered neither by Social Security nor by a private health insurance (UDAPE-PAHO/WHO, 2004). Deep conflicts over the distribution of power, land, and wealth between the descendants of Europeans and the indigenous population prevail in Bolivian society, posing a threat to the country's governance and hampering social cohesion (UDAPE-PAHO/WHO, 2004; Pavez Wellmann, 2005).

Economic Situation - The majority of the population (64.6%) lives in poverty, making Bolivia one of the poorest countries in Latin America. This situation is especially severe in rural areas and among indigenous groups. Poverty is accompanied by high levels of income disparity, with the average income of the richest percentile 15 times higher than that of the poorest 10% of the population. Unemployment and informality are high, with 50% of the population unemployed and 64.1% of workers belonging to the informal sector. Women usually suffer worse working conditions and have lower salaries and lower educational levels than men. In 1999, 16.4% of the population was illiterate (UDAPE-PAHO/WHO, 2004), and in 1997 the National Survey of Employment showed that illiteracy rates were nearly three times as high among women over 15 as among men of the same age (PAHO/WHO, 2002).

Health - Life expectancy at birth in 2003 was 65 years old; the total fertility rate remains high compared to other countries in the region, but decreased from 4.8 in 1993 to 3.8 in 2003. The incidence of exclusion

from health care among the general population is 77%, with poverty and women's illiteracy its main causes (PAHO/WHO-UDAPE, 2004). According to the World Bank, the barriers to access that result from cultural diversity remain some of "the greatest challenges to improved health among the poor in Bolivia" (World Bank, 2004).

Bolivia's health services network consists of 40 general hospitals, 30 specialized hospitals, 149 basic hospitals, 986 health centers, and 1,408 health posts. Of these facilities, 1,995 belong to the public sector, 197 to Social Security, 254 to NGOs, 101 to the Church, and 66 to the private sector. Households remain an important source of financing for the health sector, contributing to 30% of total health expenditure. Between 1999 and 2001, health care costs consumed more than 10% of monthly expenditure in about 10% of households, and more than 50% of monthly expenditure in 1.2% of households. Seventy-five percent of household health expenditures are on the purchase of pharmaceuticals in drugstores, representing 20% of national health expenditures (MECOVI survey, 2000).

Table 20: Bolivia's general situation

Contextual factor	**Health status**		**Demand for health care**	
	Deteriorates	**Improves**	**Hinders**	**Promotes**
Poverty Rate	X		X	
Education level	X		X	
No. of Rural dwelling/remote settlements	X		X	
Access to water/sanitation/electricity	X			
Government's institutional strength/fragility			X	
Country's governance			X	
Unemployment Rate	X		X	
Labor informality	X		X	

3). ANALYSIS OF THE PERFORMANCE OF THE SPHS

NOTE: The core goals of the three SPHS, as well as their strategies for implementation, were very similar. Therefore, because they succeeded each other without interruption, and also because little data for the post-2003 period exists, the analysis will deal with the combined impact of all three, using the blanket term SUMI for the sake of convenience.

a). Has it increased equity in the access to/utilization of health services?

Utilization of the formal maternal and child health care services covered by the program increased with the implementation of the SUMI. Between 1994 and 2003, the percentage of mothers who utilized health sevicies through the mother and child insurance grew from 3.6% to 53.4%, with by far the highest rate of growth taking place in the lowest income quintile (UDAPE/UNICEF, 2006). Moreover, between 1994 and 2003 this quintile, which contains the largest number of those excluded from health, showed the greatest increase in the utilization of skilled birth assistance, from 5.3% to 21.1% (UDAPE/UNICEF, 2006). The drop in mortality rates during the period (discussed below in section 'e') may be related to this increase in coverage.

However, two concerns remain: (i) in recent years, the rate of increase in coverage has been tapering off; and (ii) the equity gap between the urban and rural, the indigenous and non-indigenous, and the rich and the poor remains high. According to data from the Ministry of Health, in the year 2003 the coverage of institutional deliveries was 55% in the richest Municipal districts, as compared with 41% in the poorest ones. The MECOVI survey found that in 2001 20% of the poorest quintile had access to skilled birth attendance, compared to 89% of the richest quintile. Other studies found that, controlling for income and other characteristics, the probability of having institutional attendance at childbirth is 29% higher if the family lives in an urban area rather than in a rural area, and 17% lower if the head of household is indigenous (World Bank, 2003).

b). Has it offset social determinants that damage health and/or hinder the demand for health care?

Several social determinants act as hindering factors in Bolivia. The most important are poverty, discrimination related to ethnic background, and women's low status in society. The SUMI has helped offset high rates of poverty and unemployment/informal labor, increasing the demand for heath care among people in the lowest income quintiles by eliminating the economic barrier. It seems to have not yet reached rural areas and isolated communities, nor has it significantly encouraged women to demand health services. UDAPE found that the most frequent users of public health services were urban mothers with a relatively high income and educational level. But use of public services among mothers with no education increased nearly 300% between 1994 and 2003, while rising only 2% among mothers with a post-secondary education (UDAPE/UNICEF, 2006). To date the SUMI has not issued mechanisms to enforce the right to health. Moreover, discrimination by indigenous origin continues to be

an issue in the provision of health care (PAHO/WHO-UDAPE, 2004). The failure of the SUMI to adequately cover the indigenous majority will likely place severe limitations on its overall effectiveness.

Table 21: SUMI's performance: social determinants

Category	Performance	
	yes	**no**
Offsets poverty by eliminating or reducing economic barrier	X	
Fosters women's social status		X
Fosters health rights through Right Charts, explicit guarantees, etc.		X
Offsets unemployment/informal labor by eliminating or reducing economic barrier	X	
Offsets women's lack of education, fostering the demand for health care	X	

c). Has it increased access to and coverage of technically appropriate health interventions by eliminating one or more sources of exclusion from health care?

Results to date suggest that the SUMI has been successful in removing the economic barrier to access health services, as evidenced by the observed increase in coverage of priority services for people in the lower income quintiles. However it has not so far addressed other barriers to access that are important causes of exclusion in health in the country, such as cultural or geographic barriers.

According to the ENDSA (Encuesta Nacional de Demografía y Salud) survey, the nation-wide use of skilled birth assistance (doctor, nurse) has increased remarkably, from 27% in 1995 to 55.3% in 2003.[15] The highest rate of increase was observed between 1998 and 2000, the period during which the SBS was first implemented. Utilization of services also rose in the treatment of pneumonia in children under five. According to USAID's Partners for Health Reform*plus* (PHR*plus*), at least part of this increase can be attributed to SUMI because it exceeds the rate of increase in the utilization of non-covered services and services delivered by non-participating providers. In the case of the 4th prenatal control, the national average increased from 26% coverage in 1996 to 40% in 2004 (UDAPE/UNICEF, 2006).

15. Other sources such as the demographic and health surveys estimate that the use of skilled birth assistance (doctor, nurse) increased from 43.2 % in 1994 to 59.3% in 1998. UDAPE gives the figures of 29% in 1989 and 53.4% in 2003, with the greatest increase occurring between 1998 and 2003 (UDAPE/UNICEF, 2006).

Available data suggest that public health spending allocated to the SUMI is progressive because it has mainly benefited those in the lowest income quintiles. It is noteworthy that the financial resources allocated to the scheme have steadily increased over the years (for example, central tax transfers to municipalities to deliver the scheme went from 2.7% in 1996 to 10% in 2003), although total public expenditure on health decreased by 3.1% from 1998-2002. The country's increase in total expenditure on health, from 5% of GDP (Gross Demographic Product) in 2001 to 7% in 2002, was due to an increase in out-of-pocket expenditure, which grew by 7.1% during that time period.

The SUMI has had little impact on the supply of health services, which are unequally distributed in the country. Misallocation of services produces important access problems, due to long distances between health facilities and households and low installed capacity in rural areas. Although analysis of the SBS' outcomes (SBS, 1998-2002) shows that it improved health financing, reinforced national health priorities, promoted demand for primary health services, and empowered users, low coverage is still a problem in the public sub-sector, with 30% of the population not covered (PAHO/WHO, 2001(c)). Many problems currently persist in access to care due to the low quality of care, especially the technical aspects of the treatment of obstetric emergencies and the lack of cultural adequacy in the provision of health services. The increased demand for care may have put even more stress on already strained human and technological resources.

The SUMI, by establishing explicit relationships and coordination mechanisms between different territorial and managerial levels within the public subsystem, has helped to overcome fragmentation in the area of maternal and child interventions. It has not helped to reduce segmentation, since its goal is not the equalization of quality, content, and delivery conditions of the health services offered to different socioeconomic groups.

Table 22: SUMI's performance: Coverage and access

Category	SPHS	
	yes	no
Increases coverage (rise in number of people covered as a % of eligible population)	X	
Establishes a single guaranteed portfolio of entitlements with the same quality, content, and delivery conditions for all socioeconomic groups so as to avoid segmentation		X
Increases coordination/integration within the system so as to avoid fragmentation	X	
Improves resource allocation and organization of health interventions by increasing the number and capabilities of human resources in previously underserved areas		X
Improves resource allocation and organization of health interventions by increasing the amount of public spending allocated to the scheme	X	
Public spending allocated to the scheme is progressive	X	
Improves geographical distribution of the service delivery network and health infrastructure by increasing the number/amount of health facilities, equipment, medical devices, and drugs in previously underserved areas		X
Increases information system's coverage	X	
Increases access (rise in number of people who access goods/services provided)	X	
Eliminates/reduces geographic barrier		X
Eliminates/reduces economic barrier	X	
Eliminates/reduces gender barrier		X
Eliminates/reduces employment status barrier	X	
Improves access to drinkable water, sewerage, roads, and/or transportation		X
Improves refuse collection		X

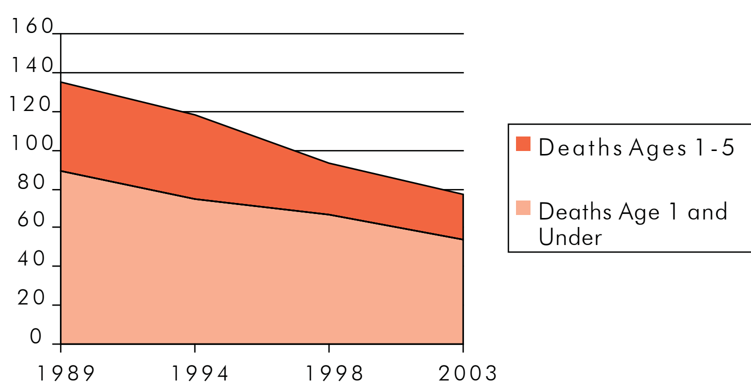
d). Have health outcomes improved?

Maternal Mortality Ratio, Infant Mortality Rate, and Neonatal Mortality Rate decreased over the period from 1998 to 2003. Infant mortality dropped from 75 to 54 per thousand, child mortality decreased from 43 to 23 per thousand, and maternal mortality fell from 390 to 229 per 100,000 births (UDAPE/UNICEF, 2006). But these gains were not always equally distributed. While the impact of the scheme on the risk of infant mortality in urban areas was significant, it was nearly nil in rural areas, with the reverse being true for the risk of under five mortality (UDAPE/UNICEF, 2006). These mixed results - significant impact on the risk of infant death in urban areas and under five death in rural areas - make it difficult to draw a causal connection between the implementation of the schemes and reduced infant mortality. But it can be argued that the

overall downward trend in maternal and neonatal mortality is linked to the increased frequency of institutional delivery among the lowest income quintiles - which characteristically exhibit the highest neonatal and maternal mortality. This rise in the coverage of institutional births is due to the lowering of economic barriers achieved by the three consecutive SPHS. In spite of the important achievements in the reduction of maternal and infant mortality rates in recent years, however, those rates are still high compared to those of other countries in the Region.

Graph N. 2

Under-5 Mortality in Bolivia, 1989-2003



Source: UDAPE/UNICEF, 2006

Table 23: SUMI's performance

Goal	Performance
Increases equity in the access to and/or utilization of health services	It has increased equity in the access to health services. Important gaps remain
Offsets social determinants that hinder the demand for health care and/or deteriorate health status	It has helped to offset poverty
Increases access to and coverage of technically appropriate health services by reducing or eliminating one or more causes of exclusion	It has increased access of previously excluded groups by reducing the economic barrier. It has increased coverage of technically appropiate health services

5.2 The Family Health Program (Programa Saúde da Família, PSF) -BRAZIL-

1). CHARACTERIZATION OF THE SPHS

The Family Health Program (PSF) is a set of community-oriented programs providing a broad array of primary health services. As an instrument for implementing interventions developed by the Ministry of Health, the PSF is considered the main government effort to improve primary health care in Brazil. Several smaller health care programs are implemented within the broad framework of the PSF. These include the Child Health Program (Saúde da Criança); the Women's Health Program (Saúde da Mulher); the National Pact for the Reduction of Maternal and Infant Mortality (Pacto Nacional pela Redução da Mortalidade Materna e Neonatal), with the goal of reducing 2004 maternal and infant mortality rates by 75% by the year 2015; and the Antenatal and Birth Humanization Program (Programa de Humanização do Pré-natal e Nascimento), which aims to improve access to, and coverage and quality of antenatal, delivery, and postpartum care, and care for newborns.

The PSF was created in 1994 with the goal of providing preventive health care to a larger segment of the population by i) reaching the municipalities not covered by Primary Heath Care facilities; ii) transforming the health care model from a passive to a more active strategy that involves the community; and iii) providing high quality primary health care, especially to the poor. By 1998, the PSF had become the center of a model of care based on the principles of decentralization, equity, and shared responsibility, one that prioritizes population groups with the highest risks of morbidity and mortality (Ministry of Health, Brazil, 2006).

Health care is delivered by a team composed of at least one family doctor, one nurse, and five or six community agents, who live in the community and are trained to carry out health promotion activities. Each team is assigned to a specific territorial unit and is responsible for enrolling and monitoring the health status of approximately 1,000 families living in the area, providing primary care and making referrals to other levels of care as required. The make-up of the PSF team was designed to foster a sense of mutual responsibility towards health by encouraging close ties with the population it serves. Physicians and nurses typically deliver services at health facilities placed within the community, while community agents provide health promotion and education services during household visits.

The services included in the PSF contain an assortment of required interventions, as well as guidelines for how they should be implemented. The PSF teams assign priority to specific actions according to the profile of each municipality. In 2005, the Ministry of Health released the "Agenda for Integral Child Health and Infant Mortality Rate Reduction" (Agenda de Compromissos para a Saúde Integral da Criança e Redução da Mortalidade Infantil), which establishes guidelines for the application of maternal and child health interventions in the context of the PSF. According to the Agenda, the minimum set of interventions that must be available to mothers and newborns includes:

- Prenatal care
- Institutional delivery (and home delivery in selected municipalities in the North, Northeast and Mid-West regions)
- Postpartum care
- Care for maternal emergencies, with access to beds in Intensive Care Units (ICU)
- Immediate care for newborns in the delivery room, with access to hospitalization and Intensive Care Units

The PSF is the basis for the "Agreed Integrated Programming" system, which organizes referrals, helping to avoid fragmentation within the system (Ministry of Health, Brazil, 2006). It is also the center of a unified health information system: both the Basic Health Care Information System (SIAB) and the National Health Card have been implemented through the PSF (Ministry of Health, Brazil, 2006).

Financing for the PSF comes primarily from transfers from the federal government on a per capita basis. The Ministry of Health offers incentives to municipalities that attain coverage of more than 70% of the population, paying around US$20,000 per team per year compared to US$10,000 for those municipalities with coverage below 5%. Considerable investments have been made in the PSF to date.

Table 24: PSF's main features

Feature	Category
Type	Free primary health care provision scheme
Mode of financing	Publicly funded
Source of funds	General taxes
Risk pooling arrangement	Community-rated
Management and management level	National/Sub-national/Local MoH Local governments
Degree of selectivity	Universal
Who is entitled to coverage	Family
Condition for access	Place of residence
Extent of risk pooling	Large pool
Explicit portfolio?	Not explicit
Degree of coverage	Comprehensive
Provision	Public

2). CHARACTERIZATION OF THE GENERAL SETTING IN WHICH THE SPHS IS IMPLEMENTED

Basic Information - Brazil is an upper-middle income country located in Eastern South America, bordering the Atlantic Ocean. It is the largest country in South America and shares common boundaries with every South American country except Chile and Ecuador. Brazil conducted a census in August 2000, which reported a population of 169,799,170, although it is now estimated at 189 million (Instituto Brasileiro de Geografía e Estatística (IBGE), 2004; 2007).

Economy – Brazil has the worst income inequality in the region of the Americas and one of the greatest levels of inequality in the world. A recent World Bank study shows that the richest quintile's share of the country's total income was 67.5%, while the poorest quintile's share was only 2.1% (World Bank 2000). According to IBGE, 57.7 million Brazilians (35%) were living under the poverty line in 2003, 22 million of whom qualified as extremely poor.[16] The national GDP per capita (about US$9,000 PPP, according to the IMF) conceals drastic regional inequalities. The highest poverty rates are found in the North and Northeast regions, where 13.8 million people are extremely poor. Extreme poverty is highest in small Municipalities under 50,000 inhabitants, where public services are very scarce (United Nations Fund for Population Activities- UNFPA, 2005).

16. Poverty is defined as the percentage of the population that has a per capita income of less than half of the monthly minimum wage.

There was considerable progress in women's development in the last decade: female illiteracy declined by a third, although the illiteracy rate is still high. The adult literacy rate (% ages 15 and above) was 88.4 as of 2003 (UNDP-HDR 2005).

Unemployment reached 11.5% in 2004. According to a survey conducted by IBGE in 2004, there were 2.1 million people unemployed in the six major metropolitan areas of Brazil. The informal sector has been growing significantly, accounting for almost 25% of the total working population of the country.[17]

Health - According to the WHO (2005), life expectancy in Brazil in 2003 was 69 years and the under-five mortality rate in 2000 was 23 per 1,000 live births; according to the World Bank, 2005, the infant mortality rate in 2002 was 20 per 1,000 live births, but Macinko et al. give the slightly higher rate of 28.9 per 1,000. The Maternal Mortality Ratio reported by the country in 2000 was around 50 per 100,000 live births, but the WHO gave a figure for the same year of 260 deaths per 100,000 live births (WHO, 2005). Child deaths from diarrhea declined by two thirds between 1990 and 2002 and deaths from acute respiratory infections were halved during the same period (Macinko et al., 2006).

In 2000 74% of the total population had access to drinkable water and 64% had access to sanitation. But these figures contain stark differences between urban and rural areas: 95% of the urban population had access to drinkable water, compared to only 53% of rural population. The gap was similar for sanitation: 84% of the urban population and 43% of the rural population benefited from proper sanitation (WHO/UNICEF, 2001).

The majority of the Brazilian population -83%- is concentrated in urban areas, with most of the poor living in shantytowns, the well-known "favelas" (UNDP-HDR 2005). Despite the trend towards urbanization, reaching isolated communities still poses a challenge due to Brazil's territorial dimensions and geography.

The 1988 Brazilian Constitution recognizes health and education as universal rights. The Constitution also determines that the Brazilian State is responsible for assuring that every citizen has equal and free access to health care. Health care in Brazil is implemented through a combination of two subsystems: the public and the private. The public subsystem covers 76% of the population through the Unified Health System (Sistema Único de Saúde, SUS) implemented in 1988 and comprised of public and private providers. The SUS offers free and comprehensive health

17. Online article: http://www.brazilmag.com/content/view/2480/49/

care for anyone, independent of contribution or affiliation. The private subsystem covers 25% of the population, which may also access the public subsystem (PAHO/WHO, 2005). In a country with such huge income disparities, the SUS has been an important mechanism for equalizing access to health services.

One of the goals of the Unified Health System was universal access to health care, especially among the most vulnerable populations. To that end a new model of primary health care was adopted, based on the principles of universality, equity, and integrality of health interventions. In 1991, the Ministry of Health implemented the Community Health Agents Program (Programa de Agentes Comunitários de Saúde, PACS) to address high maternal and infant mortality rates, especially in the Northeast region of Brazil. The PACS was the forerunner of the PSF, with its emphasis in the family and focus on demand (Brazilian Ministry of Health, 2003). Several second generation programs followed, including the PSF, the Popular Drugstore Program (Programa Farmácia Popular), which provided access to 40 essential medicines, and the National Pact for the Reduction of Maternal and Neonatal Mortality.

McGuire points out (McGuire, 2001) that, despite having the fastest per capita GDP growth in Latin America from 1960 to 1995, Brazil underperformed at reducing infant mortality. According to this author, socioeconomic disadvantage was not the main cause of Brazil's slow improvement in this area, but rather the neglect of primary health care for the poor. The inauguration of President Fernando Henrique Cardoso in 1995 launched a period of unprecedented emphasis on primary health care through the creation of PSF and the other programs mentioned above. According to the then Health Minister Jose Serra (Serra, 2001), federal spending on health at the time grew about 30% in real terms, while the proportion of total health expenditure spent on primary health care rose from 17% to 25%. General government expenditure on health was 45.9% of total expenditure on health in 2002, while out-of pocket expenditure on health was 34.6% of the total expenditure on health in the same year (UNDP-HDR 2005).

Table 25: Brazil's general situation

Contextual factor	Health status		Demand for health care	
	Deteriorates	Improves	Hinders	Promotes
Poverty	X		X	
Education level		X		X
No. of Rural dwellings/remote settlements		X		X
Access to water/sanitation/electricity	X			
Government's institutional strength/fragility		X		X
Country's governance		X		X
Unemployment Rate		X		X
Level of Labor informality		X		X

3). ANALYSIS OF THE PERFORMANCE OF THE SPHS

a). Has it increased equity in the access to and/or utilization of health services?

The PSF has so far played an important role in increasing access to and utilization of health services among the formerly excluded population. From 1987 to 1997, according to national health surveys, the proportion of the population with access to basic care rose from 73% to 95%, and the proportion of infants routinely vaccinated increased from 53% to 79% (Brazil's Ministry of Health, 2001). From 1986 to 1996, the proportion of women receiving prenatal care from trained personnel rose from 74% to 85% and institutional births increased from 80% to 91%. Because better-off Brazilians already had high coverage before the implementation of the PSF, it is reasonable to assume that a fair proportion of the improvement took place among the population previously underserved (McGuire, 2001).

In the poorer municipalities (those with median per capita family income lower than one minimum salary) PSF's coverage has expanded from 10.75% in 1998 to 58.49% of the population in 2004, while in the richest municipalities (those with median per capita family income equal or higher than two minimum salaries) coverage expanded only from 4.27% to 24.89% of the population in the same period of time. Despite this high coverage, the proportion of mothers not receiving antenatal care was higher (21%) in the poorest quintile than in the wealthiest (4%). Similarly, inadequate antenatal care was more common among the poorest (50% vs. 19%) (Barros et at, 2005). According to Ministry of Health data, the program has increased overall coverage in the country from 15% of the population in 1994 to 42.7% in 2005 (Ministry of Health, Brazil, 2006).

b). Has it offset social determinants that damage health and/or hinder the demand for health care?

The PSF has made some strides towards overcoming the ill-effects of poverty and informal employment on health, but is far from achieving complete success. Although the demand for health services has increased since the program was launched, the finding that inadequate antenatal care was more common among the poorest seems to indicate that the program needs to improve quality of care, not just coverage (Barros et al., 2005). A study performed by Barros et al. in Sergipe found that, while there was no difference in demand for health care between income quintiles, those in the lowest quintiles were far more likely to receive inadequate antenatal care, with nearly 50% of those in the lower two quintiles receiving inadequate care, as opposed to less than 20% in the highest income quintile (Barros et al., 2004).

The PSF also helps to foster rights in at least some areas of health by including a specific guarantee of rights: the National Sexual and Reproductive Rights Policy was launched in 2005, and includes family planning programs for the period 2005-2007, aimed at guaranteeing the sexual and reproductive health rights of both adults and adolescents (PAHO/WHO, 2005).

Table 26: PSF's performance: social determinants

Category	Performance	
	yes	no
Offsets poverty by eliminating or reducing economic barrier	X	
Fosters women's social status		X
Fosters health rights through Right Charts, explicit guarantees, etc.	X	
Offsets unemployment/informal labor by eliminating or reducing economic barrier	X	
Offsets women's lack of education, fostering demand for health care	X	

c). Has it increased access to or coverage of technically appropriate health interventions by eliminating a source of exclusion from health care?

As a program focused on strengthening health care delivery, the PSF has contributed to expanding the health system's infrastructure to locations not previously covered, especially the poorer ones. In February 2005, the PSF covered 83% of the municipalities in Brazil, through 21,391 primary health teams. (PAHO/WHO, 2005). The program has attained the highest coverage in the Northeast - the poorest geographic region - with 49.8%t of the population covered by the PSF. The PSF also shows a pattern of coverage expansion that has favored the less populated municipalities, clearly seeking to eliminate the geographic barrier. According to the Ministry of Health, by 2004 the program covered 65.29% of the population living in municipalities with less than 20,000 inhabitants, but only 27.5% of the population living in municipalities with 80,000 or more inhabitants (Ministry of Health, Brazil, 2006).

The PSF has attempted to avoid segmentation by establishing a set of health care services that must be available to all mothers and newborns with the same quality, content, and delivery conditions regardless of socioeconomic status. However, problems related to waiting times, hours of operation, and limitations in access to specialized services as well as laboratory and imaging services persist, prompting those who can pay to walk away from the program (Macinko et al., 2005). According to a study carried out by Barros et al. in Porto Alegre, the PSF's higher coverage among the poor was a result of self-exclusion on the part of the better-off due to problems with quality (Barros et al. 2005).

Results to date suggest that the PSF has been successful in removing economic barriers to access to primary health care services, as evinced by the observed increase in services utilization among the poor population. Although public spending in health has gone through ups and downs along with the economic crises that have rocked the country, it increased from 2.76% of GDP in 1990 to 3.6% of GDP in 2002 (World Bank, 1995; UNDP, 2005). The amount of public spending allocated to the PSF accounts for an important share of this increase. Federal transfers account for only about 40% of the costs of the program, so local resources are crucial to its existence (McGuire, 2001). Given that the Program's resource allocation has favored the poorest municipalities, it can be assumed that the public spending allocated to the program has been progressive. However, households remain an important source of financing for the sector, contributing to 34.6% of the total expenditure on health.

Table 27: PSF: Coverage and access

Category	SPHS	
	yes	no
Increases coverage (rise in number of people covered as a % of eligible population)	X	
Establishes a single guaranteed portfolio of entitlements with the same quality, content, and delivery conditions for all socioeconomic groups so as to avoid segmentation	X	
Increases coordination/integration within the system so as to avoid fragmentation	X	
Improves resource allocation and organization of health interventions by increasing number and capabilities of human resources in previously underserved areas	X	
Improves resource allocation and organization of health interventions by increasing the amount of public spending allocated to the scheme	X	
Public spending allocated to the scheme is progressive	X	
Improves geographical distribution of the service delivery network and health infrastructure by increasing number/amount of health facilities, equipment, medical devices, and drugs in previously underserved areas	X	
Increases information system's coverage	X	
Increases access (number of people who access health goods or services provided by the scheme)	X	
Eliminates/reduces geographic barrier	X	
Eliminates/reduces economic barrier	X	
Eliminates/reduces gender barrier		X
Eliminates/reduces employment status barrier	X	
Improves access to drinkable water, sewerage, roads, and/or transportation		X
Improves refuse collection		X

d). Have health outcomes improved?

According to a study carried out by Macinko, Guanais, and Marinho de Souza (2003), the PSF has contributed to the decline of infant mortality in Brazil. From 1990-2002 the Infant Mortality Rate (IMR) declined from 49.7 to 28.9 per 1,000 live births. During the same period, average PSF coverage increased from 0 to 36%. A 10% increase in PSF coverage was associated with a 4.5% decrease in IMR, controlling for all other health determinants. The results indicate that the PSF may reduce IMR at least partly through the reduction of diarrhea deaths. The PSF has also been associated with increased immunization rates, breast-feeding rates, and better maternal management of diarrhea and respiratory infections (Emond et al. 2002).

Although the Maternal Mortality ratio declined from 57.1 per 100,000 live births in 1999 to 51.6 in 2006 according to data provided by the Ministry of Health, maternal mortality is still high in Brazil when compared to other LAC countries and very high compared to the average figure for upper middle-income countries (Ministry of Health, Brazil, 2005). This is especially true when using the WHO figure of 260 maternal deaths for every 100,000 live births, placing Brazil far above the South American average of 165 and behind only Bolivia and Peru (WHO, 2007). Further efforts must be made to improve maternal health care through the PSF.

According to the Brazilian Ministry of Health, the hospitalization rate in the areas covered by the PSF decreased from 52.3 per 10,000 inhabitants to 37.7 per 10,000 inhabitants in the last three years (Brazil's MoH, 2005) which indicates that the program has been successful in dealing with health problems at the primary care level.

Table 28: PSF's performance

Goal	Performance
Increase equity in the access to and/or utilization of health services	It has increased equity in access to and utilization of health services provided by the program
Offset social determinants that hinder demand for health care and/or hamper health status	The program has helped to offset poverty and mother's lack of education
Increase access to and coverage of technically appropriate health interventions by reducing or eliminating at least one cause of exclusion in health	It has increased access by reducing the economic and geographic barriers. It has increased coverage (human resources, health facilities) in previously underserved areas

5.3 MCHSHPP: An integral and long term state policy focused on MCH social health protection -CHILE-

1). CHARACTERIZATION OF THE SPHS

Chile has a long history of public concern for the health of mothers and children. The state's efforts in this field began in 1890, with the creation of the agency of public hygiene and sanitation. In 1924, with the establishment of social security, the state assumed an active role in providing health care to workers and their families. The Maternity Care and Supplementary Food Program for workers' wives and children up to two years of age started in 1938. As early as 1942, a free milk program extended its coverage to uninsured and indigent children and pregnant women and linked provision of benefits to health check ups. The National Health Service, created in 1952, unified the health system under a single public office with one goal: to protect the health of mothers and children. To accomplish this end, three programs were created: the Maternal and Perinatal Program (Programa de salud maternal y perinatal); the Children and Teenagers' Health Program (Programa de salud infantil y adolescente); and the National Supplementary Food Program (Programa Nacional de Alimentación Complementaria, PNAC). These programs are still standing today (Idiart 2004).

During Salvador Allende's socialist government (1970-1973), the PNAC was extended to all primary school children and to all pregnant women, regardless of their employment or income condition. The existing programs were improved; complementary nutritional schemes were applied to malnourished children; and antenatal care was emphasized. Under military rule (1973-1989), in spite of severe public expenditure reductions, the mother and child health programs became, again, the first priority. It is noteworthy that infant mortality rate plunged from 65 to 20 per 1000 between 1974 and 1984, a period when the country's real per capita fell from $5,184 to $4,844 (US$ at PPP, chain index; Penn World Tables, 6.0). By the late seventies, these programs covered around 95% of all pregnant women and children (Idiart, 2004).

According to Foxley and Raczynsky, the drop in birth rates - especially among the poor - accounts for 25-30% of the decline in infant mortality during the 1974-1984 period (Foxley and Raczynsky, 1984:233). McGuire argues that the rest of the drop was due largely to a reallocation of health expenditure (McGuire, 2001). The military ruler, Augusto Pinochet, cut spending on health care, but channeled much of what was

left to prenatal care; nutrition monitoring for children under six; intensive care for malnourished children; and expansion of the PNAC's coverage to pregnant women, nursing mothers, and children under six (Hakim and Solimano, 1978; Foxley and Raczynsky, 1984; Castaneda, 1992). In the early eighties, in response to specific nutritional studies, the PNAC was transformed into a targeted program strictly aimed at underfed children, with a curative focus.

In 1990, the new democratic government began to promote strong social policies. Public health expenditure increased by 50% over the next four years to tackle the deterioration of public infrastructure. A national program for investment in infrastructure and equipment in public hospitals was implemented, for a total cost of US$500 million over six years (Jimenez de la Jara, Bosset, 1995). Important investments were made in primary care facilities to increase access to primary health care and relieve the pressure on hospitals and emergency rooms. In addition, throughout the 1990s, significant changes took place in regards to the National Health Fund, FONASA, and the implementation of specific programs that impacted the health of mothers and children.

In 1994, the government transformed the FONASA from a public health sector financial management agency into a Public Health Insurance. In 1996, FONASA launched the National Health Plan, a comprehensive health package for the whole population, and set out to promote its provisions among the public, amidst a strong campaign to attract affiliates. In the same year FONASA launched the "Patients' Rights Chart" (Carta de Derechos de los Pacientes) and established Complaint Units all over the country, alongside a national campaign to promote the right to health. FONASA's Health Plan and the "Patients' Rights Chart" boosted demand for quality health care, helped to increase the quality of health services provision in the public sector, and ensured access to institutional delivery and perinatal care.

Since the poor concentrate both high health risks and low ability to contribute, FONASA set out, right after its transformation into the public insurance, to diversify its risk pool by attracting different income and population groups. In doing so, it pushed public providers to improve quality of care. This strategy has allowed FONASA both to be financially sustainable and to raise quality standards in health care provision all over the system.

In 1995, the government launched the Family Health Plan,PSF, to be delivered at the Municipal level. The Plan is a comprehensive primary health care package aimed at meeting the family's health needs, with a focus on health promotion and preventive care. It includes family

planning, antenatal and post delivery care, newborn health check ups, nutritional counseling, in-house visits, immunizations, and the delivery of the PNAC's benefits conditioned to health check ups. FONASA makes per capita transfers to the Municipalities to ensure the delivery of the Plan and the adequate referrals. The poorer and more remote the municipality, the higher the per capita transfer. The Plan is delivered all over the country. The midwife is the Program's main human resource, and the health team also has a general practitioner, a dentist, a nutritionist, and a social worker (Castro and Camacho, 2004).

By 2002, the PNAC covered approximately 80% of pregnant women and children under six years old. The program is universal and provides supplements with different nutritional composition, delivered according to nutritional status and conditional on health check-ups. Over the years, the PNAC has allowed not only for the improvement of the nutritional status of the mother and child population; it has also been effective in promoting a primary health care-seeking behavior among its beneficiaries. The program is currently complemented by another nutritional program, this one delivered in the classroom to school age children (Programa de Alimentación Escolar, PAE), in order to ensure the continuous provision of nutritional care to this population (Idiart, 2004).

Table 29: PNAC coverage by age group, 2002

Age	**Total eligible population**	**Covered population**	**Covered population % of total eligible population**
0-24 months	343,044	307,000	89.5%
25-72 months	679,508	518,000	76.2%
Total children	1,022,552	825,000	80.5%
Pregnant women	93,617	80,903	86.4%
Total PNAC	**1,116,169**	**905,903**	**81.2%**

SOURCE: Riumallo J., Pizarro T., Rodriguez L., Benavides X. *"Programa de suplementacion alimentaria y de fortificacion de alimentos con micronutrients en Chile"*. Ministry of Health, Chile

For the purpose of this analysis, the benefits provided to the mother and child population by the Public Health Insurance, FONASA, the Family Health Plan, PSF, and the PNAC will be treated together, under the banner of MCHSHPP.

Table 30: Main Features of the MCHSHPP

Feature	Category
Type	- Public Health Insurance - Free primary health care - Conditioned in-kind transfer
Mode of financing	- Contribution- based insurance scheme - Publicly funded
Source of funds	- General taxes - Individual mandatory contribution - Individual voluntary contribution - Co-payments
Risk pooling arrangement	- Income-based (FONASA) - Community-rated (PSF-PNAC)
Management and management level	MoH at national/sub-national/local level Local government (Municipalities)
Degree of selectivity	- Universal (FONASA, PSF) - Targeted (PNAC)
Who is entitled to coverage	- Family (PSF) - Individual/dependents (FONASA-PNAC)
Condition for access	- Citizenship (PSF-FONASA) - Specific attribute: age/proof of childbirth/proof of pregnancy (PNAC)
Extent of risk pooling	Large pool (FONASA, PSF) Small pool (PNAC)
Explicit portfolio?	Explicit
Degree of coverage	Comprehensive
Provision	Public-private

2). CHARACTERIZATION OF THE GENERAL SETTING IN WHICH THE SPHS IS IMPLEMENTED

Basic Information - Chile is an upper-middle income country situated in the southern cone of South America. According to the latest Census (2002), the country has a total population of 15,116,435 people, of which 49.3% are men and 50.7% are women. The urban population is 86.6% and the rural population 13.4%. In 2001 the fertility rate was 2.0 children per woman, among the lowest in the region.

Economy - Poverty has been steadily decreasing in the country during the last fifteen years, thanks to a mix of economic and social measures. The

incidence of poverty dropped from 40% in 1987 to 18.8% in 2003, while indigence was reduced from 13% in 1987 to 2% in 2001. In the same year the unemployment rate was 8% and informal workers were around 10% of all workers (Ministerio de Salud de Chile- MINSAL 2004). According to the Central Bank, in 2002 the per capita income was US$ 4,127. The country has enjoyed political stability after a wide social movement defeated, through a national referendum, the military government that had seized power in 1973 and ruled the country for 17 years.

Health and Education- Chile's health indicators are among the best in LAC. Along with Cuba and Costa Rica, it is considered to be one of the few countries in the region that have succeeded in their efforts to satisfy the basic needs of a large proportion of their population (Horwitz, 1987). Life expectancy was 76.3 years in 2000 and prevalence of malnutrition in children under five was 0.8% in 2001. In the year 2002, the youth literacy rate (% ages 15-24) was 99% and adult literacy rate was 96%. The maternal mortality ratio was 31 per 100,000 live births in 2001, with 99.5% of all deliveries attended by skilled health staff. In the same year, total expenditure on health was 7% of GDP and public expenditure on health was around 49% of the total. Of the 51% of private expenditure on health, around 40% is used to pay premiums or make contributions to public or private health insurance.

According to the World Bank (World Bank, 2000), Chile has achieved considerable improvements in key social indicators - infant mortality, life expectancy and educational coverage - through a combination of interventions in three important areas (education, health, and housing) and its system of targeted social programs. The existence of a government office specifically focused on social policy planning and evaluation of social policies (the Ministry of Social Planning, MIDEPLAN) also seems to play a role. Although there is a high income concentration in the country, income adjustments through progressive social spending greatly reduce the effect of economic disparities. The impact of social policies in reducing income inequalities has increased along with the budget allocation to such programs. According to data from 2003, income transfers from subsidies in education, housing, and health make up for around 40% of the income increase of the households in the two lowest income quintiles (Agostini and Brown, 2007).

The current Chilean health system is based on the concept of insurance and has a mix of public and private insurers and providers. The public insurance, called the National Health Insurance Fund (FONASA) is the dominant insurer. FONASA serves 68.3% of the population, including those who choose to enroll in the public insurance and those who due to poverty or indigence cannot contribute and whose contributions are paid

by the government. On the provision side, the public sector - consisting of the Municipal subsystem for primary care and the National Health Services System for secondary, tertiary, and specialized care and complementary services - is the main provider and has an extensive service network all over the country. The whole system operates through a package of health services. The private insurers - ISAPRES - may offer different health plans, but they cannot provide fewer services than those provided by the public insurance package. The insurer buys health services from public or private providers to guarantee the coverage of the package to its affiliates (MINSAL, 1999).

Although they operate under different systems, both insurance components - public and private, FONASA and ISAPRES - have the legal obligation to cover, in all plans, the following: i) preventive medicine exams; ii) sick leave payments; and iii) comprehensive protection for pregnant women and children under six years. The latest reform introduced in the system in 2004 created the system of Universal Access with Explicit Guarantees (Acceso Universal con Garantías Explícitas, AUGE), which ensures access to a single national health plan in similar conditions of quality, opportunity, financial protection, and health services delivery for all people, regardless of whether the insurer and/or the provider are private or public. AUGE seeks to eliminate segmentation by standardizing the content, costs and quality of the guaranteed portfolio of entitlements within the system, and to reduce fragmentation regarding the insurance plans.

Table 31: Chile's general situation

Contextual factor	**Health status**		**Demand for health care**	
	Deteriorates	**Improves**	**Hinders**	**Promotes**
Poverty		X		X
Education level		X		X
No. of rural dwelling/ remote settlements		X		X
Access to water/sanitation/electricity		X		
Government's institutional strength/fragility		X		X
Country's governance		X		X
Unemployment		X		X
Labor informality		X		X

3). ANALYSIS OF THE PERFORMANCE OF THE SPHS

a). Has it increased equity in the access to/utilization of health services?

Although several inequity problems remain to be tackled in the Chilean dual insurance health system, especially in the system's financing mechanism, the three strategies under analysis have clearly increased equity in the access to and utilization of health services. Successive evaluations of the PNAC between the late 1970s and mid 1990s show that the program has consistently had higher coverage for those in the two lower income quintiles (MINSAL, 2000). Moreover, according to Idiart (2004), beneficiaries consider the program's benefits as part of their citizen's rights. The current overall coverage of the program is around 80% of total Chilean mothers and children under six.

According to Castro and Camacho (2004), the main explanation for the impressive drop in maternal mortality in Chile has been the continuous improvement in access to quality reproductive health care services for all. For instance, between 1990 and 2000, the number of women using a contraceptive method under the care of the public system had increased by 34.5%. The Family Health Plan has allowed poor families and those living in remote and/or poor municipalities to have access to the benefits of primary health care. FONASA has been the key to increased equity in the access to secondary, tertiary, and specialized health care and hospitalization for mothers and children.

b). Has it offset hindering social determinants?

Chile's overall situation tends to contribute to good health. Most important social determinants, such as literacy rate, income, women's status, institutional strength, infrastructure, and governance all work to improve health status. Those few that do not are ably tackled by the SPHS under review. The Family Health Plan has contributed to overcoming the negative social determinant of living in a poor and/or isolated community, while FONASA has helped to offset poverty and difficult employment conditions (unemployment, informality).

The programs and benefits reviewed in the previous sections have all contributed to fostering women's status and rights in Chilean society. FONASA took the lead in promoting the right to health with its "Patients' Rights Chart" (Carta de Derechos de los Pacientes), which boosted the demand for quality health care among all Chileans, regardless of their social or economic status. The PNAC has been effective in promoting the rights of pregnant women, mothers and children to health care and

adequate nutrition. PNAC has also been successful in promoting primary health care-seeking behavior among its beneficiaries, thus fostering the demand for health care especially among mothers and pregnant women (Idiart, 2004).

Table 32: Performance of the MCHSHPP: social determinants

Category	Performance	
	yes	**no**
Offsets poverty by eliminating or reducing economic barrier	X	
Fosters women's social status	X	
Fosters health rights through Right Charts, explicit guarantees, etc.	X	
Offsets unemployment/informal labor by eliminating or reducing economic barrier	X	
Offsets women's lack of education, fostering demand for health care	X	

c). Has it increased access to and coverage of technically appropriate interventions by eliminating at least one source of exclusion in health?

The observed increases in coverage of and utilization of services by the poor suggests that the Maternal and Child Health Protection Plan has been successful in removing the economic barrier to access to primary health care services, complementary nutrition and hospitalization, and specialized services. Moreover, the fact that the self-employed may choose between the ISAPRE (Instituciones de Salud Provicional) and FONASA, while indigents are covered by FONASA, overcomes unemployment and informality as barriers to access health care. By 2001, the PSF had reached over 90% coverage of antenatal care and 100% immunization coverage. Skilled attendance at birth rose from 45% in 1952 to 99.7% in 2000.

Castro and Camacho (2004) report that the important drop (76.5%) during the period 1990-1998 in the rate of maternal mortalities linked to postpartum sepsis was due to the Intra Hospital Infections Control Program, developed as a component of the Hospital Accreditation System. However, problems related to waiting times, quality of care, hours of operation, and patient satisfaction still persist.

Public spending allocated to the schemes has steadily increased over time and shows a progressive pattern. As mentioned above, in the early 1990's a national program of investment in infrastructure and equipment in public hospitals was implemented to prepare the ground for the upcoming reforms, and important investments were made in primary care

facilities. Households, however, remain an important source of financing for the sector, contributing 51% of total expenditure on health.

Eliminating geographic barriers is important in a country with geography as whimsical as Chile's. FONASA's practice of taking poverty and geographical isolation into account when administering the Family Health Plan has contributed to overcoming geographic and economic barriers to access to primary health care. The need to integrate PNAC, FONASA, and the Family Health Plan also prompted the creation of a unified information system that allows for gathering, recording, and managing data from all over the country on a regular basis.

The implementation of the dual insurance model in the '80s did have the effect of introducing segmentation into the Chilean health system. The latest reforms, introduced with the creation of AUGE in 2004, focus specifically on eliminating segmentation. Their outcomes will surely be analyzed in the years to come.

Table 33. Performance of MCHSHPP: coverage and access

Category	**SPHS**	
	yes	**no**
Increases coverage (rise in number of people covered as a % of eligible population)	X	
Establishes a single guaranteed portfolio of entitlements with the same quality, content, and delivery conditions for all socioeconomic groups so as to avoid segmentation	X	
Increases coordination/integration within the system so as to avoid fragmentation	X	
Improves resource allocation and organization of health interventions by increasing number and capabilities of human resources in previously underserved areas	X	
Improves resource allocation and organization of health interventions by increasing the amount of public spending allocated to the scheme	X	
Public spending allocated to the scheme is progressive	X	
Improves geographical distribution of the service delivery network and health infrastructure by increasing number/amount of health facilities, equipment, medical devices, and drugs in previously underserved areas	X	
Increases information system's coverage	X	
Increases access (rise in number of people with access to health goods or services provided by the scheme)	X	
Eliminates/reduces geographic barrier	X	
Eliminates/reduces economic barrier	X	
Eliminates/reduces gender barrier		X
Eliminates/reduces employment status barrier	X	
Improves access to drinkable water, sewerage, roads, and/or transportation		X
Improves refuse collection		X

d). Have health outcomes improved?

Infant and maternal health and nutrition outcomes have dramatically improved in Chile in the past decades. According to statistics from the Ministry of Health, Maternal Mortality dropped from 40 per 100,000 live births in 1990 to 17 per 100,000 live births in 2002. The main causes of this reduction are the increase in skilled attendance during childbirth and family planning interventions to prevent unwanted pregnancies (MINSAL, 2004). According to the same source, the data show a sustained downward trend in infant mortality over the past sixty years. In 1950, IMR was 136 per 1,000 live births; in 1970 the rate dropped to 79 per 1,000 live births; in 1980 it fell to 31.8; in 1990 it dropped to 16.8; and in 2002, it was only 7.8 per 1,000 live births. The main causes of this decline are the increase in utilization of skilled attendance during childbirth and periodic pediatric primary care, as well as PNAC and higher family income (MINSAL 2004).

Table 34: MCHSHPP's performance

Goal	Performance
Increase equity in the access to and/or utilization of health services	It has increased equity in the access to and utilization of health services provided by the program
Offset social determinants that hinder demand for health care and/or hamper health status	The policy has helped to offset poverty and living in isolated and poor communities. It has fostered the demand for health care by promoting health rights.
Increase access to and coverage of technically appropriate health interventions by reducing or eliminating at least one cause of exclusion in health	It has increased access by reducing the economic and geographic barriers. It has increased coverage (human resources, health facilities) in previously underserved areas

5.4 Free Maternity and Child Care Law (Ley de Maternidad Gratuita y Atención a la Infancia, LMGYAI) -ECUADOR-

1). CHARACTERIZATION OF THE SPHS

Ecuador experienced high maternal and child mortality rates throughout the 1990's: the INEC (Instituto Nacional de Estadísticas y Censos de Ecuador) Vital Statistics Yearbook reported that in 1990 the maternal mortality ratio was 117 deaths per 100,000 live births, and the infant mortality rate 30 deaths per 1,000 newborns. In 1994, in response to the challenge of high mortality rates, the government passed the first version of the Law for the Provision of Free Maternity and Child Care (LMGYAI). The law has since gone through extensive reforms, most importantly in 1998 and in 2000, when it was amended to improve resource allocation and managerial mechanisms. The Law states that every woman has the right to free quality health care, both during pregnancy and postpartum, and that every child under five years old has the right to care for the most common childhood diseases. One of the main contributions of the LMGYAI is that it establishes a legal and financial framework for the continuity of public health policies aimed at women and children, despite frequent changes in government caused by the country's political instability.

The main features of the LMGYAI are:

1. The law redefined the role of the State in the provision of social protection in health to women and children by guaranteeing access to an explicit package of free health services for mothers and children, attempting to eliminate the economic barriers that prevent vulnerable groups from accessing health care.
2. The law works through mechanisms that encourage an improvement of quality and accountability in the provision of health services, such as clinical guidelines, calculation of costs for reimbursement of services, and management agreements with municipalities for co-management of health care services (Hermida J. et al., 2005).
3. The law relies on social participation, through the organization of users' committees, to ensure the quality and responsiveness of health services delivery.

Two elements were the driving force in the creation of the LMGYAI: the role played by national and international women's movements in pressuring the state to address women's needs and the momentum created by the health sector reform process in Ecuador. It is noteworthy to mention

the role of the Women's National Counsel (Consejo Nacional de las Mujeres, CONAMU) in the creation of the LMGYAI. CONAMU was a vocal advocate for reproductive health and held the state responsible for protecting women and children's right to health and for creating a stable source of funding to face the challenge of high maternal and infant mortality rates (Quality Assurance Project, 2004).

The passing of the LMGYAI resulted in the creation of the Free Maternity Program, a public program under the auspices of the Ministry of Public Health (MSP). The goal of the Free Maternity Program is to reduce maternal, female, and infant mortality rates by increasing coverage of health care, undertaking health promotion activities, providing a better response to obstetric and pediatric emergencies, and developing a decentralized and participatory health care model.

Originally, only nine health interventions were covered by the LMGYAI. New interventions were added by the end of 2002, and as of 2003 the law included 42 interventions (see table 35). The increase was based on the Law's regulations, public need, and the consensus among the institutions that support and monitor the Law's implementation (Quality Assurance Project, 2004). The law states that the services, provided through the facilities of the Ministry of Health, should be available to the beneficiary population throughout the country and at all provision levels. Non-profit institutions and traditional medicine agents have access to the funds after completing an accreditation process and with the understanding that services must be provided free of charge (Ministry of Health, 2005).

Table 35: Interventions provided by LMGYAI, 2003

Services Provided to Women	Services Provided to Children Under 5
Antenatal Control First Control Subsequent Controls Dental Care HIV/AIDS Diagnosis Diagnosis of congenital anomalies Early identification and referral of pregnant women by a community agent Early referral of high-risk pregnancies	**Immediate care to newborns** Care of healthy newborns Diagnosis and treatment of congenital hypothyroidism Care of low-weight and pre-term newborns Intensive and intermediate care of perinatal asphyxia Intensive and intermediate care of perinatal jaundice and septicemia
Delivery Normal Delivery Cesarean Section Early referral by a community agent, resulting in normal delivery or cesarean section	**Health care to children under five years old according to the Integrated Management of Childhood Illnesses (IMCI) strategy** Under 1 year old well-child check-up Under 5 years old well-child check-up Dental care Detection and treatment of child abuse Early identification and referral of children under 5 by a community agent using IMCI Intra-hospital complications
Obstetric Emergencies Pregnancy-induced hypertension Hemorrhage during the first half of pregnancy Hemorrhage during the second half of pregnancy Hemorrhage during delivery and post partum Sepsis	**Blood and blood products transfusion**
Immediate postpartum care Postpartum control Postpartum referral and referral of newborns under 7 days Detection and referral of women with hemorrhage and postpartum complications	
Family Planning and Reproductive Health Counseling and prevention Detection and treatment of intrafamily violence against women, including medical forensic analysis Bilateral tubal sterilization Vasectomy Daily Oral Contraceptive-DOC women 34-64 years old Early detection of breast cancer in women 34-64 years old	
Sexually Transmitted Diseases-STD Diagnosis and treatment of Syphilis Diagnosis and treatment of Gonorrhea Diagnosis and treatment of Genital Herpes Diagnosis and treatment of Papilloma Virus (HPV) Diagnosis and treatment of leucorrhea	
Blood and blood products transfusion	

SOURCE: Quality Assurance Project. "Ley de Maternidad Gratuita y atención a la Infancia del Ecuador (LMGYAI)" February, 2004.

Funding for the implementation of the LMGYAI comes from a variety of sources, including (Quality Assurance Project, 2004):

1. Government resources – 3% of the revenues of Tax on Special Consumption (Impuesto a los Consumos Especiales, ICE).
2. International multilateral and bilateral cooperation agencies: USAID, AECI, UNFPA, UNICEF, PAHO, and the World Bank.
3. Solidarity Fund for Human Development: USD$ 15 million per year.
4. National Fund for Infant Nutrition (FONNIN): USD$ 3 million per year.
5. Local municipalities (fiscally responsible for transportation, treatment resulting from obstetric and pediatric emergencies, and health promotion activities).

The budgetary allocation for the LMGYAI has not been sufficiently constant to ensure the continuity and effectiveness of the program. According to the ILO, between 2001 and 2002 the budget for the LMGYAI decreased 54%, from US$ 10.4 million to US$ 5.6 million, or from 3.62% to 2.08% of the total budget allocated to social programs (ILO, 2003). Reports from the government indicate that the budget allocated to LMGYAI increased to US$ 21.9 million in 2004 (Children Rights Committee, 2005). Unstable budget allocation and the difficulty of reaching poor and indigenous communities have been the main obstacles faced in implementing the LMGYAI (Government of Ecuador, National Secretariat for the Attainment of the MDG's 2006).

Although the implementation of the LMGYAI is financed by the government, the campaign to reduce maternal and infant mortality has benefited from strong technical and financial support from international multilateral and bilateral cooperation agencies over the years. USAID, UNFPA, UNICEF and PAHO/WHO made investments in maternal and child health, and the public health projects financed by the World Bank made the reduction of maternal and infant mortality one of their main priorities (Hermida et al., 2005).

Table 36: LMGYAI's main features

Feature	Category
Type	Free maternal and child health care
Mode of financing	Publicly funded
Source of funds	General taxes Other revenues (Extra budgetary sources: AECI, USAID, UNFPA, UNICEF, PAHO, and the World Bank.)
Risk pooling arrangement	Income-based
Management and management level	MoH at national/sub-national/local level
Degree of selectivity	Targeted: women of reproductive age and children under five years old
Who is entitled to coverage	Individual
Condition for access	Specific attribute: age/proof of childbirth/proof of pregnancy
Extent of risk pooling	Small pool
Explicit portfolio?	Explicit
Degree of coverage	Complementary
Provision	Public/private non-profit

2). CHARACTERIZATION OF THE GENERAL SETTING IN WHICH THE SPHS IS IMPLEMENTED

Basic Information and Demographics - Ecuador is a lower-middle income country located in the Andean region of Western South America, bordering the Pacific Ocean, Colombia, and Peru and straddling the Equator. The country is characterized by great geographical, economic and ethnic diversity. According to the Ministry of Health, the estimated population in 2005 was 13,215,089 inhabitants (MSP, 2005). According to the National Census of 2001, 61% of the total population is urban and 39% rural. The total literacy rate for adults (% of people ages 15 and above) is 91.6%.

It is estimated that indigenous people and those of African descent represent about 30% of the total country's population, although figures vary widely. There are 13 officially designated non-Hispanic ethnic groups or nationalities in Ecuador, with the Runa and Quechua constituting around 90% the indigenous population. Poverty and social exclusion is closely linked to indigenous origin in Ecuador (ECLAC, 2005; PAHO/WHO-SIDA, 2003). Nevertheless, after a long and arduous process, indigenous groups have built complex social organizations rooted in the community level. Indigenous organizations have become stronger and are increasingly recognized as political and social actors in the country's public sphere.

Economy - Ecuador has important oil resources, which account for around 40% of the country's earning from exports and one-third of central government budget revenues in recent years (World Bank, 2006). In the late 1990's, Ecuador experienced a severe economic crisis, which resulted in a steep economic recession and a contraction in real income. Sharp declines in world petroleum prices drove Ecuador's economy into free fall in 1999 and poverty worsened significantly. Between 1995 and 2000, the number of those living in poverty increased from 3.9 to 9.1 million, and in extreme poverty from 2.1 to 4.5 million. In 2000, on the brink of hyperinflation and in the middle of a serious political crisis, the Congress approved several structural reforms that provided the framework for the adoption of the US dollar as legal tender. Although dollarization stabilized the economy and the annual growth increased from 2.8% in 2000 to 6.9% in 2004, poverty continues rampant in the country. By 2004, 45% of the population was living under the poverty line (World Bank, 2006). Other sources put this figure as high as 70% (Ministry of Health, 2005). Ecuador has the second highest Human Poverty Index in South America and, according to the Unmet Basic Needs Index, 60% of Ecuadorians live in poverty (ECLAC, 2005). By 2005, the official unemployment rate was 9.7% with an underemployment of 47%. According to ILO, in 2003 urban informal sector in Ecuador accounted for around 57% of the total urban working population (ILO, 2005).

Health and Education- Life expectancy at birth was 70 years of age for both sexes, and the percent of population aged 60 years or more has increased from 6.3 in 1993 to 7.5 in 2003. From 1993 to 2003 there was a decline in the total fertility rate, from 3.5 to 2.7 children per woman (WHO 2005). This may be due in part to the increase in women's educational levels, their entry in the labor market, and the migration from rural to urban areas.

Ecuador's demographic, cultural, and social heterogeneity continues to be a source of economic inequality and stark differences in living standards and health conditions. In the Amazon region, for example, where there is a markedly higher concentration of indigenous and poor populations, premature deaths are frequent and life expectancy from 1995-2000 was unchanged at 59.6 years. An estimated 21% of the population in the Amazon will not survive more than 40 years, whereas in the province of Pichincha life expectancy was almost 15 years longer (74.5 years), and only 6.8 percent of the population was expected to die before age 40. Similar inequalities can be seen when life expectancies are stratified according to household consumption per capita: the populations of low consumption provinces have a lower life expectancy than those of provinces with greater resources (World Bank, 2005). Around 67% of the total population has an adequate water supply and 57% has access to sanitation, with large disparities between urban and rural dwellings (Government of Ecuador: National Report on MDGs, 2005).

The reported estimated maternal mortality ratio for the period 1999-2004 was 80 per 100,000 live births, while the adjusted maternal mortality ratio in 2000 was 130 per 100,000 live births (PAHO 2004, UNICEF 2006). According to the Demographic and Maternal and Child Health Survey (Encuesta Demográfica y de Salud Materna e Infantil, ENDEMAIN 2004), in the period 1999-2004 the estimated infant mortality rate was 29 per 1,000 live births and the under-five mortality rate was 34.0 per 1,000 live births. These figures hide significant disparities seen when results are stratified by the mother's ethnic background. Thus, the infant mortality rate in children of indigenous mothers - 40 per 1,000 live births - is 48% higher than among children of mestizo (mixed Amerindians and white) mothers (27 per 1,000 live births), while under-five mortality rate is 50% higher in children of indigenous mothers - 48 per 1,000 live births - than among children of mestizo mothers - 32 per 1,000 live births. 23% of all children under five years old suffer from chronic malnourishment. This figure increases to 47% in children of indigenous mothers. It is noteworthy that the reliability of child and maternal mortality data based on statistical records has been disputed, and estimations based on demographic surveys indicate rates that are significantly higher (World Bank, 2005).

In 2002, total expenditure on health was 4.8% of GDP and public health expenditure was 36% of total health expenditure. Per capita total expenditure on health was US$ 197.00 (WHO, 2005).

Ecuador has suffered enormous political instability over the last two decades. This in turn has led to economic and fiscal instability, with significant volatility in the budgets allocated to health and education. Social spending is insufficient, regressive, and fragmented. An evaluation performed by the World Bank (World Bank, 2002) found that:

a) Compared to international standards, Ecuador underperforms in terms of education and health outcomes, even after controlling for differences in the level of development.
b) Social expenditure, especially on education and health, has declined over time and tends to be pro-cyclical, so that the least resources are available when they are needed the most.
c) Health spending declined from 1.3% of GDP in 1981 to 0.6% of GDP in 2000. This reduction, along with that in spending on education, seemed to lead to a transfer of emphasis from education and health sectors to the social assistance, especially after introduction of the Bono Solidario.
d) The budget allocated to the social sector is highly volatile, hampering the continuity and effectiveness of social programs.

The population of Ecuador faces a dangerous combination of high levels of poverty and low access to institutional health services, and challenges exist in the organization, management, and financing of the health sector. In 2000, 25% to 30% of the population did not have access to institutional health services, and three-quarters were not covered by any health insurance (PAHO/WHO, 2001(a)). In 1998, a series of reforms established the right to health and made the Ministry of Health responsible for drafting state policies in the sector. The reforms also envisioned a restructuring of the health sector through the creation of a National Health System based on universal coverage, decentralization of management, and participation of local governments and social organizations (PAHO/WHO, 2001(a)).

Ecuador's health system is deeply segmented and consists of public, for profit, and non-profit private health institutions, each of them focused on different population segments according to income (although the extremely poor are not reached by any of them) (PAHO, 2003). The Ministry of Public Health (MSP) and the Ecuadorian Social Security Institution (IESS) are the main public sector institutions. Ecuador's health care system is also highly fragmented (PAHO, 2003). Within the Ministry there are small networks, called Health Areas and defined by geographical and population boundaries, that follow a decentralized management model, especially in certain administrative, programming and budgetary activities. The IESS also operates under a decentralized administration, working within nine regions, each of which has a network of services that operate following central planning and financial directives. Each institution has its own management, organizational, and financial structure. These institutions do not articulate or coordinate, making it very difficult to draft a national plan to promote coverage and quality in the delivery of health services (PAHO/WHO, 2001(a)). This has led to an inefficient, inequitable, poor quality, and largely inaccessible system, with over 70% of the population uninsured (PAHO, 2003). The Ministry of Health and other public institutions face severe constraints on their provision of healthcare services to nearly half of the population. The share of the population currently covered by contributory health insurance is amongst the lowest in LAC and the poorest socio-economic groups have very little access to health care (World Bank, 2006). According to a study conducted by PAHO/WHO in 2000, the incidence of exclusion in health in the country is 51%. The main causes of exclusion are the deficit of public health infrastructure and shortage of physicians (PAHO, 2003).

Status of Women - Women in Ecuador are faced with intra-family violence, discrimination, and difficulties asserting their reproductive and sexual rights. They are discriminated against for two main reasons: because of their gender and because of their indigenous origin. Although women enjoy the same legal status as men, the Office of Gender report-

ed in 2005 that women often did not accede to equal rights in practice. Women receive approximately 65% of the pay received by men for equal work and there are fewer women than men employed in professional work and skilled trades. Although the law prohibits violence against women, including within marriage, abuses are widespread (US Bureau of Democracy, Human Rights and Labor, 2006). Despite legal protections of women's rights in politics, the home, and employment, discrimination against women is pervasive, particularly with respect to educational and economic opportunities for those in the lower economic strata. For example, despite increases in overall education, 12% of women are illiterate compared to 8% of men (PAHO/WHO, 2001(a)).

Table 37: Ecuador's general situation

Contextual factor	**Health status**		**Demand for health care**	
	Deteriorates	**Improves**	**Hinders**	**Promotes**
Poverty Rate	X		X	
Education level		X		X
No. of rural dwellings/remote settlements	X		X	
Access to water/sanitation/electricity	X			
Government's institutional strength/fragility	X			
Country's governance	X		X	
Unemployment Rate		X		X
Labor informality	X		X	

3). ANALYSIS OF THE STRENGTHS AND WEAKNESSES OF THE SPHS

a). Has it increased equity in the access to/utilization of health services?

Recent analyses report mixed outcomes in terms of access and equity. Vos et al. (2004) found that inequalities in access to health facilities have increased, partly because of the introduction of user fees and partly because health inputs, especially supply of drugs, have fallen well behind requirements (Vos et al., 2004). By the end of 2003, only about 30% of pregnant women were covered by the program, which reaches out to only a small portion of the most vulnerable groups. Coverage is only 19% among indigenous and rural women and only 20% of the poorest third of the population. According to official government reports, impor-

tant gaps remain in the access to health care for mothers and children of indigenous origin living in rural communities, and the poorest women remain excluded from the benefits of the law (Government of Ecuador: National Report on MDGs, 2005). To tackle this situation, the government is currently designing a Universal Health Insurance (Government of Ecuador, National Secretariat for the Attainment of the MDG's 2006).

b). Has it offset hindering social determinants?

The LMGYAI fosters knowledge of health rights by guaranteeing access to an explicit package of free health services for mothers and children and by relying on social participation to safeguard the quality and responsiveness of health services delivery. Moreover, it promotes women's social status by implementing mechanisms through which women may exert their reproductive and sexual health rights. Despite some difficulties, during the first years of the law's implementation, in making the guarantee of free-of-charge provision of the health services included in the package effective, recent reports inform that the LMGYAI has effectively lowered the economic barrier to health for the target population (Hermida J., et al., 2005). According to ENDEMAIN 2004, from 1994 to 2004 there has been an increase in the percentage of mothers receiving prenatal health care (from 75% to 84%) and in institutional deliveries (from 64% to 75%) but only a 3% increase in postpartum health care, from 33% to 36%. However, as of 2004, only 50% of total live births in the rural areas had prenatal care and institutional delivery and only one third of indigenous and illiterate mothers benefited from prenatal care and institutional delivery (ENDEMAIN 2004).

Table 38: LMGYAI's performance: social determinants

Category	Performance	
	yes	no
Offsets poverty by eliminating or reducing economic barrier		X
Fosters women's social status	X	
Fosters health rights through Right Charts, explicit guarantees, etc.	X	
Offsets unemployment/informal labor by eliminating or reducing economic barrier	X	
Offsets women's lack of education, fostering demand for health care		X

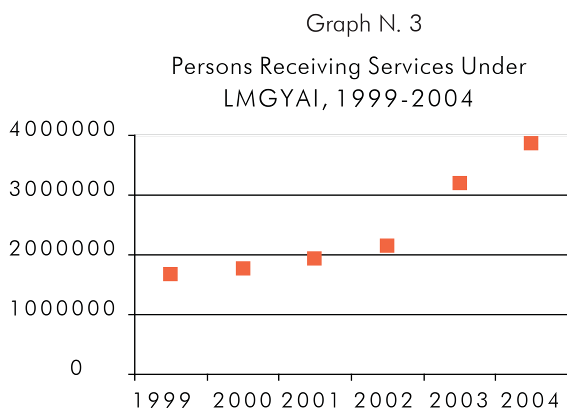
c). Has it increased access to and coverage of technically appropriate interventions by eliminating at least one source of exclusion in health?

The number of women and children who received health services covered by the LMGYAI increased from 1,600,000 in 1999 to 3,867,000 in 2004, which means that coverage more than doubled in five years of the program's implementation. As the table below shows, access to the services provided by the law has increased. The results could also be due to the fact that the number of services provided by the LMGYAI increased as the law underwent revisions (Quality Assurance Project 2004).

Despite the efforts of the Government of Ecuador to improve maternal and child health, approximately 20% of births are still unattended (INEC, 2005). This national average hides much larger percentages in some areas: while less than 12% of births in urban areas are unattended, 49% of all rural births take place without assistance, a figure which rises to more than 70% in the Amazon region (INEC, 2005).

Graph N. 3

Persons Receiving Services Under LMGYAI, 1999-2004



SOURCE: Quality Assurance Project. (February 2004).Research Report # 62: The Law for the Provision of Free Maternity and Child Care (LMGYAI)

Table 39: LMGYAI: Coverage and access

Category	SPHS	
	yes	no
Increases coverage (rise in number of people covered as a % of eligible population)	X	
Establishes a single guaranteed portfolio of entitlements with the same quality, content, and delivery conditions for all socioeconomic groups so as to avoid segmentation	X	
Increases coordination/integration within the system so as to avoid fragmentation		X
Improves resource allocation and organization of health interventions by increasing number and capabilities of human resources in previously underserved areas		X
Improves resource allocation and organization of health interventions by increasing the amount of public spending allocated to the scheme	X	
Public spending allocated to the scheme is progressive		X
Improves geographical distribution of the service delivery network and health infrastructure by increasing number/amount of health facilities, equipment, medical devices, and drugs in previously underserved areas		X
Increases information system's coverage		X
Increases access (rise in number of people who access to health goods or services provided by the scheme)	X	
Eliminates/reduces geographic barrier		X
Eliminates/reduces economic barrier	X	
Eliminates/reduces gender barrier	X	
Eliminates/reduces employment status barrier	X	
Improves access to drinkable water, sewerage, roads, and/or transportation		X
Improves refuse collection		X

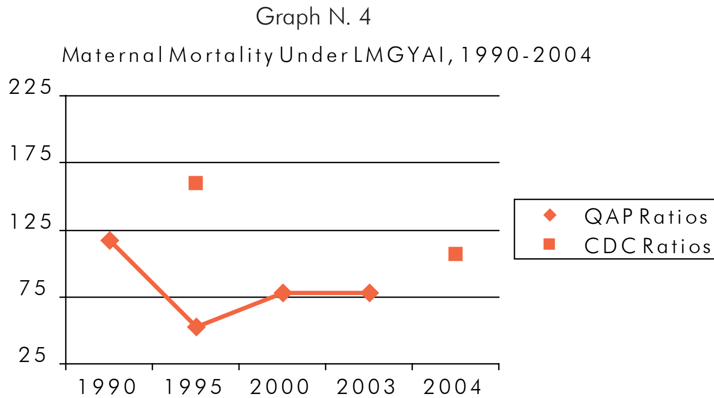
d). Have health outcomes improved?

Ecuador still has high rates of neonatal, infant, and maternal mortality from preventable causes. Available data does suggest a significant decline in maternal mortality coinciding with the program's commencement. According to INEC statistics, the maternal mortality ratio dropped from 117 per 100,000 live births in 1990 to 53 in 1998, although there are some concerns about high under reporting (Quality Assurance Project 2004). And despite the sharp decline in the MMR (Maternal Mortality Ratio) in the first half of the 90's, the rate rose again to 77.8 in 2003 (INEC 2003). The CDC puts the rates even higher, at 107 in 2004, suggesting the possibility that the perceived rise in MMR might be the result of better reporting and not actually higher rates (USAID, 2003-7). Considering that the LMGYAI was first implemented in 1994 with pregnant women as its main beneficiary and was heavily revised in

1998 to incorporate several additional provisions, we would expect to see a greater impact on maternal mortality.

According to UNFPA, the LMGYAI has not been effective in reducing maternal mortality and morbidity due to serious implementation constraints caused by a) insufficient resources allocated to the program and b) lack of organization in decentralizing those resources (UNFPA, 2005).

Graph N. 4

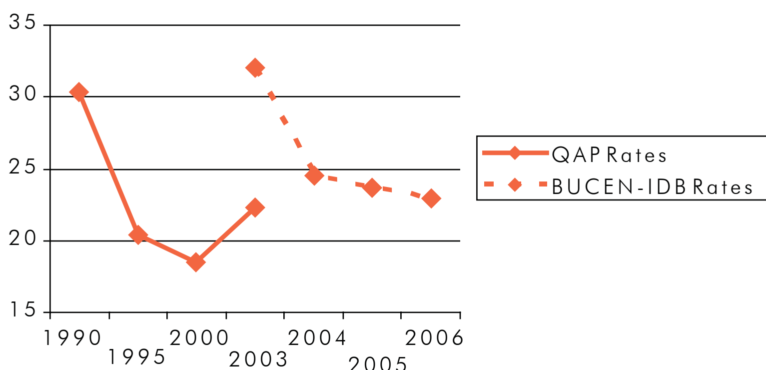


Source: Quality Assurance Project. (February 2004).
Research Report # 62: The Law for the Provision of Free Maternity and Child Care (LMGYAI); USAID Country Health Statistical Report: Ecuador, 2003-2007

The same trend is observed when examining Infant Mortality Rates (IMR). Infant mortality dropped from 140 in 1950-55 to 33 per 1,000 live births in 1995-2000. This downward trend coincides with a long-term decline in fertility, from 7 children per woman in 1950 to 2.8 in 2000-05. The graph below shows that IMR further declined from 30.3 per 1,000 live births in 1990 to 18.5 in 2000. However, in 2003, the IMR was 22.3. It is not clear whether the initial decline in infant mortality and the subsequent increase in the rate registered in 2003 are related to the application of the Law due to its relatively low coverage among children.

Graph N. 5

Infant Mortality Under LMGYAI, 1990-2006



SOURCES: Quality Assurance Project. (February 2004). Research Report # 62: The Law for the Provision of Free Maternity and Child Care (LMGYAI); USAID Country health statistical reports: Ecuador, 2003-2007

Table 40: LMGYAI's performance

Goal	Performance
Increase equity in the access to and/or utilization of health services	Inequalities in access to health facilities persist and in some cases they have increased
Offset social determinants that hinder demand for health care and/or hamper health status	It fosters health rights and women's status
Increase access to and coverage of appropriate health interventions by reducing or eliminating at least one cause of exclusion in health	It has increased coverage of health services included in the package. It has increased access by reducing the economic barrier

5.5 Mother and Child Voucher (Bono Materno-Infantil, BMI) -HONDURAS-

1). CHARACTERIZATION OF THE SPHS

The Mother and Child Voucher (BMI) is part of the Family Allowance Program (Programa de Asignación Familiar, PRAF), a larger initiative, launched in 1990 by the Government of Honduras and supported by the Inter-American Development Bank, to provide a safety net for the poorest that would protect against food insecurity and malnutrition during periods of economic adjustment (IDB 2006). The PRAF is administered by the Office of the President and consists of cash transfers under three components: School Voucher (Bono Escolar, BE), Elderly Voucher (Bono para la tercera edad), and the BMI. According to a report prepared for the World Bank, as of 2002 the three cash transfer programs altogether reached only 4.7% of the total population of the country (Ayala Consulting Co., 2003).

The BMI consists of cash transfers, given to mothers through public health care facilities, in the amount of Lps.50 (approximately US$3.00) per month per child. The delivery of the financial incentive is conditioned on the utilization of health services in the participating public health facilities. The program was implemented as a response to high rates of malnutrition and poverty and with the following goals:

- i) to complement the income of the poor;
- ii) to reduce food insecurity;
- iii) to alleviate malnutrition during periods of economic adjustment; and
- iv) to promote utilization of preventive and curative health care services for mother and child populations.

The program targets families with pregnant and/or breast feeding women, children under 5 years of age, and/or disabled children under 12 years of age. To be eligible, the families must have an income of less than US$ 36.00 per year; must have three or more unmet basic needs such as food, health care, or sanitation; and must participate in periodic antenatal check-ups, immunizations, and wellness check-ups for the children, as well as training programs in health and nutrition (IDB, 2002). The transfer is in the form of a voucher to the mother, who decides how it will be used. In its first stage, in the context of PRAF-I (1990-1998) the BMI aimed at 203,600 beneficiaries. An evaluation of PRAF-I performed by the IDB showed that the BMI had reached 84% of its target population. It also noted some problems in the implementation of the program (IDB, 2002). These were:

1. A preoccupation with the process of voucher distribution rather than results
2. Poor targeting, since 40% of BMI beneficiaries were in the two highest quintiles
3. Little evidence that demand incentives per se were improving health and/or nutritional status of the targeted population

Seeking to improve its outcomes, the program's second stage, PRAF-II (from late 1998 to present) seeks to make the transition from a model of social compensation to one of capital accumulation by the poorest families. To this end, the following changes were proposed (IDB, 2002):

a) Improve targeting towards the poorest families

b) Improve monitoring and evaluation capabilities

c) Improve information and management systems

d) Offer both supply and demand incentives to induce behavior modification both in the households as well as among services providers

e) Replace the single BMI voucher with two different subsidies: *i)* a US$ 48 per capita per year transfer (maximum two per family) to promote better nutrition for children and pregnant women and foster their demand for health care. The goal is to provide 69,000 subsidies per year. *ii)* a supply-side subsidy to encourage NGOs to provide nutrition and hygiene training to approximately 27,000 people, and a transfer of US$ 5,000 each to around 150 rural health centers to provide adequate health services to PRAF beneficiaries

The program's targeting mechanism has changed over time. Until 1998, beneficiaries were selected first based on the prevalence of stunting and poverty, and secondly according to their score on the Unmet Basic Needs index. PRAF-II attempted to create a simpler system, choosing municipalities based on malnutrition and families based on household income (Hernández, F., 2006). While PRAF-I continues in operation, PRAF-II is currently being implemented in 70 municipalities located in the seven poorest departments of the country (Government of Honduras-Office of the President, 2005), replacing PRAF-I in those municipalities.

The health portion of the program consists of a biannual transfer, totaling Lps644 per beneficiary (about 33 dollars per year). Each family is limited to two beneficiaries. Health transfers may be complemented by education supplements for older children, which are dependent on school attendance and which are slightly larger (Lps812, or about 42 dollars, per year for up to three beneficiaries) (International Food Policy Research

Institute, 2004). Handa and Davis estimated that the average beneficiary family receives 17 dollars a month from all PRAF benefits, which represent 8% of monthly income at the poverty line and 10% of monthly household spending (Handa and Davis, 2006). Benefits are set to rise dramatically in the coming years, ranging from Lps3,300 to as much as Lps4,300 (135 to 225 dollars) per beneficiary per year (Hernández, F., 2006). This rise will make the cash transfer a much larger portion of household income, more closely approximating the benefits of Mexico's OPORTUNIDADES program.

Since 1998 the BMI also includes a supply-side subsidy, called Incentive to Quality in Health (ICS) and aimed at health providers (León A., Martínez R., Espíndola E., and Schejtman A. 2004). The ICS consists of a basic package of drugs and medical equipment as well as funds to train and provide performance incentives to health workers, cover expenditures for obstetric emergencies, and provide nutrition and hygiene training to mothers. Funds per center vary from Lps. 90,000 to 220,000 per year, depending on the size of the population to be served, the amount of health workers, and the specific health center's requirements.

Although the BMI has a national scope, it has not yet reached national coverage. As of 2004 it was implemented in 211 of 298 municipalities, including La Paz, Valle, Ocotepeque, Santa Barbara, Copan, Olancho, Comayagua, El Paraíso, and Francisco Morazán. According to government documents, between 1990 and 2005 the BMI benefited nearly 1.5 million people (Hernández, F., 2006). Between 1998 and 2004, around 4% of the beneficiaries - 22,618 people - were breast feeding or pregnant women (Government of Honduras, Office of the President, 2005).

Funding for the BMI comes from the national budget, as well as from the IADB, UNESCO, the European Union, UNICEF, PAHO, and bilateral agencies.

Table 41; Main features of the BMI

Feature	Category
Type	Conditioned cash transfer
Mode of financing	Publicly funded social assistance
Source of funds	General taxes Other revenues (Extra budgetary sources: IDB, AECI, USAID, UNESCO, UNICEF, PAHO, European Union)
Risk pooling arrangement	Income-based
Management and management level	MoH at national/sub-national/local level
Degree of selectivity	Targeted: pregnant or breast-feeding women, children under five years old and disabled children under 12 years of age
Who is entitled to coverage	Family
Condition for access	Means tested specific attribute: proof of income/age/proof of child-birth/proof of pregnancy
Extend of risk pooling	Small pool
Explicit portfolio?	Explicit
Degree of coverage	Complementary
Provision	Public/private non-profit (NGOs)

2). CHARACTERIZATION OF THE GENERAL SETTING IN WHICH THE SPHS IS IMPLEMENTED

Basic Information - Honduras is a low income country located in Central America with a total population of 6,941,000. It has undergone serious macroeconomic problems since the 1980s, characterized by high external debt, a low rate of growth, and extreme volatility of growth. During the 1990's, the country also suffered two major droughts and two hurricanes which left a trail of destruction and loss in their wake. Governance is problematic, as expressed in weak norms and institutions and a limited capacity to bring about consensus and lead constructive changes. Honduras suffers from a weak court system, problems with conflict resolution, and poor citizen control over public policy and management (IDB, 2002).

Economy - Honduras is the third-poorest country in the Western Hemisphere after Haiti and Nicaragua. Its per capita income today is lower in real terms than 20 years ago (IDB, 2002). Honduras is highly dependent on foreign aid and this dependency has increased after Hurricane Mitch hit the country in 1998.

According to World Bank data, in 2004 the country's GNI (Gross National Income) was US$ 7.3 billion and the GNI per capita (Atlas method, current US$) was US$1,030 (average GNI per capita for the LAC region was US$ 3,600). Although the share of households living under the poverty line decreased from 67.5% to 63.9% between 1993 and 2002, households living in extreme poverty increased from 45.1% to 45.2% in the same period (Instituto Nacional de Estadisticas (INE), 2002). Poverty in Honduras is exacerbated by income inequality, which increased by 3% between 1991 and 1998 (World Bank, 2004). In the rural areas, where households are scattered throughout villages and remote mountainous areas, 62.7% of the population lives in extreme poverty (World Bank, 2004), and a baseline survey executed by the IDB in 2000 found that this figure was 70% in certain communities (IFPRI 2001). As of 2003, the urban population reached 45.6% of total population, while rural settlers were 54.4% of total population. While the unemployment rate is low - 4.8 % in 2002 - 54.6% of working people had a job in the informal economy and underemployment accounts for 35.9% of total employment (INE, 2002). Low productivity and low salaries may be explained by the low level of education among the working population, which has 5.3 years of education on average.

Health and Education - In 2003 the adult literacy rate (ages 15 and above) was 80% and life expectancy at birth was 67.6 years. As of 2002, 68% of the total population had access to improved sanitation and 90% of the total population had access to an improved water source (UNDP, 2005) although 47% of the population did not have access to a sewerage system (PAHO 2004).

Because of the high levels of poverty and a large rural population, the majority of Hondurans cannot afford doctors, drugs or transportation to health care facilities. A very small percentage of Hondurans have access to medical services. According to a study performed by PAHO/WHO in 2001, 56% of total population was excluded from access to health care. The main causes of exclusion were deficits in infrastructure and medical supplies (PAHO, 2004). The Garifunas, the main indigenous group, are one of the country's most excluded populations.

Other social indicators that negatively affect the performance of the health services include the proliferation of marginal urban areas, an increase in the population over age 60, and the fact that more than half of the population is below the age of 19 (PAHO/WHO, 2001(b)). The country also has weak coordination among providers in the public health services network and insufficient coordination between the public and private providers (PAHO/WHO, 2001(b)).

Honduras's Infant Mortality Rate has declined over the last decades, following the regional trend. Much of the improvement occurred in a short period in the mid-1990's, when the IMR dropped from 50 deaths per 1,000 live births to 42 (PAHO, 2004). The rate of decline seems to have slowed, however, and in 2003 the IMR was 32 per 1,000 live births. The prevalence of malnutrition/ low weight in children under five years old was 17%. Between 1993 and 2001 coverage of the expanded program of immunizations for children under one exceeded 95% for some vaccines.

Between 1990 and 1997, the country's maternal mortality ratio dropped from 182 to 108, an impressive reduction in such a short period. Some researchers suggest that this was the result of the cooperative relationship developed between international donors and national health officials, resulting in effective transfer of policy and institutionalization of the priority of reducing maternal mortality within the country's system (Shiffman et al, 2004). In 2003 the maternal mortality ratio according to modeled estimates was 110 per 100,000 live births and data for 2001 indicate that 55.7% of births were attended by skilled health staff. In 2007, the total fertility rate was 3.5 (CIA World Factbook), while the adolescent fertility rate in 2004 (15-19) was 99 births for every thousand women ages 15-19 (Global Health Facts, 2007). Adolescent pregnancy is one of the main reproductive health problems in the country.

Although the country's national public health system was created in 1959, when the Honduran Social Security Institute began to operate, the expansion of health services in all regions of the country has been very slow. In 1990 Sectoral Reform began within the context of state modernization, but no agenda was set up for the reform. In 1999, as part of the national reconstruction and transformation in the wake of Hurricane Mitch, the "1999-2001 Policy Guidelines" were established to meet the population's health expectations with equity, quality, solidarity, and citizen participation and to strengthen the health network and expand coverage (PAHO/WHO, 2001(b)).

As of 2002 Honduras's total expenditure on health as a percentage of GDP had increased to 6.2%, from 5.6% in 1998. Government expenditure on health in 2002 made up 51.2% of the total, and 41.6% of total expenditure on health was out-of-pocket. The health care needs of the population are generally met through public services provided by the central and/or municipal government, autonomous State enterprises, and private for-profit or non-profit entities. The Honduran population is guaranteed a basic level of health protection; however, in practice, more than 30% of the population does not receive it (PAHO, 2004). PAHO also estimates that in 2001 83.1% of the population was not covered by any type of insurance scheme and thus relies completely on public institutions and non-profit private organizations.

The public sector is comprised of the Ministry of Health and the Honduran Social Security Institute (IHSS). The Ministry of Health has assumed the steering and regulatory role for the social sector, formulating policies, overseeing the operations of the agencies that make up the system, and generally guaranteeing the constitutional right to health protection (PAHO/WHO, 2001(b)). The IHSS is a decentralized institution that not only collects and manages tax revenues from compulsory employees and contributes to the health sector , but also engages in health promotion, protection, and recovery activities in specific geographic areas through care networks comprised of outpatient and hospital facilities.

Table 42: Honduras: general situation

Contextual factor	Health status		Demand for health care	
	Deteriorates	Improves	Hinders	Promotes
Poverty Level	X		X	
Education level		X		X
No. of rural dwellings/ remote settlements	X		X	
Access to water/sanitation/electricity	X			
Government's institutional strength/fragility	X			
Country's governance	X		X	
Unemployment Rate		X		X
Labor informality	X		X	

3). ANALYSIS OF THE PERFORMANCE OF THE SPHS

a). Has it increased equity in the access to/utilization of health services?

The BMI has increased utilization of health resources and interventions, the IDB reports. Vaccinations, pre-natal visits, and check-ups have all increased (IDB, 2007). It is not clear that the BMI has increased equity, however, nor that it has improved health status (see below). The BMI has not yet reached all the eligible population in the targeted regions because of lack of resources and inadequate distribution of vouchers. Moreover, an evaluation performed by the IDB in 2002 found that 40% of BMI beneficiaries in the poorest areas are in the two highest quintiles (IDB, 2002).

b). Has it offset hindering social determinants?

Given its nature, it is expected that the BMI would contribute to offsetting poverty. However, it is not clear that the program has achieved this goal, given the widespread poverty existing in the country, the limited amount of resources allocated to the program, and the problems faced in the application of the program so far. In their evaluation of the programme, the IDB argues that the amount of the money given to the families is too small to induce changes on their consumption, given that it represents less than 5% of the target population's total spending (IDB, 2002). It is noteworthy that similar conditioned cash transference programs implemented in Mexico and Nicaragua represent 20% and 18%, respectively, of the eligible families' total spending (IDB, 2002).

While two of the program's four goals are related to malnutrition (to reduce food insecurity and alleviate malnutrition during periods of economic adjustment) no significant changes were found in the caloric consumption of women and children participating in the program, and the increase in protein consumption is lower than that achieved by other programs (Bitran and Muñoz, 2000). This may be related not only to the small amount of the voucher but also to the low frequency of delivery (twice a year) which means the voucher cannot be incorporated in the family budget on a regular basis (IDB, 2002).

A study carried out in 1995 showed that the BMI had an important and positive impact on women's education and thus promoted a greater demand for health services (Bitran and Muñoz, 2000)

Table 43: BMI's performance: social determinants

Category	**Performance**	
	yes	**no**
Offsets poverty by eliminating or reducing economic barrier		X
Fosters women's social status		X
Fosters health rights through Right Charts, explicit guarantees, etc.		X
Offsets unemployment/informal labor by eliminating or reducing economic barrier		X
Offsets women's lack of education, fostering demand for health care	X	

c). Has it increased access to and coverage of technically appropriate interventions by eliminating at least one source of exclusion in health?

A study conducted in three regions of the country in 1992 found that the utilization of health care and preventive services by children under five years old increased dramatically between 1990 and 1991 (Bitran and Muñoz, 2000). The author argues that this can be credited to the implementation of the BMI because health services utilization among similar populations served by health facilities that were not providing the BMI decreased over the same period, while utilization by adults served by health centers that did provide the BMI slightly increased. An evaluation conducted by the IDB in 2002 found that health services utilization and the education of the mothers regarding health and hygiene had increased, as have the number of well-child check-ups and the percentage of pregnant mothers that have 5 or more prenatal controls (IDB, 2004).

The BMI has increased its coverage over time, although many problems with voucher distribution remain. Increasing the demand for health care may be crucial to reducing maternal and child mortality, since one of the most important components of prevention is timely and adequate recognition of illness and the subsequent demand for health care. In order to achieve this goal and to reduce causes of exclusion, the program should increase coverage and reach the most disadvantaged groups.

The BMI has not been given the highest priority regarding public social spending, not even within PRAF. For example, according to the 2005 Honduras Government Report on the Poverty Reduction Strategy (ERP), in the second semester of 2004 the total budget allocated to the area of strengthening protection to specific groups was Lps. 166.6 million (US$ 8.66 million), of which Lps. 139.7 million (US$ 7.3 million) was disbursed through PRAF. The BMI was assigned 10% of this budget, around US$ 700,000 (Government of Honduras, Office of the President, 2005). Moreover, the scheme's dependency on extra-budgetary resources from international cooperation agencies remains one of its main weaknesses and threatens its sustainability over time.

One of the BMI's goals is to foster health services utilization by introducing health-seeking behavior, so that health care will be demanded when needed. In this sense, the BMI may be contributing to reducing the cultural barriers that prevent the demand for health care. However, if the BMI were to be fully applied all over the country and actually succeed in reaching all eligible beneficiaries, the resulting increase in demand for health services might pose serious strains on infrastructure as well as on the human resources needed to meet that demand. The program's low coverage, a result of financial limitations, prevents this from happening today.

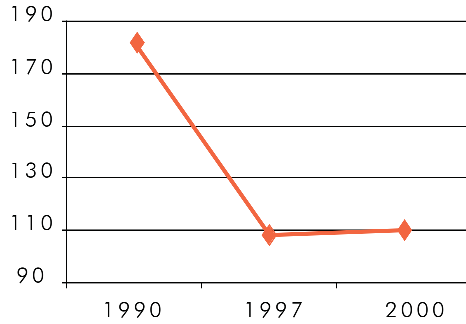
Table 44: BMI. Coverage and access

Category	SPHS	
	yes	no
Increases coverage (rise in number of people covered as a % of eligible population)	X	
Establishes a single guaranteed portfolio of entitlements with the same quality, content, and delivery conditions for all socioeconomic groups so as to avoid segmentation		X
Increases coordination/integration within the system so as to avoid fragmentation		X
Improves resource allocation and organization of health interventions by increasing number and capabilities of human resources in previously underserved areas		X
Improves resource allocation and organization of health interventions by increasing the amount of public spending allocated to the scheme		X
Public spending allocated to the scheme is progressive		X
Improves geographical distribution of the service delivery network and health infrastructure by increasing number/amount of health facilities, equipment, medical devices, and drugs in previously underserved areas		X
Increases information system's coverage		X
Increases access (number of people who access health goods or services provided by the scheme)	X	
Eliminates/reduces geographic barrier		X
Eliminates/reduces economic barrier	X	
Eliminates/reduces gender barrier	X	
Eliminates/reduces employment status barrier	X	
Improves access to drinkable water, sewerage, roads and/or transportation		X
Improves refuse collection		X

d). Have health outcomes improved?

The IDB's Office of Evaluation and Oversight reported in 2007 that the health component of the PRAF-II had "no impact on incidences of stunting, diarrhea, or [mal] nutrition" (IDB, 2007). The BMI may be playing a role in the decline of the Infant Mortality Rate but the program's low coverage makes it difficult to draw conclusions. The Maternal Mortality Ratio has decreased significantly over the period 1990-2001, although rates are still high and the rate of decline has slowed significantly. In 1990, there were 182 maternal deaths for every 100,000 live births, falling to 108 in 1997 (Danel, 1999). The most recent figure for Maternal Mortality Ratio shows little change: it was estimated at 110 in 2000 (WHO, 2007).

Graph N. 6
Maternal Mortality Rate under PRAF, 1990-2001



Source: Danel 1997 and WHO 2007.

Table 45: BMI's performance

Goal	Performance
Increase equity in the access to and/or utilization of health services	No. An important share of the beneficiaries are in the highest quintiles
Offset social determinants that hinder demand for health care and/or hamper health status	It seems to offset mother's lack of education
Increase access to and coverage of technically appropriate interventions by reducing or eliminating at least one cause of exclusion	It helps reduce the economic barrier

5.6 OPORTUNIDADES Program -MEXICO-

1). CHARACTERIZATION OF THE SPHS

Mexico's Programa de Desarollo Humano OPORTUNIDADES (originally named Progresa and now known as OPORTUNIDADES) is a cash transfer scheme designed to encourage families to invest in the health, nutrition, and education of children. A financial payment is made to the female head of the household and is conditional, among other things, on the family's registration at the nearest health post; their utilization of health services, especially those for pregnant women, lactating mothers, and children under 5; and the head of household's monthly attendance at community health classes (OPORTUNIDADES, Reglas de Operación 2007). The program covers a large spectrum of benefits, including those for senior citizens and students through college, but this analysis focuses on the maternal and child component of the scheme.

Progresa/OPORTUNIDADES was designed to tackle the country's stubbornly high poverty rate and to replace a set of food subsidies and other poverty programs that were widely considered to be ineffective. It expanded rapidly; in 2002 the program, which was originally implemented in the poorest rural areas of the country, had been implemented in 31 states. Funds allocated to the program grew accordingly, from US$34 million in 1997 to US$3.6 billion in 2007 (Sedesol, 2007). The size of the cash transfer is large, and overall these payments represent around 20% of the participating families' income (Coady, 2003; IDB, 2002). Currently the program serves about 5 million families, a group of beneficiaries that is about 25% of Mexico's total population, 50% of its poor population and almost 100% of its extremely poor population (Sedesol, 2007).

The program ensures progressive spending by using three levels of targeting to select beneficiaries. First, the government determines the general geographical areas in which the program will be implemented, based on a development index that considers income level, population density, and access to health and education. Villages within these areas are given a community poverty score based on information about educational level, occupation, and housing conditions available from national census data. Finally, poor families within those villages are selected on the basis of data about factors closely associated with income, collected through a special community census. There is no application procedure; families

e informed about the program and about their eligibility.[18] The benefit is valid for three years but is conditional on meeting the requirements stipulated by the program. After three years, the families are reviewed to determine whether they are still eligible. If they still meet the socioeconomic criteria for the program the benefit is renewed. The program covers a large spectrum of benefits, including those for senior citizens and students through college, but this analysis focuses on the maternal and child component of the scheme.

OPORTUNIDADES requires mothers to seek preventive care, such as prenatal care, well-baby care, child immunizations, growth monitoring for children 0-5 years old, and adult preventive check-ups. Pregnant women are required to have five prenatal visits in the first three months of pregnancy, and children less than 24 months must be monitored for growth and immunization every two months. Lactating women are also required to have two visits per year for nutritional monitoring. Besides cash, the program also offers free food supplements to all pregnant women and children under the age of 2, as well as to children under 5 who show signs of malnutrition.

Funding for OPORTUNIDADES comes from general taxes and the IDB and World Bank.

Table 46: Main features of OPORTUNIDADES

Feature	Category
Type	Conditioned cash transfer
Mode of financing	Publicly funded social assistance
Source of funds	General taxes Other revenues: extra-budgetary sources: IDB, World Bank
Risk pooling arrangement	Income-based
Management and management level	Ministry of Social Development, with the assistance of the Ministries of Education and Health at national, sub national and local level
Degree of selectivity	Targeted: pregnant or breast feeding women, children under 5 years of age from poor families
Who is entitled to coverage	Family
Condition for access	Means tested specific attribute: proof of income/age/proof of child-birth/proof of pregnancy
Extend of risk pooling	Small pool
Explicit portfolio?	Explicit
Degree of coverage	Complementary
Provision	Public

18. When implementation of the program first began in the rural areas, eligibility requirements were reviewed by the community, which could nominate the excluded families in event of an obvious targeting error. A process of certification of eligibility would then take place. In urban areas, eligibility was based on self-selection due to the high costs of undertaking a census prior to the implementation of the program.

2). CHARACTERIZATION OF THE GENERAL SETTING IN WHICH THE SPHS IS IMPLEMENTED

Basic Information and Demographics – Mexico is an upper-middle income country, consisting of 31 states and more than 2,438 municipalities. According to the 2005 census, its population is about 103 million (INEGI, 2005). The majority of the population - 75.5% - is concentrated in urban areas, with nearly one-third of the population living in five of the thirty-two metropolitan areas in Mexico (UNDP-HDR, 2005). Mexico is characterized by great socioeconomic and ethnic diversity both within and between regions and states. This diversity is a permanent source of social conflict and has triggered several political crises along the history of the country (World Bank, 2005; UNDP-HDR, 2005). Significant inequality between city and village persists, with the rural areas - populated mostly by indigenous groups - showing worse indicators for almost all aspects of social development including health, education, employment, income, and access to basic services. In 2004, one out of three rural residents was living in extreme poverty, compared to one out of ten urban residents (World Bank, 2006).

Governance - General elections in Mexico in 2000 ended 70 years of the Institutional Revolutionary Party (PRI)'s rule, and the one-party political system was replaced by a multi-party one. Although this process is considered an important democratic leap forward, governance has significantly weakened over the last years, overshadowing democratic gains. Some authors argue that protests against government policies and labor strikes increased dramatically during the administration of Vicente Fox.[19] Drug-related violence has also increased over the past several years (Power and Interest News Report, 2006).

Economy – Mexico's GDP grew by 4.8% in 2006, to over 1.1 trillion US dollars (PPP), and the 2005 GNI per capita was 10,560 dollars (PPP), the second highest in Latin America. However poverty in the country remains high, and as of 2003, an estimated 40% of population lived on less than US$ 2.00 a day, of which 9.9% lived with less than US$ 1.00 a day (UNDP-HDR, 2005). The Ministry for Social Development estimates that 17% of the population lives below the food poverty line (or *pobreza alimentaria* in Spanish) – that is, they can't afford to fulfill their basic nutritional needs (Cruz, de la Torre, Velázquez, 2006). According to the Ministry for Social Development, 50 million Mexicans (about 50% of the population) live in poverty, with half of those living in extreme poverty, or what the government calls "pobreza de capacidades." [20] This figure does represent an improvement over the 64% poverty rate the country experienced following the 1994-1995 financial crisis.

19. Mexico elected a new president, Felipe de Jesús Calderón Hinojosa, in December of 2006.
20. Pobreza de capacidades is defined as living on two dollars or less a day in rural areas and less than three dollars a day in urban areas (Sedesol, 2007).

Unemployment decreased from 3.7% in 1997 to 2.5% in 2003, a period during which the number of jobs in the maquiladora industry grew significantly (UNDP-HDR, 2005). However, 61.8% of the total employed persons in Mexico work in the informal economy (Negrete R., 2001), and real wages for the urban poor have decreased by 5% since 1991. Real wages have fallen mainly in the self-employment sector, where the poor are disproportionably represented. Real wages for the extreme poor who are self employed and do not own capital had fallen by 22% as of 2003 (World Bank, 2006). Real incomes for workers in Mexico's manufacturing sector declined by a cumulative 2.6% between 1995 and 2005 (World Bank, 2006).

Health - Life expectancy at birth in 2003 was 75.1 for both sexes, and the adult literacy rate (% of those aged 15 and above) was 90.3 (UNDP-HDR, 2005). Fertility rates have declined from 2.7 in 1997 to 2.2 in 2007 (Consejo Nacional de Población, 2006), but the average number of children per woman in rural areas is still high (2.3 versus 1.4 in urban areas). As of 2002, 77% of population had access to improved sanitation and 91% had access to an improved source of water (UNDP-HDR, 2005).

The health system in Mexico is comprised of three main sectors: Social security, the public sector under the Ministry of Health and the private sector. The Social Security sector covers formal workers and includes the Mexican Social Security Institute (IMSS), the Social Security and Services Institute for State Workers (ISSSTE), Petróleos Mexicanos (PEMEX), the Armed Forces (SEDENA) and the Navy. The Ministry of Health covers the uninsured population in rural and urban areas. In 2003, the government created the System of Social Protection in Health (SPSS), which established the Seguro Popular. Through a resource allocation by the central government and the states, the Seguro Popular provides health insurance for a basic package of health services to families and citizens that, due to their employment and socioeconomic condition, are not covered by the Social Security institutions.

The Mexican health system is characterized by high degrees of segmentation and fragmentation, with a number of different health care provision programs co-existing without any integration and often representing the conflicting interests of different political forces. This produces huge inefficiencies in the provision of health services. In 2005, the social security institutions covered 55 million salaried workers in the formal sector, representing a decrease of 2.56% from 2000, due to a variation in the unemployment rate from 2.2% in 2000 to 3.75% in 2005. Informal workers, the rural uninsured population, and the unemployed account-

ed for 45 million people in 2005. They received care from the Central Government's Secretary of Health and the States Secretaries of Health, which oversee public hospitals and clinics. There are huge differences between the states in terms of their availability of per capita resources to provide health services, and there are access problems for those in rural areas (PAHO, 2007).

In 2004, the under five mortality rate in México was 22.9 per 1.000 live births, high when compared to other upper-middle income countries in the region, such as Chile and Uruguay (PAHO, 2005). The maternal mortality ratio, according to modeled estimates, was 83 per 100,000 live births in 2003 (World Bank, 2003). This figure fell to 60 per 100,000 live births in 2005, according to estimates made by WHO/UNICEF/UNFPA/World Bank (WHO, 2008). Mortality rates differ widely from state to state, with the Federal District, Puebla, Oaxaca, and Chihuahua registering higher rates than other departments. Mortality from preventable diseases is high, especially in the southern region, including deaths from malnutrition, common infections, and diseases associated with pregnancy and childbirth (PAHO, 2002). Mortality rates are especially high among the country's 63 indigenous groups, whose IMR is 58% higher and MMR three times higher than that of the non-indigenous population (PAHO, 2007).

Table 47: Mexico's general situation

Contextual factor	**Health status**		**Demand for health care**	
	Deteriorates	**Improves**	**Hinders**	**Promotes**
Poverty	X		X	
Education level		X		X
Rural dwelling/ remote settlements		X		X
Access to water/sanitation/electricity		X		
Government's institutional strength/fragility		X		
Country's governance	X			
Unemployment		X		X
Labor informality	X		X	

3). ANALYSIS OF THE PERFORMANCE OF THE SPHS

a). Has it increased equity in the access to/utilization of health services?

OPORTUNIDADES has a very strong evaluation component that aims to assess the program's impact using both qualitative and quantitative methods. The evaluation allows for any necessary adjustments on the program's design and execution and assists in the tracking of the program's objectives and goals. Yearly evaluations have been performed since 1999.

Early small studies found excellent results for the targeting system in place for OPORTUNIDADES, but outcomes may have become less progressive as the program was scaled up. Household surveys executed immediately before and two years after its initiation, in approximately 300 villages that had received services and 200 villages that had not, found that almost 60% of people reached by OPORTUNIDADES belonged to the poorest 20% of Mexico's population, with 80% of beneficiaries were in the two lowest quintiles (Bitran and Muñoz 2000). The study attributed these highly progressive outcomes to the selection of poor villages and the linkage of benefits to education/health program participation by children (since the poor have more children than the better-off). But a more recent World Bank study found that only 30% of the program's beneficiaries were in the first quintile of income, and only 60% were in the lower two quintiles (Lindert, 2005). Still, those in the lowest quintile receive nine times the benefits of those in the highest (Lindert et al. 2005). This area of OPORTUNIDADES' operation would benefit from further study.

A 2004 study of the effect of OPORTUNIDADES found a highly significant (50%) increase in the demand for check-ups in towns where the program was in place compared with towns where it was not (Bautista, 2004). Bautista also showed a sharp increase in curative visits after the implementation of the program, which eventually leveled off while preventive visits increased, implying that better preventive care had decreased the need for curative care. Public health clinics received double the visits than private facilities, and the program increased utilization of health services for all age groups, except for children 0-2 years old (Gertler, 2000). Gertler hypothesizes that OPORTUNIDADES must have had a positive impact on preventing illnesses for this age group, resulting in a lower number of visits. The evaluation also shows an increase in monitoring for malnutrition and that OPORTUNIDADES children between the ages of 0-5 have a 12% lower chance of getting ill than children who are not receiving the benefit.

Since the program has been functioning in rural areas for a longer period, less attention has been paid to its impact on urban areas. Short-term results, though, are equally promising. An external evaluation found that urban families incorporated into the program increased their demand for health services by more than 25% compared to those who were not included. There were slight gains in the proportion of births attended by qualified personnel (Cruz, de la Torre, Velázquez, 2006).

b). Has it offset hindering social determinants?

Results to date indicate that the program has been successful in ameliorating poverty among the participant families. An evaluation conducted by the International Food Policy Research Institute in 2000 found that after three years of implementation, OPORTUNIDADES had reduced poverty by 8% in areas that benefit from the program when compared to those that do not. An important reason for this is the size of the cash transfer, which represents a 20% average increase in the income of households living in extreme poverty. Moreover, Hoddinott and Skoufias found that 70% of the cash transfer had been used to increase food availability in the household both in terms of quantity (calories) and quality (proteins and micronutrients) (Hoddinott and Skoufias, 2000).

But the reduction in poverty may not be equitable. One study found that, though the household income of incorporated families did rise over the period 1997-2002, the largest increase was among those households that had been the best off to begin with (Rubalcava and Teruel, 2003). These results were echoed in the findings of Fuentes and Soto, who discovered that height in children under five was positively correlated with educational and income level of the father, leading them to speculate that those families that are less poor are better able to navigate the program (Fuentes M. and Soto H., 2003). And there appears to be little relation, at least in the short term, between percentage of families incorporated into OPORTUNIDADES and poverty reduction at the state level (Parker and Scott, 2001).

OPORTUNIDADES, in an attempt to offset the negative effect on health of women's low status, has an explicit gender focus. The program engages with gender in three ways:

1) it gives the financial transfers specifically to the female head of the household
2) beginning at the secondary school level, the transfers associated with school attendance are higher for girls than for boys
3) it offers special health care benefits for pregnant and lactating

mothers

Women participating in the program have become more likely to determine on their own how to use their extra income from OPORTUNIDADES and have developed more awareness, confidence and control over their activities. Results from focus groups showed OPORTUNIDADES has promoted recognition of the contribution and role of women in caring for their families (Wodon Q., De la Briere B., Siaens C., Yitzhaki S., 2003). Results are more mixed when it comes to more important decisions. Although Wodon et al. found that OPORTUNIDADES decreased the probability that husbands made decisions alone in five out of eight decision-making categories, a similar focus-group study saw little impact on decision-making outside of the management of daily household affairs (Adato M. and D. Mindek, 2003).

Table 48: Performance of OPORTUNIDADES: social determinants

Category	Performance	
	yes	no
Offsets poverty by eliminating or reducing economic barrier	X	
Fosters women's social status	X	
Fosters health rights through Right Charts, explicit guarantees, etc.		X
Offsets unemployment/informal labor by eliminating or reducing economic barrier	X	
Offsets women's lack of education, fostering demand for health care	X	

c). Has it increased access to and coverage of appropriate interventions by eliminating at least a source of exclusion from health care?

Skoufias and McClafferty'summary of evaluations of the program (2001) found that attendance at health visits by children under 6 years of age was 50% higher in the beneficiary population. According to recent studies, this proportion has risen over the period of the program's implementation (Hernandez M. et al, 2006).

OPORTUNIDADES has not been as successful in the area of maternal and pre-natal care. Skoufias and McClafferty'summary of evaluations of the program reports an 8% increase in clinic visits by pregnant women in their first trimester (Skoufias and McClafferty, 2001). However, Bautista reports that pre-natal check-ups actually fell in both participating and non-participating clinics between 1996 and 2002. OPORTUNIDADES clinics even saw a greater drop (50%) in consultation in those clinics that

were not incorporated into the program (Bautista, 2004). The program does seem to have increased access to quality pre-natal care (measured by time of first pre-natal check-up, number of total pre-natal visits, and actions performed during those visits) in rural areas. But it has not succeeded in increasing the proportion of births attended by trained personnel in rural areas, which has actually fallen compared to the percentage among women not incorporated into OPORTUNIDADES (Hernández-Prado et al., 2005). Results are similar in urban areas: women incorporated into the program are significantly less likely (either than those eligible but not incorporated, or those not eligible) to have attendance by qualified medical personnel at the birth and/or to give birth in a medical setting (Hernández-Prado et al., 2005).

Ochoa and Garcia, based on an evaluation performed in the state of Chiapas, found few, if any, significant improvements in access to interventions among beneficiaries of the program, and often discovered that non-beneficiaries who have access to different systems of free health care, were more likely to demand care beyond those interventions that are prerequisites for receiving the cash transfer (Ochoa and Garcia, 2005). The main explanation given for these unexpected results was the poor quality of the health care offered under *OPORTUNIDADES*. Ochoa and Garcia argue that the impact of the program on health equity will be limited unless it is associated to a substantial improvement of the health services provided by the health providers (Ochoa and Garcia, 2005).

Table 49: OPORTUNIDADES: Coverage and access

Category	SPHS	
	yes	**no**
Increases coverage (rise number of people covered as a % of eligible population)	X	
Establishes a single guaranteed portfolio of entitlements with the same quality, content, and delivery conditions for all socioeconomic groups so as to avoid segmentation		X
Increases coordination/integration within the system so as to avoid fragmentation		X
Improves resource allocation and organization of health interventions by increasing number and capabilities of human resources in previously underserved areas		X
Improves resource allocation and organization of health interventions by increasing the amount of public spending allocated to the scheme	X	
Public spending allocated to the scheme is progressive	X	
Improves geographical distribution of the service delivery network and health infrastructure by increasing number/amount of health facilities, equipment, medical devices, and drugs in previously underserved areas		X
Increases information system's coverage		X
Increases access (rise in number of people who access health goods or services provided by the scheme)	X	
Eliminates/reduces geographic barrier		X
Eliminates/reduces economic barrier	X	
Eliminates/reduces gender barrier	X	
Eliminates/reduces employment status barrier	X	
Improves access to drinkable water, sewerage, roads, and/or transportation		X
Improves refuse collection		X

d). Have health outcomes improved?

Gertler found that children under 5 who were participating in the program had a 25% lower incidence of illness than their non-participating peers and suggested that morbidity rates drop the longer a child stays in the program (Gertler 2004). Infant mortality was also 2% lower in towns that were incorporated into OPORTUNIDADES (Hernández B. et al., 2005). This may be related to the finding that the program produced declines in levels of child malnutrition as measured by children's weight by height: participating children between 1 and 3 years of age experienced a 16% increase in their annual growth when compared to non-participating children (Behrman and Hoddinott, 2000). This effect seems to be progressive: incorporation into OPORTUNIDADES was positively associated with better growth among the youngest and poorest children.

The average height of this group (children under 6 months old and living in the poorest households) was 1.1 cm greater, even when adjusted for age and size at birth. OPORTUNIDADES was also associated with lower rates of anemia in low income, rural infants and children (Rivera J., Sotres-Alvarez D., Habicht J., Shamah T., Villalpando S., 2004).

The program seems to have had a positive effect on maternal mortality as well. The most recent major study, which was performed in 2003, found an 11% reduction in maternal mortality in villages that had households incorporated into the program, as opposed to those villages with no incorporated homes. This effect was strongest in areas of medium and very high marginalization, but it did not rise proportionately with the percentage of people incorporated into the program (Hernández B. et al., 2005).

Table 50: Performance of OPORTUNIDADES

Goal	Performance
Increases equity in the access and/or utilization of health services	Yes. The majority of beneficiaries are poor.
Offsets social determinants that hinder demand for health care and/or hamper health status	It has helped to offset poverty. The size of the cash transfer represents a 25% increase in income of extremely poor households. It has fostered the demand for health care among mothers. It fosters social status of women within the family and promotes girls' attendance at school.
Increases access to and coverage of appropriate interventions by reducing or eliminating at least one cause of exclusion in health	It has contributed to removing economic barriers. It has increased access to health care interventions. It has not increased coverage of appropriate interventions

5.7 Integrated Health Insurance (SIS) -PERU-

1). CHARACTERIZATION OF THE SPHS

The Integrated Health Insurance (Seguro Integral de Salud, SIS) is part of a larger strategy of the Ministry of Health, in line with the recommendations set by major international donors, to reduce high mortality rates by eliminating the economic, cultural, and informational barriers that prevent the poorest households from accessing health services. SIS was created in 2001 by integrating two preceding initiatives: the Mother and Child Insurance (Seguro Materno-Infantil, SMI) and the Free School Health Insurance (Seguro Escolar Gratuito, SEG).

The SEG was created in 1997 to benefit school children from 3 to 17 years of age. It covered accident- and disease-related health care services, which were provided in public facilities. Initially designed as a pilot project, President Fujimori ordered its implementation nationwide (Holst, 2005).

The SMI was designed to support public health priorities that focused on pregnant women, new mothers and children 0-4 years of age. It was created in 1998 and functioned as a demand subsidy that financed the costs of health services as they were needed. It was initially implemented in two pilot zones of the country and expanded to five other departments in 1999 (Jaramillo and Parodi, 2004). The SMI covered women, during pregnancy and postpartum, and all children from childbirth until 4 years old, whenever they were not affiliated to other health insurances, public or private. The SMI only covered the population of the departments where it was implemented. It insured against the main illnesses and risks associated with pregnancy, and included periodic monitoring of the pregnancy, natural births and c-sections, monitoring of postpartum, nutritional deficiencies, and oral health. In the case of children, the insurance covered child developmental screening and growth monitoring, immunizations, diarrhea, and respiratory infections. The estimated beneficiary population for the period 1999-2001 was 718,121 persons (Jaramillo and Parodi, 2004). No law regulated the creation of the SMI.

Although the SMI was directed at low income groups, usually from the informal sector, its benefits did not reach the target population. Coverage of the SMI was low, and only 33% of the population was affiliated to the program. When this figure was disaggregated by socioeconomic level, the SMI showed a regressive pattern. Only 25% of those affiliated to the SMI belonged to the lowest quintile, while affiliation in the highest quintile was 37%, according to an ENDES 2002 survey. In other words,

nearly 1 in every 3 people that used the services of the SMI was not poor (Jaramillo and Parodi, 2004).

The Group for the Analysis of Development's (GRADE) evaluation of the SMI found that (GRADE, 2004):

1. The SMI improved access to health care for mother and child populations, but the impact on equity was negative. The SMI had a significant impact only in the top quintile.
2. The report found that when the government tried to increase coverage and access to health care, the poorest were not the ones that most benefited from this increase. Targeting errors resulted in substantial leakage and undercoverage.

The SIS expanded on its predecessor's coverage in geographical and population terms (Holst, 2005). To achieve better results and differentiate itself from previous programs, the SIS was based on three Health Plans (Vera de la Torre, 2003):

- **Plan A**, for children 0-4 years of age
- **Plan B**, for children and teenagers 5-17 years of age
- **Plan C**, for pregnant women

Two more health plans were added later on, expanding coverage to other highly vulnerable population groups:

- **Plan D**, aimed at providing coverage of emergency services for adults
- **Plan E**, aimed at certain sectors of the adult population

Four other population groups were incorporated as beneficiaries by political decision and without following any enrollment criteria (Vera de la Torre, 2003):

- Popular dining facilities ("comedores populares") leaders
- Mothers of children who are beneficiaries of the Supplementary Food Program ("El vaso de leche")
- Mothers who work at public day care facilities ("Wawa wasi")
- Women who are members of Local Health Management Committees (Comités de gestión)
- Shoe shiners

In 2007 SIS began to reorganize its structure and functions in response to the mandate of extending the insurance scope, established by the Supreme Decree 004 2007. This Decree modifies the current insurance plans (focused on pregnant women, children, adolescents, and emergen-

cy care) extending SIS's coverage to all the uninsured population through two components: the subsidized component aimed at the poor (1st and 2nd income quintiles) and the semi-subsidized component focused on the population with limited ability to pay (3d income quintile). SIS also made official its List of Prioritized Sanitary Interventions (Listado Priorizado de Intervenciones Sanitarias LPIS), which includes a comprehensive set of preventive, curative and rehabilitation health care interventions. The List was created based on the existing information regarding the main health interventions available in the country. It may be expanded, modified, and adapted depending on SIS's budgetary situation and always in an incremental fashion, according to health priorities at national and sub-national level and to cost-effectiveness criteria.

Financial resources for the scheme come from the National Treasury. Most of the funding comes from general taxes. The Ministry of Health earmarks a certain amount to cover the budget and to finance the benefits (Holster, 2005). Funds from the IDB, the World Bank and bilateral agencies such as the Belgium Cooperation Agency also contribute to financing the scheme. The annual budget allocated to SIS has increased from 316,000,000 PEN (US$106,485,865)[21] in 2007 to 471,124,352 PEN (US$158,759,760) in 2008. This represents a 50% increase in real terms. (Belgian Cooperation Agency, 2008)

21. Exchange rate: 1 US$ = 2,96753 Peruvian Nuevo Sol

Table 51: SIS. Benefit Plans

Plan	Covered population	Health Package	Services covered
Plan A	Children 0-4 years of age	• Preventive health services • Diagnosis and treatment of common illnesses • Care of children born with HIV-AIDS • Emergency transportation services • Funeral expenses	• Immediate care for healthy new-borns • Hospitalization for newborns with pathologies • Well-child check-ups • Low-weight newborns check-ups • Emergency care • Drugs • X Rays and other imaging services • Laboratory • Surgery • Dental services (hygiene, restora-tion, treatment, extraction) • Transfer • Burial expenses
Plan B	Children and teenagers 5-17 years of age	• Diagnosis and treatment of common illnesses • Emergency transportation services • Funeral expenses	• Check-ups • Emergency care • Drugs • X Rays and other imaging services • Laboratory • Surgery • Dental services (hygiene, restora-tion, treatment, extraction) • Transfer • Burial expenses
Plan C	Pregnant women	• Prenatal care • Institutional normal and high risk delivery • Postpartum care (up to 42 days after delivery) • Diagnosis and treatment of other health problems • Emergency transportation services • Funeral expenses	• Medical check-ups • Emergency care • Drugs • X Rays and other imaging services • Laboratory • Surgery • Dental services (hygiene-restora-tion treatment-extraction) • Transfer • Burial expenses
Plan D	Adults' health emergen-cies	• Immediate emergency care • Emergency transportation services • Funeral expenses	• Emergency care • Drugs • X Rays and other imaging services • Laboratory • Surgery • Transfer • Burial expenses
Plan E	Targeted Adult	• Health care • Emergency transportation services • Funeral expenses	• Medical check-ups • Emergency care • Drugs • X Rays and other imaging services • Laboratory • Surgery • Transfer • Burial expenses

SOURCE: Vera de la Torre, 2003; World Bank, 2006

Like the SMI and SEG, the SIS operates as a demand subsidy, reimbursing health providers when they supply to SIS beneficiaries those services that are included in SIS benefits. It is noteworthy that payments are not prospective but rather are reimbursements for services already provided. The SIS relies on public providers for service delivery, using the Ministry of Health's existing human resources and infrastructure. NGOs, Social Security, and private providers are not allowed to participate in the scheme as providers. Only in special cases was a patient referred to a nonpublic facility. Services are provided at the following levels:

- Health posts and centers (urban and rural): services include primary health care, immunization, pharmacy, obstetrics/gynecology, and basic dental services, with a few facilities undertaking lab diagnosis.
- First and Second Level Hospitals: basic health care specializations, such as internal medicine, surgery, pediatrics, and gynecology. Larger hospitals offer additional specializations such as cardiology, gastroenterology, traumatology, neurology, etc.
- Third Level: represented by the Institute for Child Health and the Maternal and Perinatal Institute; both institutes offer high-complexity treatments such as neonatology, neurosurgery, etc, and are equipped with intensive care units, scanners, ultrasounds, x-rays, and complex lab diagnosis.

By December 2005 the SIS covered 11,026,607 people, amounting to around 39.5% of total population (Ministry of Health, 2006).

Table 52: Main features of the SIS

Feature	Category
Type	Free primary health care provision and Free maternal and child care
Mode of financing	Publicly funded health programs
Source of funds	General taxes Other revenues (extra-budgetary sources: IDB, World Bank, Belgian Cooperation Agency)
Risk pooling arrangement	Income-based
Management and management level	MoH at national/sub-national/local level
Degree of selectivity	Targeted; poor population belonging to the specific segments: pregnant or breast feeding women, children 0-17 years of age, adults in health emergency situations, targeted adults
Who is entitled to coverage	Individual
Condition for access	Means tested specific attribute: proof of income/age/proof of childbirth/proof of pregnancy
Extend of risk pooling	Large pool
Explicit portfolio?	Explicit
Degree of coverage	Complementary
Provision	Public

2). CHARACTERIZATION OF THE GENERAL SETTING IN WHICH THE SPHS IS IMPLEMENTED

Basic Information - Peru is a lower-middle income country located in the western part of South America, with an estimated total population of 28.3 million as of July 2006, distributed across three major geographical regions: the coast, the Andean plateau and the Amazon forest (UNDP-HDR, 2006). GDP per capita is around US$ 2,000, but there are huge inequalities in income distribution. By 2000, 72.8% of the population lived in urban settlements. Regarding access to water and sanitation, 77 % of population had access to an improved source of water and 76% had access to adequate sanitation in 2000 (UNDP-HDR 2002). Adult literacy rate (% of people ages 15 and over) was 87.7% by 2004 (World Bank, 2006).

Although Peru is a multiethnic country with nearly half of its population of indigenous origin, a small elite of Spanish descent controls most of the wealth and political power, while indigenous Peruvians are largely excluded from both and make up for many of the population groups that live in poverty (BBC News, 2006). The country is deeply divided political-

ly and economically and in its recent past it has alternated between democracy and military dictatorship. In the 1980s and 1990s Peru endured a brutal war between government forces and Maoist rebels in which as many as 69,000 people were killed (BBC News, 2006). The country has been facing a strong governance crisis for for the last twenty years, with very low government approval rates. During 2000 and 2001, Peru was embroiled in a turbulent but peaceful political controversy. A corruption scandal ended Alberto Fujimori's third term as President and ushered in a transitional government which ruled the country until Alejandro Toledo was elected to the Presidency in July 2001 (World Bank, 2006). In 2006, Alan García was inaugurated as the new President of Peru.

Economy – According to the National Household ENAHO 2004-2007, poverty in the country fell from 48,6% of population living under the poverty line to 39,3% between 2004 and 2007. Extreme poverty decreased from 17,1% in 2004 to 13,7% in 2007 (ENAHO, 2007). The same source informs that both poverty and extreme poverty are highest among indigenous people living in rural areas in the mountainous region of the country.

According to the International Labor Organization ILO, Peru reduced its urban unemployment rate from 10.1% in the third trimester of 2005 to 8.7% in the same period in 2007 (ILO, 2007). This figure means that unemployment in the country is lower than in Argentina, Brazil, Colombia, Ecuador, Uruguay and Venezuela when compared in the same period of time, but higher than the Region's average of 8,5%. One of the most pressing problems in the country is the lack of decent employment.[22] Data of the Ministry of Labour shows that underemployment in the country reaches 65% and between 65% and 70% of the total employed population works in the informal economy. Moreover, between 2006 and 2007 the urban unemployment rate decreased for men but it did not change for women, which means that the gender unemployment gap increased. The labour market conditions contribute to increase migration to other countries. Data of the Direction of Migration and Naturalization indicate that an average of 1,150 Peruvians (210 thousand in all) traveled legally or illegally to other countries in the first semester of 2006, which represents an increase of 39% when compared to the same period in 2004.

Health and Education - Maternal and child mortality rates in Peru are among the highest in South America. Although maternal mortality has declined in the past ten years, the maternal mortality ratio (MMR) remains high at a reported 164 deaths per 100,000 live births (Ministry of Health, Peru, 2002), with the WHO reporting the far higher figure of 410 (WHO, 2007). This high figure still hides geographic disparities, with some low-

22. According to ILO, decent work can be defined as "productive work in adequate conditions of freedom, equity, security and dignity, in which rights are protected and has adequate salary and social protection"

income rural regions reporting an MMR of over 500 per 100,000 live births (Ministry of Health, 2001). Underlying the high mortality is the fact that institutional deliveries remain low in Peru, because the country continues to lag behind its neighbors in the coverage of basic clinical interventions. In 2000, 59.3% of total deliveries were attended by skilled staff in the country, whereas almost 75% of deliveries in rural, low-income communities occurred in non-institutional settings (World Bank, 2006; USAID, 2005). Under-five mortality and infant mortality rates have improved significantly and they were 29.2 and 24 per 1,000 by 2004 (UNICEF, 2006). However, despite these improvements they remain high for a country of Peru's income. Further decreases in infant and child mortality will require a focus on perinatal mortality, since this has increased relative to other causes of infant mortality (World Bank, PID 2006).

As in most of the countries in the region, the health system in Peru is highly fragmented and segmented. Two subsystems provide health services: the public sector, comprised of the Ministry of Health and the Social Security System; and the private, made up of for profit providers (clinics, physician's offices, etc) and non-for-profit providers (NGOs). The Ministry of Health (MINSA) steers the health sector, drafts health policies, and provides services to the poor population who cannot afford insurance; social security (Seguro Social de Salud de Perú- ESSALUD) covers workers in the formal sector; and the private sector provides services to those in the general population who can afford it.

There are four main health insurance schemes in Peru: ESSALUD, which covers formal workers and their families; the insurance for the armed forces and the police; private insurance; and the Integrated Health Insurance (SIS). According to a 2002 survey by the Instituto Nacional de Estadística e Informática (INEI), only 30% of Peru's population was covered by ESSALUD and half of the population was not covered by any insurance scheme.

Inequality in the access to health care as well as in health outcomes remain a top concern in Peru. Among the eight Latin American countries for which there is a demographic and health survey (Bolivia, Brazil, Colombia, Dominican Republic, Guatemala, Haiti, Nicaragua and Peru), Peru has the greatest inequality in infant mortality (World Bank, 2006). Moreover, by 2003 40% of the population was excluded from access to health care, with poverty and living in a rural settlement the strongest predictors of exclusion (PAHO, 2003). Geographic inequalities in access to health care continue to lead to poor health outcomes compared to other countries in the region.

Table 53: Peru's general setting

Contextual factor	Health status		Demand for health care	
	Deteriorates	**Improves**	**Hinders**	**Promotes**
Poverty Level	X		X	
Education level		X		X
No. in Rural dwelling/ remote settlements		X		X
Access to water/sanitation/electricity		X		
Government's institutional strength/fragility	X			
Country's governance	X			
Unemployment Rate		X		X
Labor informality	X		X	

3). ANALYSIS OF THE PERFORMANCE OF THE SPHS

a). Has it increased equity in the access to/utilization of health services?

According to several studies, the SIS has improved access to health care for the lower income quintiles, including the indigenous population (Vera de la Torre, 2003; World Bank PID 2006; Cotlear, 2006). However, the scheme has yet to reach the poor efficiently. By 2003, only 64% of SIS beneficiaries came from the two poorest quintiles, and almost 50% of SIS resources benefited the non-poor population (World Bank, 2005). A benefit-incidence analysis carried out by the World Bank in 2004 showed that the SIS is slightly pro-poor at the household level with a concentration coefficient of -0.08, but is slightly regressive (non-pro-poor) in terms of geographic distribution, with a concentration coefficient of 0.04 (Cotlear, 2006). Despite these mixed figures, it is still the most equitable of Peru's social programs (compare its concentration coefficient of -0.08, to that for expenditures in Ministry hospitals, 0.21) (World Bank, 2007). And, the World Bank argues, the small grant that eliminates the economic barrier to hospital care for those in the lowest income quintiles in turn improves the targeting of the much larger subsidies granted to hospitals (World Bank, 2007).

Although affiliation with and resource allocation for the scheme have favored regions with high poverty levels, the highest number of affiliations and the greatest provision of health services so far have not been con-

centrated among the poorest population. While in two Health Districts (DISAS) affiliation and health care have mostly benefited those people living in extreme poverty (Tumbes and Lima Sur) five DISAS (Ayacucho, Bagua, Jaén, Loreto, and San Martín) show a regressive pattern (Vera de la Torre, 2003).

b). Has it offset hindering social determinants?

The SEG, the SMI, and the SIS all produced a remarkable increase in the demand for health care, especially for child and maternal health services (Vera de la Torre, 2003). The implementation of SIS and the corresponding availability of free prenatal and delivery care services led to an increase in demand for maternal care. For example, institutional births rose by 10% between 2000 and 2004. However, the SIS has been unable to keep up with demand, and complaints of inadequate and delayed reimbursements to health care providers have arisen. As a result, the financial problems have placed the burden of payment back on the users (USAID, 2005).

Table 54: Performance of the SIS: social determinants

Category	Performance	
	yes	**no**
Offsets poverty by eliminating or reducing economic barrier	X	
Fosters women's social status		X
Fosters health rights through Right Charts, explicit guarantees, etc.		X
Offsets unemployment/informal labor by eliminating or reducing economic barrier	X	
Offsets women's lack of education, fostering demand for health care		X

c). Has it increased access to and coverage of appropriate health interventions by eliminating at least one cause of exclusion from health care?

The SIS has increased access to maternal and under-five health services. The percentage of pregnant women living in the project implementation area with 4 or more antenatal controls increased from 32% in 2000 to more than 57% in 2006. And the percentage of births attended by skilled personnel also nearly doubled in the covered area, from 27.6% to 50.9% in the same period of time (World Bank, 2007). But health care utilization by children and teenagers 5-17 years of age has decreased (Vera de la Torre, 2003).

The SIS uses public facilities to deliver health services, but it has not improved public health infrastructure accordingly. Since it did increase demand for health care, it has put further pressure on the public health subsystem's resources. And it increases fragmentation within the system by adding yet another insurance scheme to the multiple ones already in existence.

Although the executed expenditure for SIS is 30% higher than that of the SEG and SMI added together, analysis of real expenses per treatment show that SIS's budget is far behind the real costs of the program (Vera de la Torre, 2003). Budget deficits are not the only obstacles to improved coverage. In a study carried out in 2005, USAID identified seven operational barriers to the provision of essential services for safe motherhood (USAID, 2005). Besides funding shortfalls, they were:

- Arbitrary and inconsistent implementation of the SIS by individual health establishments, either because personnel at health facilities do not know SIS guidelines or because the facility's financial situation does not allow the provision of all the services offered by the SIS. This leads to confusion and uncertainty for users who expect, but not receive, free services.
- Restriction of reimbursement to those services provided by physicians. Thus, the cost of care provided by midwives in cases of low risk-pregnancies are not reimbursed and must be absorbed by health facilities.
- Professional attendance at home births and transport from the household to a health facility are not covered by SIS. This forces low-income rural women to choose between paying out-of-pocket for transportation to a health facility or delivering at home.
- Availability of health personnel at different facilities does not correspond to the volume of users for which each facility is responsible.
- Maternal health delivery practices fail to take local culture into consideration.
- Health networks are not organized in a fashion that facilitates the referral process.

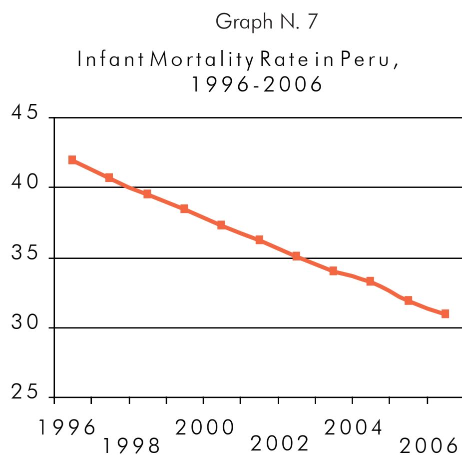
Table 55: SIS. Coverage and access

Category	SPHS	
	yes	**no**
Increases coverage (rise in number of people covered as a % of eligible population)	X	
Establishes a single guaranteed portfolio of entitlements with the same quality, content, and delivery conditions for all socioeconomic groups so as to avoid segmentation		X
Increases coordination/integration within the system so as to avoid fragmentation		X
Improves resource allocation and organization of health interventions by increasing number and capabilities of human resources in previously underserved areas		X
Improves resource allocation and organization of health interventions by increasing the amount of public spending allocated to the scheme	X	
Public spending allocated to the scheme is progressive	X	
Improves geographical distribution of the service delivery network and health infrastructure by increasing number/amount of health facilities, equipment, medical devices, and drugs in previously underserved areas		X
Increases information system's coverage		X
Increases access (number of people who access health goods or services provided by the scheme)	X	
Eliminates/reduces geographic barrier		X
Eliminates/reduces economic barrier	X	
Eliminates/reduces gender barrier	X	
Eliminates/reduces employment status barrier	X	
Improves access to drinkable water, sewerage, roads, and/or transportation		X
Improves refuse collection		X

d). Have health outcomes improved?

Health outcomes have certainly improved in Peru since the implementation of SIS, but there is little evidence to link SIS to the improvements in health. The World Bank reports that the Infant Mortality Rate fell from 48 to 28.3 in the project area during the implementation period (2000-2006), a drop of 41%. But Peru's overall IMR actually fell by 45%, implying that the observed improvements were not necessarily due to project implementation (World Bank, 2007). It is difficult to state, however, how much of this decline was due to the SIS. Access to diarrhea treatment increased by 16% in the same period, which does seem attributable to SIS. Births attended by skilled personnel through SIS increased by 9% (from 65.4% to 71.4%) between 2002 and 2004 (Ministry of Health, 2006). The fact that perinatal mortality has increased relative to other causes of infant mortality inspires some concern about the quality and coverage of perinatal care.

Graph N. 7



SOURCE: United States Census Bureau, International Database, 2007.

Table 56. Performance of SIS

Goal	Performance
Increase equity in the access to and/or utilization of health services	Mixed results so far. It has increased equity at the individual (household) level; shows a regressive pattern in the geographic distribution of health services utilization
Offset social determinants that hinder demand for health care and/or hamper health status	It has increased the demand for health care. It helps offset poverty
Increase access to and coverage of appropriate health interventions by reducing or eliminating at least one cause of exclusion in health	It has increased access by reducing the economic barrier. Coverage has not been strengthened accordingly

6 RESULTS

6.1 Overview of the SPHS analyzed

The seven SPHS analyzed are classified according to the conceptual framework as shown in table 57.

Table 57: Social Protection in Health Schemes (SPHS) analyzed

Name	Type	Coun-try	Year of creation
Seguro Universal Materno- Infantil (SUMI)	Free maternal and child care	Bolivia	1996
Programa Saúde da Família (PSF)	Primary health care provision	Brazil	1994
Mother and Child Health Protection Plans (MCHSHPP)	- Public Health Insurance - Primary health care provision - Conditioned in-kind transfer	Chile	1979 1995 1952
Ley de Maternidad Gratuita y Atención a la Infancia (LMGYAI)	Free maternal and child care	Ecua-dor	1994
Bono Materno-Infantil (BMI)	Conditioned cash transfer	Hondu-ras	1990
OPORTUNIDADES	Conditioned cash transfer	Mexico	1997
Seguro Integral de Salud (SIS)	Free maternal and child care Primary health care provision	Peru	2001

6.2 Analysis of the strengths and weaknesses of the SPHS

6.2.1 INCREASE EQUITY IN THE ACCESS TO AND/OR UTILIZATION OF HEALTH SERVICES

Four out of the seven schemes under analysis - Bolivia's SUMI, Brazil's PSF, Chile's MCHSHPP, and Mexico's OPORTUNIDADES - have increased equity in the access to and/or utilization of health services. Two programs - the LMGYAI and SIS - show mixed results and in some cases increase inequity in the access to or utilization of health services. Not enough information on the BMI has been gathered to assess whether or not it has increased equity, but studies of its previous incarnation found that its effect was limited due to poor targeting and low coverage.

The source of equity problems in the operation of the LMGYAI and SIS is a combination of poor targeting and low utilization on the part of the target population. Often this latter factor is the result of geographical or cultural barriers – health services are not available in the area, or they are offered in a different language or with a different set of cultural assumptions from those of the local inhabitants. In the case of LMGYAI, outreach efforts have been too minimal to attract new users to the program.

But even those programs with a generally progressive impact face problems. In Bolivia, the SUMI must focus on dealing with cultural and geographic barriers to continue to improve equity in the access to and utilization of health services. Vast health inequalities between rural and urban areas persist, a situation that may require a more active focus on poor mothers and children than SUMI can provide.

The mechanism through which OPORTUNIDADES targets eligible families - a two stage process, involving the selection of the localities first and then the selection of beneficiary families within the selected localities - has been highlighted as the main factor in the program's progressive spending. However, the proportion of beneficiaries from the top two income quintiles has been rising. Consequently, it remains to be seen whether the expanded program can replicate the highly progressive spending of its early years. Unless targeting efforts improve, middle-class families may receive cash payments meant to encourage them to demand services they would already have used.

The fact that Chile and Brazil's SPHS are universal and horizontally delivered may explain the increased equity in access to and utilization of health services. In both cases the better-off may opt out of the schemes, but the poor stay. Brazil's PSF is an effective combination of horizontal and targeted delivery with poorer areas the first to receive health teams, while the MCHSHPP exhibits the high coverage of a mature, well-funded program. The national scope of the programs and the fact that the SPHS are implemented all over the country account for the reduction in geographic barriers in Chile and Brazil, although geographic accessibility continues to be a challenge in both countries, especially - given its size - in Brazil.

6.2.2 OVERCOME SOCIAL DETERMINANTS THAT NEGATIVELY IMPINGE UPON HEALTH STATUS AND/OR PREVENT THE DEMAND FOR HEALTH CARE

All of the schemes under consideration helped to offset at least one of the negative social determinants of health, most frequently poverty, but only four of the analyzed schemes - Bolivia's SUMI, Brazil's PSF, Chile's MCHSHPP, and Mexico's OPORTUNIDADES - had a clear and unambiguous effect. All of them have helped to offset poverty among the covered population, increasing the demand for health care.

In the case of OPORTUNIDADES - a conditioned cash transfer program - the amount of the transfer, which represents a 25% increase in family income, is successfully helping to offset poverty among beneficiary families. The program's high coverage, which allows it to effectively reach those in need, is also an important component of its success. This is in contrast to the mixed performance of the BMI, whose much smaller transfer represents only a small portion of income (about 10%, according to some estimates). It remains to be seen whether the BMI achieves better results in terms of overcoming the health effects of poverty in the coming years, as transfers rise significantly.

Another conditioned transfer program - Chile's PNAC - has successfully changed patterns of demand for health care over the years by conditioning the delivery of milk and cereals to health check ups for pregnant women and children. It has also improved the nutritional status of mothers and children. Continuity through different governments, a focus on promoting health-seeking behavior, close monitoring of results, and a sense of national ownership (the program is delivered in public as well as in private facilities all over the country) seem to be key to PNAC's success. The in-kind transfers of PNAC also make it easier that resources are used specifically to benefit mothers and young children, unlike in OPORTUNIDADES and the BMI, where cash transfers may be used to meet the needs

of other family members. In Chile, issues of fairness within the family are at least partly addressed by the Programa de Alimentación Escolar, which complements the PNAC providing benefits to school-age children.

The Chilean Public Health Insurance, FONASA, has increased awareness of the right to heath among Chilean citizens. Years of campaigns promoting the Patient's Chart and making public the contents of the public insurance health plan have brought about changes in the pattern of demand for health care, making quality and the content of health packages central issues and therefore improving quality of delivery in the public facilities and prompting the health insurance companies, ISAPRES, to adopt FONASA's health plan as the benchmark for their own diverse health packages. It would be somewhat misleading to measure the short- or medium-term results of the other SPHS analyzed in this paper against Chile's outcomes after for intance, fifty years of implementation of the PNAC, but some SPHS show promising signs of increased beneficiaries of its empowerment. The LMGYAI, which offers a specific set of benefits encoded in the law, is very clear on patients' rights, although it is difficult to assess to what extent Ecuadorians are aware of them. Brazil offers a limited statement of Patient's Rights in their National Sexual and Reproductive Rights Policy, which guarantees certain reproductive health rights.

Mexico's OPORTUNIDADES program has achieved the most noteworthy success in the area of women's empowerment. The program's specific focus on gender issues (turning benefits over to the female head of household over the male and increasing benefits for female students at the secondary level and beyond) has resulted in increased empowerment of women. In the long term, the program will hopefully increase the average educational level of female children of beneficiaries (since parents of female students receive higher transfers), helping to offset a major social determinant of health. Ecuador's LMGYAI, passed with the specific support of women's groups, helps to empower women by making their health a national priority.

6.2.3 INCREASE ACCESS TO AND COVERAGE OF TECHNICALLY APPROPRIATE HEALTH INTERVENTIONS BY ELIMINATING ONE OR MORE CAUSES OF EXCLUSION IN HEALTH

We found that all of the seven analyzed schemes have contributed to increasing access to technically appropriate health interventions by reducing at least one cause of exclusion in health. All of them remove economic barriers by providing financial protection. All of them achieve some degree of solidarity in financing by funding the interventions through general taxes, along with other sources. But while all of the programs un-

der consideration have increased access to health interventions, in many cases it remains unclear whether they have increased access to quality care.

Both the Chilean Plan de Salud Familiar and the Brazilian Programa Saúde da Família have contributed to overcoming geographic isolation as well as geographically determined income disparities, i.e. the effect of living in a poor locality. The national scope of both programs, the important investment made in the supply-side – usually in the form of public primary health care facilities - as well as the progressiveness of the payment mechanism (in the case of Chile), seem to account for this achievement. The amount of investment, the degree of coverage, and continuity over time appear to be the crucial factors in the ability of these SPHS to deal with negative social determinants. Despite these successes, the Brazilian PSF struggles with quality of care issues.

The reduction of geographical barriers to access achieved in Chile and Brazil is not the norm. In Peru, for example, under-funding, poor coordination among health centers, and lack of transportation has hindered access to health care in poor and rural areas. Poor distribution of health care facilities in Bolivia and Ecuador, where services tend to be concentrated in richer and/or urban areas, means that the geographical barrier to health remains an impediment for many women, even when the economic barrier is removed by the SPHS.

OPORTUNIDADES has significantly increased utilization of health services, but many users report dissatisfaction with the quality and accessibility of services, as is seen in Ochoa and Garcia's report from Chiapas. In the case of Bolivia's SUMI, low quality of care, and low cultural adaptation of the provision of servicies delivery seem to be the main challenges. And although the BMI has significantly increased demand for health interventions in Honduras, there is no evidence that the increased utilization of health care has led to improved health outcomes, which implies either that the care is of poor quality or that other social determinants of health must still be overcome.

Only in two cases - those of Chile's MCHSHPP and Bolivia's SUMI - have schemes achieved more than 60% coverage of the eligible population. This high coverage accounts to a great extent for the success of the MCHSHPP, and is at least partly the result of long-term commitment to the program on the part of the Chilean government. Although, as mentioned above, continuity is crucial to achieving such high coverage, institutional capacity and the degree of decentralization of the program's management seem to play an important role as well, as seen in the outcomes of Bolivia's SUMI and Ecuador's LMGYAI.

Table 58. Coverage

Health protection scheme	Scope	Years of implementation	Reported coverage: % of eligible or targeted population	Reported coverage: number of people covered	Date of report	Source
SUMI	national	9 years	74%	1,600,000	2004	Ministry of Health
PSF	national	11 years	42.7%	74,298,000	2005	Ministry of Health
MCHSHPP	national	13 years PSF	90% (PSF)	13,500,000	2005	Ministry of Health
		28 years FONASA	68.3% (FONASA)	11,000,000	2007	
		53 years PNAC	81.2%(PNAC)	905,903	2004	
LMGYAI	national	9 years	30%	3,867,000	2004	Vos et al.
BMI	sub-national	15 years	51.8%	105,614	2004	Government of Honduras
OPORTUNIDADES	national	10 years	40%	25,000,000	2007	Sedesol
SIS	national	5 years	39.6%	11,026,607	2006	Ministry of Health

Table 59. Compliance with performance parameters

Health protection scheme	Increases equity in access/utilization		Offsets hindering social determinants		Increases access / Increases coverage			
	yes	no	yes	no	yes	no	yes	no
SUMI	X		X		X		X	
PSF	X		X		X		X	
MCHSHPP	X		X		X		X	
LMGYAI		X	X		X		X	
BMI		X		X		X		X
OPORTUNIDADES	X		X		X			X
SIS		X	X		X			X

Not enough data has yet been collected regarding the financial sustainability of the SPHS. However, four out of the seven schemes - SUMI, LMGYAI, BMI, and SIS - reportedly face financial shortages that may threaten their sustainability.

7 DISCUSSION AND LESSONS LEARNED

Several questions arise from an analysis of the outcomes of the different SPHS, as well as certain issues that must be discussed.

a). Is it useful to analyze the SPHS with the parameters established in this paper?

The parameters established in this paper (increase equity in access to and utilization of health services; help offset negative social determinants that deteriorate health status or hamper the demand for health care; and increase the access to and coverage of appropriate health interventions) are all in line with the schemes' declared objective of helping to achieve universal access to appropriate health interventions and increase equity in health. These parameters should be used on a regular basis to monitor the performance of the SPHS.

b). The importance of primary health care

There is considerable information showing that Primary Health Care-based Health systems[23] "are more likely to have better and more equitable health outcomes, be more efficient, have lower health care costs, and

23 We adopt here the definition stated in the document "Renewing Primary health care in the Americas. A position paper of the PAHO/WHO" published in Washington DC, 2007. Therefore, we define a PHC-based health system as one that makes the right to the highest attainable level of health its main goal while maximizing equity and solidarity through an overarching approach to its organization and operation.

achieve highER user satisfaction than those health systems with a weak PHC orientation" (PAHO/WHO, 2007). In the Americas, the experience of Costa Rica illustrates that a system with a strong emphasis on PHC can improve health outcomes. After five years of implementation of a PHC-oriented health reform, child mortality in Costa Rica was reduced by 13%, even after controlling for other health determinants (PAHO/WHO, 2007).

The main attributes of a PHC-based system are: accessibility, continuity, comprehensiveness and coordination. This means that the primary health care team provides a continuum of care that combines preventative, palliative and curative care for a variety of health problems for a wide range of patients, irrespective of social class and cultural background. Studies in Mexico, Bolivia and India show that PHC programs that focus on improving the health of socially deprived populations in less developed countries or territories, succeeded in narrowing the gaps in health between these groups and more socially advantaged populations, thus reducing inequity (De Maeseneer et al., 2007).

By focusing on the needs of the population within a specific territory, PHC also has the potential for empowering the communities reached by it. PHC teams identify the community's health problems, implement specific interventions to address priority health issues and monitor their impact over time on the health of the population. PHC also favors intersectoral collaboration as a mechanism to better address the community's needs. In summary, the PHC approach, operating in a network with other sectors can promote health equity through increased social cohesion and empowerment (De Maeseneer et al., 2007).

The Brazilian and Chilean cases show that allocating resources to primary health care and bringing health services to where they are most needed significantly improves equity in access to and utilization of health services, regardless of the amount of public health expenditure. This lesson may be useful in continuing to allocate resources to primary health care through LMGYAI in Ecuador.

c). Sustained political and financial commitment, no matter the political contingency

The experiences of the SPHS under review show that sustainability and long-term political commitment are two of the most important external factors that determine a program's success. More than a temporary or one-time agreement between parties, political support for a program must be based on long-term societal commitment. Peru's current SIS and Ecuador's LMGYAI may benefit from social and policy dialogue to bring about wider consensus and support for those countries' SPHS.

In addition, significant investment must be made in order to achieve an adequate degree of protection in health. A large factor of success in the case of Chile's programs was the continued support for maternal and child health programs over time. Even though there were drastic cuts on public expenditure on health during the Pinochet's government, the fact that the remaining resources were channeled into child and maternal care maintained the advances in this field. Again, although macroeconomic constraints may exist, the analysis shows that only those countries that invest in health, education, and other social services with an eye for the long term are likely to reach the social development that is necessary for economic development.

Too little spending can be almost as bad as none at all. A comparison of the results of the BMI in Honduras and OPORTUNIDADES in Mexico illustrates the importance of adequate allocation of resources for SPHS. The small transfers provided by the BMI have mostly failed to lift families out of poverty, simply because they represent too small a percentage of average family income. In Mexico, a greater financial commitment has resulted in larger transfers that have had a real impact in family income. Honduras, recognizing this problem, has committed to increasing transfers significantly, but it remains to be seen whether this increase in funding will be sustained by successive governments. And as the experiences of the SIS and the LMGYAI show, political and financial commitment to eliminate the economic barrier to health care may not achieve the expected results without a corresponding effort to improve the quality and availability of services.

In the context of the urgency created by widespread poverty and high maternal and infant mortality rates, interventions that help achieve quick gains in improving health outcomes for mother and child populations may be confused with sustainable solutions. However, in a setting characterized by low levels of institutional capacity and a lack of sustainable financing, additional progress in achieving health outcomes that extend beyond these initial gains may prove to be increasingly difficult. The Chilean case shows that further improvement in the health status of mothers and children strongly depends on strengthening institutional capacity as well as on providing equitable access to jobs and basic services such as roads, transportation, electricity, recreation areas, refusal recollection, water, and sanitation.

d). Stigma vs. Social cohesion

Among other definitions, social cohesion has been defined as "the ongoing process of developing a community of shared values, shared challenges and equal opportunity within a given country, based on a sense of trust, hope and reciprocity among all citizens."[24] Stigma, discrimination, stark differences in income and access to good and services, and social exclusion have been identified as leading to the lack of social cohesion (WHO, 2003). On the other hand, social health protection and long-term care is an essential issue in the context of social cohesion. According to GTZ-ILO-WHO Consortium (2007), social protection in health bears a potential to foster economic growth via three channels, one of them being its contribution to social cohesion and social peace, which are prerequisites for sustainable economic growth. Social cohesion implies the existence of some sort of joint endeavour. It involves shared values and rules which give the members of society a sense that they all belong to the same social body. The examples of Chile's PNAC and FONASA and Brazil's PSF indicate that shared ownership and awareness regarding the right to health are powerful tools to increase citizenship, create a sense of social responsibility, and contribute to increase social cohesion.

24. Social Cohesion Network, Policy Research Initiative, available at http://www.schoolnet.ca/pri-prp/networks/cohsoc/socialco-e.htm

Stigma is a problem policymakers have to deal with regarding the implementation of social protection schemes, especially when they seek to reach a diverse population in terms of social status, income, and ethnic background. The analyses of Bolivia's SUMI, Ecuador's LMGYAI, and Peru's SIS suggest that further improvements in coverage might require training health workers and administrators to fight stigma related to ethnic background in the point of service.

e). There must be a balance between fostering demand for health care, increasing access to health services, and improving health infrastructure

The mixed successes of the SPHS reviewed here show that simply eliminating one or more access barriers to health care is not enough to guarantee health for all. Effective social protection in health is the result of a combination of actions in multiple fronts. The analyses of Bolivia's SUMI, Ecuador's LMGYAI, and Peru's SIS indicate that efforts to increase access to already available services and to foster the demand for health care - without strengthening health system infrastructure correspondingly - can place the health care network under strain and may affect quality and availability of health care both for the people who are new to the system and for those already covered before the scheme was put in place. In order to avoid this, the health care delivery network must be strengthened as programs are expanded.

The early years of implementation of the SIS in Peru are instructive. The program successfully increased demand for health care without having adequately prepared health centers and managerial support for the surge in demand. As a result, slow or non-existent payments to doctors made them wary of accepting beneficiaries of the SIS for treatment. And under-equipped health centers often did not have the resources to provide the guaranteed portfolio of services to all beneficiaries who requested it.

The case of Ecuador is also illustrative. The passing of the LMGYAI technically removed the economic barrier to health care for the mother and child population. But the increased demand for health care that followed put a strain on the resources of the health delivery network, resulting in

limitations on access due to low availability of some goods and services such as medicines. Coverage remains low in rural areas and among indigenous communities. Improvement of the health infrastructure to handle new demand and to allow for the expansion of services throughout the country will help the LMGYAI to better achieve its goals.

Infrastructure issues may also affect the sustainability of the BMI in Honduras. The mixed success of the BMI has at least spared the country's already over-burdened health system. But if coverage increases, infrastructure will have to be improved accordingly. Even those countries with more successful programs, such as Mexico and Brazil, have felt the strain placed on health infrastructure by an increase in demand. In Brazil, poor-quality care is far more common among users of PSF than of private primary care.[25] In Mexico, the majority of infant deaths take place in hospitals. Reducing infant mortality will thus require attention to infrastructure, human resources, and quality of care (Aguilera, 2007).

f). Overcoming the economic barrier is important but not sufficient

In ethnically diverse countries, and/or those with geographically isolated settlements, removing the economic barrier may not be enough to eliminate exclusion and grant access to health care, as shown by Bolivia's SUMI, Honduras's BMI and Peru's SIS. Further efforts must be made to reduce or eliminate cultural and geographic barriers. And more attention must be paid to delivery networks problems that result in denial of services (see section e above).

In Bolivia, the provision of free care for the mother and child population has not been enough to overcome existing equity gaps between income quintiles and urban and rural populations. Although the implementation of the SUMI has increased utilization across the board, it has not corrected preexisting inequities, and the average affiliate is still a relatively well-educated urban dweller. This may be due in part to geographic barriers: many of those in rural areas can not reach a health center (the Bolivian Ministry of Public Health is attempting to combat isolation from health

25. Barros, Aluísio J.D., Cesar G. Victora, Juraci Cesar, Nelson Arns Neumann, and Andréa D. Bertoldo "Brazil: Are health and nutrition programs reaching the neediest?" in Reaching the Poor with Health, Nutrition and Population Services. The World Bank, Washington D.C., 2005

services by the addition of mobile health brigades under the Extensa program). And cultural barriers to health can still prevent utilization of care.

In Honduras, utilization of services has increased markedly among beneficiaries of the BMI, but there is no evidence that health outcomes have correspondingly improved. This is a reminder that ensuring access to health care is not the same thing as ensuring access to health. Low quality of care and negative social determinants can thwart even the highest coverage of care. The case of Honduras may indicate that overcoming the economic barrier to care is not enough to offset the negative impact of poverty on health.

Countries that have successfully eliminated geographic barriers, such as Chile, Mexico and Brazil, have usually done so through the use of either targeted programs (PNAC, OPORTUNIDADES) or universal programs whose implementation is focused on targeted areas where access to health care is difficult (Brazil's Programa Saúde da Família, Chile's Programa de Salud Familiar). However, even a successful program like both PSFs may find it difficult to cover large areas of sparsely populated land. Brazil's isolated Amazon Region has far lower rates of coverage than the rest of the country, often below 25%; and some areas have no coverage at all (Sampaio, 2007).

g). The challenge of migration

Migration is a widespread phenomenon in the LAC countries, within countries as well as between them. In some cases, migration has been shown to have a positive effect on certain health indicators, including maternal and infant mortality (Development Research Centre, 2005). This may be because migrants usually travel from rural to urban areas where health care is more widely available and more institutionalized. But the health status of rural-urban migrants is usually poorer than that of other urban residents, and migrants, especially those participating in illegal or forced migrations, face many dangers while in transit (Development Research Centre, 2005).

SPHS that are targeted to certain geographical areas, as well as universal schemes that focus their initial implementation on certain areas, present the problem of covering migrants both to and from the target area. This is a problem that territorially-based schemes, such as OPOR-

TUNIDADES, may have to face. Cash-transfer schemes, which condition benefits on the fulfillment of certain co-responsibilities, are particularly prone to letting temporary or seasonal migrants slip between the cracks. Fulfillment of co-responsibilities in schemes like OPORTUNIDADES and the BMI require registration at a local health center, requiring long-term residence in one place. Such programs must develop the information-sharing capacity to allow their beneficiaries to fulfill their co-responsibilities and receive care and the cash transfers in health centers all over the country. Furthermore, successful geographically targeted schemes may attract more migrants to their areas of operation, putting undue strain on local health infrastructure. Only truly universal schemes that eliminate both the economic and the geographic barrier are likely to be able to cover migrants at all points of their life.

Rural to urban migration, by concentrating population in urban areas, is acting to counterbalance the concentration of heath services in urban areas that is seen in so many LAC countries. The challenge for LAC countries is to fully incorporate both rural populations and rural-urban migrants into the network of SPHS.

Using citizenship as a condition for access poses the same challenge for national schemes that must confront immigration from other - usually poorer - countries. But while citizenship conditions make it more difficult for immigrants to enroll in certain SPHS, they are at equal, if not greater, risk for poor health. Many studies have shown that migrants, especially illegal ones, are far more vulnerable than legal inhabitants of a country and that they often lack any form of social protection (Sabates-Wheeler, 2003). Inter-country or inter-regional agreements should be considered as avenues to overcoming these restrictions. The development of portable social protection across national borders may be key to achieving true universal social protection in health.

h). The advantages and limitations of targeted programs

Targeting is often a less than ideal approach to providing protection: it is difficult to avoid wrongful exclusion and inclusion, it is expensive and administratively difficult to do well, and it reduces social solidarity (Shepherd, Marcus, Barrientos 2004). However, targeting has certain advantages in reaching vulnerable or excluded groups when universal and equitable access to health care is not within reach. Targeted in-kind or cash-transfer programs have been shown to be successful in increasing demand for health care when they are conditioned to health seeking-behavior and used as incentives to health services utilization, as with the PNAC in Chile and Mexico's OPORTUNIDADES. As learned from these experiences, conditioned programs achieve better outcomes when they are directed to families instead of individuals and when the mother is the recipient of the monetary or in-kind benefit. The case of OPORTUNIDADES also shows that giving control of monetary benefits to the mother improves the status of women within the family.

However, issuing age-targeted conditioned-transfer schemes in a scenario of widespread poverty and without further support to the beneficiary families brings up the issue of equity inside the household and how resources are distributed within the family. What happens with the food or the money designated for children under five and pregnant mothers once it reaches the household and there are several family members to feed and various family needs to meet is impossible to control. The fact that Honduras's BMI has achieved little improvement in poor children's nutritional status forces us to question how the money was used.

And targeting the maternal and child population, using age or pregnancy as a main criteria, brings up the question of equity of access to health for the rest of women of reproductive age and for older children. Although targeted schemes may provide preventive services that could benefit the covered children once they grow up, this may not be enough to satisfy their health needs, especially when there are no other services available to them on a regular basis. It is important to explore whether the gains made in avoiding mortality in the under-five population still translate into a better quality of life and longer life expectancy for children who go without health care between the ages of 6 and 15 (when they may again be targeted by reproductive health programs).

In the case of women's health care, targeting only those who are pregnant begs the question about whether this may be an incentive for poor women to become pregnant in order to access health care and related benefits. While fertility rates decreased in Bolivia between 1989 and 2000 under the SBS, which included women of childbearing age, it would be useful to monitor the fertility rate trend among the poor starting in 2003, when SUMI began to restrict benefits to pregnant women.

PNAC is a successful example of using age-targeted mechanisms to reach universal coverage while still striving for vertical and horizontal equity. PNAC is aimed at children under six years old and is continued when this population group ages out (turns six) by the School Food Program (Programa de Alimentación Escolar) which is administered in schools.

Insurance schemes that target the poor must face the challenge of a risk pool that increases in inverse proportion to the beneficiaries' ability to contribute. The experience of FONASA and SIS show that, in order to be sustainable, the insurance scheme should look for diversity in terms of age, social status, income and economic activity of the people included in the pool.

Whatever the selecting criteria, targeting specific population groups requires making investments in targeting technology and continued monitoring, lest the actual beneficiaries of the program end up being the upper income quintiles, as has happened in the case of Peru's SIS. When targeting technology is not fully developed, the best targeting is the lightest – targeting can be carried out where there are simple categories which make sense (age, location, widely recognized degree of exclusion), within which provision ideally should be universal. As administrative capacity evolves, more sophisticated approaches to targeting can be undertaken.

Disease-based targeting is one form of targeting that should be avoided at all costs, due to the disadvantages it has shown in the field. From an operational standpoint, the main constrain of disease-based programs is that funds are directed through narrow channels to a particular program/disease, meaning that the government has a big amount of money to support certain specific activities related to that program -for example, ARV-distribution to mothers and children- but cannot use that money to

support the provision of basic health care services such as obstetric care or well child check ups. The shortcomings of disease-based programs running outside health systems with their own budget, management and personnel have been widely acknowledged: low or no community participation, donor-driven approach that has weakened the National Health Authority, lack of coordination of donors activities, little impact on equity, drain of human resources from health systems to the programs (Garrett, 2007; Jack, 2007; Lewis, 2005). This form of targeting should be carefully avoided when creating social protection in health schemes.

i). The necessary learning curve

The differing results of the LMGYAI and SIS show that a necessary learning process must occur for the scheme to improve its results. Both schemes show improvements over time, both in their ability to increase access to health services and to improve equity in access to and/or utilization of health services. The learning curve is most clear in the case of the SIS, which has performed remarkably better than its predecessors, the SMI and SEG.

In summary, as other studies suggest, sustaining affordable long-term improvements in safe motherhood and child health depends on improving the functioning of health systems as a whole. This in turn means that health sector reforms have large implications for achieving these goals.

Improvements resulting from vertical and targeted approaches may raise expectations while undermining the overall system. Although important achievements can be made in the short run through the implementation of targeted programs, the development of the whole health system and of sound intersectoral policies is the key to achieving sustainable development in the long run.

A sustained political will and commitment to improving social outcomes is clearly a crucial factor in successfully extending social protection in health to all mothers and children. Continuity in decisions, investments and outcomes seems to be key to success, regardless of the political contingency. There is no overnight solution.

Expanding financial coverage by merging various partial schemes and extending entitlements to the whole population obviously requires sufficiently increasing public funding to ensure an adequate supply of services, with a benefits package that covers a wide range of interventions, including those required to improve maternal, newborn, and child health. The challenge is to capture the different sources of funding so as to scale up both access and financial protection in a stable and predictable way. In most countries, financial sustainability will only be achieved in the short and middle term by looking at all sources of funding: external and domestic, public and private.

As Dr. Abraham Horwitz stated long time ago, there is a "golden cluster" of actions that lead to success in protecting the health of mothers, newborns, and children: these actions include ensuring the provision of health services and equitable access to those services, making policy decisions based on sound information systems, and interventions in education, water and sanitation, family planning, and nutrition.

The technology and knowledge to extend social protection in health to all mothers and children is available. The agreement and alignment of all of the players involved both in the national and in the international community, is required to achieve this goal.

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60

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