Citizen Monitoring to promote the right to health care and accountability

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When I went to the doctor at the hospital, he said: "What is this about monitoring? We work hard here. Or would you like me to come to monitor you at home?"
I told him, "Excuse me, doctor, we are health care promoters and have been trained by the Ombudsman and the ForoSalud for monitoring. We know our rights. You cannot go to monitor my house, because it is private, but I can come to monitor the hospital, because it is a public institution, is the State-run. And here are my credentials"
"Ok, come right in ..." he told me.

Testimony of Nilda Chambi Monroy,
Health care Monitor from Azángaro (Puno)

1. Introduction

In countries with as much inequality as Peru, where approximately one of every two people are living in poverty, achieving the Millennium Development Goals (MDGs) on health care will not be possible with only technical interventions and increased resources allocated to health care. Significant and sustainable changes can only be achieved if Peruvians are more involved in the design and adjustment of social policies and the programs that implement them, thus ensuring that their needs have been properly considered and addressed.

In general, officers and professionals who are responsible for formulating and implementing public policies to combat poverty still display a limited understanding and commitment to the right to health care and to citizen participation. At the beginning of this decade, according to estimates by the Ministry of Health (MOH), 25% of the Peruvian population (close to 6,500,000 people) lacked access to health care when it was needed.[1]

With respect to progress towards achieving the MDGs, it seems to be insufficient in terms of reducing maternal mortality to 66 per 100,000 live births[2], despite the recent decline in the maternal mortality ratio reported by the National Statistics and Information Institute - 265 maternal deaths per 100,000 live births in 1996, 183 in 2000 and 103 in the year 2008 (the latter with a confidence interval of 50 - 120).[3]

The situation is aggravated by the deep and unfair differences in access to health care services that are capable of a comprehensive response to the needs and expectations of the population (that is, that are accessible, acceptable, culturally appropriate and of high technical quality), in the extension of knowledge and care of maternal and child health in the community and in the absence of citizen participation of women in the design and implementation of

[1] Ministry of Health (2002) Sectorial Policy Guidelines for the 2002-2012 period, p. 14.
[2] The Lancet, Volume 371 April 12, 2008.
[3] Demography and Family Health Survey (ENDES), National Statistics and Information Institute - INEI, 1996, 2000, 2009.

health care policies. In poor rural areas, where there are heightened (high) conditions of vulnerability, maternal and neonatal death constitute a clear indicator of social exclusion faced by rural women living in poverty - especially indigenous women - but also of the structural deficiencies and the inequities that must be addressed by the health care system and by the national and regional authorities.[4] This requires not only technical interventions, but placing priority on tackling these inequalities and on the effective involvement and the joint efforts of different stakeholders towards this goal.[5]

Health care programs face the urgent need to be properly designed and targeted according to the real needs of the most vulnerable population. This requires new types of relationships among civil society coalitions, representatives of the poor and excluded, governmental authorities and those responsible for such programs, which will contribute to democratic dialogue, governance, legitimacy and the sustainability of policies that are more inclusive and fair.

2. Description of the Problem

Peru has been classified as a middle-high income country as a result of its economic progress during the past twenty years. However, two characteristics define the reality of its society: diversity and inequality. The interior of Peru still displays major inequities, discrimination and poverty, resulting in a high incidence of preventable disease and mortality among the poorest and most excluded, but also in the rural population living in the regions with little social and economic development.

The maternal mortality rate in Peru is among the highest in America. As indicated above, in 2000 the maternal mortality ratio was 183 maternal deaths per 100,000 live births, which in absolute numbers represents more than 1,250 deaths per year.[6] However, national averages hide a discriminatory and unjust situation: there is an unacceptable gap between the regions with better socioeconomic conditions and those that are poorer: maternal mortality rates for that year in the regions of Puno, Huancavelica, Cuzco and Huánuco were 361, 302, 288 and 272 maternal deaths per hundred thousand live births, respectively.[7] This correlates with the high percentages of the population living in poverty: while an average of 52% of Peru's population was living in poverty in 2007, this figure was 85.7% in Huancavelica, 67.2% in Puno, 64.9% in Huánuco and 57.4% in Cusco.[8] These higher levels of maternal mortality among poor populations in the Peruvian highlands and jungle evidence a profound social injustice and gender inequality: in Peru the right to a healthy and safe motherhood is still denied to a share of the population that is mostly indigenous women, the poor and those in the most remote rural areas.

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[4] Physicians for Human Rights. Deadly delays: maternal mortality in Peru. A rights-based approach to safe motherhood. 2007. http://physiciansforhumanrights.org/library/report-2007-11-28.html (accessed on May 10, 2010).
[5] Frisancho, A., Comment to the editor on the study of Hogan MC, Foreman KJ, Naghavi M, et al., Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards Millennium Development Goal 5, *Lancet* 2010; **375:** 1609–23. Published in *The Lancet,* Vol.375, June 5, 2010, p. 1966.
[6] Demography and Family Health Survey 2000, INEI, May 2001, p.122.
[7] Watanabe Varas, Teresa. Trends, Levels and Structure of Maternal Mortality in Peru. 1992 - 2000. INEI. 2002.
[8] National Statistics and Information Institute. Annual National Household Survey: 2004-2007.

Despite recent progress in the increase of institutional deliveries and reducing the maternal mortality ratio, due in large part to different policies implemented by the Peruvian Ministry of Health (MoH) to address the barriers faced by pregnant women in poor and remote populations of country, the rate of decline in maternal mortality does not seem to be sufficient to achieve Goal 5 of the Millennium Development Goals related to its reduction.

In order to reduce the economic barriers that limit access to health care services for children and pregnant women living in poverty and extreme poverty, the Peruvian Ministry of Health (MoH) implemented in 1997 and 1999 so-called "public insurance" for school age children, pregnant women and newborns, respectively. The two schemes were united in 2001, constituting the Integral Health Insurance (SIS), all being cost reimbursement mechanisms for health care services. The current government has announced the future expansion of this modality to promote a system of "universal insurance." However, there are challenges related to the quality of care - and particularly the treatment of users of health care services - that have not been resolved. Moreover, despite the SIS's having existed for ten years, there is still a rejection by women to use health care services due to the mismatch between the "Western" characteristics of the services offered and the expectations of the women and men in rural communities.[9]

The insecurity and rejection to go to the health facilities is accentuated by frequent episodes of mistreatment of health care services' users; mistreatment is worse for female, poor, indigenous and non-spanish speaking users. Various studies look at the issue of abuse and illegal charges - "fines" for not giving birth in the facility[10] or charges for medicines and transport that the "insurance" should cover - as serious problems that threaten the dignity and rights of these people, and that limit or deny the acceptability of the health care services,.[11,12,13] The existence of a single health care provider for the poorest people, and the unequal and inequitable power relations that exist between health care workers and the users of such services, aggravate this situation.

"The ladies say that they cannot talk during the health care consultancies, because the doctor attends to them quickly and doesn't listen to what they want to say. Sometimes doctors don't even look at their face and don't know who they are treating. We have to tell them that there must be good care, asking the patient's name, talking calmly with women and, if possible, in quechua, and asking how they feel. That is the attention we want."

Testimony of Benilda Huayta Mamani, Health Monitor in Azángaro

[9] Amnesty International (2006) Peru: poor and excluded women – Denial of the right to maternal and child health, pp 26-30
[10] Ibid, pp 26-30
[11] Ibid, pp.21
[12] Peruvian Ministry of Health (2006). Health Care Letter: Listening to the Voice of Population. Crusade for Citizenship Rights and Responsibilities in Health Care. General Office of Communications – Health Care Rights Program (CARE Peru)
[13] PHR USA (2007) Fatal Delays: Maternal Mortality in Peru. A human rights approach to safe motherhood.

These facts, which seem to be unknown – or in the end, accepted - by the authorities in charge, result in a poor prognosis for the proposed "universal health insurance" if its design relies solely on efforts of the services offered. A collective, informed and organized - in sum, empowered – voice is needed to deal with these unfair situations of exclusion and the significant levels of "leakage" in the implementation of the SIS, which ends up benefiting those who do have resources to pay for their health care.

On the other hand, although the still-incomplete process of decentralization has facilitated the creation of new spaces for dialogue and agreement on regional and local policies, it needs to strengthen these still-limited mechanisms and contribute to a better balance of power within to promote changes in social policies that respond to the needs of the most marginalized and vulnerable groups of the population. At the same time, civil society actors should implement alternative mechanisms for dialogue: mechanisms of citizen monitoring and the promotion of accountability by state officers. They should also promote a legal framework to facilitate the demand for the right to health care and citizen participation.

3. Citizen monitoring and public policies

Citizen health care monitoring is a mechanism of citizen participation in which organized and informed people develop activities aimed at monitoring and verifying compliance with the duties, obligations and commitments of the State authorities and public servants in the health care of the population. Citizen monitoring promotes transparency and accountability, characteristics of good governance and democracy.

There has been increased international consensus in recent years on the vital importance of citizen participation to ensure the legitimacy and sustainability of social policies. It is assumed that social policies that have been generated / developed in a participatory manner will have greater legitimacy and sustainability and will better promote development and social control of their implementation. This is true not only in terms of better governance, but also for the health care rights approach. In this regard, and due to the realization of the III National Health Conference organized by ForoSalud (2006), Paul Hunt, United Nations Special Rapporteur on the Right to Health, issued a public statement in which he highlighted:

> ***"The right to health not only emphasizes the importance of reducing the burden of disease and damage to health and the conditions for a healthy life, but also involves the importance of this goal being achieved through processes that are democratic and inclusive."*** [14]

Lines ahead, he states that the right to health requires processes in which citizens exercise their right to participation, and that this participation, in turn, opens spaces for a group of processes of development and citizen empowerment.

Likewise, the World Bank, in its 2004 World Development Report[15], presented a conceptual framework to analyze the performance of social sectors and to better understand the causes of their performance, particularly the institutional factors affecting the performance of services,

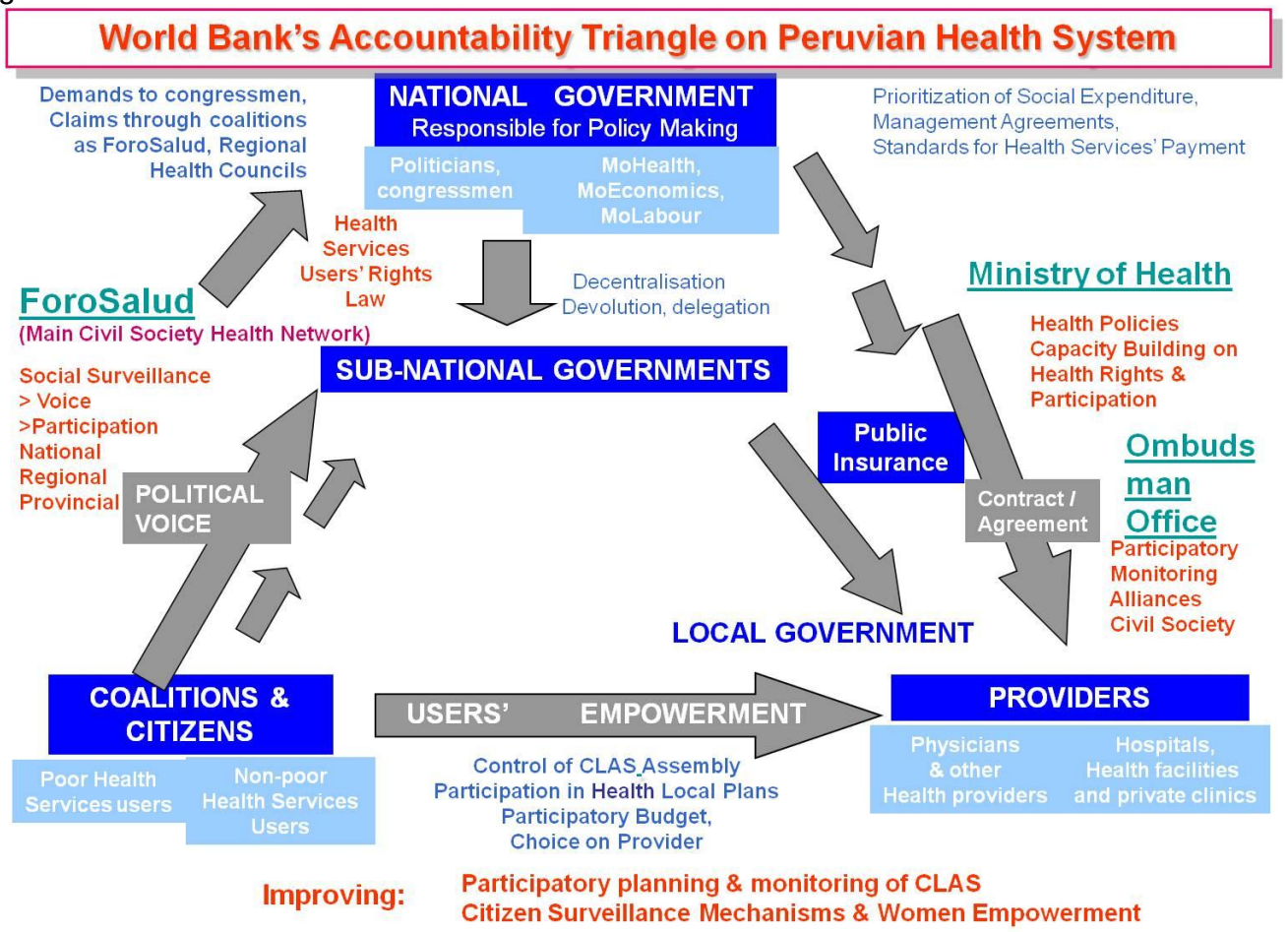
[14] Paul Hunt, special United Nations Rapporteur for the Right to Health Care. Public statement for the Third National Health Care Conference, Lima, July 2006.
[15] World Bank (2004) World Development Report, Washington DC, February 2004

highlighting the relationship between three main actors: public policy makers, the providers and the citizen-users.

Public policy makers are the different levels of government (national, regional and local), with the health facilities, including managers of the facilities and the health care personnel, being the providers. The population and its various groups are the citizens-users. The relationships among these three groups of actors are seen in the Triangle of Accountability (see Figure 1).

According to this approach, citizens can influence better performance and responsiveness of health care services and facilities (and achieve health policies that better address their needs) through the so-called political *voice* (the relationship between citizens organized into groups or networks and policy makers at different levels of government) or through the empowerment of the health care services' users and consequent social pressure placed directly on the suppliers.

The figure below adapts the World Bank's approach to Peru's health care sector. Added in red letters are different "inputs" through which the different actors of the State and civil society act to encourage greater citizen participation, which is the road to better health care governance.



Frisancho, A., Fernandez, D. (2006), adapting figure of the World Bank on Peru's Health Care Sector, in World Bank, *A New Social Contract for Peru: An Agenda for Improving Education, Health care, and the Social Safety Net*, Cotlear, D. (ed.) p. 194.

For the so-called *"long route"* - the construction and development of *political voice* to influence people in charge of health care policy nationally and regionally through citizens' coalitions or civil society networks – highlights the development that, in the last ten years, has been shown by the Peruvian Civil Society Forum on Health, the ForoSalud, and other citizen groups (networks of patients / users of health care services, groups of people living with certain health conditions or diseases). For the so-called *"short route"* - the direct interaction of citizens with those responsible for health care services - in addition to CLAS - created in 1994, through which citizens elected by the population join a committee to plan and manage the resources of the local health care facilities - and the participatory budget, highlights the role played by initiatives of citizen monitoring of health care services.

5. *An Actors-Oriented Approach for the promotion of Accountability*

The Participatory Voices Project (April 2008 - March 2011) was a joint effort between CARE Peru and CARE UK in the framework of a Program Partnership Agreement with the United Kingdom's Ministry for International Development (DFID). Its objective was *"to strengthen the capacities of national and regional civil society networks for the implementation of strategies and mechanisms of social monitoring and political advocacy to improve the policies and programs on health care and social development."*

The project worked with a wide range of actors, from both the public sector and civil society, seeking to strengthen governance in health and the incorporation of a rights-based approach in public actions. Its working approach prioritised four strategies:

a) Strengthening capacities of civil society networks and state officers & public authorities to facilitate improved interaction, dialogue and negotiation;
b) Identification and association with key actors at the national, regional and local levels who share the rights-based approach and who may promote the sustainability of actions;
c) Building partnerships with non-governmental organizations, international cooperation agencies, grassroots social organizations, civil society networks and key international actors; and
d) Political incidence and technical assistance to the Ministry of Health, Congress, regional and local authorities and other public actors in order to improve the responsiveness of the health care system to the poorest and most vulnerable population.

One of the main lines of action developed by the project was to build alliances with civil society networks, grassroots social organizations and the Office of the Ombudsman to strengthen citizen participation, particularly for the implementation of mechanisms for citizen monitoring of the quality of maternal and child health care services that are provided to poor, rural Andean women.

The initiative began as a pilot in early 2008. It was based on the joint work experience of CARE Peru and the Civil Society Health Forum (ForoSalud) – the largest civil society network on health in Peru - in the development of capacities for a greater presence and ability to impact health care policy. Added to this was the joint initiative with the organization Physicians for Human Rights / USA. CARE Peru and PHR-USA allocated resources to

promote a pilot for citizen participation in oversight and advocacy of quality in maternal and child health care services in two provinces of Puno (Melgar and Ayaviri), favoring: a) building strategic alliances between CARE Peru, ForoSalud and the Office of the Ombudsman, and b) strengthening of rural women leaders who would develop processes of citizen monitoring. The initiative looked to propel the mobilization and involvement of key actors at the local and regional levels: The Regional Government of Puno, the Regional Health Directorate, the Regional Office of the Ombudsman, the ForoSalud, and the networks of Promoters and Defenders of the Sexual and Reproductive Rights.[16]

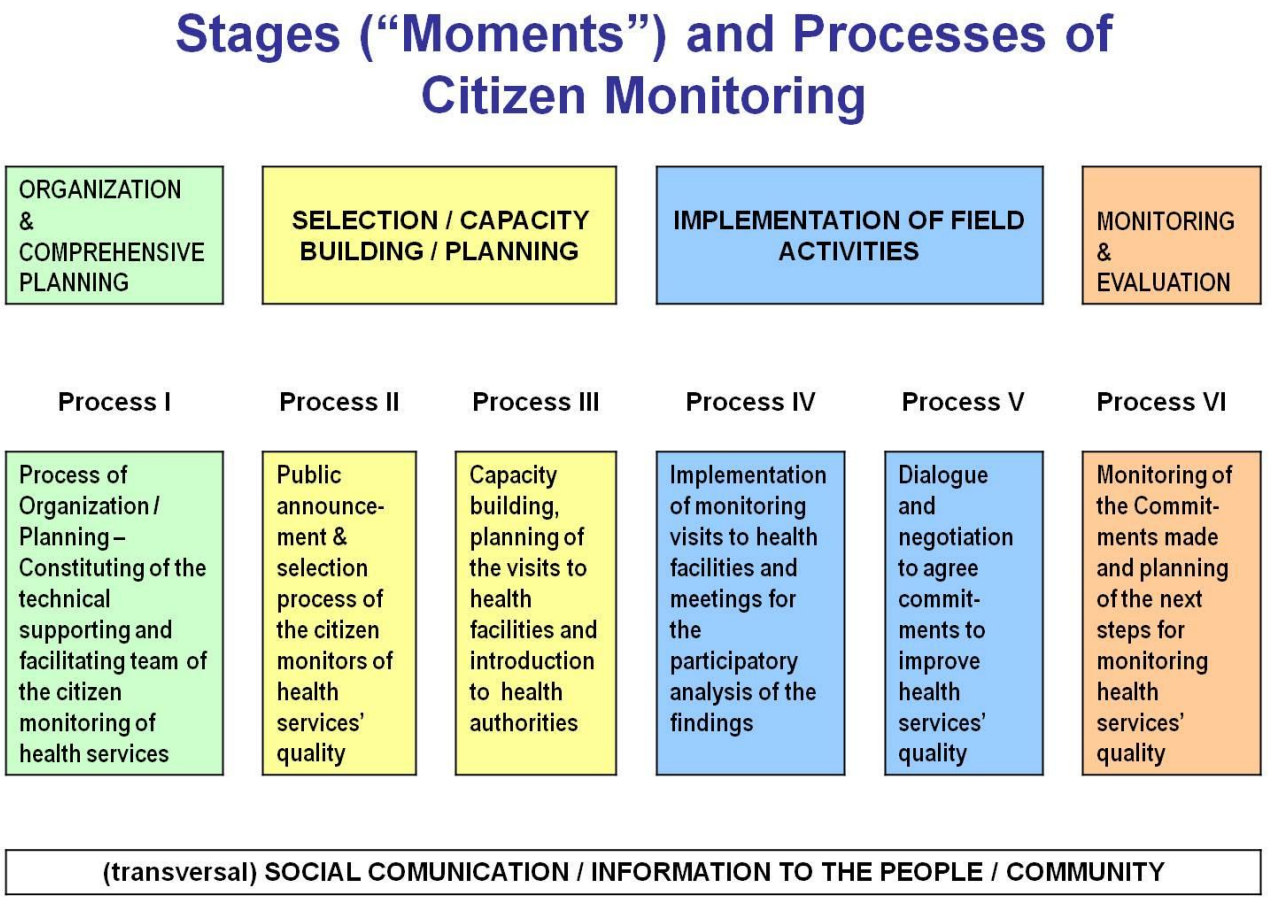
The pilot initiative culminated in April and continued in action in the context of the Participatory Voices Project until March 2011. Currently, the model of citizen monitoring of the quality of maternal and child health services has been taken by the Ministry of Health as one of the basis for the formulation of national policies to promote public health care monitoring[17] and it is spreading, in partnership with ForoSalud, to four regions of the country with support from CARE UK and the European Union. Likewise, the capacity building model of citizen monitoring has been adopted by the Peruvian MoH for national extension of the experience, and by the United Nations Population Fund (UNFPA) for the promotion and implementation of citizen monitoring of maternal health care, in partnership with women's organizations in two other regions of Peru.

Stages and Processes of the Citizen Monitoring

[16]Regarding the latter, it is noteworthy that the experience of working with Sexual & Reproductive Rights' defenders is the product of ten years of work by the ReproSalud Project (USAID-Movimiento Manuela Ramos), which formed promoters and defenders of sexual and reproductive rights with the aim that women know their rights, and defend them, through schemes of monitoring and negotiation with their husbands, community authorities and health care providers in their establishments. These networks of advocates for sexual and reproductive rights remain active.

[17]Ministry of Health of Peru (2011), Guidelines for Health Policy in Citizen Health Care Monitoring (R.M. 040-2011/MINSA. January 14, 2011).

On the basis of the experience gained, the model of citizen health care monitoring comprises four broad stages (see Figure 2):



a) The organization and comprehensive planning of activities by the technical supporting team (in this case, CARE Peru, the ForoSalud and the Puno Office of the Ombudsman);
b) The public announcement, selection and capacity building of the members of the future monitoring committees and the planning of their activities;
c) Implementation of field activities (visits to health facilities, analysis of the findings and reaching commitments for improvement by the authorities); and
d) The monitoring of the commitments and evaluation of the proceedings.

In turn, every stage can be divided into processes:

a) With respect to ***the organization and comprehensive planning of the activities by the technical supporting team,*** we can highlight **the constitution of the technical supporting and facilitating team of citizen health care monitoring and the comprehensive planning of the activities.**

For this, after presenting the idea of the initiative and after several joint planning sessions, an agreement was signed between the Office of the Ombudsman's, CARE Peru and ForoSalud Puno. They agreed on the main components of the model, the roles of each organization in capacity building and the support for activities to be undertaken by future monitors. The

various lines of action were planned, including the call for women community leaders, the visits for introducing the initiative to the authorities, the frequency of meetings to analyze the findings and presentation of the results of the monitoring to the health care authorities.

b) ***The public announcement, the selection and capacity building of the women members of the citizen monitoring committees and the planning of their activities,*** which includes both **the public announcement,** which is open to the leaders in each town of the district (radio announcement and through personal communication with the community leaders) and **the capacity building for citizen monitoring,** which incorporates the selection of members of the monitoring committees for each prioritized facility and the planning of its "field" activities.

Because several female community leaders were integrated in the large regional network of the Puno ForoSalud, contact could be resumed quickly, and then design in a participatory manner how the citizen monitoring initiative could be implemented to improve the quality of health care services, increase the demand for timely health services and thus help reduce maternal mortality.

On the basis of the joint analysis, the women, the CARE facilitators and the Office of the Ombudsman identified the two provinces for the development of citizen monitoring, Azángaro and Melgar, provinces with extreme poverty, with about 95% of rural population, a high number of maternal and child deaths and a history of constant complaints from the users because of the treatment received by poor women in the health facilities. Working together, the facilities in which the citizen monitoring activity would be taken, the number of people from each province who would perform these activities in their local health centers, and a possible working schedule, which included the training activities, were tentatively identified.

The topics for training were developed in modules, and the times were adapted to the convenience of the leaders (in this case, weekly meetings on two consecutive days). The meetings were held in Quechua and Spanish or in Aymara and Spanish, depending on the group, because several leaders needed to use their native language for understanding and building conceptual elements from their experience. The facilitators also used different participatory methods based on self-reflection, which allowed the participants to build, for example, the concepts of human rights, democracy and citizenship, and to analyze the role to play in promoting better treatment, a greater respect for their culture in health care services and respect for the right to quality in their care.

In short, the issues covered in the capacity building were human rights, health care rights, elements of democracy and citizenship, sexual and reproductive health and rights, organization and operation of health care services, the rights of SIS users, citizen participation and citizen monitoring, access to information, laws that protect citizen monitoring, ministerial norms on vertical delivery with cultural adaptation and the free issuance of the certificate of live birth. After each training workshop, practical cases were analyzed on how rights were or were not respected in health care, what legal framework protects people in case of their not being respected and finally, to reflect on what role the monitors would have to promote quality and rights in health care services.

At the end of the training workshops, the profile of the community leaders that would perform the monitoring was defined in a participatory manner; the content and shape (layout) of the

formats (tools) used to gather information during the visits to the health facilities; how the monitors would self-introduced themselves within the health facilities; and also the way in which they would conduct the monitoring activity in each health facility. Once these issues were defined, the monitors were selected for both provinces. Among the *selection criteria* agreed upon with them, was the time available for monitoring, their proximity to health facilities, and the interest shown by each participant, the knowledge learned in the training workshops, as well as their commitment and perseverance. The schedule of visits to health facilities is made with the selected monitors, and the frequency and dates of the meetings to discuss the findings, together with the ForoSalud, CARE Peru and the Office of the Ombudsman.

c) *The implementation of field activities* includes the **visits to the facilities** as well as the **meetings for participatory analysis of the findings** and the **agreement on commitments for improvement** by the authorities.

One step prior to the monitoring visits to health facilities occurs after the schedule of visits is defined: the monitors are given an ID provided and signed by the three organizations that facilitate the process. Joint visits are also planned to the regional health authorities, as well as to the hospital and health micro-networks, in order to present the initiative, explain its objectives and scope, and obtain their support.

The monitors visit the health facilities in pairs 2 to 3 times per week, and remain for approximately 6 hours. They perform direct observation and talk with other women in their own language. They consult and observe compliance with the schedules of the health care personnel, consult with the users regarding how they were treated by the staff, if they did not have to wait long, if they were given information about their condition in their own language and in a way they could understand, if their culture was respected along the health care provided, if rights to free care were respected, if they were given clear information on the functioning of the SIS and their rights in the program, if there were drugs in the pharmacy, and if the examinations ordered by health care professionals were performed, among other things, which are those most often mentioned as important by the users of health care services themselves.

Next, the monitors inform them about their rights as health care services' users or, for example, which free services they are eligible for if they are users registered with the SIS. Their observation, together with the direct and trusting dialogue with the users, and the knowledge developed in the training activities, permit them to detect erroneous and exclusionary practices – such as the lack of immediate attention of women insured by the SIS, or discrimination, neglect and extensive waiting-time by the poor, Quechua-speaking, and rural women – and even illegal actions, such as improper charges (under-the-table payments) to the beneficiaries of JUNTOS Program (which provides conditional cash transfers to poor families). All these observations are registered in the formats they were trained to fill out and that they helped to design. At the conclusion of monitoring activity, they request the leaders of the facility and the health personnel they worked with, to sign the monitoring formats as proof of their visit and of their findings.

Each of the women monitors accumulates a minimum of four to eight visits a month; in some cases it may be more, depending on their time availability. Every two to three months, meetings are held among the women monitors in each province with the representative of the

Office of the Ombudsman in Puno, and the members of ForoSalud and the director of the CARE Peru Participatory Voices Project to discuss the findings of the citizen monitoring, and to formulate and prioritize the proposals that are brought to the meeting by the monitors and those responsible for the health care service networks ("dialogue agenda"). In addition, the monitors report on how they felt while performing the monitoring, the doubts and fears they felt, the dialogues they had with the workers at the health facility, and the findings they found in the monitoring. Each of the monitors (called *"vigilantes"*) presents an oral report of the most important aspects of the monitoring, report on the attitude with which the providers received the monitors, noting precisely the facts on the basis of the records made, providing names, dates, and descriptions of events. The whole group shares and discusses the experiences, clarifies data that may be needed for the development of activities, and makes decisions on how to improve the monitoring.

For example, given the finding by the Office of the Ombudsman in Puno on the ignorance of most health care teams of the rules and laws that protect and safeguard the rights of people in health care, a file was prepared – to be carried by each pair of monitors – with copies of the main rules and legal norms (norms on vertical delivery with cultural adaptation, free issuance of the certificate of live birth, laws that protect citizens' participation at the national, regional and local levels, etc.)

The **dialogue with health care officials and providers** is the space for discussions and agreements, nonexistent until the implementation of citizen monitoring, in which the "dialogue agenda" constructed with the participation of the monitors and the facilitating organizations, is taken, together with its proposed solutions, to these internal spaces of negotiation with the local and regional health care authorities and with those in charge of the facilities, to agree on commitments for improvement. In these spaces, the monitors and the facilitating organizations highlight both the good findings (to strengthen and compliment them) and the bad ones (to correct them).

These spaces, initially resisted by many health care professionals, have become institutionalized, despite the frequent change of health care authorities and directors of micro-networks, which has often meant starting over with the work of sensitization and advocacy to try to ensure the fulfillment of commitments. A major breakthrough has occurred in some micro-network managers, which have even requested training for their health care staff on issues of health rights and citizen participation.

d) Monitoring of the commitments made is conducted on the basis of the minutes signed by the authorities present at the consultation meetings. Public hearings are being planned that will be attended by local authorities and the press media and highlight the progress being achieved. Finally, a participatory assessment is periodically performed of the initiative's achievements, progress and challenges. Recently the monitors themselves selected ten leaders from among themselves who developed participatory research on their achievements and challenges.[18]

Finally, it is important to note that **Social communication and information for people about their health care rights** constitutes a cross-cutting strategy. Simultaneous with the

[18]Zapata, R. (2011) Systematization of the Activity-Research Initiative on Governance with a Gender Focus: Impact of Health Monitoring and Participatory Budgeting by Women in Puno, Peru. CARE UK, Lima.

implementation of citizen monitoring activities, it provides information to the rural population on their right to good health care, particularly with respect to sexual and reproductive health. One of the initiatives developed by the community leaders, and facilitated by the Puno ForoSalud and CARE Peru, has been the production of radio messages – in Quechua and Aymara – on the rights of health care services' users, what to do to prevent maternal mortality, the importance of citizen participation and the role of monitoring and having the active involvement of the monitors. This material is distributed to local radio stations, and is broadcast by the local programs with the largest audience in the rural communities of each province. In a second stage of this process, the production of radio messages aimed at the regional level is planned, with the support of the Regional Health Directorate for their dissemination.

The attached image shows Eusebia, an Ayaviri monitor, explaining the various processes developed to implement citizen health care monitoring. At her side are some of the Ayaviri monitors next to the representative of the Puno Office of the Ombudsman, the coordinator of the Dialogue Assembly for the Fight against Poverty (*Mesa de Concertación de Lucha Contra la Pobreza*), and the Puno head of Integral Health Insurance (SIS), an organization that has joined to the partners of the technical supporting team.

5. Main results of the experience

- The identification of bad practices that prevent rural women from seeking care (for example, health services that are closed at times of peak demand, long waiting times, poor care, ignorance of standards that promote culturally appropriate vertical delivery and improper charges for services and medicines that should be free)
- The existence of systematic spaces for dialogue and local consultation between health care providers and rural women, in which they express what they expect from health care services and the strengths and weaknesses of existing health care
- The agreement of commitments for the improvement of health care (opportunity, treatment, information, language, culture)
- The initiative has contributed to the *empowerment* of women and to address unjust power relations between health providers and rural women
- The initiative has contributed to a better understanding of the rights of health care services' users

- Health care providers and authorities are accountable for their successes and shortcomings with respect to the needs of the population

The qualitative assessment of the experience[19] has shown that those challenges in terms of the quality of service that were most frequently mentioned:

- Medications missing or incompletely delivered to the SIS users
- Poor treatment of the users, especially in the case of poor and indigenous women
- Discrimination
- Improper (under-the-table payments) charges
- Health care services with limited cultural appropriateness.

Analyzing the achievements of citizen monitoring, the most frequently mentioned changes are:

- It has improved the treatment received by women users of the services
- Greater acceptance and promotion of culturally appropriate practices within health care at the time of delivery. Thus, the husband may be present, one can "bind" the head of the women during childbirth (given the belief that there would be a "division" of the woman's body, and they want to maintain the unity of the head)
- Not washing them with cold water (given the implications of the balance between hot and cold in the Andean region)
- The number of students entering the delivery room has been reduced (usually 8-10 medical and obstetric interns entered to learn from a single patient)
- Access to laboratory auxiliary exams has increased

Citizen monitoring has contributed to improvements in the organization of the services:

- the citizen monitoring initiative has contributed to an increase in the allocation of health care workers and a better enforcement of working hours (by placing the roll of the doctors' working hours in in a prominent, visible location)
- place the prices of medicines and procedures in a prominent location
- provide receipts for all payments made by the users
- use of the identification of the health personnel (something that is regulated, but not enforced)

Also mentioned is the improved relationship and cooperation between leaders and health personnel, especially since the monitors provide information and orientate health services' users – especially rural & poor women - on the importance of their controls and the implementation of best practices in taking care of one's own health.

Highlights of other improvements include the increased attention to the right to health by health authorities, community members and public opinion. Also worth mentioning are the increased demand for institutional delivery and maternal - child health care, as well as a clear

[19] Saavedra, C., (2011) Evaluación Cualitativa de la Iniciativa de Vigilancia Ciudadana de la Calidad de los Servicios de Salud en la Provincia de Melgar. CARE Perú, Lima, Perú.

perception of improvement in issues that are sensitive to the population with respect to the quality of care. [20, 21]

The focus groups conducted with various stakeholders show a clear perception of the benefits of citizen monitoring and the positive changes generated through its implementation over the years. These changes and benefits are not only identified by the monitors and their partner organizations and other observers, but also by the authorities and health care personnel themselves at different levels of the health care system. However, there is still a long way to go before doctors and other health care professionals recognize the problems faced by the health care users, since some only recognize the lack of drugs, while arguing that it *"does not depend on them."*

The quantitative evaluation of citizen health monitoring[22] and the Participatory Action Research on citizen monitoring shows a variety of positive changes in the health care services where citizen health monitoring was implemented. The changes were evident when comparing variations in the indicators before and after the intervention and comparing these same indicators in health facilities with citizen monitoring and control facilities. The evaluation showed improved progress in health care indicators, both when analyzed as a group of facilities with citizen monitoring and when analyzed individually. The main differences are observed in a) the opportunity of the control of the pregnant mother (early control), b) the coverage of pre-natal control, c) care during institutional delivery, and d) access to laboratory tests provided by Comprehensive Health Insurance (SIS). Quantitative data showed increased access to culturally appropriate birth delivery - vertical birth delivery - from 194 in 2008 to 437 in 2009 in Azangaro Province.

Moreover, this work has contributed to the institutionalization of citizen surveillance as part of Peru's national policy and the launch in 2011 of National Policy Guidelines to Promote Citizen Surveillance.

6. Conclusions (Lessons Learned)

a. In countries with a high level of inequality, the achievement of the MDGs in health will not be possible with simply more resources and technical interventions. Significant and sustainable change will only be achieved if people have a greater involvement in the design and adjustment of social policies and programs and in their implementation. The citizen monitoring initiative provides lessons that can be transferred to the monitoring of the implementation of Universal Health Insurance, the actual benefits (in service) of conditional cash transfers, the implementation of participatory budgeting and the monitoring of outputs-oriented budgets (OOBs or PPR in spanish).

b. The key importance of strategic alliances with public (Ombudsman and Integral Health Insurance) and private (ForoSalud) actors to strengthen the capacity of rural women's agency and to address unequal power relations.

[20] Ibid.
[21] Zapata, R. (2011) Sistematización de la Iniciativa de Investigación-Acción sobre Gobernabilidad con enfoque de Género: Impacto de la Vigilancia en Salud y en Presupuestos Participativos realizada por Mujeres en Puno. Perú. CARE UK, Lima.
[22] Valdez, W. (2011) Evaluación Cuantitativa de la Vigilancia Ciudadana de la Calidad de los Servicios de Salud. CARE Perú, Lima, Perú.

c. The principles of the International Human Rights framework have been used at the local level in an effort to strengthen the quality of care provided in health care services. This is particularly important following the resolution of the United Nations Human Rights Committee (June 2009) which states maternal mortality as a human rights concern[23].

d. The Importance of implementing an accountability approach based on dialogue and the promotion of good governance, rather than on "naming and shaming": building mutual understanding, increasing trust and credibility among health care officers / professionals and citizen representatives.

e. There are still major challenges. Among them are the low quality of local health management (in which leadership, as well as skills to manage and monitor the national / regional policies and their enforcement, have been lost) and the lack of definition of performance indicators. This is worsen by evidence of discrimination and the undervaluation of citizens' capacity for dialogue and negotiation. As already mentioned, the high turn-over of officers and public authorities in the region affects the sustainability of commitments and local policies.

7. Promoting the political decision to support new forms of participation

One of the greatest achievements of political advocacy that this initiative has contributed to has been its becoming a national reference point for the issue of citizen monitoring of the quality of health care services. As a result of a visit to Azángaro in May 2008, the Minister of Health knew the monitors and their work personally. As a result of that and the technical assistance activities of CARE Peru, a first Ministerial Resolution was issued in recognition and support of the Citizen Health Monitoring Committees (R.M. 422-2008/MINSA, DA 133-2008-MINSA/DEST-V01).

Since then, CARE Peru has continued with the activities of political advocacy and technical assistance to the Ministry of Health. Together with other cooperation agencies, and on the basis of the experience of Puno, in January 2011 the National Policy Guidelines for the Promotion of Citizen Health Monitoring (RM No. 040-2011 / MINSA, 14 January 2011) were promulgated. Still to be done is a joint effort in which the Ministry of Health, the regional and local governments and the civil society networks converge to ensure implementation of these mechanisms of citizen participation. It is hoped that the citizen monitoring process becomes a process that contributes to the improved performance of the health care teams at different levels of management, delivery and governance of health care. Its implementation makes it possible that the expectations, perceptions and demands of the people provide feedback and enrich the performance of the health care teams. In this view, citizen monitoring is a stimulus and catalyst for health care services' responsiveness that contributes to the health system's governance.

"Change does not happen overnight. I think that some doctors, nurses and mid-wives have begun to understand

[23] United Nations' Human Rights Council (2009) Resolution on Preventable maternal mortality and morbidity and human rights, A/HRC/11/L. 16/Rev.1 / 16 June 2009.

why we are doing this volunteer work .... little by little, they will see that their work also improves this way"

Eusebia Atayupanqui, Citizen health monitor from Ayaviri (Puno)

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