The Right of Healthcare: New Scenarios and Challenges
First Latin American Health Summit: Social Determinants and Citizen Participation
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First Panel: Are models of public health in Latin America equitable in terms of economics, gender, age and multiculturalism?

Paper: "From Project to Public Policy: The Experience of the FEMME Project in Peru"

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We begin by recognizing that, although there have been improvements in health indicators for countries in the Latin America and Caribbean region (LAC), we can move more quickly toward the goals of the governments that are signatories of various international agreements and commitments, the most important being the Millennium Development Goals.

According to a 2009 report by the Pan-American Health Organization (PHO), in the beginning of the 21st century, the demographic situation of the American continent is characterized by a state of transition with population growth and low fertility rates, decreased mortality, and a high level of urbanization. Nonetheless, together these characteristics obscure important differences between one country and another and within each country that are associated with profound socioeconomic inequalities.

The models of public health are still not equitable; other reports characterize the region as the most unequal and inequitable region in the world. In economic terms, the public funds required are not being allocated. In terms of gender equity policies, some legislative initiatives have been promoted in recent years; however, at the level of service provision, adolescents do not receive specialized services, there are few government services, (in some countries they are currently in the process of being designed and implemented) and the risk of maternal mortality for girls aged 10 to 14 is higher than for women and girls of other ages. (PHO, 2009). It should be noted that there is, at least, an interest by policymakers, especially focusing on Andean countries (Bolivia, Ecuador and Peru) to formulate culturally relevant strategies and policies. In Peru, they are implementing vertical delivery and culturally sensitive programs, such as maternity homes that aim to improve access to health services by pregnant women in rural and Amazon zones.

Latin America and the Caribbean have the technical capacity to successfully reduce maternal mortality; the challenge is to join efforts. LAC has important networks of civil society, professional and academic associations, as well as partnerships among women groups and government agencies, and the common goal should be to implement cost effective strategies aimed at reducing maternal and neonatal death (Women Deliver, 2009). Participation in this First Latin American Health Summit is a way of meeting this goal.

1. **Brief description of the status of health systems en Latin America:**

In the last few decades, the health systems of the countries in the Americas region have undergone a continual process of change and/or reform. Nevertheless, progress in the region is still incomplete and presents numerous challenges.

To understand these health systems, we must analyze them using a framework that looks at their diverse dimensions, which comprise the government, economic activity, and social organization of each country.[1]

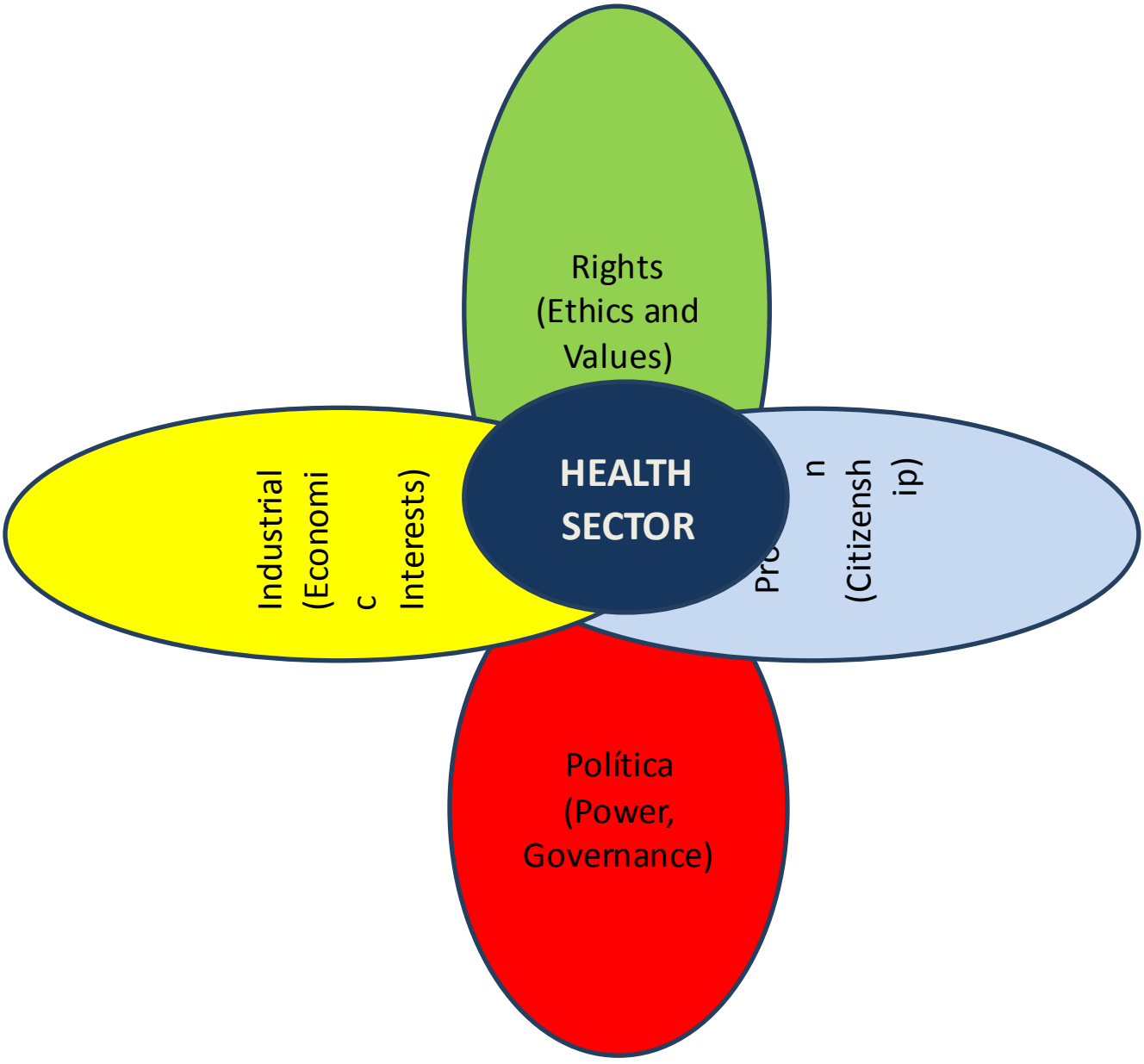


Figure 1. Dimensions of the Health Sector

[1] Moran, M., 1995, Fredman, R. & Moran, M., 2000.

Rights Dimension: The intersection of the social values and ethics of each country. Translates into a cohesive society and respect for citizenry, as well as the guarantee and ongoing defense of the human, civil, political, economic and social rights of its residents.

Political Dimension: A component of a democratic government. Where there is institutionalization and coordination, and conflicts are resolved; or the strengthening of social cohesion with a significant impact on governance and national integrity.

Social Protection Dimension: A component of social well-being.

Industrial Dimension: A component of a capitalist economy (businesses, employees, customers). The World Health Organization (WHO)[2] estimates that the health sector's economic activities represent 10% of worldwide gross national product. This is the so-called "medical-industrial complex,"[3] which comprises the production/consumption of healthcare goods and services.

On the other hand, societies organize their health systems according to fundamental values that are expressed in ethical, ideological and political categories that reflect systematic principles that are explicit in the constitutions of each country, and as a mandate, they make up the structures of the institutions. Based on these legal frameworks, health policies are developed and proposed. In their legal or constitutional frameworks, the majority of the countries in the Americas region express the following values, principles and objectives of their health systems:

Values: Right to health, equality, solidarity, equity, dignity, development	**Principles:** Efficiency, efficacy, quality, participation/social control, integrated services, multiculturalism, transparency, decentralization	**Objectives:** Protect the health of individuals and improve quality of life, provide services based on the needs of the population, economic protection, others

To respond to the central question of the panel, we would also like to address the development of health systems in the Americas region. Part of the history of public health in LAC shows that our health systems have been influenced by the model of the "government benefactor" of the West (beginning of the 20th century). However, Latin American systems were created based on a mixture of Western models, focusing on specific strata of the population that are grouped together by social class, income, occupation, participation in the formal market, ethnicity or residence (urban or rural). This produced the phenomenon of population segregation, which also stratified the exercise of the right to healthcare.

The 80s and 90s saw macroeconomic reforms in a majority of the countries across the globe, as well as globalization of knowledge and technology. These processes have generated debate about the viability and future of systems of social protection in the world. Globalization increased poverty, worsened income distribution and increased differences between the rich and the poor. The changes exposed countries to risk, emphasizing privatization and strengthening of the private sector. Little importance was assigned to improving the public sector, creating inequality between the state and the market. In this context, the Latin America and the Caribbean region became the most unequal region of the world. Resources for public financing of social programs became highly insufficient, leaving millions of people excluded from access to healthcare goods and services, translating into a high cost that

[2] WHO/HSS, Strengthening health systems to improve health outcomes, Geneva, June, 2007 (draft)
[3] Cordeiro, H., 1980; Gadelha, C., 2003

currently represents around 50% of the total healthcare expenditure in several countries in the region.[4,5,6,7,8]

Various institutions, organizations, experts and social researchers that analyze reforms in the LAC region's healthcare systems agree that we face two phenomena that represent the key challenges for the coming years -- **segmentation[9] and fragmentation[10]** of healthcare systems, which continue to create enormous consequences for healthcare system functioning. This is reflected in the current conditions of healthcare networks, which are responsible for the provision of services despite major limitations in poor areas, whether they be rural Andean or Amazonian areas with dispersed populations, where access to healthcare by poor families continues to be difficult. Generally, healthcare networks have limited integration and communication, as well as different levels of complexity and problem-solving capacity. When these networks are located in rural zones, they have limited qualified staff and hours of operation, and facilities, equipment and transportation are either unavailable or lack funding for repair and maintenance. Services are often concentrated in the wealthiest urban areas, creating an insufficient use of sectorial resources and leaving unprotected the most poor, those in the informal economy, the indigenous, and marginalized people in both rural and urban areas.

To conclude this part, we will describe the situation related to healthcare and the agenda for all governments of the region regarding MDG 5, and the factors that limit progress toward achieving the goal of reducing maternal mortality by three fourths.

2. Maternal Health in the LAC region: Some thoughts on action

At the global level, developing countries reduced by 23.6% the rate of maternal mortality in pregnancy and childbirth from 1990 to 2005. In Latin America and the Caribbean, it decreased 26.3% in the same period. Nonetheless, despite the fact that some countries, like Honduras, have made great advances in reducing maternal mortality, other countries in the region have demonstrated limited progress and others have lost ground. In order to move toward reaching the goals of MDG 5, it is necessary to reduce the rate each year by 5.5% between 2005 and 2015.[11]

BanKi Moon, Secretario General of the United Nations, in the 2009 annual report from the United Nations Population Fund (UNFPA), stated that, *"The slow progress toward reaching the goal of MDG 5 — to improve maternal mortality rates — illustrates the need to intensify political commitment and*

[4] Stiglitz J., 2002
[5] CEPAL., 2007
[6] Mesa – Lago C., 2005; Medici A., 2006; CISS, 2004
[7] Levcovitz, E., Acuña C., 2003
[8] OPS/ASDI, 2003
[9] **Segmentation**: Coexistence of subsystems with distinct forms of financing, affiliation and provision, each one specializing in different segments of the population according to type of employment, income level, ability to pay, and economic and social class. This type of organization consolidates and deepens inequalities in access to healthcare by different populations.
[10] **Fragmentation**: Coexistence of many groups that are not integrated into healthcare services networks. The existence of multiple agents operating without integration prohibits the appropriate standardization of quality, cost, and provision of healthcare services and leads to the creation of healthcare networks that do not work together in a coordinated, coherent, or synergistic way. These networks tend to ignore others and compete with other providers, which increases costs of services and promotes significantly inefficient use of resources in the overall system.
[11] Hill K et al. "Estimates of maternal mortality worldwide between 1990 and 2005: an assessment of available data." The Lancet, October 13-19, 2007, 370 (9555): 1311-1219.

to increase investment in healthcare systems, in particular, in reproductive services and supplies. A healthcare system that meets the needs of mothers also benefits entire communities. We must do everything possible to prevent the unnecessary loss of life of women due to complications of pregnancy and childbirth, especially in times of crisis and conflict. For too long, the health of mothers and children has lagged behind advances toward MDG goals, even when we know that it is the basis of stable and productive societies.[12]

At the same time, Thoraya Ahmed Obaid, Executive Director of UNFPA (for the same period), stated in the same report that "*in 2009, there was a growing drive in the countries toward reaching the MDG goals to improve maternal health. Actions were reinforced by a high level meeting on maternal health in Addis Ababa and an important resolution by the Conference on Human Rights of the United Nations that denounced the great disparities in mortality resulting from motherhood and declaring that maternal health is a human right.*"[13]

And according to information provided by the ministries of health of the countries in the region, in 2003, there were 11,652 maternal deaths. The gaps among countries in the Americas with respect to maternal mortality are large. For example, in 2007, seven non-Latino Caribbean islands registered no maternal deaths in that same year. Among the countries reporting maternal mortality rates for 2003 – 2007, the rates ranged from 5.9 per 100,000 live births in Canada to 630 per 100,000 live births in Haiti. That is to say, the probability of maternal death in Haiti was 107 times higher than in Canada and the probability of death in Bolivia was 39 times that of Canada.[14]

The Latin America/Caribbean region has the technical capacity to reduce maternal mortality; it is a question of effort.

For the last few years, the region has seen the implementation of various projects and efforts to strengthen the management of quality maternal and neonatal health services, as well as models of community, social mobilization and citizen participation interventions. Since the 1990s, we have been working on models and strategies that include multiculturalism, not only in services, but in new public policies.

Various projects and programs have been implemented by health workers with international support, and the knowledge generated, successful experiences, and lessons learned should be systematized, and the impact should be evaluated in order to then share them at the subnational, university, NGO and international levels. The data should be disseminated through national and international forums at the regional level, informing political decision makers of the changes needed to replicate them in their countries. It would be ideal to have research on cost effective strategies to share through advocacy with health officials or politicians in order to mobilize resources and/or with the private sector.

There are clear examples of how the creation of alliances has been key to overcoming challenges to reducing maternal and neonatal death. Communication among all development sectors can address in an integrated way the totality of the determinants of maternal and neonatal health and dispel the perception that it is the exclusive responsibility of the healthcare sector. Working with legislators would guarantee the implementation of the diverse activities needed for safe motherhood, as well as

[12] Ban Ki – Moon, Secretario General of the United Nations, 2009 UNFPA Annual Report.
[13] Thoraya Ahmed Obaid, Executive Director of the UNFPA, 2009.
http://www.unfpa.org/webdav/site/global/shared/documents/publications/2010/annualreport_09_sp.pdf
[14] PHO, Health Situation in the Americas: Basic Indicators 2008, Washington, D.C., 2008.

funding or maintenance of the progress in the areas of safe abortion and universal coverage of health services. The synergies, like civil society groups, would strengthen monetary systems and oversight to ensure the fulfillment of sexual, reproductive and maternal rights in the region that are currently very weak.

Political will and economic investment is urgently needed.

Despite the fact that the LAC region has the technical capacity, more work is still needed to create greater visibility on the countries' political agendas and to engage politicians in ensuring that commitments regarding MDG 5 goal are kept.

Success in reducing maternal mortality has been associated with the political will of governments. Two examples are Honduras and the Ayacucho region of Peru. It is possible to mobilize and refocus civil society and local NGOs on creating political will in those responsible for public administration and financing.

"Invest in women. It pays" is one of the strong beliefs that Women Deliver[15] spreads throughout the world to support networks and institutions that advocate for a reduction in maternal mortality. Progress toward meeting MDG 5 is possible. – We know what we need to do. We know the cost of doing it, and sadly, we know the cost of not doing it.

Healthier and better educated women are financially more productive and are critical for ensuring healthy children, strong families and communities, and productive nations. Investments in maternal, neonatal and reproductive health will have a dramatic and sustainable impact on the economic and social fabric of developing countries. En many countries, it is more likely for a woman's income to be used to pay for food, education, medicine and other family needs than a man's income. In almost all counties, women make important decisions about nutrition, medical care, and the use of the families' resources. Caring for mothers is essential for keeping children alive.

When a mother dies or becomes ill, her children are much more likely to leave school and suffer health problems – and even to die from those illnesses. The production and income of mothers are lost to entire families and communities.

3. From project to public policy: The experience of the FEMME[16] project in Peru

To look at the experience of CARE Peru with the Ministry of Health and other partners and international allies, we will describe: the maternal mortality situation in Peru and the FEMME project; the development of public policy; advocacy efforts to generate visibility for maternal mortality problem in the public; and the methodology for scaling up to the national level.

[15] For more references, go to: www.womendeliver.org

[16] FEMME stands for "Fundamentos para mejorar las emergencias obstétricas" (Basis for improving obstetric emergencies). It was an initiative developed in association with the University of Columbia, AMDD, CARE Peru and the Ministry of Health in the Ayacucho region from 2000 to 2005. For more information on the FEMME project, technical documents, policies generated, impact evaluation and other references, go to: www.care.org.pe

The maternal health situation in Peru and its relationship to MDG 5

In Peru in 2010, the results of the last ENDES (Demographic and Family Health Survey) 2009 Causes of Maternal Mortality report estimated 103 x 100 thousand live births, representing an important reduction for the last decade (ENDES 2000 estimated 185 x 100 thousand live births). Despite this average, in the interior of the regions there is still evidence of significant gaps in areas with high levels of poverty and illiteracy, especially among women, such as in mountain and forest regions. The rise in mortality in health centers and public hospitals is worrisome and could reflect a lack of skills as well as delays in referrals.[17]

At the level of government reform in the last few years, there has been a decentralization of healthcare, which contributes to regions prioritizing regional health policies, among which are those that contribute to improving maternal health. The current government has initiated the implementation of universal healthcare, in which the Central Plan for Universal Healthcare seeks to benefit mothers and children. Since 2007, the Ministry of Economics and Finance and the Ministry of Health have been implementing strategic programming, including the Strategic Program for Maternal and Neonatal Health in the framework of results-based management.[18]

The decentralization of health services is being implemented in stages; it is yet to be seen if progress will continue. In the case of universal healthcare, implementation has been initiated in pilot regions (Ayacucho, Apurímac and Huancavelica). Financing will be a challenge for the next government; on the other hand, the Strategic Budgeted Programs through the Results-Based Budget is also a recent project that is under development. Capacity building at the national and regional levels is needed – including at the administrative levels (in provincial municipalities) as identified by the Organized Follow Up[19]-- for the design, execution and evaluation of public financing, and dedicated resources are needed to achieve the predicted results.

In this context, there is an urgent need to promote public policies at all levels; mobilize the will of governments; ensure that greater financial resources, whether public or private, are provided to health systems, accelerate and expand evidence and cost effective strategies in the different targeted regions, among other actions; transform the work of the Advocacy Group led by the UNFPA into actions; and ensure that, in the next few years, there will be sustainable progress toward reaching the goal of reducing maternal mortality in each country by 66 x 100,00 live births.

The path from project to public policy…an ongoing process

In the current context of the country, for CARE Peru, the focus is on transferring successful projects validated by evidence to public programs or policies at the local, regional and national level to contribute to accelerating the reduction of poverty and improving the living conditions of poor families. To validate a proposal, hypothesis, or methodology requires a continual process of monitoring and evaluation to identify the successful strategies, validate them, systematize them, and

[17] In May 2010, the Advocacy Group sponsored a meeting of the 11 regions that still have high maternal mortality rates, and developed a multisectoral commitment among regional governments, Mesa de Concretación de Lucha Contra la Pobreza (Roundtable on the Fight Against Poverty) (MCLCP), Ombudsman

[18] For more information on strategic programming and Results-Based Management, go to www.mef.gob.pe

[19] Organized Follow Up" is a space for participation of civil society led by the MCLCP, participating agencies, NGOs, professionals, to follow up on the implementation and execution of the budgets and verify that the budgets were executed, and that progress is being made on health indicators.

identify lessons learned so that new knowledge or technologies can serve as a reference to public administrators and other actors at the local, national and international levels.

The model of FEMME project administration…The facilitator role

From the start of implementation, the project team took the role of facilitator working with actors that participated in the process: the regional government, regional health authorities, provincial health personnel, and members of the Regional Committee for the Reduction of Maternal and Neonatal Mortality.

We understand the facilitator role and the need to begin implementation with a vision for the future: sustained action that produces results; commitments that generate evidence and documentation; systematization, promotion and dissemination of research with quantitative and qualitative validity; recognition of the importance of analyzing cost effectiveness (required by groups interested in replicating the model); and employment of advocacy strategies from the start of implementation and at all levels. It is very important that: universities are included; proposals are based on evidence; resist the idea of "hand-outs" and being in charge, while allowing the actors to be the leaders; share the impact of interventions with opinion leaders, whether they be politicians, researchers, the public sector; be aware of history; and adapt models whenever possible.

After 10 years, I can say that while it has not been easy, we have seen that the region has completely adopted the process in terms of healthcare services and the political officials. Peru has one of the regions that develops maternal and neonatal health policies and offers technical assistance by the Ministry of Health to other regions of the country.

In 2000, the Ayacucho[20] region became one of the first regions with high maternal mortality. A baseline report showed that there was little capacity in healthcare facilities. According to UN Process Indicators, access by women suffering obstetric complications was only 30% (when 100% is standard) and the rate of obstetric death was 1.7%, (when the standard is 1% maximum). At the healthcare network level, there was no coordination for referrals and there was mistreatment of personnel and of patients needing the most extensive services. Personnel were not trained in managing obstetric emergencies or other types of health problems. There were no basic obstetric health services available that targeted rural areas. The only facility qualified to offer essential obstetric services was the Regional Hospital of Ayacucho.

Given these results, the purpose of the FEMME Project was to increase access, quality and use of obstetric services for pregnant women in the northern zone of the Ayacucho region between 2000 and 2005. The key results of the intervention were:

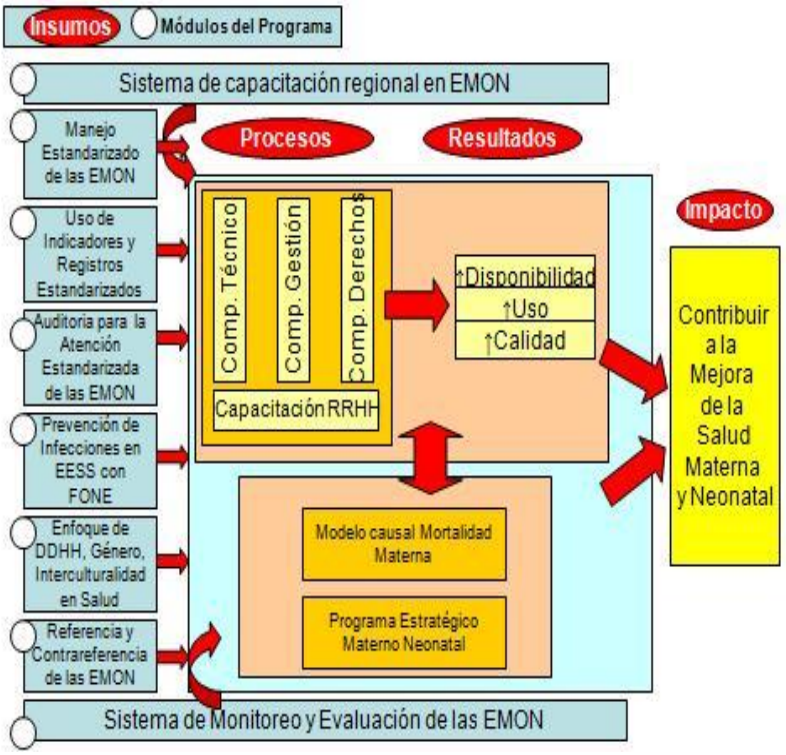
- An increase healthcare coverage for women that suffer from obstetric complications from 30% to 75%;

[20] The department de Ayacucho is located in the Southwest zone of Peru in the central region of the Andes Mountains and it borders parts of the forest. In 2007, the population of the department of Ayacucho was estimated to be 669,120,000. The most populated provinces in the region are: Huamanga (34%) , Huanta (13%), La Mar (12%). The Regional Health Department of Ayacucho (DIRESA) has 395 heath centers, 7 networks, 30 micro-networks, 8 hospitals, 51 health centers and 336 health posts.

- A reduction in maternal mortality for the intervention period from 35 to 19 maternal deaths (in 2010 there were 11 maternal deaths);
- A decrease in the maternal mortality rate of 234 to 50 x 100,000 live births from 2000 to 2010 respectively, according to The Regional Health Department DIRESA of Ayacucho, which was lower than the national average;
- Consolidation in the central region of training in obstetric and neonatal emergency care, which continues to work and is one of the most sustainable in the country;
- Consolidation of the registration processes for analyzing process indicators. Guides for levels of care were one of the first strategies that reached a national level following validation with 10 other regions in 2006
- Implementation of some culturally relevant initiatives; and
- Improvement in coordination among healthcare networks for referrals, among other activities.

The results achieved and the impact evaluation study are available at: www.care.org.pe.

Grafic 2. Modules of the Intervention Model



In 2006, the Ministry of Health y CARE Peru decided to develop an impact evaluation study to learn about achievements and to describe valid strategies. In that same year, two important studies were conducted on the systematization of the eight validated strategies, structured into models in which the actors of the intervention participated actively. They were validated in another region and received support from other national experts. (see graphic 2). At the end of 2010, the models were completed with support from other agencies and NGOs. The Ministry of Health also initiated the process of implementation in the targeted regions.

Source: RM Intervention Model N° 223-2009/MINSA

Building public policy from evidence-based interventions

In general terms, we will refer to the concept of public policy as how to organize decision making and actions that guide governments' activities and that put them into practice through programs or strategies, in this case, in public administration organizations.

Ozslak y O' Donnel (1981) state that despite the extent to which the term government or public policy may be debated, it is conceived as a set of actions and non-actions that express the choice of intervention of government when facing a question or problem that draws the attention, interest or

mobilization of other actors in civil society. In this sense, the concept of public policy refers to the set of initiatives and responses, given or implied, that tell us about the predominant position of a government regarding the problems, needs and demands of the society it represents.[21]

According to Beteta (1985), it is a type of process or action, and public policies can be divided into three phases: ***formulation, action and results.***

Planning	It is an explicit declaration by an organization with state power that expresses the intention of the government to carry out specific actions (programs o projects) to solve problems or address situations that affect a specific social group or society as a whole. Generally, policy planning is shaped into government plans or in a "framework document" created by the technical planning organization or by teams of experts.
Action	Understood through the implementation and execution of plans, programs and/or projects that specific government institutions carry out to solve social problems and meet demands and needs, and put into practice the objectives and goals that are identified or in policy plans.
Results	Understood in two ways – as a "product" and as "social impact." The first expresses the level of efficiency of government action, understanding efficiency as achieving the objectives and goals of explicitly developed policies. Likewise, efficiency here is understood as the timeliness of the product generated. Social impact refers to the policy actions in the social context. That is to say, the changes, transformation and/or modifications taking place in the living conditions of the social groups that are the direct beneficiaries.

Following this structure, the FEMME Project has advanced in the first phase of planning at two levels: at the regional level, it has issued Regional Executive Policy N° 214- RER – GRA/2009, which declares the Intervention Model as a public policy with strategies validated in health services in the Ayacucho region. In addition, the Ministry of Health of Peru issued Ministerial Resolution N° 223 – 2009/MINSA, which resolves to incorporate national reproductive health policies in the national Intervention Model in order to improve the availability, quality and use of healthcare facilities that provide obstetric and neonatal services.

At the action level, the Model of Intervention is being implemented with MINSA with *"National Facilitators,"*[22] and since 2009, has begun to be scaled up in targeted regions through the implementation of universal healthcare in Apurímac, Huancavelica, Ayacucho and Cajamarca. In each region, there is also work on the development of *"Regional Facilitators,"* whose functions will be the same as those at the national level. The process of decentralization requires strengthening the capacity of local teams, creating sustainability for the future. To date, national facilitators have conducted two workshops out of six; the scaled up program should complete the cycle of training on the new technologies.

Therefore, at the action level, processes and follow up on the results remain to be done.

[21] Virgilio Alvarado – Guatemala, in Interculturalidad y Políticas Públicas (Multiculturalism and Public Policy).
[22] The "National Facilitators" are 35 health professionals, including OB/GYNs and neonatal physicians, who were selected by the Ministry of Health and who received training on diverse topics related to sexual and reproductive health, using adult learning methodologies. They offer technical support, support at the central level in the implementation of new national policies, accompany the Ministry of Health on monitoring and supervision visits to the regional health offices and the main hospitals of the 24 regions of the country.

Ensuring financial resources…

CARE conducted a cost analysis study of the Intervention Model to respond to concerns of planners, policy makers, local governments and other donors that have committed to providing the needed funding. The implementation proposal is for a minimum of three years of support for strengthening and managing the Obstetric and Neonatal Network (which in Peru, consists of the following levels: Essential, Basic, and Primary Intensive Obstetric and Neonatal Services). This includes funding for completing the entire implementation process from baseline, and for the teams' needs, infrastructure, supplies, transportation, human resources, and medicines, as well as the implementation of each one of the eight strategies of the Intervention Model. The regional and local governments can decide to invest incrementally. This study is in its final phase. However, validation done in 2010 in five regions has already contributed to strengthening the cost structure of the national maternal and neonatal health program.

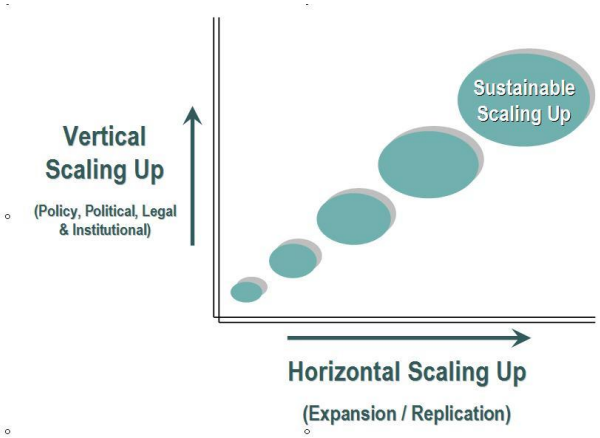
Likewise, we worked with the Ministry of Health in 2010 so that these new technologies to improve maternal and neonatal health are incorporated in the budget through the Budgets for Results of the Strategic Maternal and Neonatal Program for 2011. The majority of regions have included funding in their regional budgets for at least two regional workshops that should be conducted in every province to increase the size of the intervention, at least at the local level. However, it is important to continue working with the strategy of Sexual and Reproductive health and the Budget and Planning Unit of the Ministry of Health to continue to ensure funding in the budget in the regions for 2012.

As it is necessary to mobilize all possible resources, the Antamina Miner Fund, which develops resources in the Ancash region, could provide financial resources for three years of work on the implementation of the same strategies in that region, making it possible to create a regional training center at Guzmán Barrón Hospital in the province of Chimbote. The center could respond to the need to build capacity of personnel in the region as has been implemented in the intensive telemedicine neonatal services of the Maternal and Perinatal Institute of Lima, among others.

On the other hand, in 2009, with support from CARE Peru and the UN Population Fund, technical assistance was provided to create project profiles in order to improve maternal and neonatal health with public resources at the Ayacucho regional government level and the five municipalities of Valle del Río Apurímac and Ene: Ayna, Santa Rosa, Sivia, Llochegua and Anco. Both profiles were created with active participation of the local actors. A strategy has been to mobilize the political will of regional governments to demonstrate to other regions that it is possible to invest in health, and in women in particular. In the last trimester of 2010, both profiles were approved by the respective offices of planning and investment of the regional and municipal governments of Ayna. In 2011, we are working with the support of UNFPA to ensure that those profiles that were approved continue to be developed and to initiate implementation. Additional references of both profiles can be seen at the following links:

It is an institutional objective to mobilize resources to continue with the following stages, and UNFPA is a strategic ally due to its support of MINSA, the regional government of Ayacucho and Ucayali, as it continues to do advocacy work at the local level and to help ensure there are resources at the local level for reproductive health programs.

It is recommended that anyone who wants to address these challenges plan for the costs of the implementation of successful strategies, because following advocacy efforts with governments, the private sector or other allies – whether NGOs or others – there are not only commitments, but also questions: What needs to be done? How does it need to be done? How much does implementation cost?



Experience of scaling up and advocacy

There are different pathways to scaling up; here we refer to that described by the WHO (More information at: http://www.expandnet.net)

We should keep in mind that interventions backed by locally generated evidence about programmatic effectiveness and feasibility increase the probability of succesful scale-up.

Scale up involves the work of institution building, which requires a variety of techncial, administrative, human resources, leadership and special funding support, as well as longer term project cycles.

Scale up must be related to sustainable public policies and the development of short and medium term programs, as well as both institutional capacity and the availability of financial resources. When interventions require a high level of change in institutions that seek to adopt them, scaling up requires a great deal of technical support and time. The adaptability of innovations in health services for sociocultural, economic and institutional contexts in the course of expansion is vital for success.

To develop this scaling up process, it is necessary to define and plan advocacy actions; know who the actors and the interest groups are that would be willing to take on these innovations; mobilize the support of other partners and allies; and to be able to count on the support of well-known persons and researchers, because they will play a role in some of the stages of the scale up plan.

In Peru, the Advocacy Group of the Alliance for Maternal and Neonatal Health has agreed that to unite the efforts of various agencies of the United Nations, bilateral and multilateral organizations and civil society to encourage the design, development and implementation of programs and policies to reduce maternal and neonatal morbidity/mortality, creating synergies to achieve Millennium Development Goals 4 y 5 in Peru.

The Advocacy Group consists of: PHO, UNICEF, USAID, CARE, Pathfinder, PRISMA, MCLCP, and UNFPA, which is currently acting as coordinator.

The purpose is to contribute to improving maternal and neonatal health to meet Millennium goals 4 and 5 with a focus on reduction of inequities. And the general objective is to promote the design, development and implementation of intersectoral policies and programs in support of maternal and neonatal health, with an emphasis on the most vulnerable and excluded populations in Peru.

The main action steps of the Advocacy Group are to: Promote political commitments and the mobilization of resources to finance the implementation of sustainable maternal and neonatal health

programs; encourage the monitoring of programmatic strategies and intersectoral and multisectoral policies; raise visibility of the problem of maternal and neonatal death, with a focus on the reduction of inequalities between rural and urban areas, indigenous groups and levels of poverty through advocacy work at the key national and regional levels; and generate and disseminate knowledge, best practices and lessons learned in the field of maternal and neonatal health.

Since 2007, advocacy work has been carried out by Advocacy Group, which wrote ***the Act of Commitment by the "National Alliance for a Safe and Healthy Motherhood in Peru,"***[23] which also included the protection of newborns. The agreement was ratified in 2008 by participating congressional commissions. In May 2010, the Advocacy Group, together with the Ministry of Health, promoted the development of the "Multisectoral regional plans for the reduction of maternal and neonatal mortality" workshop in the five target regions of the country.

Together with other civil society networks, they mobilized to ensure fulfillment of the political commitments by the new regional governments who pledged to prioritize maternal and neonatal health and continue reducing malnutrition. They established goals of reducing by maternal mortality by 35% and deaths of children under 1 month by 30%. Candidates for president signed these commitments a few weeks ago.

The Advocacy Group has brought together the principal institutions/organizations that, due to their experience, ability to mobilize and presence in various regions of the country, are able to exercise their strategic role between the state and civil society to contribute to progress toward MDG 5 in which Peru has committed to reaching 66 x 100,00 live births.

The path through which FEMME was scaled up and its contribution to policies of maternal mortality reduction in Peru

In conclusion, the following framework shows the major steps that we have taken to date. Five years of intervention – validating a working hypothesis and improving accessibility, quality and use of healthcare facilities that provide obstetric services in order to improve access by women who suffer from obstetric complications and thereby reduce maternal mortality. In 2006, an impact evaluation was developed by the Ministry of Health to identify the main accomplishments, improve coverage indicators and validate strategies.

Between 2007 and 2008, studies of the usefulness of the strategies and the costs of the model were conducted.

In 2009, the Ministry of Health and the regional government of Ayacucho issued health policies and regional public policies. In this same period and in 2010, they contributed to building cost estimation tools and developing profiles for public investment, and worked with the Ministry of Health so costs of the Strategic Program for Maternal and Neonatal Health were included in the 2011 budget.

Between 2007 and 2009, they developed exchanges with the Ministry of Health and Sports of Bolivia through implementing partners such CARE Bolivia, EngenderHealth, Partners in Health, Procosi, GSI and others, which contributed to strengthening the capacity to manage services and improve skills for maternal and neonatal care in some health networks, with participation from the target municipalities

[23] The Commitment Act was signed on 22/05/07 by the Ministry of Health, five presidents of congressional commissions, the director of CARE, and representatives from UNICEF, OPS/OMS and UNFPA.

in the region of Santa Cruz, Tarija, Beni. In this period, they supported internships with the Ministry of Health in Peru and travel to the Ayacucho region, as well as work on the development health service policies. Funding was from USAID Bolivia.

In 2009 and 2010, implementation in the target regions began, which should continue in 2011. In addition, we are participating in follow up to the Strategic Program for Maternal and Neonatal Health at the national and regional levels. We plan to continue with scale up, as well as follow up and monitoring of the political commitments made, and to work with target regional and municipal governments to encourage funding for sexual and reproductive health.

Conclusions

1. Despite progress in some indicators in the region, in the health systems in the LAC region, the challenge of creating more equity in terms of investment, and of gender, age-related and multicultural policies remains.
2. The LAC region has the technical capacity and knows what to do to progress in reducing maternal and neonatal mortality. It is critical to join efforts of social, scientific, political and civil society networks.
3. Progress in reducing maternal mortality in the region is unequal; it is necessary to further mobilize political will and increase investment in health systems, prioritizing the poorest areas.
4. Documentation of successful projects and programs should be disseminated everywhere to reduce gaps in knowledge and make innovations more accessible.
5. It is important to mobilize citizen participation to focus on rights, accountability, and advocacy to follow up on the commitments made by various governments to achieve MDG 5 in 2015.

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Speakers:

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