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GUIDELINES FOR ESTABLISHING CENTERS TO IMPLEMENT ALTERNATIVE DISPUTE RESOLUTION TO INCREASE ACCESS TO HEALTHCARE

OCTOBER 2007

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The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.

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EXECUTIVE SUMMARY

This booklet presents guidelines on using alternative dispute resolution (ADR) mechanisms to increase access to healthcare, particularly for poor and vulnerable populations. The ADR approach uses techniques such as negotiation, mediation, conciliation, and multi-actor dialogue to enable clients and providers to work together to resolve concerns about health service access, quality, and other issues. While it is important to have such mechanisms in place for the general public, it is especially beneficial for the poor, who are more likely to face barriers to service access, lack of information, and mistreatment or discrimination from healthcare providers. To help operationalize the ADR approach, the USAID-funded POLICY Project provided technical and financial assistance to establish five Centers for the Resolution of Conflicts in Health (CEPRECS) in Peru from 2001–2004. The centers are managed by local NGOs and employ multidisciplinary teams of individuals with legal and health service backgrounds. The centers' Boards of Directors include leaders from various sectors as a way of fostering widespread community support.

The CEPRECS experience demonstrated that the centers provided a much-needed venue to receive and address complaints to protect the rights of users in health facilities. During the period 2002–2004, the five centers addressed about 750 cases dealing with issues such as mistreatment, lack of information, difficulties using the social insurance system, lack of informed consent, and violations of privacy. The outcomes of the individual cases show that conflicts in health facilities can be resolved through the involvement of civil society and collaboration with healthcare policymakers and providers. Moreover, by collating information from individual cases to respond to issues from a systemic perspective, the five centers were successful in promoting policy decisions to improve local public health systems and services. While there is still much work to be done to ensure access to healthcare, guarantee high-quality health services, and promote respect of the right to healthcare without discrimination, the CEPRECS model contributes to these goals by resolving conflict at the individual level, strengthening community consensus, and fostering policy change at the systems level.

To further promote the use of ADR in health settings, Task Order 1 of the USAID | Health Policy Initiative has prepared guidelines based on the experiences and lessons learned from using ADR and operating a CEPRECS. This document reviews the implementation process of the five local-level centers in Peru and outlines the CEPRECS operational model. It also presents guidelines for replicating the model, focusing on five key principles and associated strategies that were critical to the success of the Peruvian centers:

1. Use a problem-solving approach consistently at all levels of implementation.
2. Citizens, authorities, and health personnel must work together to improve the health system.
3. Users must know their rights in health facilities and have appropriate channels in order to fully exercise those rights.
4. Be aware of the specific needs of vulnerable population groups and tailor ADR services accordingly.
5. Consider sustainability from the beginning.

The guidelines presented in this booklet can be adapted for implementation in a variety of contexts, including rural or urban areas, public or private sector facilities, clinics, hospitals, and community or other health facilities. Readers should consider their own local context and characteristics of the health sector and draw on existing national laws and regulations when replicating the CEPRECS model.

ABBREVIATIONS

ADR	alternative dispute resolution
AIDS	acquired immune deficiency syndrome
APDS	Asociación Peruana de Derecho Sanitario (Peruvian Association of Health Law)
BOD	Board of Directors
CEPRECS	Centro de Prevención y Resolución de Conflictos en Salud (Center for the Prevention and Resolution of Conflicts in Health)
CENPRECS	Centro Nacional de Prevención y Resolución de Conflictos en Salud (National Center for the Prevention and Resolution of Conflicts in Health)
CSO	civil society organization
ENDES	Encuesta Nacional Demográfica de Salud Familiar (National Demographic Family Health Survey)
EsSALUD	Seguro Social de Salud (National Social Security Health Services)
HIV	human immunodeficiency virus
HPI	Health Policy Initiative
IEC	information, education, and communication
INEI	Instituto Nacional de Estadística e Informática (National Institute of Statistics and Information)
IPE	Instituto Peruano de Economía (Peruvian Institute of Economics)
MOH	Ministry of Health
NGO	nongovernmental organization
PLHIV	people living with HIV
USAID	United States Agency for International Development

GLOSSARY

Alternative dispute resolution mechanisms—complaint, problem-solving procedures—including assessment, consultation, negotiation, conciliation, mediation, and application—which result in consensus to prevent or resolve complaints by users of health facilities.

Conflicts in health facilities; health conflicts—barriers to accessing health services, including mistreatment during medical examination, mistreatment at health facility, poor healthcare services, poor administrative services, lack of information to the patients, problems related to health insurance, no service at the emergency room, violation of the right to freedom, unlawful charges, absence of healthcare personnel, insufficient pharmaceutical drugs available, and lack of culturally appropriate health services.

Health facilities—hospitals, health centers, health posts, community health centers, and other places delivering health services.

Health facility users; health users—current or potential persons seeking healthcare services in health facilities.

Health rights—a provision found typically in the national constitutions of countries in Latin America.¹ An example is the Political Constitution of Peru, providing that everyone has the right to the protection of their health, within the family and the community contexts, as well as the task of contributing to promoting and defending that right; and that those not able to defend themselves due to a physical or mental disability have the right to their dignity and a legal regimen of protection, attention, re-adaptation, and safety.

Litigation—carrying on a lawsuit in a court of law.

¹ Fuenzalida-Puelma, Hernan L., and Susan Scholle Connor (Eds.). 1989. “The Right to Health in the Americas: A Comparative Constitutional Study.” *Scientific Publication* No. 509. Washington, DC: Pan American Health Organization.

PART I. INTRODUCTION

I.1 Background

These guidelines for using alternative dispute mechanisms to increase access to healthcare draw on experiences and lessons learned in designing, implementing, monitoring, and evaluating five Centers for the Prevention and Resolution of Conflicts in Health (CEPRECS) in five regions of Peru during the period 2002–2004. The centers, managed by local NGOs, are venues to receive and address complaints to protect the rights of users in health facilities and employ multidisciplinary teams of individuals with legal and health service backgrounds. The outcomes of about 750 cases handled by the Peruvian centers illustrate that through the involvement of civil society and collaboration with other decisionmakers in healthcare, conflicts in health facilities can be resolved and strategic policies can be created, changed, or improved to better serve health facility users. The guidelines provided are flexible and can be adapted for implementation in various contexts, including rural or urban areas, public or private sector facilities, clinics, hospitals, and community or other health facilities.

This document is divided into three parts and seven appendices. Part 1 presents the background and methodology used in preparation of the guidelines. Part 2 describes the implementation of the five local-level centers in Peru. Part 3 describes the center model, the operational process, and guidelines for replicating a CEPRECS, as well as guiding principles for implementation. The appendices include resource documents that will be useful for replicating the dispute resolution model.

The document aims to share the experience of the centers and equip organizations and individuals interested in funding or implementing similar activities with comprehensive and practical guidance.

I.2 Methodology

Preparation of these guidelines required a thorough review of project documents pertaining to the design and implementation of the centers (2002–2004), field visits to two cities where the centers functioned, and interviews with individuals who participated in the project.

Document review. An extensive review of monthly CEPRECS activity reports and the final project report provided information and lessons learned in running the centers. Additionally, a review of documents on health rights[†] and conflict resolution provided background and context to understand how these two topics were addressed within the CEPRECS model in Peru.

Field visits and interviews. Project staff conducted field visits to Pucallpa and Huancayo in October and November 2006. Staff members interviewed 10 key informants—including center directors, members of local partner organizations, beneficiaries, and members of the local board of directors—to gain a better understanding of how local-level center activities are implemented (see Appendix A for the interview questionnaire). Interviewees shared their challenges in reaching the local population, making allies out of health personnel affiliated with the health facilities, and getting civil society organizations (CSOs) involved. They also shared their center successes and requirements for sustainability.

[†] Health rights may mean different things in different country contexts; they do not necessarily confer any international legal rights outside that context, including the right to abortion. U.S. funds are restricted from promoting or providing abortion as a family planning method.

PART 2. CEPRECS IMPLEMENTATION IN PERU

2.1 Context for the CEPRECS in Peru

To increase the use of health services, it is important to reduce or eliminate barriers to user's access to health facility services. One way of reducing barriers is to ensure that people can voice complaints about health services and ultimately receive high-quality, client-centered care at health facilities. This can be done by building in effective alternative dispute resolution (ADR) mechanisms—which include negotiation, mediation, conciliation, and multi-actor dialogue.



Using ADR to solve problems

Experiences reported (2002):	ADR: Alternative dispute resolution mechanisms:
- Complaint boxes	- Negotiation
- Satisfaction survey	- Mediation
- Face-to-face problem-solving responses (Complaints Office)	- Conciliation
	- Multiactor dialogue



While it is important to have these mechanisms in place for the population in general, particular groups may face greater barriers to healthcare access and require additional support to be able to exercise their rights as health users. Socially and economically vulnerable populations are more likely to face problems in health facilities, such as mistreatment by healthcare personnel due to stigma and discrimination, lack of information about where and how to voice complaints, and inability to pay for services. They may also be more likely to experience difficulty in voicing complaints and demanding better care because of language barriers and lack of empowerment.

The Peruvian health system comprises public and private sector providers and is concentrated largely in urban areas. It is characterized by a low level of coordination between the two sectors. The Ministry of Health (MOH) is the principal health provider in the country, serving more than 56 percent of the population (14 million in 2004) (IPE, 2004). The intention of the MOH is to target its largely subsidized health services toward the poor, but the MOH faces challenges in reaching residents of remote, rural areas. The National Social Security Health Service (EsSALUD) provides services to 14 percent of the population, mainly formal sector employees, and its facilities are concentrated in urban areas. A third provider is the police and armed forces, which offers health services exclusively to its personnel and their dependents (2%). Finally, the private health sector provides services in clinics and hospitals to a minority who can afford to pay (9%)—either through costly private health insurance or out-of-pocket payments (IPE, 2004).

Despite the diversity of providers, healthcare coverage is not universal in Peru. Nearly 20 percent of the population (4.6 million in 2004) does not access health services—the majority of whom are poor and reside in rural areas (IPE, 2004). Poorer Peruvians are much less likely to use healthcare services than those who are wealthier, and those residing in urban areas are more likely to seek healthcare than those in rural areas (Valdivia, 2002). Based on figures from the year 2001, nearly 54 percent of the total population is considered poor—of which half are considered extremely poor. Eighty-four percent of poor women ages 15–49 reside in rural areas, and 25 percent speak indigenous languages (ENDES Continua, 2004). Many of Peru’s poor face geographic, financial, language, and cultural barriers (both perceived and actual) to accessing, seeking, and receiving healthcare. These complex barriers must be addressed to increase access to healthcare in Peru.

Although Peru’s legislation[‡] mandates universal access to healthcare and Peru’s 1993 political constitution includes a right to health protection,[§] healthcare providers and health facility users are often unaware of these legal provisions or how to exercise or protect these rights. Even if users are aware, many are not empowered to voice their opinions and demand fair treatment and high-quality health services and products in health facilities.

While healthcare providers in Peru have attempted to improve services in health facilities by establishing rules of conduct and protocols for medical intervention, most efforts to respect and protect users’ health rights have only included installing user-complaint boxes or implementing user satisfaction surveys. The mechanisms to actually resolve existing complaints or rights violations and to prevent future complaints are not in place in health facilities.

Findings from a qualitative study in Peru (Garate, 2002) revealed that family planning users, nonusers, and community leaders had little faith in the health system’s ability to find and implement adequate and appropriate solutions to violations of health facility users’ rights. The findings also suggested that any solution for increasing the access to and quality of health services would require creativity, require a minimum amount of resources, be perceived as reliable to the public to guarantee legitimacy, be accessible to the average healthcare user, and have the capacity to address issues in an efficient and timely manner.

2.2 A Solution: CEPRECS

In response to these findings, the POLICY Project^{**} and the Peruvian Association of Public Health Law (APDS) designed the CEPRECS activity to promote the prevention and resolution of complaints from health facility users with the participation of multiple actors who use and provide health services (e.g., decisionmakers, users, providers, local leaders, and authorities). The activity, which continues to operate, is grounded in the Peruvian Constitution’s right to health as well as the following goals:

- **Conflict resolution:** work cooperatively to strengthen relationships that facilitate the resolution of conflicts in a personal, timely, efficient, and constructive manner.

[‡] See Appendix F for a list of health-related Peruvian legislation and international human rights treaties to which Peru is a States Party.

[§] Government of Peru. Political Constitution of Peru, 1993. Article 7: “Everyone has the right to the protection of their health, within the family and the community contexts, as well as the task of contributing to promoting and defending that right; [and] that those not able to defend themselves due to a physical or mental disability have the right to their dignity and a legal regimen of protection, attention, re-adaptation, and safety.”

^{**} POLICY was funded by USAID under Contract No. HRN-C-00-00006-00, beginning July 7, 2000. The project was implemented by the Futures Group, in collaboration with the Centre for Development and Population Activities (CEDPA) and Research Triangle Institute (RTI).

- **Reduction of stigma and discrimination:** break the pattern of exclusion and mistreatment in healthcare among those with special healthcare needs or with minority social traits.
- **Gender equity:** reduce power imbalances within the user/provider relationship.
- **Quality of care:** promote the notion that high quality in healthcare services is a human right.
- **Citizen participation:** create partnerships between health providers and civil society organizations to stimulate dialogue and foster new initiatives.

The CEPRECS pilot project included three strategies: conflict management, conflict prevention, and awareness raising (see Appendix B for a CEPRECS’ objectives and activities). The conflict management and prevention aspects of the project concentrate around the development of specialized centers, designed to promote health facility user’s rights and to respond to users’ complaints through negotiation and conflict resolution. The project is based on concepts of neutrality, impartiality, confidentiality, respect for health facility users’ rights, empowerment of health users, and consensus building between civil society and the health sector. A CEPRECS has two functions: (1) carry out health facility user consultations and case resolutions on an individual, case-by-case basis and (2) share patient cases with the center’s multisectoral Board of Directors (BOD) to monitor patterns in complaints and identify interventions to be addressed through policy change at the health facility or health directorate levels—ultimately to prevent future conflicts in health.

A CEPRECS serves a specific geographic area and tends to be linked with a particular public health facility, usually a hospital. Individuals can report problems experienced in those health facilities, such as mistreatment during service provision or at the facilities; unsatisfactory service from health providers or administrative staff; problems with insurance coverage or the levying of unlawful charges; lack of informed consent prior to a procedure; absence of a healthcare provider in the emergency room or other areas; lack of health supplies or medicines; refusal to discharge the patient due to inability to pay for medical bills; and/or discrimination due to ethnicity or culture.

At the individual level, center staff use ADR—such as negotiation, mediation, and conciliation—to find appropriate solutions to health complaints and conflicts. When a conflict is identified, the CEPRECS team often uses consensus-based and informal face-to-face talks with providers as a form of negotiation. In other cases, an encounter between provider and user is addressed with mediation. If a case appears to be related to medical

malpractice, the center provides information about places where the user can go to address it, as medical malpractice is classified as a felony and handled by other institutions. In addition, centers can help users through the provision of technical, legal, or medical information.

CEPRECS staff prepare a weekly report of cases managed at the center, and based on these reports, they compile information for a monthly report—with figures and proposed recommendations for health-facility level improvements or policy changes—to present at monthly center BOD meetings. During the

CEPRECS: Principles

- Neutrality
- Impartiality
- Confidentiality
- Respect of rights of persons using health services
- Empowerment
- Consensus building

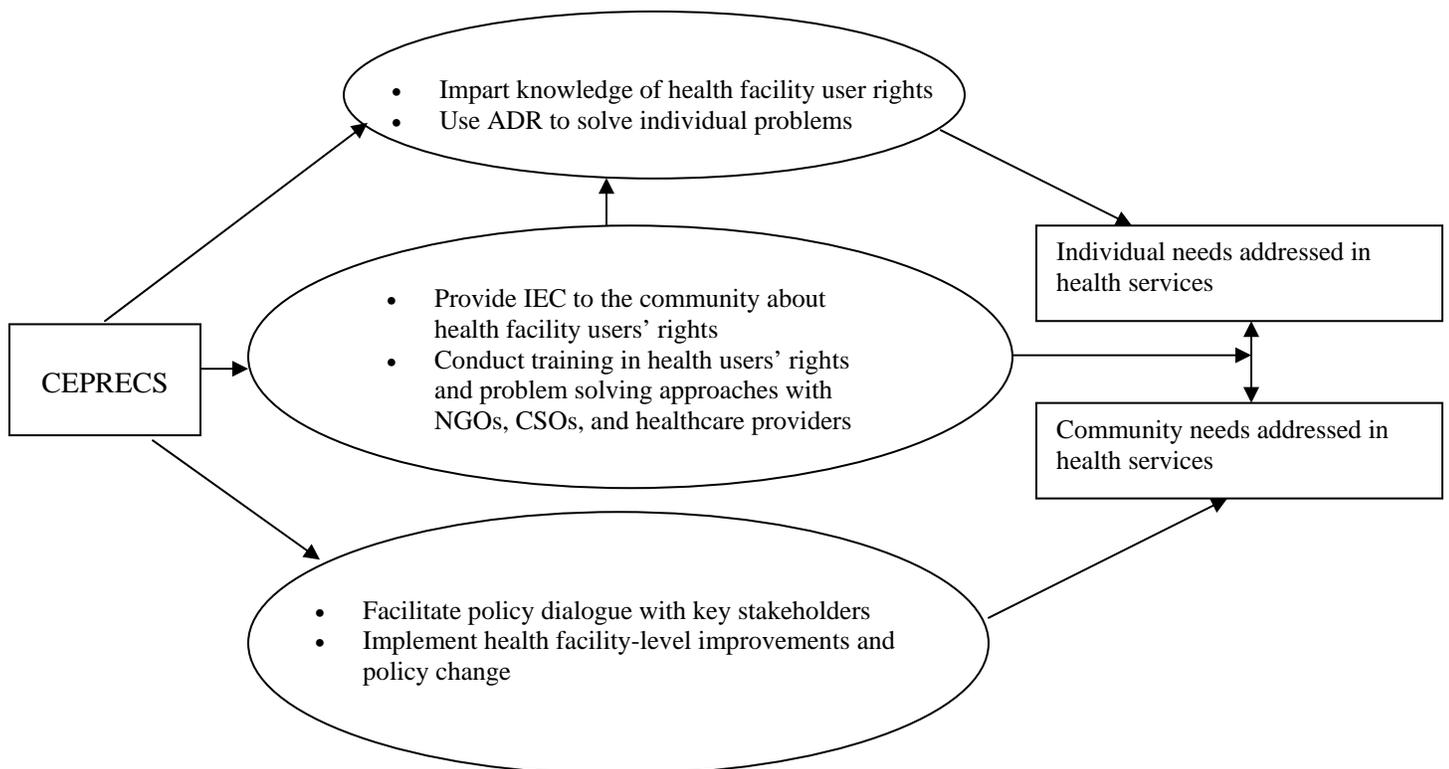


meetings, CEPRECS staff facilitate discussion of the main problems in the health facilities and work with the BOD to define actions and policies that can be implemented to prevent future occurrences of similar problems. The health sector representative of the BOD, usually the hospital director, notes the recommendations and makes the necessary changes to improve the services and increase access.

Center awareness-raising activities include equipping and empowering users and providers with knowledge and information about health rights, as described in Articles 6, 7, 9, 11, and 65 of Peru’s Constitution; and about the existence of ADR mechanisms for resolving conflicts in health facilities. CEPRECS staff also conduct informational workshops for healthcare providers and users on health rights and how to identify, resolve, and prevent conflicts in health facilities. CEPRECS staff also conduct outreach activities to inform the community about user rights and the existence of the center for addressing and resolving complaints. To this end, CEPRECS staff hang posters and distribute flyers, develop web pages, and air radio spots.

Figure 1 depicts the process through which a center conducts its activities to resolve individuals’ conflicts in health facilities. The process includes (a) working with the greater community to impart information, education, and communication (IEC) about health rights; (b) training providers on health rights; and (c) facilitating policy dialogue to achieve policy changes in the health system.

Figure 1. CEPRECS Strategic Approach to Address Individual and Community Health Needs



2.3 Results from CEPRECS Implementation in Peru

The project strengthened technical and social support for resolving conflicts in health facilities, with the aim of addressing individual and community needs in five locations in Peru: Ayacucho, Huancayo, Pucallpa, Tarapoto, and Northern Lima.

While it took time to build trust among users and healthcare providers and communicate the mission of a CEPRECS, the five centers eventually received and subsequently relied on widespread political and community support, which worked to strengthen communication channels and consensus among users, health providers, and health facilities.

The centers provided a much-needed venue to receive and address complaints to protect the rights of users in health facilities. While baseline information is not available to determine the impact of CEPRECS or to ascertain whether complaints increased or decreased as a result of CEPRECS activities, anecdotal accounts confirm that CEPRECS activities did result in the satisfactory resolution of user complaints.

Some case examples follow:

In Junin, for example, after CEPRECS intervened, a woman was able to have a nurse midwife explain the causes and consequences of vaginal bleeding and helped set up a follow-up appointment for her.

In Ucayali, a CEPRECS intervention helped an HIV-positive person get better treatment from a doctor who had mistreated him earlier.

In Ayacucho, CEPRECS helped a woman access translation services in order to learn—in her own language—about the need for an operation. CEPRECS also counseled the family about how to access additional disability support following the surgery.

During the period 2002–2004, the five centers managed 753 cases of health facility user complaints at the individual level. Of those cases,^{††} 53 percent were related to mistreatment by healthcare personnel in a health facility, 37 percent to a lack of provision of medical information to users, 18 percent to problems with using the social insurance mechanism for poor women, 10 percent to a lack of informed consent from the user, and 6 percent to violations of privacy rights. Ninety percent of the 753 cases were resolved using negotiation (44%) and legal advice (46%); while 9 percent were resolved via mediation. The majority of persons (65%) attending the centers were women.

The health service areas that received the most complaints were general medicine and gynecology, followed by emergency, pediatric, and surgical services (see Table 1).



^{††} The cases referred to in this paragraph typically involve more than one type of complaint and more than one resolution mechanism; consequently, percentages total more than 100 percent.

Table I. Number of Complaints by Service

Services	Complaints
Medicine	115
Gynecology	114
Emergency room	74
Pediatric	51
Surgery	44

Source: Ormachea and Huaita, 2005.

Using information from individual cases to respond to the problem from a systematic perspective, each BOD for the five centers was successful in making policy decisions to improve the local public health system and health services. For instance, the Pucallpa Regional Hospital improved the quality of attention to people living with HIV (PLHIV), implemented a more appropriate schedule, and required all personnel to wear photo identification nametags. In most of the five locations, regional directorates of health issued recommendations to inform health professionals about the health rights of users and the obligation to comply with current regulations. In Ayacucho, a regional government representative on the BOD submitted a proposal to the regional government to sponsor the local CEPRECS.

Finally, the project created a network of institutional allies from the centers' BODs, which included individuals from regional health directorates, Ombudsman's offices, medical and nurses' associations, and NGOs intended to promote capacity building of health professionals in the prevention and resolution of conflicts related to health rights. The Peruvian experience underscores that changes and improvements in health services cannot happen unless decisionmakers are convinced of the importance of building effective social and institutional responses to problems.

Conducting training courses on the right to health and conflict resolution not only resulted in a group of trained healthcare providers and users on these subjects but also helped to legitimize the project and gain acceptance from healthcare providers. The training courses produced a demand from local universities to include these subjects in their curricula.

CEPRECS teams faced challenges in determining the best strategies to promote their services and attract cases. To address this challenge, the teams implemented creative outreach activities to ensure that the communities knew about user rights in health facilities and the centers. The centers made contacts to gain access to TV and radio programs, conducted talks for local CSOs, and advertised services with users in health facility waiting rooms. CEPRECS staff involved local media in project activities to serve as communications resources. For instance, the Huancayo CEPRECS invited a representative from a newspaper to be a board member, and the Pucallpa CEPRECS created a network of communicators and journalists on health and human rights.

One main challenge facing the centers in Peru is sustainability, as the CEPRECS activity was implemented as a pilot project. Steps must be taken to continue open dialogue among different private and public sector actors; to ensure implementation of any new policies or legislation; and to secure financial resources for the centers. In two sites (Pucallpa, Ucayali region and Huancayo, Junin region), CSOs were willing to continue working to maintain center achievements and advocate at the regional level. As a result, the Ucayali Regional Council approved a Regional Statute adopting a system of protection of user rights at health facilities. In Junin, the Regional Health Council installed a special committee on health facility users' rights and approved policies on the protection of health facility users. These achievements at a policy level were possible because citizens, authorities, and health personnel continued to work together.

PART 3. GUIDELINES FOR REPLICATING A CEPRECS

The following guidelines are the product of an analysis of the center model and incorporate the lessons learned from the Peruvian pilot experience. In Part 3, the center operational model and systems components are discussed to provide a structural framework for implementation; and five key guidelines, along with recommendations, are shared to inform successful implementation of CEPRECS activities in alternative settings. For ease of reference, the appendices present resource documents (used in establishing the centers) that will be useful for replicating the CEPRECS model in other countries.

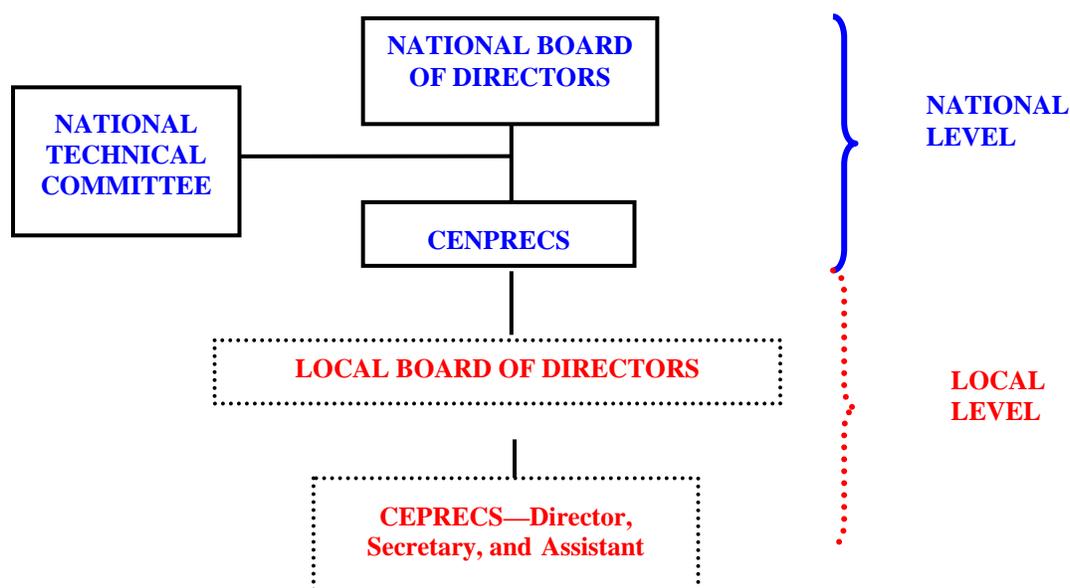
The center model is based on the notion that action should be taken to fulfill health rights outlined in the Political Constitution of Peru—for example, that the State provides access to and delivery of healthcare products and services that meet high standards of safety and efficacy. Health facility users, in turn, can learn to demand high-quality services from the health facilities and the State. APDS and the POLICY Project established the centers in three stages, which provide important guidance for replicating the process in other settings:

- *Stage 1, Start Up:* Design the center model, identify locations for the centers, collaborate with local organizations, and open the first CEPRECS.
- *Stage 2, Implementation:* Strengthen the existing center, document lessons learned, establish contacts with the MOH to encourage its involvement in CEPRECS activities, and explore new cities where another center can be established.
- *Stage 3, Informed Expansion:* Incorporate lessons learned in the opening of a new center.

3.1 CEPRECS Operational Model and Process

This section describes (1) the organizational model of a CEPRECS and the roles and responsibilities of each entity and (2) the operational process. This information is also described in the CEPRECS organizational and functions manual prepared by APDS and the POLICY Project (See Appendix F). The project design focuses on operations at the national and community levels, as shown in Figure 2.

Figure 2. Organizational Model of CEPRECS



3.1.1 Description of National-Level Bodies and Functions

The CEPRECS organizational model suggests the support of three key national bodies: a National Board of Directors, a National Technical Committee, and a National Center for the Prevention and Resolution of Conflicts in Health (CENPRECS)—each of which strengthens the CEPRECS approach by bringing visibility and commitment at the national level.

- **National Board of Directors:** A political entity that includes major institutions working in the diffusion, promotion, training, and implementation of health and human rights projects. It is intended to promote changes in the health sector to improve access to healthcare and protect the right to health at the national level.
- **National Technical Committee:** A professional and academic entity that aims to include professional and educational institutions involved in training health professionals. Its main role is to provide technical assessments of conflicts in health service delivery.
- **CENPRECS:** It is composed of a team of experts in human rights, ADR/conflict resolution, and health issues. The CENPRECS primarily serves to design, implement, and monitor the performance of local centers and offer operational support and technical assistance. CENPRECS responsibilities can, however, vary along with the project cycle and be tailored to the different needs of local CEPRECS teams.

In Peru, only CENPRECS existed, as it was logistically too difficult to set up and support a National Board of Directors and a National Technical Committee given human and financial resources available. The Peruvian experience reveals that CENPRECS is sufficient for the CEPRECS organizational model to operate at the local level. However, a National Board of Directors and a National Technical Committee, would together function to pull together regional experiences to determine national-level health sector changes, which could have broad reaching benefits for the Peruvian population as a whole. Such a national-level presence could also work to encourage and facilitate the replication of the CEPRECS model to other areas, and continue to strengthen local health sector capacity in responding to user needs.

3.1.2 CENPRECS

Because Peru did not have a National Board of Directors or a National Technical Committee, only CENPRECS activities will be outlined in detail. A CENPRECS is critical to the success of local centers, in that it serves as a national-level coordinating and monitoring body.

CENPRECS activities

CENPRECS activities include project and systems design for local centers, selecting CEPRECS sites and local NGO coordinators, providing organizational support and technical assistance to the local centers, and monitoring and evaluating and facilitating exchange among CEPRECS sites.

The first task of a CENPRECS is to design how the project will function at the local level by identifying local center sites, finding suitable NGO coordinators for each site, and strengthening local support for each site. CENPRECS members can conduct field visits to identify CEPRECS sites and NGOs and verify local interest in working on the issues. Prior to opening a local center, CENPRECS informs other relevant local organizations about the CEPRECS and encourages their support. A CENPRECS member can accompany the NGO coordinator to meet and network with CSOs and other local leaders to ensure that key actors join the local BODs.

A CENPRECS provides ongoing organizational support to local center teams throughout implementation—although this support is more important at the beginning. A CENPRECS leads workshops for a CEPRECS team on how to operate the center model, including setting up the monitoring and evaluation system and reporting requirements. Appendix C includes a sample intake form used in reporting. The CENPRECS conducts quarterly monitoring to verify local-level center achievements; supervise case-management; review intake forms and monthly statistics; discuss and address any challenges the CEPRECS team is facing; and review tools for collecting, sharing, and reporting information.

Throughout implementation, the CENPRECS organizes meetings with all local center sites. In Peru, these meetings provided a forum where CEPRECS teams could share their experiences, validate their methodology, and discuss their challenges and successes.

A CENPRECS also serves as a national technical resource, preparing training curricula and conducting trainings for local- and national-level stakeholders on health rights and stakeholders' roles in exercising them, as well as the role of local centers in facilitating solutions to conflicts in health facilities. In addition, a CENPRECS ensures that local teams have continual access to technical updates and information on the resolution of conflicts in health facilities by inviting speakers to CEPRECS sites and by teaching training skills to center staff. This technical assistance ensures that center staff can adequately inform and build the capacity of CEPRECS constituents. In addition, the CENPRECS can offer case consultation to local centers on legal and medical issues.

3.1.3 Local NGO Coordinator

Incorporating a local NGO coordinator strengthens local capacity and provides a neutral party to work with health facility users and providers. The NGO coordinator must have experience in human rights or in health-related issues, working with civil society, using a rights-based approach in project activities; and must be a socially well-respected local institution to provide a community anchor for CEPRECS. For example, the NGO coordinator for the Pucallpa CEPRECS was well-regarded in the community due to its past two decades of work fighting human rights abuses committed by the military and guerrilla groups.

NGO responsibilities

Once the CENPRECS selects an appropriate NGO, the NGO prepares for coordination of a CEPRECS by (1) making a directory of local organizations working in health and human rights issues; (2) documenting local experiences in health conflict prevention and resolution; (3) finding an appropriate location for the CEPRECS, hiring personnel, and providing administrative support for the center; and (4) joining the local BOD. After completing these activities, the NGO assumes the responsibility of fiscal management of CEPRECS, including paying CEPRECS staff and operating expenses, and providing technical guidance to CEPRECS as needed.

3.1.4 CEPRECS

A CEPRECS is a specialized center for promoting conciliation and resolution of complaints of health facility users. The CENPRECS first identifies the general area for a CEPRECS—selecting small cities rather than larger ones can help a center build on existing social networks, which are more likely to exist in smaller places, and can ultimately help to establish cooperation among providers, users, CSO representatives, and authorities. Political will from health decisionmakers and providers, as well as the Ombudsman Office, is important in establishing a center, as it ensures commitment to addressing and resolving conflicts in healthcare facilities. Finally, strong local leaders and an organized civil society can

contribute to a site's success. Generally, centers are physically located near a specific health facility and provide services to those residing in the geographic area and using the health facility. Peru's centers were located near major hospitals in provincial capital cities. Given that the hospitals are fairly large, users could be assured anonymity in their complaints.

CEPRECS staff characteristics

In the Peru model, the CEPRECS team includes a director, general secretary, and an office assistant. The director manages and oversees the center, reports to the local BOD and CENPRECS Director, and supervises the other two staff members. The director should have formal training in law, conflict resolution, and ADR techniques. The general secretary, a health professional with an understanding of the health system, manages the day-to-day operations and reports to the director. The office assistant provides administrative support and assists the general secretary with daily activities. Additionally, CEPRECS personnel must have skills in conducting networking, advocacy, and communication activities; and be adept at interacting with users and health providers, promoting trust and confidence.

CEPRECS responsibilities

The principal responsibilities of a CEPRECS include training and information dissemination, problem-solving activities, and monitoring and reporting of cases. Specific personnel responsibilities are detailed in the Organizational and Functions Manual for CEPRECS (Appendix F).

Local centers lead workshops and training courses, conduct visits to health centers and other public spaces, and use print and television/radio media for key messages. The main goal is to inform healthcare personnel and users about health rights and CEPRECS services in order to address existing health-related conflicts and prevent future ones.

CEPRECS staff members provide services to healthcare users and personnel in addressing and resolving a problem around health service delivery or receipt, relying principally on ADR mechanisms and the provision of advice. CEPRECS staff document each case so that individual experiences can be classified according to a predefined typology and intake process (see Appendix C); prepare monthly reports on the number of cases classified according to the type of complaint; present weekly statistical briefings and monthly reports to CENPRECS (see Appendix D) and the BOD (see Appendix E); and follow up on BOD recommendations to ensure their implementation.

3.1.5 Board of Directors

The BOD serves as a governing body for a CEPRECS, but also as a forum that brings together persons knowledgeable about health facility users and their health rights and health issues. In Peru, the center BODs included representatives from the Ombudsman Office, the Hospital Directorate, local government, and CSOs. In some sites, representatives of vulnerable groups (e.g., PLHIV, indigenous organizations) were also BOD members.

Board of Directors responsibilities

The BOD is responsible for promoting collaboration between users and providers, supporting the promotion of health facility user rights among healthcare providers and users, promoting the technical and political legitimacy of the CEPRECS, and importantly, proposing system-wide changes to improve the quality of healthcare services. Based on the center's case reports and information, the BOD makes recommendations and decisions aimed at improving health services in the region and preventing future

conflicts. For example, a BOD can suggest policy changes to increase access to healthcare, improvements to increase the quality of local health services, and/or activities to enable the local population to voice complaints.

3.2. Guiding Principles for Program Implementation

This section presents the five key guiding principles and strategies considered critical to the success of the Peruvian centers and should be followed when replicating a CEPRECS in other countries.

3.2.1 Guiding Principle #1: Use a Problem-Solving Approach Consistently at All Levels of Implementation

A CEPRECS uses a problem-solving approach. From a conflict-resolution perspective, problem solving entails identifying the issues dividing parties and developing a solution that appeals to both sides (Pruitt and Rubin, 1986). The main idea is to identify problems and find solutions through a cooperative attitude, without looking for a guilty party. The approach promotes open dialogue between two parties to improve the opportunities for respecting, protecting, and exercising health facility users' rights.

Strategies

Implement a training program. It is crucial to train health personnel, CEPRECS teams, and the local population on the importance, relevance, and application of a problem-solving approach and ADR mechanisms, such as negotiation and mediation. Health personnel should not only use a problem-solving approach but should also develop critical thinking in how they treat their patients and seek any needed policy changes. A training manual on the rights of health facility users and on resolving conflicts in health facilities (Huaita et al., 2005) was prepared for the trainings. A final report on implementation of the centers in Peru was also prepared (Ormachea et al., 2005).



Lawyer of the Tarapoto CEPRECS provides training to health providers of the Maternal Health Center in San Martin. 2003. Photo courtesy of Marcela Huaita, HPI Peru.

A provider from Pucallpa commented on the training's value and incorporating the new approach:

“It all began when I decided to participate in the graduate course offered on the right to health where [trainers] talked about patient’s rights. It was then that I realized that [healthcare personnel] were violating many of these rights [at the health center]. For example, we did not have a door in the pediatrician’s room, and there was no privacy.”

We also agreed that we should start calling out patients names with more respect, without shouting. [The training] made us change certain attitudes inside the health facilities.”

Promote collaboration at all times. Collaboration implies that all stakeholders can contribute to improve the quality of decisionmaking and find a satisfactory solution. A collaborative approach should be promoted and modeled in regular CEPRECS activities among center staff, with the local NGO coordinator, among the BOD members.

Provide CEPRECS services using a problem-solving approach with ADR mechanisms. The CEPRECS team must use all possible consensus-based ADR mechanisms at hand (see Box 1). Center representatives must provide counseling or initiate a negotiation process, but not litigation. It is important to facilitate the active participation of the user and healthcare provider and to help them realize that they must jointly arrive at a consensus to be satisfied with the outcome. Appendix G contains detailed procedure flow charts for applying each of these ADR mechanisms.

Box 1: Description of ADR Mechanisms

Negotiation: Direct face-to-face discussion between the CEPRECS representative and a health provider to resolve a complaint.

Mediation: A mechanism by which an impartial third party (CEPRECS representative) facilitates communication between conflicting parties to clarify underlying issues and help find solutions.

Conciliation: A mechanism similar to mediation, with the exception that the CEPRECS representative can also propose options to resolve the parties' conflict.

Recommendations

- When training people on how to use a problem-solving approach, it is important to demonstrate the approach so participants can understand it clearly.
- A CEPRECS works with individuals from various professional backgrounds and educational levels; therefore, it is critical to promote and demonstrate the use of collaboration among parties.
- To win an ally, such as a healthcare provider, offer him/her a clear explanation of how he/she can contribute to the center and benefit from it.

3.2.2 Guiding Principle #2: Citizens, Authorities, and Health Personnel Must Work Together to Improve the Health System

When different actors in a health system are given the opportunity to work together, ideally they will engage in dialogue and achieve consensus on ways to improve the health system for users. Dialogue should be facilitated among:

- Healthcare users and healthcare providers,
- Authorities and civil society, and
- Professionals of different disciplines.

Strategies

Ensure the local NGO coordinator has the technical capacity to promote multisectoral collaboration.

The local NGO coordinator must have experience in health and/or human rights issues, have the willingness and capacity to oversee a CEPRECS, and have a sound reputation among the population and the health sectors. Most NGOs selected for the Peruvian pilot only had experience in human rights, and, as a result, it was an interesting and challenging process for them to switch from a broader human rights approach to one focused on health. NGOs also had to switch from an advocacy approach to a problem-solving approach.

Ensure the CEPRECS is true to its mission. CEPRECS services must be considered confidential, user friendly, free of charge or low cost, accessible and close to a health facility, and trustworthy in order for the center to gain the respect, recognition, and visibility among healthcare users and providers as a central, neutral space. Given adherence to its mission, centers can be implemented in a variety of locations (e.g., public or private facilities, clinics or large hospitals, urban or rural areas) with success.

One healthcare user in Pucallpa commented on the value of placing a CEPRECS near a health facility:

“...most people are mistreated at health facilities and if the CEPRECS is not near, people might have second thoughts about going and filing a complaint... and I noticed that when the CEPRECS was near the hospital lots of people went there, but when it moved to San Fernando [further from the hospital] fewer people visited the CEPRECS.”

Get support of key local actors. In addition to the local NGO coordinator, it is necessary to identify and gain support from institutions that play a key role in enabling the local population to demand high-quality health services. Such key actors can include MOH representatives, health facility directors, local/regional government authorities, CSOs interested in health and human rights, professional schools and associations (nurses, doctors, midwives), journalists, and where possible, representatives of organizations of vulnerable groups (e.g., disabled, indigenous groups, PLHIV).

The Pucallpa CEPRECS Director shares how his staff were creative about getting local support:

“At first, we thought we would use radio and TV spots, but these are expensive and not sustainable. Based on this fact, we changed our communications strategy and created a communications network on human rights and health. Through this network at no cost, journalists could spread news about CEPRECS and about rights of users of health facilities. They understood the role CEPRECS played in enabling people to exercise their rights, and they understood that information can be spread in various ways besides TV and radio spots. The key lesson here is to make journalists and communicators your allies by making them a resource to protect and inform about people’s rights in health facilities. We achieved that through providing them with training.”

Create a space where decisionmakers and policymakers make and discuss recommendations for the health sector. A center’s mission is not only about solving individual problems at health services but also about fostering policy change to improve access to health services and enable people to exercise their right to health. Changes in health services cannot happen unless the decisionmakers are convinced of the importance of building effective social and institutional responses to problems at health facilities and understand their role in implementing those changes. The BOD promotes dialogue among all the influential policymakers to facilitate changes in the local health system. CEPRECS staff must educate the BOD on user rights in health facilities and inform them about the types of policy and organizational changes that can address issues and prevent violations of user rights in health facilities.

Recommendations

To achieve important and lasting changes at local health facilities, it is important for a center to

- Ensure that the responsible authorities understand the importance of making policy changes to protect the health rights of health facility users; and
- Work with responsible authorities both within and outside of the CEPRECS BOD so that they understand their role in introducing and enforcing the policy and organizational changes suggested by the CEPRECS and CSOs.

3.2.3 Guiding Principle #3: Users Must Know Their Rights in Health Facilities and Have Appropriate Channels in Order to Fully Exercise Those Rights

Health facility users will be more inclined to demand healthcare services that meet high-quality standards when they are informed and have accessible and appropriate channels for successfully demanding their health rights. In turn, when healthcare providers are informed and knowledgeable of the rights of users, they can work to protect them. As such, efforts to enable people to exercise their rights must include information dissemination and training. In some settings, however, issues of power and existing inequities may make dialogue difficult. It may be necessary to provide specialized training to different actors (i.e., healthcare users, healthcare providers, civil society) to overcome communication barriers and ensure respectful dialogue. Communication strategies may also need to consider power dynamics (i.e., between men and women) and their impact on seeking CEPRECS services.

Strategies

Inform healthcare users and providers about CEPRECS services and the rights of users of health facilities

Train healthcare providers and build alliances. Healthcare providers must become allies in enabling users to exercise their rights in health facilities. Therefore, providers must be familiar with the concept of high-quality, client-centered care and how to promote it. A useful way to reach healthcare providers is by organizing training courses that offer university credits at a graduate level to those who successfully complete the courses. These courses should have both a theoretical and a practical component, whereby healthcare personnel have to put in practice what they have learned and share the results with the rest of the students.^{††} Providers should also be familiar with how a CEPRECS works, its mission, and the guarantee of confidentiality regarding the complaint and the resolution process.

In carrying out training courses, centers must work closely with health facility authorities so that they are knowledgeable of users' health rights, recognize the importance of respecting and protecting those rights, and understand and value the mission of the CEPRECS.

Build relationships with civil society organizations. The support of CSOs is also crucial in successfully implementing center services, as CSOs tend to be more in touch with the local population's needs, can exercise social and political pressure on local authorities, and can help disseminate information to the public. Thus, it is important that CSOs and centers share a common understanding of the rights of health facility users and what can be done to protect and promote those rights.

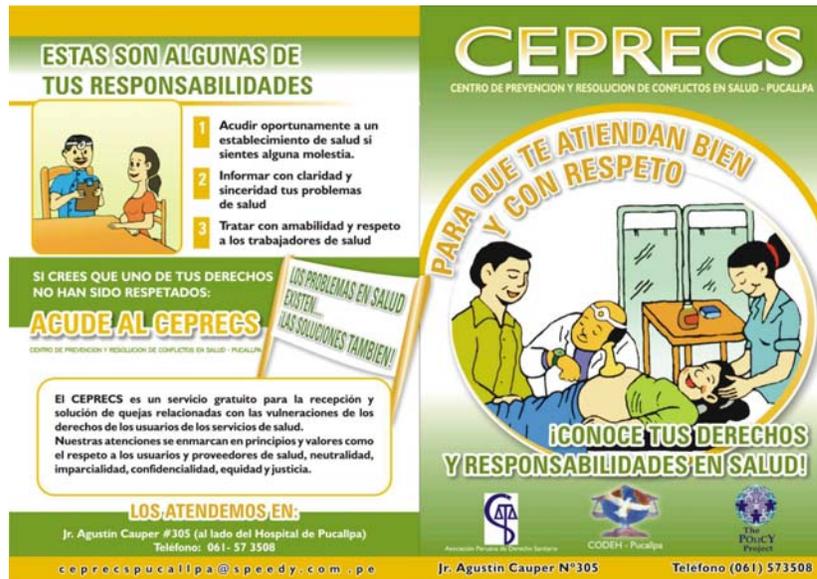
^{††} People without a professional degree receive a university certificate upon completing the course.

CEPRECS can hold informational workshops with CSOs to inform them about health rights and listen to their ideas and suggestions for solutions. Additional meetings should complement the workshops to inform CSOs about CEPRECS activities and their potential and actual roles in implementing activities.

Design a communication strategy to reach the local population. In Peru, the CEPRECS motto was “Conflicts in health exist... solutions as well. Come to CEPRECS!” (“Los conflictos en salud existen... las soluciones también. ¡Ven al CEPRECS!”).

The motto helped to advertise the aims of CEPRECS services in a user-friendly way. To reach and inform the local population about user rights in health facilities, conflict resolution, and the availability of center services, CEPRECS representatives can facilitate three main informational activities:

1. *Outreach.* Outreach activities must be designed by the local CEPRECS team and require a previous knowledge of the best places to reach people and talk about health conflict resolution. In Peru, CEPRECS teams visited waiting rooms of health facilities, weekly markets, and other public spaces to interact with potential CEPRECS users. The usual strategy was to approach people and ask them about their recent experiences at the health facility, disseminate flyers about the center, and discuss the rights individuals have as healthcare users.
2. *Use of mass media.* Designing and airing television and radio spots, while an expensive option, has the potential to reach a large proportion of the local population. This option requires prior training for the CEPRECS team on basic concepts about marketing and advertising.
3. *Distribution of printed material.* Center teams can design flyers and advertisements to distribute at health facilities and in the community. The Peru CEPRECS teams tailored the flyers to the local context and included simple and informative text and explanatory drawings to accommodate those who might be illiterate or non-Spanish speaking. For example, in Peru, users of CEPRECS services were mostly women, and because many poor women in Peru do not read or write, the flyers had more graphics than text and were oriented toward local women (see example below).



This promotional material from the Pucallpa CEPRECS explains the CEPRECS mission and where the center is located. The material encourages the reader to “know your rights and responsibilities in health,” ... “so that health professionals treat you well and with respect.”

Recommendations

- Developing and implementing a communications strategy is crucial for reaching the local population, and it may be necessary to have a specialized team working on it to ensure the strategy takes into account local context, including gender and power dynamics.
- If the CEPRECS team is responsible for its own communication strategies, the team must receive basic training on how to work with mass media, organize a press conference, write a press release, and conduct an interview.
- Radio and television spots can be expensive; if used, there must be a separate budget to ensure that advertisements command attention and are appropriate.
- To effectively reach people, it is important to identify the best communal spaces for conducting outreach activities and to be aware of the social dynamics and characteristics of the target audience(s).

3.2.4 Guiding Principle #4: Be Aware of the Specific Needs of Vulnerable Population Groups and Tailor CEPRECS Services Accordingly

Some population groups are simply more vulnerable to having their health rights violated. It is important to identify which groups are considered vulnerable, get them involved in CEPRECS activities, and respond to their needs in a tailored way.

However, it is important to note that there are broader social, economic, historical, and cultural contexts that determine the way these groups are perceived and treated by society, and that while a CEPRECS may not be able to change these perceptions, it can help to question them. In Peru, in the Junin region, there is a large population of Quechua-speaking people. However, the majority of healthcare personnel do not speak this local indigenous language, and, historically, this population group has experienced discrimination—making them vulnerable and less likely to demand high-quality, client-centered care. A member of the Huancayo CEPRECS team, in Junin, spoke Quechua, and she proved to be highly useful in conveying key messages to this vulnerable and marginalized group.



In Ayacucho, women from grassroots organizations role play on mistreatment at health facilities. 2003. Photo courtesy of Marcela Huaita, HPI/Peru.

Strategies

Empower vulnerable groups through information dissemination. One way to empower vulnerable groups is to provide them with adequate information about user rights in health facilities, while learning from them about the main barriers they experience in exercising their rights as health users. Strategies for addressing those barriers can be designed accordingly, with input from vulnerable groups.

Strengthen the leadership skills of vulnerable groups. Often vulnerable groups are organized in an association, support group, or CSO. If this is the case, the organization should be invited to participate in

BOD meetings and encouraged to become a board member. In Peru, many of the BODs included CSOs representing women's groups, the disabled, youth, and religious groups.

Recommendations

- Individuals from vulnerable groups often lack the confidence to demand and exercise their rights as users in health facilities. Therefore, it is necessary for a CEPRECS and the local NGO coordinator to provide extra support to continually empower these groups.
- To improve healthcare access for vulnerable groups, health personnel must be also involved in the process.

3.2.5 Guiding Principle #5: Consider Sustainability from the Beginning

Sustainability should be a key concern for a center. Initially, centers might have a private funding source, but, ideally, local authorities will eventually consider CEPRECS services important and assume financial responsibility for the centers. Sustainability depends on four key conditions:

1. Political will of local authorities
2. Financial support
3. Social support
4. Perception of effectiveness

Strategies

Identify and secure funding sources for continuing center implementation beyond the pilot phase.

Depending on local conditions, various possibilities for continuing implementation exist, such as:

- Local NGO coordinator continues providing operational support to the CEPRECS
- Local universities continue operating the CEPRECS
- Local Health Directorate (or equivalent) continues operating the CEPRECS

In Peru, the Huancayo CEPRECS, while it closed after the pilot, has reopened and is now part of the organizational structure of the Junin Regional Health Directorate (thanks to support from the regional health director). This support guarantees that by law the center will receive funding to continue its activities. Unfortunately, the allocated budget can only cover the salary of one staff member, which limits capacity for outreach activities and other informational strategies and to handle case loads; and, as a result, fewer users are visiting the center. Despite these limitations though, the CEPRECS can remain operational, and the regional health directorate showed its commitment to continuing to protect the rights of users of health facilities.

Recommendations

- Centers must maintain an ongoing focus on achieving sustainability and building local buy-in. It is important to identify and map those institutions with the interest and capacity to continue



Inauguration of CEPRECS at the University of the San Martin Region. 2004. Photo courtesy of Marcela Huaita, HPI/Peru.

implementing CEPRECS services. Ideally, government authorities, specifically those in health, would be interested in continuing and building on CEPRECS achievements. In Peru, the MOH is both a health service provider and a regulator in charge of policymaking and was therefore an important potential player in assuming responsibility for the CEPRECS. In other countries, however, the situation and the appropriate players may be different.

- The first step for achieving sustainability is guaranteeing funding for at least three years, which will likely allow a CEPRECS to demonstrate its importance and effectiveness in protecting and addressing the rights of users in health facilities. After three years, it would likely be easier to (a) find other sources of financial support or (b) convince local authorities of the benefit of having a CEPRECS.
- Analyze thoroughly whether CEPRECS services should be free. In Peru, stakeholders decided to make services free to prevent financial barriers to accessing CEPRECS services, particularly among vulnerable groups, and to generate demand for the services, as they were new. The centers first had to gain recognition as legitimate problem solvers before charging clients. Nevertheless, if there is an existing culture of paying for public services, and it is considered appropriate, charging fees could be feasible and would contribute to financial sustainability. Another possibility is asking the government to subsidize CEPRECS services.
- If governmental authorities (e.g., municipality, state, regional) take over the CEPRECS, there is a need to advocate for a regional policy that ensures the creation and functioning of an entity responsible for protecting the rights of users in health facilities.

CONCLUSION

These guidelines are informed by the Peruvian pilot experience of implementing and managing a CEPRECS in five cities.

Implementation of the Peru centers illustrates that it is possible to empower people to exercise their health rights and effect changes in the health system through collaboration with civil society, healthcare providers, and the MOH; and through local government and community consensus. Changes in healthcare can occur when decisionmakers are convinced of the importance of building effective social and institutional responses to problems with health services. While there is still much work to be done to ensure access to healthcare, guarantee high-quality health services, and promote respect of the right to healthcare without discrimination, a CEPRECS contributes to these goals by building community consensus, resolving conflict at the individual level, and fostering policy change at the systems level. The CEPRECS operational model, and the experience of its application in Peru, can be adapted and applied in other countries in Latin America and the Caribbean, as well as in other regions. The guidelines presented in this publication set out five key principles and associated strategies. When replicating a CEPRECS, one should consider the local context and characteristics of the health sector and draw on existing national laws and regulations.

APPENDIX A. INTERVIEW QUESTIONNAIRE FOR KEY INFORMANT INTERVIEWS

- How important was it to have the technical team's support at the beginning, middle, and end of the project? Specify.
- How important is the prestige of the institutions promoting the CEPRECS? Why? Will it have worked without this prestige?
- What are the minimum qualifications or requirements a CEPRECS team member should have to provide good services? How do you evaluate the experience of working with the other civil society organizations and with the regional government and health sector to address issues related with health services provision? (lessons)
- What characteristics of the Board of Directors (members, frequency of meetings, etc.) were the most important to guarantee its efficacy?
- What was a key element to promote an improvement in service provision through the Board of Directors?
- How did the CEPRECS (i.e., being part of the Board of Directors) promote a better understanding of the hospitals' capacity and limits to address health facility user's expectations?
- What IEC (information, education, and communication) strategies were used for reaching the local population?
- Which were the most effective? Why?
- What were the main challenges in promoting health rights among the local population?
- Which groups were specifically vulnerable in relation to the right to health? Why?
- How did the CEPRECS experience help these groups?
- What IEC strategies were used for reaching health personnel?
- Which were the most effective? Why?
- What were the main challenges to promoting health rights among health personnel?
- What strategies did you use to make health personnel perceive the CEPRECS as an ally rather than a threat to their work?
- How important was it to have a CEPRECS office near the hospital facilities? Is this as a key element for a future experience? Why?
- What were the key achievements of the CEPRECS? Why?
- What key characteristics should the host NGO have? Why?
- What are the main challenges to enacting laws and regulations that will result in changes within the health sector to incorporate good standards of services and increase access to health services?
- Name and explain three main elements in achieving the sustainability of a CEPRECS project somewhere else.

APPENDIX B. CEPRECS OBJECTIVES AND ACTIVITIES

Main objective: To organize strategies for the prevention and resolution of health conflicts with the participation of multiple actors (decisionmakers, health facility users, providers, local leaders, and authorities) who use and provide health services				
Specific objectives	1. To strengthen capacity for the prevention and resolution of conflicts in health facilities within civil society organizations and state agencies	2. To promote the rights of health users and the mechanisms to prevent and resolve health conflicts	3. To establish a CEPRECS in several locations	4. To implement a system of prevention, management, and resolution of health conflicts
Activities	Exploratory visits to possible locations for the project	Organization of national and international seminars on the prevention and resolution of health conflicts	Formalization of institutional alliances to organize a CEPRECS	Writing of operational manuals for the CEPRECS
	Publication of local directories of organizations and providers of health services	Publication and distribution of posters and fliers about the center and its services	Opening of the CEPRECS in the selected locations	Organizational design of the CEPRECS model
	Writing of a database of experiences in rights surveillance and management of health conflicts	Production of radio programs to diffuse health rights	Technical assistance and monitoring of the open CEPRECS	Writing of a standard operational procedure for case management
	Writing of training materials	Organization of information events about the services provided by the centers		Preparation of final report on the CEPRECS experience
	Execution of a training program in the selected locations			

APPENDIX C. CEPRECS INTAKE FORM

FORM N°

EXP N°

Center for the Prevention and Resolution of Conflicts in Health Facilities

CEPRECS
(City)

Date of complaint:...../...../.....

BENEFICIARY^{§§}

Name and Last Name

Age..... Sex: M () F () ID N°

Educational Level

- | | |
|-------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> illiterate | <input type="checkbox"/> incomplete primary schooling |
| <input type="checkbox"/> complete primary schooling | <input type="checkbox"/> incomplete high schooling |
| <input type="checkbox"/> complete high schooling | <input type="checkbox"/> incomplete technical education |
| <input type="checkbox"/> complete technical education | <input type="checkbox"/> incomplete college education |
| <input type="checkbox"/> complete college education | <input type="checkbox"/> special education |

Address:.....

Area of residency: Urban () Urban Marginal () Rural ()

Phone.....

Occupation

CONSULTANT^{***}

Name and Last Name.....

Age..... Sex: M () F () ID N°

Educational Level

- | | |
|-------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> illiterate | <input type="checkbox"/> incomplete primary schooling |
| <input type="checkbox"/> complete primary schooling | <input type="checkbox"/> incomplete high schooling |
| <input type="checkbox"/> complete high schooling | <input type="checkbox"/> incomplete technical education |
| <input type="checkbox"/> complete technical education | <input type="checkbox"/> incomplete college education |
| <input type="checkbox"/> complete college education | <input type="checkbox"/> special education |

Address:.....

Area of residency: Urban () Urban Marginal () Rural ()

Phone.....

Occupation.....

How did you find out about CEPRECS?

- Radio TV Flyers Sticker Newspaper Talk
 I was referred by Other

^{§§} A beneficiary is the person who has directly suffered a problem at the health facility.

^{***} A consultant is the person reporting the problem suffered by the beneficiary. Sometimes the beneficiary and the consultant can be the same person.

Case

Date problem happened..... Time.....
Name of Health Service Area.....

Motive

The beneficiary/consultant states that:
.....
.....

Name of person doing the intake

DOCUMENTS ANNEXED.....

Signature or fingerprint of consultant	Signature of person doing the intake
----------------------------------------	--------------------------------------

TO BE FILLED ONLY BY A CEPRECS REPRESENTATIVE

Case classification (include all the relevant)

- Mistreatment during service provision (produced by situations between healthcare users and healthcare providers. It includes unfair treatment, lack of respect, insults, etc.)
- Organizational mistreatment (long lines, delays, problems caused by the disorganization of the health services)
- Bad administrative service (administrative personnel does not offer an adequate service)
- Bad health service (health personnel have delivered a poor service to the healthcare user)
- Problems related with health insurance (either coverage or unfair charges)
- Problems related with the driver’s insurance for accidents
- Problems related with EsSALUD (national social security service)
- Problems related with private insurance
- No informed consent
- Lack of information
- No attention at emergency room
- Against the right to freedom (the patient is not allowed to go home unless he/she pays all the expenses)
- Unfair charges
- Problems caused by cultural differences (e.g., language, different medical knowledge, etc.) (specify)
- Other

Mechanism(s) used at the beginning of the case

Assessment Negotiation Mediation
Conciliation Dialogue/BOD Others

Actions taken

Date	Description of the action taken	Mechanism used	Responsible

Follow up activities:

New visit to the consultant / beneficiary ()

Phone call ()

Visit to the consultant / beneficiary ()

Other

Follow up result:

Date:.....

.....
.....

APPENDIX D. STATISTICAL REPORT FORM FOR CENPRECS

This form presents the monthly statistical information that each CEPRECS gathers and submits to the CENPRECS.

STATISTICAL INFORMATION FORM ON THE (CITY) CEPRECS EXAMINED CASES

About the users	
Total number of users	
Sex	M () F ()
Age (in age groups)	0–5 years () 6–10 years ()
	11–15 years () 16–20 years ()
	21–25 years () 26–30 years ()
	30–35 years () 36–40 years ()
	41–45 years () 46–50 years ()
	50–55 years () 56–60 years ()
	61–65 years () 66–70 years ()
	71–75 years () 76–80 years ()
	81–85 years () 86–90 years ()
90 years or more ()	
About the consultations	
Type of health facility	Hospital () Health Center () Health Post () Community Health Center () Other ().....
Services or areas	
Typology of consultation cases	Mistreatment during medical examination () Mistreatment at health facility () Poor healthcare services () Poor administrative services () Lack of information to the patients () Problems related to the Health Insurance () No service at the ER () Violation of the right to freedom () Unlawful charges () Absence of healthcare personnel () No drugs available () Others ()
Frequency of the use of problem-solving mechanisms	Assessment () Negotiation () Mediation () Conciliation () Concertation () Others ()
Typology of reasons examined cases were closed	Total agreement () Partial agreement () No agreement () Absence of 1 party () Absence of 2 parties () Abandonment ()

APPENDIX E. STATISTICAL REPORT FORM FOR BOD

This statistical report is presented to the Board of Directors and contains recommendations based on the statistics.

REPORT NUMBER OF THE (CITY) CEPRECS

About the users	
Total number of users	
Sex	M () F ()
Age (in age groups)	0–5 years () 6–10 years () 11–15 years () 16–20 years () 21–25 years () 26–30 years () 30–35 years () 36–40 years () 41–45 years () 46–50 years () 50–55 years () 56–60 years () 61–65 years () 66–70 years () 71–75 years () 76–80 years () 81–85 years () 86–90 years () 90 years or more ()
About the consultations	
Health facility	Hospital () Health Center () Health Post () Community Health Center () Others ()
Services or areas	
Typology of consultation cases	Mistreatment during medical examination () Mistreatment at health facility () Poor healthcare services () Poor administrative services () Lack of information to the patients () Problems related to the Health Insurance () No service at the ER () Violation of the right to freedom () Unlawful charges () Absence of healthcare personnel () No drugs available () Others ()
Frequency of the use of problem-solving mechanisms	Assessment () Negotiation () Mediation () Conciliation () Others ()
Typology of reasons examined cases were closed	Total agreement () Partial Agreement () No agreement () Absence of 1 party () Absence of 2 parties () Abandonment ()

Based on the collected information, the (city) CEPRECS professional team presents the following recommendations to the Board of Directors so that they can be discussed at the meeting.

(Example)

RECOMMENDATION #1:

We recommend that the emergency personnel at the XXXX Hospital are provided with a training workshop on health users' rights and communication techniques during conflict situations in order to improve the quality of services and attention in this area.

The training workshop will be the responsibility of the CEPRECS team and will be done during the two following weeks.

RECOMMENDATION #2:

(...)

RECOMMENDATION #3:

(...)

Place, date, and signatures of the CEPRECS team members that will follow up on the recommendations.

APPENDIX F. CEPRECS ORGANIZATIONAL AND FUNCTIONS MANUAL

ORGANIZATIONAL AND FUNCTIONS MANUAL FOR CENTERS FOR THE PREVENTION AND RESOLUTION OF CONFLICTS IN HEALTH (CEPRECS)

**Asociación Peruana de Derecho Sanitario (APDS)
POLICY Project**

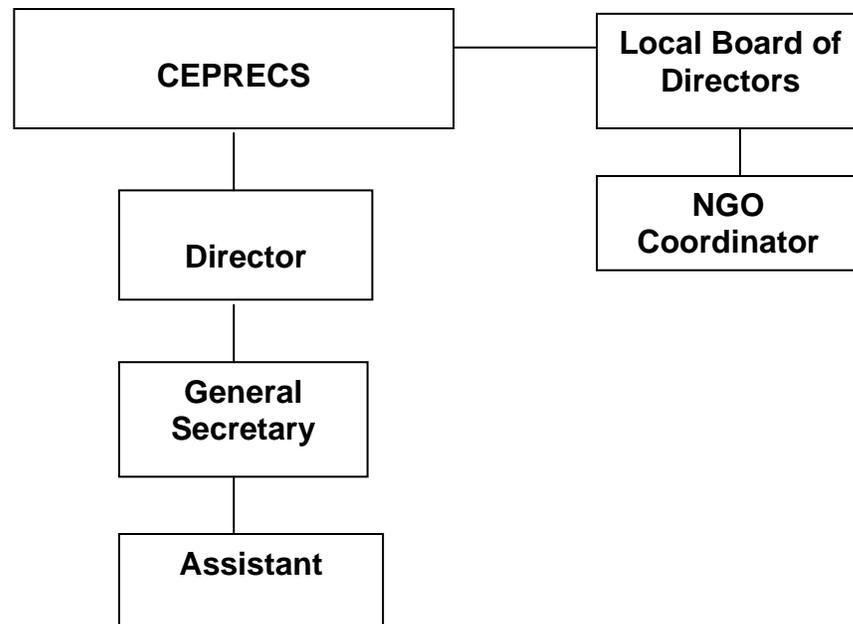
April 2003

“Este documento ha sido posible gracias al aporte del Proyecto POLICY II de USAID, contrato N° HRN-C-00-00-00006-00. LA 5906.951.APDS.1 Las opiniones expresadas no reflejan necesariamente los puntos de vista de USAID.”

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- VII. GENERAL PROFILE OF THE POSITIONS

CEPRECS INTERNAL ORGANIZATION AND HIERARCHICAL RELATIONS



I. INTRODUCTION

This document describes the functions of Centers for the Prevention and Resolution of Conflicts in Health Facilities (CEPRECS). They were created as part of a system that uses “Mechanisms to prevent and solve conflicts in the exercise of the right to health,” developed by the Peruvian Association of Public Health Law (APDS). A Director, a General Secretary, and an Assistant serve these centers.

II. CEPRECS DUTIES

The CEPRECS aim to promote the prevention and successful resolution of conflict that arises from provision of healthcare services. It promotes the health rights of health facility users, offering services in assessment, negotiation, mediation, conciliation and concertation and it is an active participant in the spaces where these conflicts may arise. CEPRECS perform preventive activities and in some cases also provide interventions.

III. CEPRECS ORGANIZATIONAL STRUCTURE

The CEPRECS have a specific structure designed to facilitate the exercise of its functions. The structure is as follows:

The Board of Directors has the following functions:

- Articulate healthcare providers with healthcare users to solve the conflicts that are the product of the relationship between these two groups, in an harmonious way.
- Promote the technical and political legitimacy of the CEPRECS.
- Propose policy changes to improve the quality of healthcare services.
- Support the promotion of the right to health among healthcare providers and healthcare users.

IV. APPLICABLE LAW

This document defines the specific functions that will be developed in the CEPRECS. The following Peruvian law is applicable to CEPRECS:

- Political Constitution of Peru (1993)
- Covenant Act of Health N° 26842
- Mandatory Conciliation Act N° 26872
- Creation of the Social Security of Health Act N° 27056
- Modernization of the Social Security of Health Act N° 26790
- Consumer Protection Act D.Leg N° 716

The following international declarations and human rights laws are applicable to CEPRECS:

- Universal Declaration of Human Rights (UDHR), 1948
- International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966
- Convention on the Elimination of All forms of Discrimination Against Women (CEDAW), 1979
- International Convention for the Elimination of All Forms of Racial Discrimination (Racial Convention), 1965
- Convention on the Rights of the Child (CRC), 1989

V. HIERARCHICAL RELATIONS

1. CEPRECS Director

Reports to: Board of Directors and CENPRECS Director
Supervises: CEPRECS General Secretary

2. CEPRECS General Secretary

Reports to: CEPRECS Director
Supervises: CEPRECS assistant

3. CEPRECS Assistant

Reports to: CEPRECS General Secretary

VI. SPECIFIC DUTIES

Director's Duties:

1. Plan, organize, direct, and supervise CEPRECS administrative and financial activities.
2. Represent the CEPRECS before any administrative or judicial authority.
3. Represent the CEPRECS before the National Council of Conciliation Centers.
4. Elaborate an operational plan as well as workplans and the CEPRECS budget.
5. Promote CEPRECS services with healthcare provision entities, healthcare users, and mass media.
6. Guarantee the logistics support to open and implement the CEPRECS as well as for promotion and training events.
7. Elaborate reports that inform the achievements of the CEPRECS operational plan and whenever the CEPRECS requires a report.
8. Promote cooperation agreements with local organizations.
9. Propose changes in the CEPRECS functions.
10. Select the candidates to work as conciliators in the CEPRECS.
11. Present and defend the CEPRECS financial statements to the CENPRECS.
12. Propose new funding sources for CEPRECS functioning.
13. Organize the local Board of Directors and coordinate its activities.
14. Twice a month present the CENPRECS and the local BOD with the statistics, showing the most frequent cases and their possible solutions.
15. Perform any other duty assigned by the CENPRECS and that are contained in the norms on which this document is legally sustained.
16. Perform, according to the situation and the CEPRECS, requirements of some or every duty of the General Secretary.

General Secretary Duties:

1. Elaborate and keep up to date the directory with the local civil society organizations.
2. Collect experiences on conflict resolution around health problems in the city.
3. Implement diffusion and training activities targeted at healthcare users, healthcare providers, and CSOs according to the preventive goal of the CEPRECS.
4. Receive and manage users' complaints.
5. Invite to convene or mediate.
6. Receive, organize, and classify the application forms of the candidates for conciliator.
7. Evaluate the supporting documentation required by law to be a conciliator.

8. Register the personal documents of the conciliators and the final evaluations of the “Encuentros de Actualización Interna.”
9. Systematize the statistical information of the CEPRECS activities.
10. Store the acts and coordinate the follow-up of the processes under the local BOD.
11. Do other functions assigned by the CEPRECS Director that are related to the goals and functions of the CEPRECS. Perform any other function demanded by the conciliation and arbitration procedures according to the law.

CEPRECS Assistant Duties:

1. Execute the stocking, logistical support, and internal service activities of the CEPRECS.
2. Take note of the CEPRECS meetings.
3. Receive register, classify, and distribute the CEPRECS mail and documentation and the invitations to conceal and/or mediate.
4. Receive and refer phone calls. Organize and keep an updated phone directory of the CEPRECS external contacts.
5. Prepare and mail any CEPRECS document.
6. Keep the CEPRECS office clean and organized.
7. Be responsible of the stock, receipt, and delivery of office and cleaning materials.
8. Responsible for the CEPRECS petty cash.
9. Responsible for sending notification notes.
10. Do other functions assigned by the CEPRECS Director or the General Secretary.

VII. GENERAL PROFILE OF THE POSITIONS

Director’s Profile

- Health or law professional with knowledge of the legal base that supports this manual. Or a professional with knowledge of health issues. Ideally he/she should be accredited as an extra judiciary conciliator and trained in conflict resolution.
- Proactive and with decisionmaking capacity.

General Secretary’s Profile

- Health or law professional with knowledge of the legal base that supports this manual. Or a professional with knowledge of health issues. Ideally he/she should be accredited as an extra judiciary conciliator and trained in conflict resolution
- Proactive and with decisionmaking capacity.

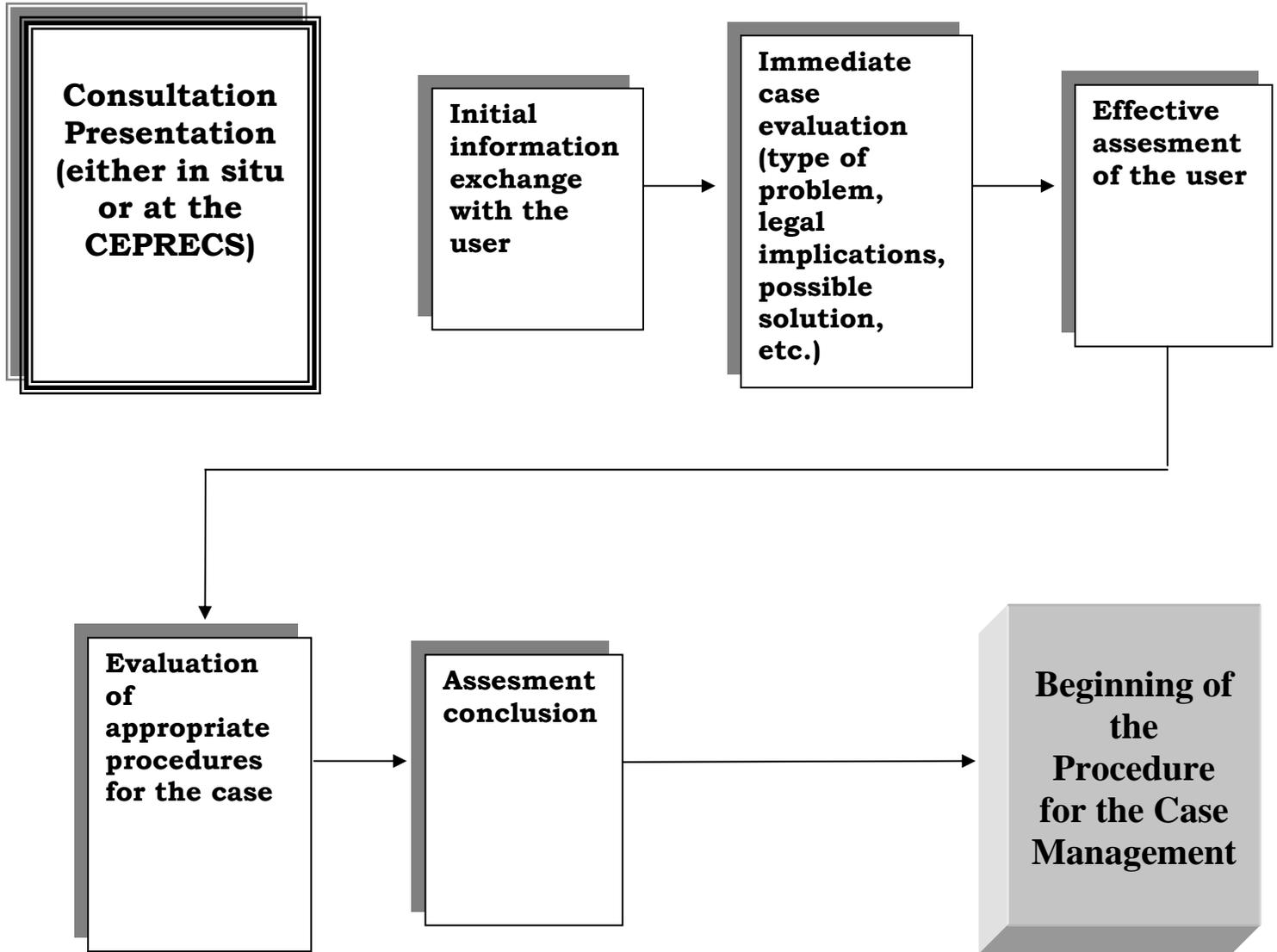
Assistant’s Profile

- University student with knowledge of the legal base that supports this manual. Preferably with some training in conflict resolution and ADR mechanisms.
- Team working skills and initiative for work.

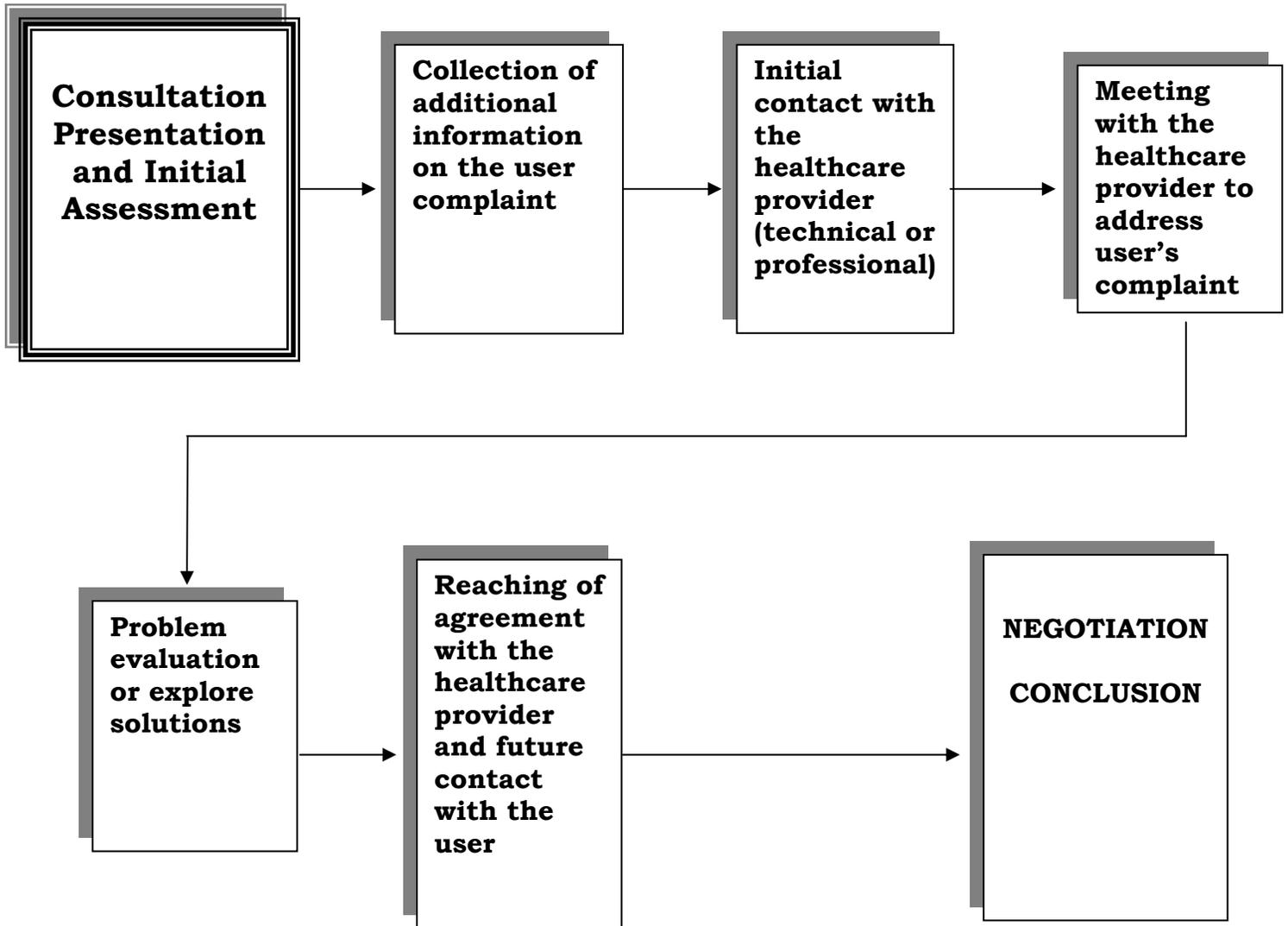
A law professional is required at the CEPRECS office. This is enforced by the Mandatory Conciliation Act N° 26872. This role will be exercised either by the CEPRECS Director or the General Secretary.

APPENDIX G. CEPRECS PROCEDURE FLOWCHARTS

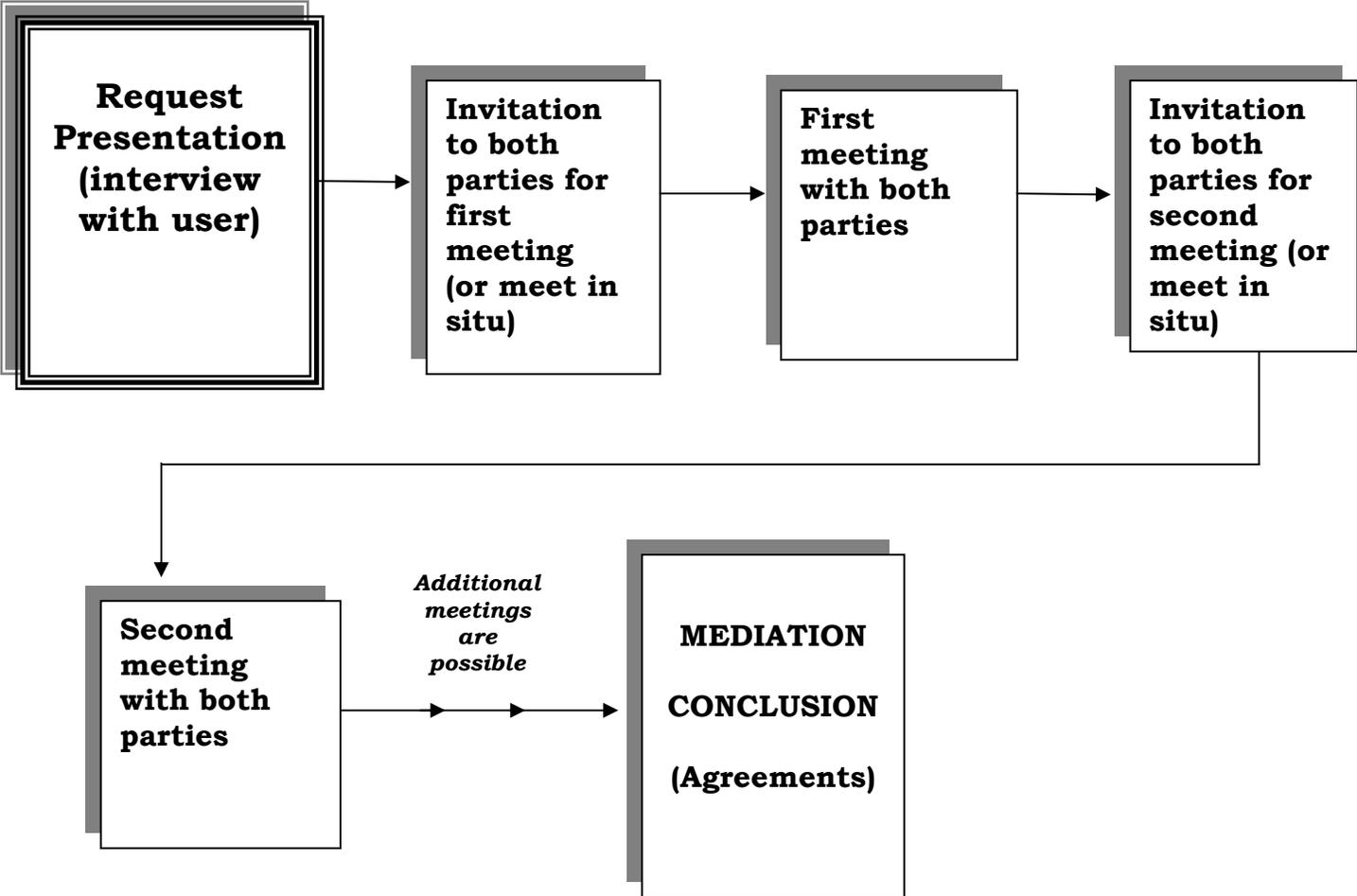
CEPRECS Assessment Procedure



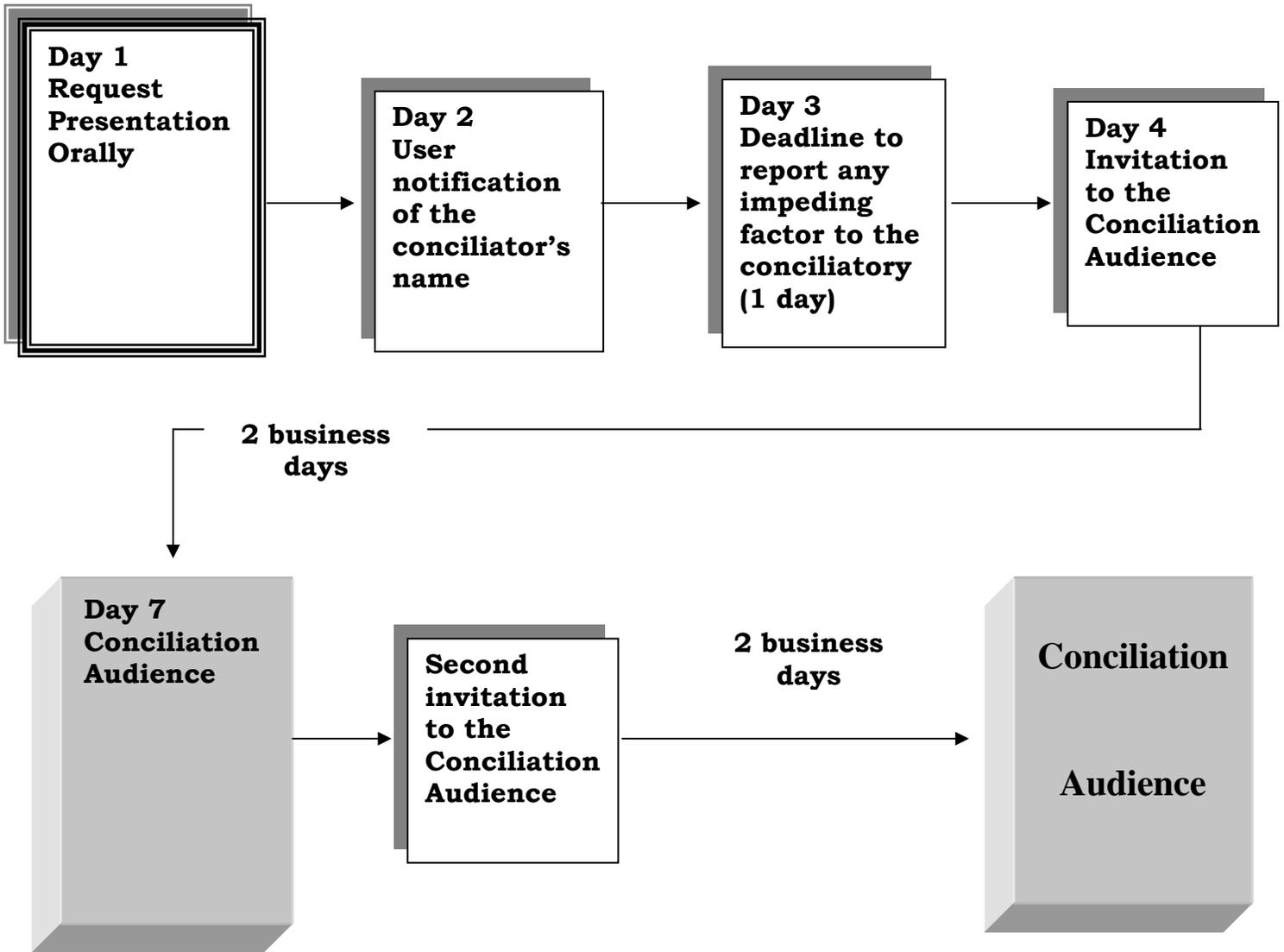
CEPRECS Negotiation Procedure



CEPRECS Mediation Procedure

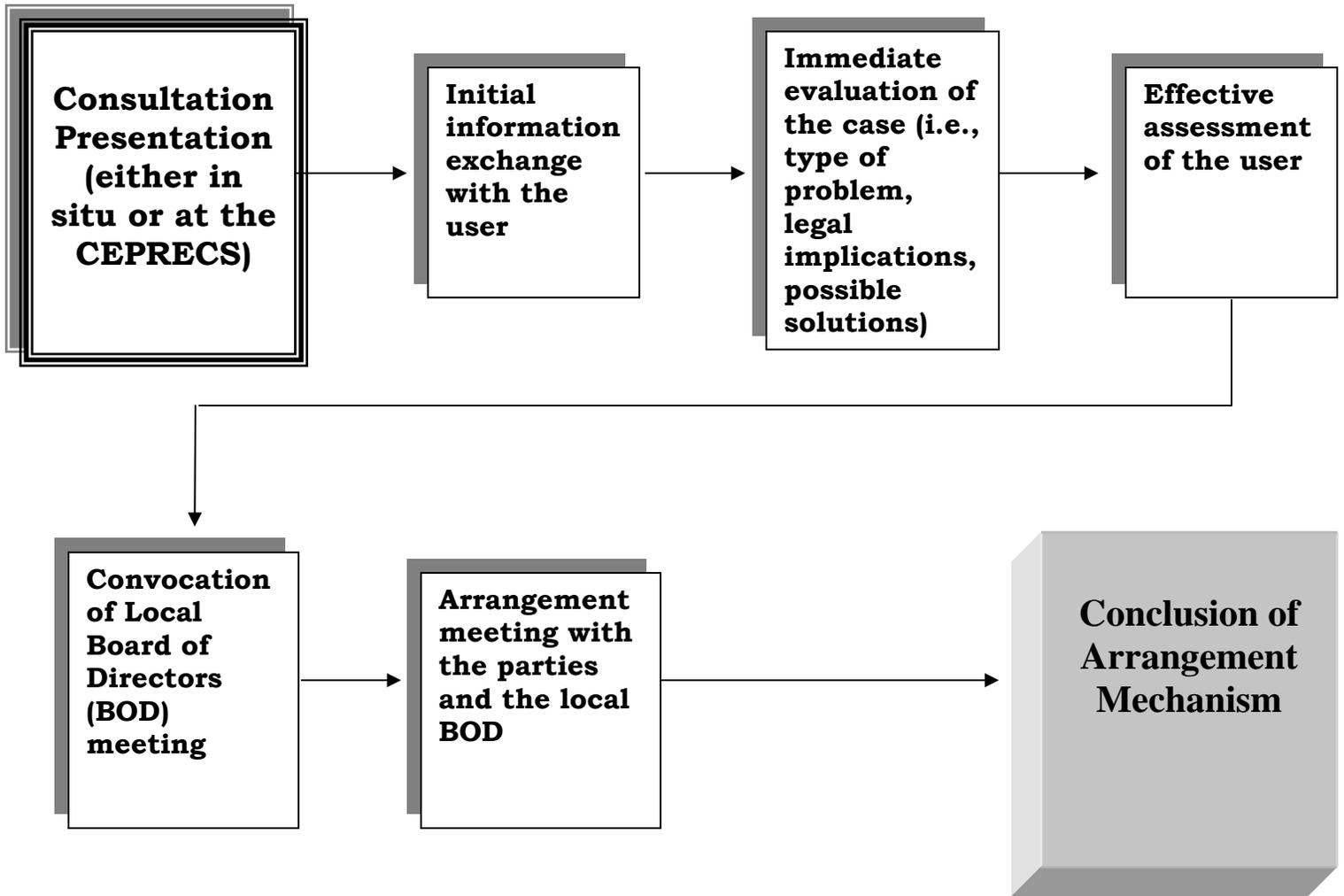


CEPRECS Conciliation Procedure



- All the time frames are in business days.
- If one of the parties does not participate in the conciliation audience, they will be invited for a second time.
- The time between an invitation and a conciliation audience can be delayed up to thirty (30) calendar days since the first law summons, if both parties agree to do so.

CEPRECS Arrangement Mechanism



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