Citizen participation, accountability and respectful maternal care: challenges and opportunities

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Measuring Advocacy for Policy Change: the case for respectful maternal care
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“Now you shout, now you are claiming, aren’t you?

Why you didn’t shout or claim the moment you were ‘doing it’?"
Why Women don’t go to health facilities?

• Ministry of Health established “Maternal Health Insurance” – Public reimbursement to eliminate the financial barrier to access (1998) Now Universal Health Insurance

• Still rural, indigenous pregnant women reject going to health facilities due to lack of knowledge / respect for people’s cultural beliefs & practices

• There are frequent episodes of women’s dis-respect, abuse, under-estimation of women’s “voice” and rights and under-the-table-payments

• “Teaching hospitals and people’s invisibility”

FOROSALUD – National Health Forum

ForoSalud: major health civil-society network, space for policy dialogue
ForoSalud has strengthened the capacity of citizens to participate in the formulation of health-policy proposals 11 years of existence. Wide range of allies, including CARE Peru, which now is a national NGO

Major achievements

- Law on Health Services Users’ Rights
- Balancing representation at “invited spaces”
- Law on Healthy Nutrition for Children
- Citizen monitoring on quality – main issue: rights and entitlements – of health services and social programs implementation
Stages ("Moments") and Processes of Citizen Monitoring

**ORGANIZATION & COMPREHENSIVE PLANNING**

**PROCESS I**
- Process of Organization / Planning – Constituting of the technical supporting and facilitating team of the citizen monitoring of health services

**SELECTION / CAPACITY BUILDING / PLANNING**

**PROCESS II**
- Public announcement & selection process of the citizen monitors of health services’ quality

**IMPLEMENTATION OF FIELD ACTIVITIES**

**PROCESS III**
- Capacity building, planning of the visits to health facilities and introduction to health authorities

**PROCESS IV**
- Implementation of monitoring visits to health facilities and meetings for the participatory analysis of the findings

**PROCESS V**
- Dialogue and negotiation to agree commitments to improve health services’ quality

**PROCESS VI**
- Monitoring of the Commit-ments made and planning of the next steps for monitoring health services’ quality

(transversal) SOCIAL COMUNICATION / INFORMATION TO THE PEOPLE / COMMUNITY
Achievements

• Identification of practices that were deterring women from utilizing services, such as unavailability of services at times of day most needed, disrespect of women, disrespect on their culture and denial / charging for medicines and services that should be free

• Space for a sustained, systematic dialogue on what women expect from the health care system and the achievements and pitfalls of health care delivery

• Commitments to improve health care (opportunity, treat, information, language, culture appropriateness)
“When I introduced myself with the hospital doctor he asked me: ‘What is all this ‘Quality surveillance’ thing about? Here we are working hard, you should be doing the same instead of losing your time…or would you like me going into your home and watching all what you make there?’

I told him

‘Doctor, we are vigilantes and we have been trained for this activity. We know the laws. You can not go to my home because my house is private, but I can come to the hospital because this is a public service, and here are my credentials…’

Nilda Chambi, Azangaro women leader
Empowerment of women community leaders

Improvement in obstetric & child care (access to integral pre-natal control, vertical birth delivery, change of attitudes amongst health providers).

Increased demand of maternal health services and institutional birth deliver (and vertical birth deliver)

Medical practitioners and health authorities more accountable to people’s needs

Increased general awareness of rights among health authorities and within patients and local communities
Advocating and Promoting Political will (more sustained political framework)

Visit of Peruvian Minister of Health to Ayaviri and Azángaro (Puno): national norm for institutional recognition of citizen monitoring initiatives (2008)

Advocacy and technical assistance: Peruvian MoH took citizen monitoring into account within the design of changes for the current Health Sector Reform Policy: National Policy Guidelines for CM promotion (2011)

National Health Quality Guidelines include as the 12th National Health Quality Policy the promotion of citizen surveillance
Lessons Learned

• Improving the health of the poor and marginalized in countries with deep, unjust inequalities can not be achieved solely through technical interventions and funding: significant, sustainable change will only happen if the poor and their leaders have a much greater involvement in shaping policies, practices and programs and ensuring what is agreed actually happens.

• Key Partnership and alliances with public (Ombudsman, SIS) and non-state (NGOs) actors to increase women’s agency and to address unequal power relations.
Lessons Learned

• International human rights framework/principles used at a local level in an effort to strengthen the quality of attention given in health service delivery

• Accountability based on dialogue and governance strengthening, not public “name and shame”: building mutual understanding, confidence and credibility

• But…Accountability can not be transformed into a “check-list” process. Accountability should have the people at the center of its design and implementation
Conditions – requirements to propel RMC, people – centeredness approaches (premise: Working WITH the People)

a) Political will

b) Context and people-based norms

c) “appropriateness” and support to the transforming initiatives by Peruvian authorities: institutional arrangements for implementation, analysis and allocation of resources

d) Capacity building on both rights-holders and duty-bearers

e) Policy-dialogue spaces:

   - Clear, participatory rules of the game (“learn to listen”)
   - Responsiveness
   - Binding decisions
f) Informed citizens on their rights and responsibilities, with inter-acting capacities (attention to gender approaches)

g) Implementation of a social communication strategy

h) Articulation amongst diverse civil society organizations («especialized»)

i) Civil society organizational “maturity”:
- Share leadership
- downplay own power relations
- leadership of women and young people
- social mobilization and advocacy skills
**RMC and Health Systems challenges**

- Poor quality and performance standards
- Weak local management of health services
decentralization “autonomy”
- Discrimination (both individual & political: resource allocation gaps / disperse, indigenous populations)
- Medical schizophrenia / High officers turn-over / lack of supplies / poor working conditions / poor salaries / lack of a career path
- Non-just power relations

*Reflect of our most influential society (“normalization”)***
Salud firma acuerdo con administrativos y exhorta a médicos a retomar el diálogo

Unos 95 mil trabajadores administrativos levantaron la huelga iniciada el miércoles. Los médicos, en tanto, reafirmaron su paralización.

Con la promesa de una reforma que mejore los salarios de los trabajadores de la salud, la ministra Midori de Habich frenó ayer la huelga iniciada por el personal administrativo del sector. En la firma del acuerdo, instó a los médicos a dialogar.

Durante la firma del acta, en el auditorio principal del Ministerio de Salud (Minsa), De Habich detalló que el acuerdo con la Federación Nacional Unificada de Trabajadores del Sector Salud (Fenusa) incluye incrementos al 100% para el 2013 y el pago de asignaciones extraordinarias por trabajo asistencial, lo que mejoraría las pensiones de retiro de esta categoría de trabajadores.

“Esta acta pretende compensar algunos atrasos en los gremios y compromisos que no se venían cumpliendo con celebridad”, remarcó De Habich.

A su turno, el secretario general de la Fenusa, Bethman Quesado, calificó de histórico el acuerdo con el Minsa y dijo que los reclamos beneficiarán a 11,600 trabajadores de los 95,000 que conforman el gremio en todo el país.

“Esta es una propuesta concreta y que después de años de espera se ha hecho justicia”, manifestó el dirigente de la Fenusa.

La ministra también tuvo palabras para los médicos que acatan una huelga indefinida desde el 18 de setiembre: “Vuelven a exhortar a los médicos para que retomen la mesa de diálogo y así esta huelga no dure un día más”, dijo luego de confirmar que los descuentos se aplicarán desde mañana.

En tanto, el presidente de la Federación Médica, César Palomino, insistió en que su gremio radicalizará su protesta este lunes con la entrega de hospitales. Ayer unos 200 médicos hicieron un plantón en el hospital D. Matías, donde también hubo reacciones de jefes médicos.

El dirigente criticó la labor de la Fiscalía de Prevención del Delito que desde la semana pasada realiza inspecciones en los hospitales para evaluar la responsabilidad penal en la huelga.

Ariel Frisancho, coordinador del Ministerio de Trabajo, señaló que la reforma no debe ser solo salarial, pero que debe incluir la mejora del financiamiento general del sector que permita incrementar el gasto en salud en aproximadamente 0,5% del PBI cada año para superar el límite de 3%. Pero hay que saber que si bien las medidas son un avance importante, no constituyen una reforma integral. La reforma no puede ser solo salarial, sino que debe incluir la mejora del financiamiento general del sector y los salarios de los trabajadores de la salud.

PIDE UNIDAD. De Habich cuenta con el apoyo de 12 gremios del sector, a cuyos dirigentes ofreció participar del proyecto de reforma.

Piden renuncia

La dirección médica señaló que la actual ministra “no está facultada” para liderar el sector Salud.

autonómica, el gobierno debe asegurarse un verdadero sistema nacional que garantice un acceso a la salud.
Crearán nueva entidad que gestione hospitales y dos viceministerios

**REFORMA DEL SISTEMA DE SALUD EMPIEZA ESTE AÑO.** Así lo anunció el ministro de Economía, según la reforma, se mejorará además la escala salarial de galenos, considerando criterios como la especialización y el desempeño.

Carlos Contreras Chimpana

Un problema común que encuentran los médicos de pacientes que acuden a una posta de hospital es que existe una escasez de medicamentos que se encuentra hoy en día y el alto déficit de personal médico especializado.

Otro factor que complica este grave situación son los continuos reclamos de los galenos por mejoras salariales. Estos son unos de los principales aspectos que se tratan de solucionar. Precisamente, el miércoles último, el Ejecutivo solicitó facultades extraordinarias al Congreso de la República para impulsar una reforma integral del sistema de salud pública, a través de dictos legislativos.

Hay que indicar que son solo las materias que componen dicha reforma que comenzará este año y que, "será de carácter prioritario", como aseguró ayer el ministro de Economía y Finanzas, Luis Nepo Linares, asesor de la Alta Dirección del Ministerio de Salud (Minsa).

Así, entre las novedades que trae esta reforma del sistema de salud está la implementación de un nuevo organismo público, adscrito al Minsa, que se responsabilice por la gestión de todos los hospitales nacionales. "Este aparato, con una capacidad de autonomía y una gestión moderna podrá responder rápidamente a estas urgencias de mejora de calidad y eficiencia de los procesos de atención", detalló.

Asimismo se instaurarán una entidad estatal que fortalezca la fiscalización que se debe ejercer a los medicamentos. A esta se suma la creación de dos viceministerios. Uno encargado de la conducción política y otro, de las intervenciones de salud pública.

### NUEVA ESCALA SALARIAL

Esta reforma del sector Salud propone también una nueva política integral de remuneraciones donde se unifique y ordene las 18 normas que componen el concepto íntegro del pago que perciben los médicos. "No es suficiente y se necesita prestar los méritos. Por eso se añadirán criterios vinculados a las especializaciones, calificaciones de desempeño y por zonas alejadas donde laboran", aseguró.

Y es que hoy la diferencia salarial entre un galeno que recién entra a trabajar y uno que tiene 25 años es solo de dos sueldos por hora.

### DEFÍCIT DE GALENOS

Se conoció que otro aspecto que tratará en la reforma es la reducción del déficit médico. Se prevé que a través de un decreto legislativo se permita al Minsa que los especialistas de salud que laboran en un sector puedan brindar sus servicios en otro. "Por ejemplo, hoy un anestesiólogo nombrado en Huancayo no puede atender por la tarde en Lima a paciente de un hospital del Minsa, por las restricciones normativas. Se trata de aprobar", resaltó.

Otra medida que se tomará para atender es la gran brecha en la infraestructura en el país, tal como lo informó la titular de Salud, Midori de Habich, quien mencionó que se identificó 750 establecimientos estratégicos y 170 hospitales intermedios con las especialidades básicas.

### FECHA DE LEGISLACIÓN

Midori de Habich también confirmó que en próximos días el Congreso aprobará delegar las facultades extraordinarias a dicho órgano, solicitó el Poder Ejecutivo. Por su parte, nepo precisó que dentro de 120 días, después de la elección del Congreso, se irán legislando los anuncios mencionados.
Context and Health System Challenges

• Donors are focused on value for money and performance metrics (pressure to our M&E and Advocacy work)

• Defining impact and results of complex, long run processes with not necessarily predictable resources? (Empowerment measures)

• Same words, different meanings (Universal Health Coverage = Universal Health Insurance?)

• Lack of an Accountability Culture (Accountability to whom?)

• Costs of citizen participation

• Co-option and partisans political interests
Facilitating People’s centeredness

- Empowerment, fighting discrimination, capacity of duty bearers, alliances
- Working with duty bearers and rights-holders and strengthening spaces for negotiation
- Political will & technical assistance
- Learn to listen (Listen to women!!)
- Gender equality approach
- Work at all levels, including global / Windows of Opportunity
- Come together and keep on learning


- UN Secretary Initiative on iERG on Accountability on Maternal and Child Health: 10 Recommendations

- Not self-reports, but participatory ones

- Avoiding the capture of the concepts

- Analysing Health Systems through RBA lenses
Health systems and the right to health: an assessment of 194 countries

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60 years ago, the Universal Declaration of Human Rights laid the foundations for the right to the highest attainable standard of health. This right is central to the creation of equitable health systems. We identify some of the right-to-health features of health systems, such as a comprehensive national health plan, and propose 72 indicators that reflect some of these features. We collect globally processed data on these indicators for 194 countries and national data for Ecuador, Mozambique, Peru, Romania, and Sweden. Globally processed data were not available for 18 indicators for any country, suggesting that organisations that obtain such data give insufficient attention to the right-to-health features of health systems. Where they are available, the indicators show where health systems need to be improved to better realise the right to health. We provide recommendations for governments, international bodies, civil-society organisations, and other institutions and suggest that these indicators and data, although not perfect, provide a basis for the monitoring of health systems and the progressive realisation of the right to health. Right-to-health features are not just good management, justice, or humanitarianism, they are obligations under human-rights law.

Introduction
December, 2008, marks the 60th anniversary of the Universal Declaration of Human Rights. The declaration provides the foundation for the international code of human rights. This code gives an internationally agreed set of standards to guide and assess the conduct of governments across a wide range of sectors and has a direct, close bearing on medicine, public health, and the strengthening of health systems.

The international code of human rights consists of legally binding international components. Among the most important of these components for health systems are the International Covenant on Economic, Social, and Cultural Rights (ICESCR) and the Convention on the Rights of the Child (CRC). Both of these international development treaties are legally binding for those countries that have ratified them. Most states have ratified the ICESCR and all but two (Somalia and the USA) have ratified the CRC. The right of everyone to enjoy the highest attainable standard of physical and mental health—sometimes known as the right to the highest attainable standard of health—is an integral part of both of these international treaties. All countries have ratified one or more binding treaties that include the right to health, such as the International Covenant on the Elimination of All Forms of Racial Discrimination. Also, many countries include this right in their national constitutions. The Constitution of WHO and the United Nations Declaration on Social Integration are explicitly designed to protect people’s rights to health. The 1978 World Health Assembly resolution on a comprehensive national health plan, the 1980 charter for health promotion, the 1980 charter for health promotion in a globalized world, and other important documents agree by the health community also recognize this fundamental human right.

In recent years, national and international policy makers, courts, non-governmental organizations, and other human rights, health, and poverty reduction. Courts, too, are explicitly relying on the right to health in their decisions, most recently in a landmark judgment of the Colombian Constitutional Court. On the basis of a detailed analysis of the right to health, this court effectively ordered a phased restructuring of the country’s health system by way of a participatory and transparent process based on current epidemiological information. Civil-society leaders in the right to health are increasing in number, and many civil-society organizations use these in their work. Both the United National Assembly and Human Rights Council have discussed numerous reports on the right to health, covering a wide range of issues, such as neglected diseases, sexual and reproductive health, maternal health, and mental health. The MDGs, medicines, and water and sanitation are also recognized. A strong health system is an essential element of a healthy and equitable society. For example, in Colombia, the achievement of the MDGs, medicines, and water and sanitation are also recognized.

Recognition that a strong health system is essential for a healthy and equitable society is growing. For example, in Colombia, the achievement of the MDGs, medicines, and water and sanitation are also recognized. A strong health system is an essential element of a healthy and equitable society. For example, in Colombia, the achievement of the MDGs, medicines, and water and sanitation are also recognized.

However, according to a recent WHO publication, health systems in many countries are failing and collapsing. Too many health systems are inequitable, regressive, and unsafe. WHO also confirms that sustainable development, including achievement of the MDGs, depends on effective health systems.

If the right to health is not only a human right, it is a human right in its own right. It is a right that is fundamental to the realization of other rights. It is a right that is essential for the achievement of sustainable development. It is a right that is necessary for the protection of the rights of marginalized groups. It is a right that is important for the protection of the rights of vulnerable groups. It is a right that is important for the protection of the rights of women. It is a right that is important for the protection of the rights of children. It is a right that is important for the protection of the rights of older people.

In recent years, national and international policy makers, courts, non-governmental organizations, and other
Ways forward

• Is RMC a “quality issue”? a “human resources issue”? a “management issue”? a “health system issue”?

• What are the non-explicit ingredients that Universal Health Coverage should make explicit to address a “mandate” on RMC?

• Beware on forgetting “minorities”: the fashionable speech of the “accomplished task” and “post-transition”

• What could we learn from national, in-country efforts? (New platforms to leverage existing capacity?)

• How do we work an alliance with health providers?