STRUGGLING WITH THE STATE: RIGHTS-BASED GOVERNANCE OF REPRODUCTIVE HEALTH SERVICES IN PUNO, PERU

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
Dalla Lana School of Public Health
University of Toronto

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2015

Abstract

This dissertation explores the complex process of how socially excluded women carry out rights-based governance in state-operated health facilities. It addresses a central tension: how can marginalized actors exercise a governance influence over institutions that have systemically excluded them? The study examines the efforts of a group of Quechua-speaking indigenous women in the southern Peruvian Andes who act as citizen monitors of their reproductive health services. In a country where profound inequalities are embedded in the health care system, the monitors (aided by a network of strategic allies) seek to combat abuse and strengthen health service provision. Key to their governance strategy is the use of a human rights-based approach to health, intended to influence monitors’ power by repositioning them as rights holders.

Theoretically, the dissertation draws on feminist political economy to examine the emergence of reproductive health care as a site of struggle between civil society and the state in Puno, Peru since the 1990s. It examines the monitoring initiative in Puno as an example of ongoing struggles with the state for the provision of quality reproductive health care. Methodologically, it
uses institutional ethnography to link the work of citizen monitors with broader social, political and economic forces that shape their governance efforts.

The study’s findings suggest that human rights-based approaches can help monitors to exercise power in governance struggles. Citizen monitoring in Puno has produced some important gains, including curbing everyday injustices such as discriminatory treatment and illegal fees in health facilities. Monitors have been less effective at influencing other types of systemic problems, such as understaffing. The initiative has created opportunities for hands-on learning and the creation of new kinds of alliances. More broadly, the study suggests that rights-based governance can contribute to the democratization of reproductive health service delivery and the promotion of inclusive citizenship.
Acknowledgments

I am indebted to the many people who made this research project possible. First and foremost, I would like to express my sincere gratitude to all of the citizen monitors in Ayaviri and Azángaro who graciously agreed to share their stories with me, as well as all of the key informants in Ayaviri, Azángaro, the city of Puno, and Lima. Equally, I would like to thank CARE Peru, especially Ariel Frisancho in Lima, and Luz Estrada and Milagro in Puno for their generosity, and their willingness to facilitate entry into the project. I am also grateful to the many Peruvian scholars in Lima and Puno, including Jeanine Anderson, Carmen Yon, Ruth Iguiñiz, Rosa Mujica, Luperio Onofre, Meliton Lopez Paz, and Fermín Laquí Ramos, who took time to meet with me and discuss early ideas about this project.

I was fortunate to have the guidance and support of an exceptional team of scholars at the Dalla Lana School of Public Health. Anne-Emanuelle Birn and Ted Myers, my co-supervisors, and my committee member, Lisa Forman, played a huge part in moving this project from a loose idea to completion. Anne-Emanuelle’s incredible breadth of knowledge, close attention to detail and encouragement to consider the big ideas helped me develop this project far beyond what I originally envisioned. Ted Myers’ willingness to share his deep research knowledge and experience together with his unflagging support helped me keep moving through the program when I was not always sure I still had the energy. Lisa Forman’s kind invitation to attend a research workshop she had co-organized in Lima with Ariel Frisancho while I happened to be the city in 2009 was the original catalyst for this research project. Her close reading of my work and her engaged guidance, especially related to health and human rights, played an important role in this work. I am grateful to all three of you.

Doctoral studies are a long and sometimes arduous process. It would have been extremely isolating without the good friends I made along the way at the DLSPH. A huge thanks to Amrita Daftary, Krista Maxwell, Kimberly Gray, Franziska Satzinger, Tess Sheldon, Wendy McGuire, Laurie Corna, Sarah Steele, Catherine Maule, and Emma Richardson. Outside of DLSPH, thank you also to my dear friends who supported me through the project, especially Judith Pyke and Kelly Gallagher-Mackay. I’d also like to express my gratitude to two excellent scholars, Kathryn Church and in memory of Roxana Ng, both of who were pivotal in setting me on my academic journey and who were so supportive over the years.
I thank my mother, Evelyn Samuel for her love and encouragement over the years, and my aunt, Jean Johnson, for the same. You are both wonderful role models. My gratitude also to the rest of my B.C. family and Toronto family.

Finally, there are no fitting words to thank my partner, David Szablowski, and my sons, Kai Samuel-Szablowski and Nikko Szablowski. I am so lucky to share my life with the three of you.

This project would not have been possible without the generous financial support from the Canadian Graduate Scholarship program of the Social Sciences and Humanities Research Council and from the University of Toronto’s Open Fellowship and the Hastings Memorial Fellowship.
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Chapter 1

Introduction: Addressing Reproductive Health Inequality in Andean Peru

In 1994, 179 countries endorsed the landmark Programme of Action that emerged from the UN International Conference on Population and Development (ICPD) held in Cairo. The Programme of Action marked a significant shift away from the population-control approach, which had been dominant since the 1960s, toward an emphasis on gender equality, reproductive health and human rights (UNFPA, 1995). Twenty years later, the world is far from fulfilling this ambitious agenda. While maternal mortality decreased globally by nearly 50% between 1990 and 2010, everyday approximately 800 women still die from preventable causes related to pregnancy and childbirth. In 2008, an estimated 47,000 pregnancy-related deaths were linked to complications from unsafe abortion. Approximately 222 million women have an unmet need for modern contraception, with the highest need in places where the risk of maternal mortality is greatest (WHO, 2014, p.2). An extensive 2013-14 review of the original ICPD Programme of Action identified significant barriers to its fulfillment, in particular stemming from “large inequalities both between and within countries, the absence of quality in service provision, and the need for accountability” (WHO, 2014, p.2).

This dissertation tells the story of a group of rural women in the southern Andean region of Puno, Peru. While geographically far from the global-level ICPD policy debates, these women have been struggling to address severe problems with access and quality in relation to their
publicly provided reproductive health services, the very circumstances which ICPD seeks in
general to address. These are mainly indigenous, Quechua-speaking women who have long
experienced discrimination and exclusion within Peruvian society. The women and their
communities have often had difficult relationships with the health services provided to them
through the state. For them, the health system is a site where they commonly face cultural
barriers, abusive treatment or discrimination, in addition to other problems linked to the
systematic neglect or mismanagement of their local facilities. Problems related to discrimination
and mistreatment can be particularly charged in relation to reproductive health care, where poor
quality and barriers to access threaten women’s health as well as their control over their sexual
and reproductive lives. To confront these barriers, the women highlighted in this study
participate in an initiative that conducts human rights-based governance of reproductive health
services offered through government-run local health facilities. The initiative brings together a
series of different local, national and transnational actors, ideas and organizing strategies, using
an approach that is called “citizen monitoring” (vigilancia ciudadana).

1 The Programme of Action developed at the International Conference on Population and Development (ICPD)
adopted the following definition of reproductive health:

Reproductive health is a state of complete physical, mental and social well-being and not merely the
absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and
processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life
and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.
Implicit in this last condition are the right of men and women to be informed and to have access to safe,
effective, affordable and acceptable methods of family planning of their choice, as well as other methods of
their choice for regulation of fertility which are not against the law, and the right of access to appropriate
health-care services that will enable women to go safely through pregnancy and childbirth and provide
couples with the best chance of having a healthy infant (UNFPA, 1995:para. 7.2).

2 The ICPD Programme of Action defines reproductive health care as:

the constellation of methods, techniques and services that contribute to reproductive health and well-being
through preventing and solving reproductive health problems. It also includes sexual health, the purpose of
which is the enhancement of life and personal relations, and not merely counselling and care related to
reproduction and sexually transmitted diseases (UN, 1994:para. 7.2).
The citizen monitoring initiative aims to improve the quality of reproductive health service provision in the local health facilities (including main hospitals, mid-sized health centres and remote health posts) of two provinces in Puno. In this initiative, the women monitor service provision through direct observation as well as by conversing with health care users and health workers. The participants, called citizen monitors (*vigilantes*), work on a voluntary basis with allied actors to engage health officials in direct dialogue about their findings and to press for remedial actions where necessary. The allied groups involved in the initiative include: CARE Peru, the Peruvian affiliate of an international NGO (CARE International) that has organized and supported the initiative; ForoSalud, Peru’s largest civil society network on health; the Puno office of the *Defensoría del Pueblo* (National Human Rights Ombudsman); and a transnational epistemic community of scholars and activists promoting a human rights-based approach to public and reproductive health.⁴ The way in which a human rights based approach has been

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³ Haas defines an epistemic community as a network of professionals with “a shared set of normative and principled beliefs which provide a value-based rationale for social action of community members” and “a common policy enterprise” (Haas, 1992:3).

⁴ CARE Peru was established in Peru in 1952. It shares the same mission statement as CARE International:

CARE’s mission is to serve individuals and families in the poorest communities in the world. Drawing strength from our global diversity, resources and experience, we promote innovative solutions and are advocates for global responsibility.

We promote lasting change by: strengthening capacity for self-help; providing economic opportunity; delivering relief in emergencies; influencing policy decisions at all levels; addressing discrimination in all its forms.

Guided by the aspirations of local communities, we pursue our mission with both excellence and compassion because the people whom we serve deserve nothing less (CARE International, 2012, p.2; CARE Peru, 2012, p.3).
adopted and adapted for use on the ground in Puno to strengthen governance of reproductive health service provision is a central theme that will be followed throughout this research.

This dissertation explores the complex process of how socially excluded women carry out rights-based governance in their local state-run health facilities. Using a theoretical approach derived from feminist political economy, I examine the efforts of these women as a form of struggle with the state over its involvement in reproductive health care. I regard the citizen monitoring initiative as a type of governance “from below”: an attempt by non-state actors, acting in coalition with various allies, to influence in a systematic way how health care services are delivered. The term governance refers broadly to “all those activities of social, political and administrative actors that can be seen as purposeful efforts to guide, steer, control or manage societies” (Kooiman, 1993, p.2). The study examines the specific strategies used by the citizen monitors to exercise a governance influence, in particular their use of a human rights-based approach to health. I also attempt to understand the citizen monitoring initiative in the broader historical and contemporary political and social context. This involves understanding the forces and developments that have led to the initiative. Methodologically, I employ a fieldwork-based, institutional ethnographic approach to understand the work processes and power relationships involved in the activities of the citizen monitors.

ForoSalud (Foro de la Sociedad Civil en Salud/Civil Society Forum on Health) was founded in 2002. Since its inception, ForoSalud has sought to build a national movement to promote the right to health and promote social equity by influencing the national policy and programmatic agenda related to health and development. It operates at a national level as well through Foros in 19 regions of Peru (Miranda & Yamin, 2011). There is a regional level ForoSalud in Puno that connects the citizen monitors to other civil society actors involved in health in the region.
Problematic reproductive health services are the result of many interconnected factors that have shaped Peru’s public health system over time. These reflect longstanding, intersecting inequalities and the social exclusion of rural indigenous women, and therefore they concern questions of power. By drawing on a human rights-based approach to health, the citizen monitoring initiative is designed to reposition an excluded group so that its members are able to exercise influence over the quality of their reproductive health care.

Attention to power relations in the citizen monitoring initiative reveals a core tension. The initiative is designed to address challenges that indigenous women experience in public health care facilities. The strategy to do this involves volunteer indigenous women performing oversight activities in these health facilities. As we shall see, however, a large number of the daily challenges that indigenous women face in health facilities arise from the exclusion that they experience in these settings. Peru is a deeply unequal society where ethnic and gender inequalities are embedded in institutions such as the health care system (Thorp & Paredes, 2010). Indigenous women acutely experience the effects of intersecting inequalities. Thus, paradoxically, this means the initiative depends upon the ability of indigenous citizen monitors to exercise power in a setting in which they have traditionally been marginalized.

In this study, I investigate three interrelated research questions. The first two are largely descriptive; the third, analytical.
1. What are the characteristics, origin and evolution of the citizen monitoring initiative in Puno?

2. How is a group of indigenous women in Puno, Peru engaged in the governance of local reproductive health services and what are the implications for service delivery?

3. How does the initiative (including its use of a human rights based approach to health) affect power relations among the citizen monitors and other key actors involved in the governance process?

My study focuses specifically on citizen monitoring of reproductive health care in local, state-run health facilities. Freedman and Schaaf observe that it is important to build an understanding of these kinds of governance efforts that is grounded in “the reality of women’s interactions with the forces that shape their lives on the ground” (Freedman & Schaaf, 2013, p.104). They call for an approach that “begins with the dynamics of power on the frontline of the health system, deeply embedded in the broader social and political dynamics of local life” (2013, p.104). Certainly, reproductive health and rights are affected by a much wider set of conditions than only those related directly to health care. However, I agree with Freedman and Schaaf, who argue “health services, while they always have a technical dimension, are also always deeply political” (2013, p.104). They consider health services to be “core social institutions.” As such, “people’s interactions with the hierarchies of power that shape such institutions often create or reinforce the very exclusion and disempowerment that are at the heart of sexual and reproductive health and rights violations” (2013, p.104). These authors also contend, however, that the health system
can be a place where “entitlements are articulated, asserted and vindicated” (2013, p.104). By examining rights-based governance of local reproductive health care, I have the opportunity to explore precisely this tension of the health system as both a site of exclusion and a site for the articulation of rights.\(^5\)

The goal for the remainder of this chapter is to introduce foundational components that will be used throughout my thesis. The chapter is split into four parts. In Part I, I introduce a conceptual framework for understanding inequality in Peru. In Part II, I provide some background context on the development of the public health care system in Peru and the process through which intersecting gendered, racialized and class-based inequalities became embedded in the system. In Part III, I introduce some of the central ideas behind the strategy used by the citizen monitors in their struggle for better quality reproductive health services. I conclude this section by briefly discussing a human rights-based approach to health. In Part IV, I provide a roadmap for the remainder of the thesis.

1.1 Conceptual Underpinnings: Inequality, Exclusion and Intersectionality in Peru

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\(^5\) Freedman and Schaaf go on to explain that “in taking a stance on the future Sustainable Development Goals and the direction of the ICPD beyond 2014, sexual and reproductive health and rights activists still need to act globally, but their actions on global stage need to be differently informed by local realities” (2013:104).
Critical scholars, including feminist and critical race theorists, have developed a number of different concepts through which to understand forms of social subordination. Notions of inequality, exclusion and intersectionality are well developed in the literature, and in this section I will explore these concepts and their relevance to this study.

Gootenburg calls Latin America “a critical region for the global study of inequalities” (Gootenburg 2010, p.3). He argues that it is not the poorest region of the world, nor the most divided, but it is “by far the most unequal,” with huge disparities between the region’s poor and its “extraordinarily wealthy” upper classes (Gootenberg, 2010, pp.3-4). In Peru, as in many other countries, inequality has deep ethnic and racialized dimensions (Drinot, 2006; de la Cadena, 2000). Rooted in the inequalities of the colonial caste system, racist attitudes in Peru conceive of indigenous peoples as foreign to the nation and as obstacles to its development (Drinot, 2006, pp.15-19). For much of the country’s history, Peru has been divided ethnically and geographically between a Spanish-descended coastal population that has dominated the institutions of government and the economy, and an indigenous population in the Andes that is largely tied to the land and engaged in subsistence agriculture or pastoralism. Land reform in the 1960s and 1970s and large-scale migration of Andean populations to coastal shantytowns in the decades that followed have complicated but not changed the fundamental nature of these racialized divides. Many have argued that Peru’s civil war of the 1980s and 1990s, which claimed nearly 70,000 victims during fighting between the army and insurgent groups

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6 Peruvian economist Pedro Francke notes that despite Peru’s ranking as an upper middle income country, its income inequality measured by the Gini Coefficient is nearly 0.60. Peru also ranks 13th out of 17 countries in the region on the Human Opportunity Index (Francke, 2013:1).
(particularly the infamous Shining Path, a Maoist revolutionary group), was made possible and exacerbated by “the indifference of Peru’s ‘included’ few to the predicament of the ‘excluded’ many” (Drinot, 2006, p.9). Salomon Lerner, the chairman of Peru’s Truth and Reconciliation Commission, which investigated abuses during the conflict, observed that the Commission’s report reveals that Peru “is a country where exclusion is so absolute that tens of thousands of citizens can disappear without anyone in integrated society, in the society of the non-excluded, noticing a thing” (Lerner, 2003 cited in Drinot, 2006, pp.21-22). Drinot argues that racism “is central to the exclusionary character of nation-building in Peru” and that its attitudes are “institutional, hegemonic, legitimising, normalised” (Drinot, 2006, p.19).

Thorp and Paredes also stress the racialized and ethnic dimensions that characterize Peruvian inequalities. They argue that, in Peru, the “extreme nature of overall inequality has much to do with the depth and embeddedness of ethnic inequality” (Thorp & Paredes, 2010, p.2). Like Drinot, they note that these inequalities are often embedded in Peruvian institutions. Thorp and Paredes observe that:

the mechanisms of reproduction of inequalities, the norms and values that sustain particular inequalities across groups, as well as the opportunities for organization and the construction of political identities to challenge these inequalities, have been historically defined, reproduced and consolidated over the years by the institutions built around them (Thorp & Paredes, 2010, p.7).
Thorp and Paredes’s analysis highlights not only the historical dimensions of ethnic inequalities, but also the spatial dimensions. They argue that inequalities in Peru have become embedded over both “time and space” (2010, p.3). The spatial dimension is especially pertinent in Peru, where many indigenous groups historically have resided in remote Andean or Amazonian regions of the country. Despite shifting patterns of migration over time, inequalities in the country based on geography remain in place (Thorp & Paredes, 2010).

Social exclusion is another core concept that is closely related to inequality. Like inequality, exclusion can have economic, social or political dimensions, among others. The term refers to a “set of structural mechanisms that prevent certain social groups from fully participating in the economic, social, political and cultural spheres of society” (Valdivia et al., 2007, p.604). These mechanisms can limit access to health, housing, employment, education, political representation, etc. The term “social exclusion” originated in France in the mid-1970s and began to be used more broadly in Europe and elsewhere in the 1980s and 1990s (Sen, 2000). It is a useful concept within a Latin American context, where multiple forms of exclusion continue to be experienced by historically disadvantaged communities such as indigenous and Afro-descended populations (Hooker, 2005; Buvinic et al., 2004; Fleury, 2010). These concepts direct attention to the barriers to full participation in society that different groups may experience, whether social, economic, cultural or political.

Intersectionality, the third concept to be outlined here, provides a complementary dimension to inequality and exclusion. The notion of intersectionality addresses the issue of multiple social
positionings and, in particular, multiple forms of oppression (Lutz et al, 2011). The concept was developed to capture the experience of those facing cumulative forms of oppression (Crenshaw, 2011, pp.25-26). Critical race theorists such as Crenshaw have criticized uni-dimensional views of oppression for their tendency to “erase” those who do not fit easily within their boundaries. Intersectional analysis does not consider such factors as gender, class, ethnicity or sexuality either separately or simply as components to be added together. Instead, it seeks to understand how these social categories intersect in specific historical contexts to produce particular social positions and identities (Rousseau, 2011, p.7). Thus, the concept of intersectionality helps to explore and understand the context-specific forms of subordination experienced by groups that fall into multiple categories of oppression. For example, the complex relationship between gender, class and indigeneity in the Andes is suggested by Marisol de la Cadena’s article “Las mujeres son más indias” (“Women are more Indian”) in which she argues that women are seen as more indigenous than men and that as a result they suffer from more profound social inequalities (de la Cadena, 1992). The specific forms of intersectionality experienced by Andean indigenous women in Peru help to shape the construction of reproductive health services designed to serve their communities. They also influence the ability of indigenous women to exercise authority in official settings.

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7 The concept of intersectionality can be traced back to the 19th century, for example through former slave, abolitionist and activist Sojourner Truth’s famous 1851 speech “Ain’t I a Woman” at the Women’s Rights Convention in Akron, Ohio (Brah & Phoenix, 2004).
Indigeneity is a complex issue in the Andes, where indigenous peoples struggling for social inclusion have sought to build alternative subject positions that challenge dominant identities. In Peru, indigenous movements in the highlands have generally resisted using ethnicity or indigeneity to frame their claims to protect their land, resources or ways of living. Instead, as Oliart observes, movements in Peru have sought “to affirm their rights as Peruvian citizens” rather than as “cultural others” (Oliart, 2008, p.291). Various scholars refer to this as “the Peruvian anomaly.” They note that despite similarities in ways of life and social struggles among highland indigenous peoples in the Andean region, Peru alone among Andean countries historically lacks an indigenous political movement that includes these groups (Oliart, 2008; de la Cadena, 2000). This situation contrasts sharply with Andean movements in Bolivia and Ecuador, for example, that strongly assert indigenous identities. García, on the other hand, argues that these assessments of indigenous politics in Andean Peru are based on preconceived ideas about what indigenous movements should look like. She argues that they ignore the realities of identity formation and social struggle prevalent in the Peruvian highlands (García, 2005).

Certainly an emphasis on citizenship has become “a key component of political discourse and claims making in Latin America” over the past 20 years (Jenson & Rousseau, 2006, p.9). In line with this citizenship-based politics in the Andes, the citizen monitoring initiative in Puno offers the monitors the opportunity to claim citizenship rights and to contest the limited or incomplete notions of citizenship they are offered in narratives describing their place in the Peruvian nation (Vigil & Zariquiey, 2003).

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8 In recent years, however, connections with the transnational indigenous movement have promoted the use of indigenous discourse among some social leaders and intellectuals in the Peruvian highlands (Oliart, 2008:292; García, 2005).
Most of the citizen monitors involved in the initiative are rural indigenous women living in conditions of poverty. Indigenous women face great challenges because of the presence of pervasive gendered as well as racialized discrimination in both the metropolitan coast and the rural highlands. These intersecting inequalities can greatly complicate the ability of indigenous women to play public leadership roles in their communities and to engage effectively with public officials (Oliart, 2008).

1.2 Inequality and Exclusion in the Peruvian Health System

In this section, I will discuss the emergence of intersecting inequalities within the Peruvian health system, provide a brief overview of the structure of the contemporary health system and highlight inequalities in reproductive health and service provision.

1.2.1 The Emergence of Intersecting Inequalities within the Peruvian Health System

As noted by Thorp and Paredes, inequalities in Peru have become embedded over time and space and are reflected in the country’s institutions (Thorp & Paredes 2010). This is certainly evident within the country’s health system. Ewig argues that the creation of the public health system in Peru beginning in the late 1800s was founded on categorical inequalities based on gender, race
and class. The manner in which the system took shape further reinforced and embedded these categorical inequalities within the system over time:

Pre-existing class, race and gender inequalities in Peru served to shape the formation of Peru’s health system in ways that reflected those inequalities. Once established, the resulting health system served to reinforce and perpetuate inequalities by privileging some groups over others, in a feedback effect (Ewig, 2010a, p.54).

These dynamics are evident in the development of the Peruvian state’s first public health initiatives from the late 1800s through to approximately the 1930s. During this period, the state began to try to control outbreaks of epidemic diseases. These interventions targeted predominantly indigenous peoples and Asian immigrants (Cueto, 1992). As a result, ill health came to be associated with racialized characteristics, “rather than due to the structural underpinnings of racial and economic inequality that actually enhanced [the] susceptibility” of these populations (Ewig, 2010a, p.59). Eventually, “to be targeted by public health officials was to be racially stigmatized, so much so that upper-stratum Peruvians often hid their illnesses” (Ewig, 2010a, p.59).

The Dirección de Salubridad Publica (Public Health Board), which would later become the Ministry of Health, was established in 1903 (Cueto, 1997, p.35). Still, by the 1930s, the public health services provided by the state were very few and reached only a tiny portion of the
population. For the most part, poor people in both rural and urban areas relied mainly on traditional forms of healing or, in some urban areas, on Catholic charity hospitals.

Beginning in the 1930s, important changes occurred. At that time, increased migration from rural to urban areas and an increase in industrialization led to the emergence of new groups of urban, white and mestizo working-class and middle-class workers who began to organize themselves into unions and political parties, chiefly in the coastal region of Peru. These groups used their new collective political and economic power to demand social benefits from the state. In response, by the late 1930s the oligarchic state eventually began to create state-run health insurance programs with their own hospitals and health services targeted to specific groups (railway workers, public servants, the military). These important gains were the result of workers’ struggles with the state. The new social security health system largely excluded rural indigenous people, women and the vast number of workers in the informal sector, however. Instead of using this moment to fight for better health benefits for all, the formal sector, urban workers sought to defend their own newly granted, superior quality health benefits (Ewig, 2010a). Meanwhile, other groups had to make do with the minimal publicly provided services offered by the state, pay for services out of pocket or rely on traditional forms of healing. The result of this historical legacy is a health care system that remains segmented and fragmented today (Cotlear et al. 2014).

This historical context, reflecting ethnic, class and gender inequalities in Peru, helps to situate the shape and realities of the present-day Peruvian health system.
1.2.2 Overview of the Contemporary Peruvian Health System

The pattern of segmented health care delivery linked to overlapping gender, ethnic and class inequalities persists in the contemporary Peruvian health system. Services are provided by (1) the Ministry of Health and its regional counterparts; (2) EsSalud, through the social security health system; and (3) private health providers for the wealthy and (private) traditional healers in rural communities.

Overall, the Ministry of Health (Ministerio de Salud, MoH) oversees public health as the nation’s governing body for the health sector (Francke 2013, p.18). The MoH and its regional counterparts (Regional Health Directorates/DIRESAS) provide health services, including reproductive health services, through a network of public hospitals, health centres and health posts. The MoH/DIRESAs are the main health service providers in the country, in particular in rural areas and small towns. The system suffers from substantial problems including chronic underfunding, drug shortages, workforce shortages, unrest and poor training, as well as weak management (Sánchez-Moreno, 2013).

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9 Sánchez-Moreno (2013) notes that primary problems in the area of human resources for health in Peru are reflected in low wages, ongoing labour conflicts between workers and the state, gaps in health worker education and training, and an insufficient number of health care professionals in hospitals and all other levels of care. He also stresses the increasing migration of health workers to foreign countries as a significant loss to the health system. Difficulties within the organization of the health workforce have contributed to poor staff coverage and high turnovers in health facilities, in particular in rural areas (Physicians for Human Rights, 2007).
The public provision of health services is funded through the national treasury, as well as, to a lesser extent, through user fees (Alcalde-Rabanal et al., 2011; Francke 2013). In the early 2000s, the national government introduced the Seguro Integral de Salud (SIS), a comprehensive health insurance scheme that covered care in public health facilities. The objective of the SIS is “to promote equitable access to quality health services with priority given to uninsured individuals and vulnerable populations living in poverty and extreme poverty.” (Francke 2013, p.4). The scheme covered a set package of services related to 20 percent of the causes of morbidity, based on the Prioritized List of Health Interventions. With the adoption of SIS, health facilities are officially no longer allowed to charge user fees to SIS affiliates for services covered through the scheme. People join SIS by applying at health facilities and receive either fully or semi-subsidized coverage, depending on their income. This is determined in health facilities through a proxy means test, the Socio-Economic Evaluation Sheet. Coverage through SIS can only be used for services proved in Ministry of Health facilities. Clients cannot use the coverage in health facilities run by other entities. In 2007-08, some attempts were also made by the government to specifically target poor, rural districts, but so far this has not been broadly implemented. In 2009, the government passed the Universal Health Insurance Law (AUS), which focused on broad health sector reform. According to Francke, AUS created a minimum for all insurance plans (government, social security and private), created a public body (SUNASA) to supervise and monitor the quality of insurance providers, and created the possibility for SIS to buy services from private providers (2013). Soon after, the Ministry of Health introduced the Essential Health Assurance Plan (PEAS), which officially increased government-provided health service coverage to 65 percent of the causes of morbidity. However, the government has not provided sufficient financial resources needed to implement the new AUS/PEAS, so implementation has been extremely slow (Francke, 2013).
Parallel to the Ministry of Health’s public system is the social security health system, EsSalud. EsSalud is an expanded version of the system first established for formal sector workers in the 1930s. It provides coverage and services to workers in the formal sector through its own exclusive network of health facilities, which are located mostly in urban areas (Alcalde-Rabanal, 2011, pp.S247-8; Francke, 2013). The police and the military also have their own publicly funded subsystems that provide these groups and their families with insurance coverage and health care services in their own facilities.

There is also a small private sector that provides health care primarily to upper income members of the population. Only a small percentage of Peruvians (3-5 percent) hold private insurance. They rely entirely on service provision obtained through private health facilities, mainly located in major urban centres. Traditional healers are another source of private health care provision in Peru and play a particularly important role in rural areas of the country (Necochea, 2014).

Total expenditure for the health system is five percent of the Peruvian GDP, with only 54 percent of these resources directed to the public system (Francke, 2013). The inequalities embedded in the health system are strikingly revealed by the amount spent on financing different forms of coverage. In 2012, the SIS, which provides coverage to the poorest segment of the population through public facilities, spent US$35 per patient per year. In contrast, the social security-based EsSalud, which provides services and coverage to formal sector workers, spent US$196 per patient, and private insurance providers spent US$542 per patient, per year (Sánchez-Moreno,
2013, p.679). Approximately 20 percent of Peruvians, mostly from low-income groups, still lack any health insurance (Sánchez-Moreno, 2013, p.679). Since indigenous people in Peru are disproportionately poor and less likely to be employed in the formal sector because of a combination of geography, access to education and discrimination, these arrangements produce clear inequalities based on gender and ethnicity as well as class.

The inequality of these arrangements is also reflected in the inequality of health outcomes in the country, especially as applied to women’s reproductive health. While Peru has the second-highest maternal mortality ratio (MMR) in South America, maternal mortality is unevenly distributed across the country. In 2000, for example, the MMR for the capital city, Lima, was 52 deaths per 100,000 live births, while in the Andean, poorer, substantially rural and indigenous department of Puno, the MMR was 362 per 100,000 live births. In the Andean region, women with problems of access to health services have reported greater difficulties (particularly the absence of personnel and necessary medicine) than those in the national capital and the coastal region (INEI, 2009, p.186). The rural/urban divide is also significant. For example, a study by Physicians for Human Rights (2007) shows that women with higher education in urban areas of Puno are likely to have received more thorough prenatal care than women in rural areas (p.111).

A lack of available, accessible, acceptable and quality obstetric services is linked to the high rate of maternal mortality in Peru, especially deaths related to obstetric emergencies (Del Carpio, 2014).

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10 Maternal mortality is a cause of death closely tied to a lack of obstetric care, in particular emergency obstetric care (Say et al. 2014).
Unsafe abortion accounts for 16 percent of maternal deaths, and it was estimated in the mid 2000s that there were approximately 66 abortions for every 100 live births in a country where abortion is essentially illegal.\footnote{Officially, abortion for therapeutic reasons (to avoid grave health risks and save women’s lives) was decriminalized in Peru in 1924. However, amidst political and social pressures, the Ministry of Health did not introduce any official protocols to guide the medical practice, making therapeutic abortion unobtainable through public hospitals and difficult to obtain except through clandestine channels. Peruvian women’s health rights activists and other civil society activists have carried out a concerted advocacy campaign for the introduction of an official protocol. Finally, in June 2014 the national government approved an official norm through the Ministry of Health that provides medical guidelines for the provision of therapeutic abortion (Alvarez, 2014). The norm guarantees legal access to free, safe, therapeutic abortion in all hospitals with the informed consent of women within the first 22 weeks of pregnancy (MINSA, 2014). Whether and how the norm will be implemented remains to be seen (Alvarez, 2014).} It is estimated that at least 30 percent of abortions result in some form of complications, thereby increasing the risk of maternal death (Miranda & Yamin, 2008, p.8).

Intercultural and ethnic divisions also create problems in the delivery of reproductive health services. In Peru, a Physicians for Human Rights report (2007) noted “the health system is perceived across many indigenous communities as a westernizing, colonizing force that does not respect indigenous cultural traditions and preferences” (p.113). Although the public health facilities have officially adopted culturally sensitive norms, such as vertical birthing, in practice, health workers do not always implement these (Nureña, 2009).

This discussion demonstrates the enduring nature of inequalities in Peru, as persistently reflected in the public health system and reproductive health care. Nonetheless, Gootenberg stresses that while inequalities may be entrenched, they are not inevitable (Gootenberg, 2010). He argues that Latin America is an especially interesting useful vantage point from which to consider
inequalities, in that it is a region where the topic is openly and widely debated. As well, over the last two decades, progressive political parties have been elected in a large range of Latin American countries, forming government administrations and enacting policies that have placed greater priority on the need to address inequalities.

1.3 Challenging Inequalities in Reproductive Health Care: The Citizen Monitoring Initiative in Puno

The above sections demonstrate that there are systematic patterns of inequality and exclusion in the provision of reproductive health services available to rural, indigenous women in Puno. I have also discussed the manner in which these entrenched conditions of inequality became institutionalized within the public health system.

The citizen monitoring initiative in Puno that is the subject of this study aims to challenge these inequalities. In this section I will introduce and discuss two key sources of inspiration that have greatly influenced the citizen monitoring initiative in Puno. The first is vigilancia ciudadana, a set of accountability initiatives that has been gaining ground in Peru since the early 2000s. I will discuss the logic behind citizen monitoring of public institutions in Peru and how it differs from conventional approaches to public participation. The second source of inspiration is drawn from a “human rights-based approaches to health,” which is the product of a transnational movement (or epistemic community) of scholars, activists and officials seeking to reform public health
practice. As I will further elaborate in chapters two and five, the citizen monitoring initiative draws extensively upon both of these sources to constitute a rights-based form of governance.

1.3.1 Vigilancia Ciudadana and Participation

The approach used by the citizen monitors in Puno and their allies draws in part on ideas generated by a loose family of accountability initiatives that has been developed in Peru since the early 2000s. These various initiatives, all of which use the name vigilancia ciudadana (in English, “citizen monitoring” or “oversight”), arose as a result of intense popular frustration with official corruption and misuse of power. These problems were particularly prominent by the end of the 1990s with the collapse of the regime of President Alberto Fujimori amid a wave of revelations of corrupt practices throughout his administration (Murakami, 2007). In general, the term vigilancia ciudadana is applied to a form of public participation in which citizens exercise an oversight role over various forms of public administration (Barrientos & Alvarado 2006, p.53; Gamero et al., 2004). The notion of vigilancia has been taken up by public initiatives relating, for example, to participatory municipal budgeting and the forced resignation of local authorities.12

Civil society coalitions have also developed vigilancia initiatives to oversee the management of public finances and the regulation of extractive industries.13 Civil society vigilancia initiatives in the health sector include the generation of national-level report cards on a range of health issues and a vigilancia roundtable on sexual and reproductive rights.14 Advocates of vigilancia also


13 See, for example, Grupo Propuesta Ciudadana, “Vigila Peru” http://www.participaperu.org.pe/n-vigilaperu.shtml.

14 See, for example, www.unfpa.pe/intranet/aqv/informes/INFAQVOO15.pdf
identify a number of similar mechanisms that have been carried out in other countries. These include municipal health councils in Brazil and the *comités de vigilancia* in Bolivia.

A small body of practitioner-oriented literature published by coalitions of NGOs and research institutes has sprung up to discuss, define and elaborate upon *vigilancia ciudadana* in Peru (Barrientos & Alvarado, 2006; Gamero et al., 2004; Saco, 2008). In this literature, *vigilancia* is seen as a way to avoid some of the pitfalls of conventional forms of citizen participation in government decision-making.

Participatory approaches to public administration and health have generated a large body of scholarship (see, for example, Landa Vasquez, 2004; La Rosa Huertas, 2002; Menendez, 2006; Remy, 2005). Participation in the planning and implementation of health was promoted as a major component of international health policy at the Alma Ata Conference in 1978, a seminal meeting focused on the importance of primary health care. Since then, participation has become entrenched in mainstream health discourse at local, national and international levels (Morgan, 2001).\(^{15}\)

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\(^{15}\) Latin American government ministries connected with agriculture and urban development began to incorporate participatory approaches in the 1950s and 1960s, while the health sector took some time to follow (Ugalde, 1985). In the 1970s, many Latin American government health ministries, including in Peru, began to include participatory approaches in their policy orientations and program designs (Ugalde, 1985; Reyes, 1989).
Participatory approaches have had important successes but have also been criticized for providing opportunities for clientelism, for the cooption of civil society actors and for a failure to meaningfully share decision-making authority (Cooke & Kothari, 2001; Hickey & Mohan, 2004; Landa Vasquez 2004; Remy 2005). A loosely defined term, participation has been adopted and promoted by different actors for different reasons, and with varying degrees of commitment. Participatory initiatives that seek to bring about the kinds of redistributive reforms required to address health inequity are unlikely to fit into a model of cooperative and consensus-based decision-making. As Birn observes, the historical record around the world shows that equality-enhancing reforms involve substantial and often long-term political struggle (Birn, 2009, p.175). Participatory arrangements that propose to address health inequality are likely to generate disputes over power relations (Morgan, 1990). Participation programs have often lacked effective mechanisms to cope with disputes over power, however. Where such mechanisms are lacking, Morgan argues, participatory programs are likely to fall short of expectations (Morgan, 2001).

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16 Participation may also be seen as another area of devalued or uncompensated work performed by women: part of the “third shift.” U.S. academics have developed this term to refer to caregiving and community work done outside the home, often through volunteer activities. This work is done in addition to the “first” and “second shifts” of paid work and housework/child care (Boserup, 1970; Gerstel, 2000; Hochschild & Machung, 1989).

17 Morgan argues that, for international agencies, community participation satisfied key ideological-political needs. Faced with promoting health in starkly unequal societies in the developing world, these agencies sought “a cooperative non-confrontational approach to address issues of poverty and inequitable distribution of wealth” (1990:212). Developing-country governments and political parties have at times viewed the rhetoric of participation as a useful resource in domestic politics. Donors and governments have been accused of taking advantage of the “cosmetic” value of participation: its ability “to make whatever is proposed look good” (Chambers, 1995 cited in Morgan, 2001:222).

18 For example, Ugalde contends that participation in health programs is less likely to succeed in highly stratified societies where social relations of power are particularly unequal (Ugalde, 1985).

19 The capacity of different kinds of participatory arrangements to appropriately distribute and channel power has long been the subject of criticism. In 1969, Arnstein proposed a “ladder of participation” to show how inconsistently the term could be used. Arnstein’s ladder runs from tokenistic or non-participatory approaches at one end
In contrast to conventional forms of public participation, proponents of vigilancia ciudadana see it as a particularly active form of involvement in decision-making that attempts to redefine the power relations between citizens and officials. Proponents of vigilancia ciudadana stress the need for rights to active citizenship in order to observe and oversee the functioning of state institutions. These initiatives are not intended to displace the state or limit its role in society, however. Instead, citizen monitoring proposes a way to improve government decisions and especially to respond to the failure of state institutions to meet their obligations to the public.

While these initiatives have emerged in a context of deep cynicism about the state, proponents of vigilancia ciudadana argue that citizen monitoring should provide institutionalized opportunities for cooperative problem solving (Barrientos & Alvarado, 2006, p.53; Saco, 2008: 35). A fundamental challenge for all of these kinds of initiatives, however, concerns how to get state officials to agree to the oversight power relationship implied by vigilancia ciudadana.

1.3.2 Human Rights-Based Approaches to Health

The second major source of inspiration for the citizen monitoring initiative is the notion of human rights-based approaches to health. Latin American countries and social movements have
had a long history of engagement with human rights.\textsuperscript{20} In the context of authoritarian regimes and civil conflict in much of the region during the 1970s and 1980s, human rights law and discourse were used to advance claims to civil and political rights. After the end of the Cold War, and with many transitions to democracy in the region, human rights issues became even more politically prominent. During this period, international donors funded human rights-based projects and programs to “consolidate the fragile democracies that were emerging,” and “democracy and human rights moved up the development agenda” (Molyneux & Lazar, 2003, p.1). NGOs in particular began to take up the language of human rights in their development work (Molyneux & Lazar, 2003, p.23). In many ways, this created a favourable environment when the health and human rights movement started to become active in region in the 2000s.

The health and human rights movement is a transnational epistemic community of scholars, practitioners, officials and activists who have sought to respond to the limited progress achieved by international human rights institutions in promoting the human right to health (Mann, 1997:115). The right to health has been recognized in a number of human rights treaties, for many years.\textsuperscript{21} The right is authoritatively set out in the International Covenant on Economic, Social and Cultural Rights (ICESCR) as “the right of everyone to the enjoyment of the highest

\textsuperscript{20} There was substantial Latin American involvement in the drafting of the Universal Declaration of Human Rights (UDHR) (Glendon, 2003).

\textsuperscript{21} The key treaties include the Universal Declaration of Human Rights; the International Covenant on Economic, Social and Cultural Rights (ICESCR, adopted in 1966); the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, adopted in 1979); and the Convention on the Rights of the Child (CRC, adopted in 1989). The content of the right was further elaborated in 2000 by General Comment 14 to the ICESCR.
attainable standard of physical and mental health” (Article 12). It was not until the emergence of health-related human rights activism in the 1980s and the rise of the health and human rights movement in the 1990s, however, that systematic efforts began to be made to reform the practice of public health with reference to international human rights law (Mann, 1997, p.115; Gruskin et al, 2010).

Gruskin et al. observe that, early on in the 1980s and 1990s, the concurrent efforts of women’s health and human rights movements helped to promote the idea of rights-based approaches to health (2008). For example, these movements strongly influenced the 1994 International Conference on Population and Development (ICPD) and the 1995 Fourth World Conference on Women (WCW). Both conferences produced outcome documents that emphasized the importance of promoting women’s rights (especially sexual and reproductive rights) in order to promote women’s health (Gruskin et al., 2008). Gruskin et al. argue that this kind of activism has been very important. As a result of these efforts, maternal mortality in the developing world—which despite its prevalence was not seen as a public health concern at a global level before the 1980s—has begun to attract substantial attention through its framing as a human rights concern (2008, p.590; IIMMHR, 2010).

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22 CEDAW guarantees sexual and reproductive rights to women including the right to access to health care services without discrimination, and the right to “appropriate services in connection with pregnancy” (Article 12).
As well, during this period, key actors such as Jonathan Mann began to lay out the conceptual work for linking public health and human rights (Mann et al., 1994; Marks, 2001). Influenced by HIV/AIDS activism and administration, Mann found that this linkage brought a paradigm shift to both public health and human rights practice. He argued that a health and human rights analysis challenges traditional epidemiological ways of thinking about poor health by requiring that practitioners uncover “the rights violations, failures of rights realization, and burdens on dignity which constitute the societal roots of health problems” (Mann, 1997, p.115). He also argued that linking health and human rights challenges the established ways of conceptualizing and protecting rights and shows that “new forms of action to promote and protect human rights are clearly needed” (Mann, 1997, p.116).

The health and human rights movement has sought to promote advances in health and human rights in three ways: through advocacy, using legal mechanisms where these are available and by promoting rights in the delivery of care and programming through the development of a “human rights-based approach to health” (Gruskin et al, 2013, pp.35-38). The notion of a rights-based approach to health draws upon international human rights law, including the right to health and the right to propose a systematic re-visioning of public health policy making and programming in line with human rights principles and legal standards (Gruskin et al, 2010; Hunt & Backman, 2008).

Important parts of the development of a systematic formulation of a rights-based approach took place within the agencies of the United Nations in the 1990s. The idea of a rights-based approach
was first articulated in relation to development programming by the United Nations Development Programme (UNDP) in the mid-1990s (Gruskin & Tarantola, 2013). A process of “human rights mainstreaming” within UN agencies led to the elaboration in 2003 of a “Common Understanding” of the human rights-based approach to development within the UN system. In line with the UN Common Understanding, the World Health Organization has developed a human rights-based approach to health (WHO, undated). In addition to WHO, various foreign aid agencies and NGOs have also committed themselves to implementing rights-based approaches to health over the past two decades (Gruskin et al, 2010). However, organizations differ in how they articulate these commitments. Scholars and advocates note a “lack of conceptual and operational clarity of RBAs” (Gruskin et al, 2010, pp. 137-138; Cornwall & Nyamu-Musembi, 2004).

In general, human rights-based approaches aim to influence the processes through which public health policy, programming and implementation are carried out (Hunt & Backman, 2008). The WHO approach provides that these processes should be guided by key human rights standards and principles such as public participation, equality, non-discrimination and accountability

23 The common understanding commits UN agencies to use the standards and principles found in international human rights law to guide development efforts.

24 Including those of the US, UK, Sweden and Spain (Gruskin et al, 2010).

25 Including Oxfam, CARE, Planned Parenthood and Save the Children (Gruskin et al, 2010).

26 This mirrors the adoption of rights-based approaches to development by UN agencies, governmental development agencies and NGOs (Cornwall & Nyamu-Musembi, 2004).
The rights-based approach used by the NGO, CARE International also includes a commitment to promote more equal power relations between officials and health users (Frisancho et al, 2011, p.275). Since the 1990s, certain UN agencies, international donors, and NGOs have sought to influence governments in the global South to adopt and institutionalize elements of a rights-based approach in their public health programming (Barrientos, Gideon & Molyneux, 2008; Gruskin et al, 2010).

Advocates of human rights-based approaches to health argue that they provide unique resources to promote progressive change in public health. They see international human rights law as a source of legitimacy and leverage in the struggle to encourage states to address neglected public health problems (London, 2008). Gruskin et al. stress that a human rights focus tends to highlight government responsibility—either through action or inaction—for health problems. For example, where life-saving treatment exists but is not accessible, framing maternal mortality as a human rights issue helps to highlight the responsibility of those who prevent access (Gruskin et al., 2008, p.591). Elson and Gideon assert that “despite limitations and ambiguities, rights language retains considerable rhetorical and mobilizing power” through which women can “articulate strong claims for equality” (Elson & Gideon, 2004, p.134).

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27 In its rights-based approach, the NGO CARE emphasizes the importance of addressing power imbalances between marginalized health users and public health authorities or others able to influence the allocation of public health resources (Frisancho et al, 2011, p.275).
Some scholars contend that human rights-based strategies enable activists to call upon a set of authoritative norms that can be used to recast the relationships that citizens have with governments. As Jochnick observes,

> The real potential of human rights lies in its ability to change the way people perceive themselves vis-à-vis the government and other actors. A rights framework provides a mechanism for reanalyzing and renaming ‘problems’ as ‘violations,’ and, as such, something that need not and should not be tolerated (Jochnick, 1999, cited in Yamin & Irwin, 2010).

Advocates of human rights-based approaches to health argue that it changes the relationship between states and citizens. States become duty-bearers, with binding obligations to protect and promote the health and participatory rights of citizens, who are rights-holders (Potts, 2008; Yamin, 2009). There can be a confrontational aspect to this relationship. The human rights framework invests the wronged rights-holder with moral and legal authority to assert her claim for justice. It places an “emphasis on assigning responsibility” (Yamin & Irwin, 2010).

Other scholars contest some of these optimistic views about the potential of rights-based approaches to alter power relations between citizens and state officials. Some critics argue that international human rights law and its discourses are too Western, individualist, legalistic and state-centred to serve as an effective universal standard (Petchesky, 2003, p.22). Skeptics of rights-based approaches point to “a lack of empirical evidence of their added value” (Gruskin et al, 2010, p.138).
As Elias notes, however, these perspectives miss important and dynamic aspects of rights advocacy in the context of grassroots social struggles (Elias, 2010, p.842). Human rights concepts and discourse are enthusiastically appropriated in different ways by diverse social movements around the world, where they are used as important symbolic resources (Petchesky, 2003, p.22; Merry, 2006). A rights framework is often believed to have a strong capacity to inspire and mobilize social movements that push for change (Chapman, 2011). Sally Merry suggests that this provides an important opportunity for critical scholars. She argues that it is important to “explore the practice of human rights, focusing on where and how human rights concepts and institutions are produced, how they circulate, and how they shape everyday lives and actions” (Merry, 2006, p.39). This kind of work focuses on “the social processes of human rights implementation and resistance…. Instead of asking if human rights are a good idea, it explores what difference they make” (Merry, 2006, p.39).

1.4 Roadmap of the Thesis

The remainder of this thesis is divided into chapters two through seven.

In chapter two, I set out the theoretical framework that I use to organize and inform my inquiry. This framework is grounded in feminist political economy and involves understanding the citizen monitoring initiative as a form of governance “from below”, where members of an excluded group attempt to influence the state’s involvement in social reproduction. Relations of power between different actors play a key role in governance struggles over the state’s involvement in
social reproduction. The chapter begins by presenting debates about social reproduction and considers them in relation to my study. Next, I present an approach for understanding power relations in struggles over governance. I conclude chapter two by drawing again on political economy to consider reproductive health as an arena of contestation.

In chapter three, I set out my methodological approach, which is based on institutional ethnography (IE). IE uses an investigation of the daily work processes of a specific group of people as a methodological starting point for research. In the case of my study, I began by investigating the work of the citizen monitors in Puno. An IE approach helps to link these daily experiences with broader social, political and economic forces, with a view to understanding the social relations of power that shape people’s experiences. Initial interviews in Puno helped to identify themes for further exploration and provided a starting point for the selection of key policy-level informants in Puno and Lima, as well as the selection of documents. The interviews also revealed the significance of monitors’ experiences with reproductive health care service delivery in Puno in the 1990s and early 2000s. This provided important entry points from which to start to historically contextualize my study, the focus of chapter four.

In chapter four, I explore the period from 1990 to 2005, when reproductive health care in Puno emerged as an arena for increased participatory engagement involving civil society, NGOs and state-run health services. It was during this period that the state began to significantly expand its role in reproductive health service provision. The state also adopted the language of reproductive health rights, although in practice its actions at times entirely contradicted or even abused these
rights. Also during this period, an influential large-scale project, ReproSalud, was launched in various regions across Peru, including Puno. The project aimed to strengthen reproductive health and rights among socially-excluded women. A number of the current citizen monitors first began to be active in efforts to improve reproductive health through this earlier project. The experiences and lessons learned by those involved with ReproSalud have helped inform the development of the citizen monitoring initiative in Puno.

In chapter five, I present findings concerning my empirical investigation of the citizen monitoring initiative in relation to three dimensions of governance: ideas, everyday practices and institutions. Within this framework, I examine in detail the work of the citizen monitors and their allies, the implications for service delivery, and the corresponding theme of power relations. I pay particular attention to how a human rights-based approach to health is used by the monitors and their allies in an effort to advance their agenda, and the implications of this approach on power relationships between the monitors and the diverse actors involved in the initiative.

In chapter six, I bring together and analyze the findings from the previous chapter. I return to my theoretical approach from chapter two as well as my methodological approach from chapter three to help guide my analysis. I consider both the potential as well as the limits of the initiative. One of the most interesting outcomes resulting from the initiative concerns the new political consciousness and skills that monitoring work seems to have provided to citizen monitors. It appears that through “hands-on learning”, citizen monitors are gaining the capabilities and interest for broader political activism and advocacy.
In my concluding chapter, I consider how the insights from my investigation of rights-based governance in Puno contribute to broader discussions concerning the strengthening of reproductive health care for socially excluded groups in the context of ICPD twenty years onward. In recent years civil society and states in a number of countries in Latin America have been struggling with confronting the legacies of exclusion embedded in their health systems. The study suggests that new forms of citizen engagement involving rights-based governance can play an important role in promoting the democratization of reproductive health care and inclusive citizenship. I close the discussion with a review of lessons learned from the initiative and the questions this raises for further research.
Chapter 2
Theoretical Approach

2.1 Introduction

In this chapter, I lay out a conceptual and theoretical framework to organize and inform my inquiry into the citizen monitoring initiative. Using the tools of feminist political economy, I explore the initiative as a localized example of a global phenomenon: the struggle over how states are involved in supporting social reproduction through, in this case, reproductive health care. Models for understanding these struggles need to be sensitive to the developing context of state-society relations in Latin America. Welfare states in Latin America developed quite differently than did welfare states in the global North (Kunz, 2010). Also as I shall explain, states in Latin America had a different trajectory through neoliberal restructuring than states in other regions (Molyneux, 2008).

Analytically, citizen monitoring can be seen as a form of social struggle where civil society actors seek to be involved in governance. Governance is a broad term widely used by political economists and other social scientists to rethink how authority and influence are exercised both within and outside of the political institutions of government (Kooiman, 1993). Governance that involves socially excluded groups needs to be especially concerned with power relations; otherwise, “interactions may simply replicate and reproduce preexisting power relationships”
(Gaventa, 2004, p.24). In this chapter, I develop a relational understanding of power that draws on several sources in order to inform the discussion in later chapters.

I conclude the chapter with a discussion of how women’s reproductive health is a particularly contentious aspect of social reproduction. The stakes are high for women in these struggles, especially given the tendency for various actors to seek to exercise controls over women’s reproductive health that are guided by notions of policing morality, reinforcing gender subordination or neo-Malthusian population control. Women who are struggling to increase their reproductive autonomy through access to reproductive health care can face various forms of formal and informal opposition.

2.2 Social Struggles Over State Involvement in Social Reproduction

While the events described in this dissertation mostly take place in one corner of Andean Peru, they are also part of a global story. Around the world, diverse social movements and citizen initiatives are attempting to address inadequate public health systems, including reproductive health systems. These issues may arise from budgetary pressures, from limits on coverage or quality of services, or from patterns of inequality and exclusion. Political economists suggest that many of these failures are linked to shifts in the global political economy, with important implications for lives and livelihoods, especially those of women (Bakker, 2007). As a result,
attempts to challenge these problems also involve confronting and challenging shifts in political economy.

In the language of feminist political economists, the citizen monitoring initiative is an example of a social struggle in which members of an excluded social group are trying to govern the way in which the state is involved in social reproduction (Bakker & Gill, 2003). The term “social reproduction” refers first to processes of biological reproduction of people and the labour force, including the production and distribution of food, shelter and other necessities. More broadly, however, social reproduction also concerns the development and maintenance of all of the social relations necessary to enable economic activities such as production, exchange as well as continued social existence. Thus, social reproduction takes place within and beyond the household and “involves institutions, processes and social relations associated with the creation and maintenance of communities — and upon which, ultimately, all production and exchange rests” (Bakker & Silvey, 2008, p.3). In many contemporary societies, social reproduction is an area with substantial state involvement, not least through public institutions “that provide for socialization of risk, health care, education and other services” (Bakker & Gill, 2003, p.18).

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28 Bakker and Silvey observe that feminist political economists have broadened the definition of social reproduction to include “the work of maintaining existing life and reproducing the next generation” (Laslett & Bernner, 1989 cited in Bakker & Silvey, 2008, p.4) and “the fleshy, messy, and indeterminate stuff of everyday life” (Katz, 2001 cited by Bakker & Silvey, 2008, p.4).
Beginning in the 1970s, feminist political economists directed new attention to the concept of social reproduction, focusing on women’s unpaid domestic labour and its subsidizing of capitalist reproduction (Bakker, 2007, p.541). In recent years, however, feminist political economists have argued for a renewed focus on social reproduction in international political economy (IPE), particularly its relation to shifts toward “increasingly privatized forms of social provisioning” (Bakker, 2007, p.541). In their groundbreaking text, Bakker and Gill (2003) argue that standard critical approaches to IPE are chiefly concerned with explaining the restructuring of world society in terms of power and production. Thus far, these approaches “largely failed to fully integrate into [their] explanations … the analysis of transformations in fundamental social processes, and the mechanisms and institutions upon which societies and communities … are built”—that is, social reproduction (Bakker & Gill, 2003, p.3). An emphasis on social reproduction allows political economists to take into greater consideration the social and gendered dimensions of neoliberal globalization.

Bakker and Gill assess the changes in political and economic arrangements under neoliberalism over the last three decades and examine their ramifications for the conditions of social reproduction. They hypothesize that there is a contradiction between the new power acquired by capital under neoliberalism and the capacities for social reproduction among the majority of the world’s people (Bakker & Gill, 2003, p.4). In other words, with its new power, capitalism often threatens the entitlements, relations and resources that people rely on for social reproduction. One consequence of this contradiction has been the retreat of the state from progressive involvement in social reproduction in many parts of the world. Bakker argues elsewhere that the “increasingly privatised forms of social provisioning and risk” that characterize neoliberalism
have strong gendered effects, with significant negative impacts on women. As a result, “the everyday activities of maintaining life and reproducing the next generation are increasingly being realized through the unpaid and paid resources of (largely) women as states withdraw from public provisioning, with the result that capitalist market relations increasingly infiltrate social reproduction” (Bakker, 2007, p.541). Thus, under neoliberalism the burden of social reproduction is increasingly shifted to the private domain and disproportionately onto women (Ewig, 2008, p.143). Bakker and Gill suggest that social struggles play an important role in determining the degree of success or failure of efforts to shift the burden of social reproduction away from the state to the private domain (2003, p.4). This makes understanding efforts such as the citizen monitoring initiative particularly important.

The analysis developed by Bakker and Gill provides a valuable lens through which to view the material and social aspects related to reproductive health and reproductive health services. A number of scholars, however, have articulated qualifications to this broad thesis. These should be taken into consideration when using social reproduction as a lens through which to understand the citizen monitoring initiative in Puno.

Particularly relevant to my own study are the qualifications elaborated by Rahel Kunz (2010). She argues that the “re-privatization of social reproduction” insight articulated by Bakker and Gill is clearly important, but that it is not a universal phenomenon (Kunz, 2010, p.914). She notes that, especially in areas in the Global South with historically little state involvement in social provisioning, social reproduction has always been a significantly private concern. She
points out that feminist international political economy has tended to focus on industrialized countries with active welfare states, and she argues that we should be cautious before we apply assumptions developed in these contexts to other parts of the world.

In Latin America for example, state involvement in social provisioning has tended to be fragmented rather than universal (Segura-Ubiergo, 2007), with particularly strong gendered effects. While some Latin American countries were early adopters of social-protection programs, these initiatives were initially provided to small, relatively privileged segments of society (such as the military and civil servants), and were only gradually extended to the best organized and most strategically located sectors of the working and middle classes and their dependents (Segura-Ubiergo, 2007, pp.26-7). These sectors tended to be occupied primarily by urban, white and mestizo men from coastal parts of the country, thereby excluding large segments of poor, indigenous women and men in rural Andean and Amazonian regions (Ewig, 2010a). In Peru, large groups such as informal workers and peasant farmers were mostly excluded from state social protection efforts until the 1970s (Segura-Ubiergo, 2007). As outlined in the introductory chapter to this thesis, Peru developed a multi-tiered health system in line with this model that largely excluded or marginalized rural indigenous populations (Ewig, 2010). This fragmented approach to social protection corresponds with what O’Donnel calls “low intensity democracies” in which “‘gray areas’ of the national territory exist” where the government has limited presence, “levels of inequity are high, and social exclusion is ubiquitous” (O’Donnel, 2002, cited in Fleury, 2010, p.35).
Kunz argues that a focus on a quantitative assessment of state involvement in social reproduction can obscure important qualitative changes in how states influence social reproduction. In a study conducted in rural Mexico, Kunz observes that changes in state involvement “transform forms of thinking, behavior and subjectivities through responsibilization processes, and simultaneously open up spaces for resistance and empowerment” (Kunz, 2010, p.936). She argues that this “is an expression of the contradictory and paradoxical nature of neo-liberalism that on the one hand contributes to ‘heightened forms of gender, sexual, cultural and economic normativity’, while at the same time opening new terrain for activism and empowerment (Kunz, 2010, p.936). Kunz cautions against limiting our analysis of the global crisis in social reproduction to focus narrowly on changes in the amount of state involvement. She argues instead that “it is essential to analyze changing forms of state involvement” in order to understand the “variety of ways in which the global crisis of social reproduction manifests in different locations” (Kunz, 2010, p.915, italics in original).

Kunz’s observations about social reproduction are particularly relevant to the study that I am presenting here. Puno, the region in which I have conducted my research is a “grey zone” in which the Peruvian state has historically had limited involvement. As I will elaborate in chapter four, this long period of neglect changed in the mid-1990s, after which successive governments, with support from international donors, expanded the provision of public reproductive health services in the region. As I will show in subsequent chapters, however, concerns regarding the qualitative nature of these services persist. In the 1990s, these concerns included a forced sterilization program that targeted indigenous women. In the 2000s, discrimination, exclusion and exploitation continued to plague public health services in the region. It is important to
consider the role played by historical patterns of inequality and exclusion experienced by rural indigenous populations in Puno in shaping different forms of state involvement in reproductive health care.

In a similar vein, Molyneux argues that neoliberal reform in Latin America has not resulted in a simple “hollowing out of the state.” Instead, she asserts that neoliberal restructuring in the region has involved “a marked redefinition of state-society relations” and changing forms of state involvement in social reproduction (Molyneux, 2008, p.793). In a review of the Latin American experience with neoliberal restructuring since the 1980s, Molyneux argues that countries in the region did go through an initial “market fundamentalist” stage involving privatization, liberalization of the economy and, often, a retreat from involvement in social reproduction. She argues, however, that since the 1990s, the character of neoliberal reform has changed. While macro-economic policy remained generally the same, the new agenda included an emphasis on poverty relief and a series of “good governance reforms” intended to democratize local governance and service delivery (Molyneux, 2008, pp.781-784). This package of reforms was taken up differently in different countries. In general, however, it changed the way that states in Latin America are involved in social reproduction. This new policy direction “signals a state that is not only still present, but is also functioning in different ways, with some of its capacities weakened but others devolved to the local level and exercised in some form of partnership with civil society” (Molyneux, 2008, p.793).
A further wave of change began in the 2000s with the rise of left-of-centre governments in the region, supported by strong growth and new revenue from the boom in commodities. Widely seen as a “post-neoliberal” phase of policy-making, many Latin American governments have been expanding their efforts to address poverty and inequality, and to promote “greater inclusivity in education, health and social insurance” (Gideon & Molyneux, 2012, p.294).

However, “overcoming social exclusion and including marginalized groups in decision-making processes” are continuing challenges for these governments (Barrientos, Gideon & Molyneux, 2008, p.770).

I will examine the citizen monitoring initiative in Puno as an example of a struggle between indigenous women, in alliance with a range of local, national and transnational actors, to govern the involvement of the Peruvian state and its delivery of reproductive health services. Drawing on Kunz, Molyneux and other scholars, we can add to Bakker and Gill’s insight about the importance of social struggle. These struggles are not only over the resources and services allocated by the state, but also concern the qualitative dimensions of state involvement in social reproduction.

As I suggested in chapter one, the efforts of the citizen monitors to govern how state health facilities deliver reproductive health services face a core tension: The citizen monitoring initiative depends upon the ability of indigenous citizen monitors to exercise a governance influence in settings in which they have traditionally been marginalized. This raises the
interconnected issues of power and governance in the contested field of reproductive health care. In the sections below, I will outline a framework for discussing these issues.

2.3 Governance and Power Relations in Struggles Over Women’s Reproductive Health Care

2.3.1 Governing From Below

Struggles over the state’s involvement in social reproduction are struggles over governance. Political economists and other social scientists have adopted “governance” as a broad concept that includes both public and private efforts to direct and shape societies. For feminist political economists like Bakker and Silvey, governance consists of struggles over regulation “within both state institutions and civil society as these operate within particular sites or across national boundaries in regional and global frameworks” (Bakker & Silvey, 2008, p.4). Although the term includes the traditional activities of “government” (such as making and enforcing laws), its meaning is far broader and is used to understand changes in the diffusion of authority within society. According to Kooiman, governance encompasses “all those activities of social, political and administrative actors that can be seen as purposeful efforts to guide, steer, control or manage societies” (Kooiman, 1993, p.2). The notion of governance acknowledges that authority is diffused and decentred and that it can involve multiple actors including states, international
agencies, NGO coalitions, social movements and policy networks (Rhodes, 2007; Rosenau, 1995; Yanacopulos, 2005).

Since the early 1990s, the term governance has also been adopted by the World Bank to refer to a particular reform agenda it calls “good governance.” This set of reforms is intended to address problems the organization has identified in governments in the global south (World Bank, 1992; Hickey, 2012; Yanacopulos, 2005). The project of promoting “good governance” had a particular resonance in Latin America in the 1990s when many countries in the region shifted back to democratic rule. This sparked interest in democratizing reforms involving decentralization, accountability, and participation (Molyneux, 2008). Despite its use in this way by the World Bank, from an academic perspective, governance does not offer a normative theory about how systems of rule should work. Instead, it offers an “organizing framework” for paying attention to diverse efforts to direct and shape societies (Yanacopulos, 2005, p.252). This broader interpretation is useful since, as Hirst says, “government in the classical liberal sense is less and less a reality, and new methods of control and regulation are required that do not assume the state or the public sector has a monopoly of such practices” (Hirst, 2000, p.22).29

29 Some scholars use the notion of “accountability” as a guiding concept to examine these kinds of initiatives. For Schedler, for example, accountability applies when two dimensions are present: answerability and enforcement (Schedler, 1999). Answerability involves the duty of an accountable actor to justify its actions. Enforcement concerns the availability of mechanisms to impose sanctions on the accountable actor for improper actions (George, 2003). Accountability in this sense is a relationship that falls within the larger concept of governance. While accountability is certainly a valid frame to use for the purposes of analysis, I feel that it is unnecessarily narrow for my study. I have chosen to use the wider concept of governance, in order to facilitate a broader scheme of analysis of the citizen monitoring initiative.
The citizen monitoring initiative is a kind of governance “from below” (some scholars call this participatory governance) where members of an excluded social group attempt to influence a state institution, such as the public health care system, by engaging directly with it in an organized way (Gaventa, 2004; Gaventa, 2006, pp.15-7, 19-20). As I outlined in the introductory chapter, the initiative is also “rights-based” in that it draws upon a human rights-based approach to health. The monitors and their allies use rights-based strategies as a tool in their struggle with a public health care system in which they have long experienced unequal relations of power.

2.3.2 Thinking About Power Relations in Governance

A meaningful discussion of governance needs to be alert to power relations, particularly where the governance effort is developed by disadvantaged actors seeking to influence more advantaged sectors of society (Gaventa, 2004, p.24).

In this research study I use a conception of power that draws upon multiple sources. I draw upon a Foucauldian conception of power as a relational construct, something that is fluid, dynamic and open-ended (Petchesky, 2003, p.26). Foucault argues that:
power is not an institution, and not a structure; neither is it a strength we are endowed with; it is the name that one attributes to a complex strategical situation in a particular society.... Power is not something that is seized, or shared, something that one holds on to or allows to slip away; power is exercised from innumerable points, in the interplay of non-egalitarian and mobile relations (Foucault, 1979, p.93).

For Foucault, power is dispersed throughout society as the product of networks of social relations (Cronin, 1996, p.57). Individuals do not “have power”; rather, power resides in the positions that they are able to occupy in these networks of relations.

Peruvian sociologist Anibal Quijano’s notion of the “coloniality of power” is useful in this context as well (Quijano, 2000). He uses this idea to refer to the racialized hierarchies that were established in Latin America in the colonial era. Quijano argues that these racialized classification systems have endured beyond their colonial contexts and that these ideas of race (to which we should add gender) continue to shape modernity and capitalist relations (Quijano, 2000). Quijano’s vision provides a useful framework to account for how colonially inspired

30 See Petchesky, 2003, pp.22-7 for an interesting discussion on power, in particular as it relates to human rights.

31 In Foucault’s view, “power is diffuse, embodied (in discourse and elsewhere), and constitutive – as something that acts upon subjects and is enacted rather than used.” (Garner and Hancock, 2014, p.377).

32 Despite the important work of scholars like Quijano, Latin American experiences and scholarship have generally been “only partially integrated” into the broader field of postcolonial studies (Bortoluci and Janson, 2013, p.200). Colonialism and postcolonialism did unfold differently in Latin America than in other regions. Bortoluci and Janson are among the current scholars who are attempting to bring Latin American experiences and scholarship into postcolonial studies.
relations of power persist for long periods of time despite substantial social and political changes.

Despite the durability of power relations and their embeddedness in social institutions (Thorp & Paredes, 2010), in actual encounters between people in the moment, power relations can always to some degree involve contestation. For Foucault, “the exercise of power at the local level always potentially encounters resistance and relations of domination are inherently subject to reversal” (Cronin, 1996, p.63). Foucault coined the term “the micro-physics of power” to refer to “the strategic play of domination and resistance in which subjects act on one another” (Cronin, 1996, p.63). To exercise influence in governance, excluded groups need to navigate the difficult politics involved in the micro-level contestation of power. Actors are enmeshed in relations of power even as they try to contest them. The struggle to challenge barriers to social participation in governance and to counteract intersecting inequality takes place both within and through these networks of social relations.

In my study of the citizen monitoring initiative in chapter five, I will discuss my findings concerning how the citizen monitors are able to navigate power relations in their attempts to govern the delivery of reproductive health care for their communities. I will do so using an analytic framework proposed by Bakker and Silvey. Citing Bakker and Gill (2003), these authors contend that governance has three important dimensions:
[it] involves ideas that justify or legitimate political power and influence, institutions through which influence is stabilized and reproduced and material practices which sanction or act as incentives to compliance with rules, regulations, norms and standards (Bakker & Silvey, 2008, p.4).

I will also discuss both the strategies used and the challenges confronted by the citizen monitors in their efforts to exercise power in each of these dimensions: ideas, institutions and material practices. As I outlined in the introductory chapter, the citizen monitoring initiative in Puno draws upon a human rights-based approach to health in order to reposition the citizen monitors in power relations. I will examine the strategies used for doing so in chapter five.

2.3.3 Struggles Within the Contested Sphere of Reproductive Health Care

Women’s reproductive health care is a potentially contentious area involving particular networks of power relations. Reproductive health care is an important issue for women, and not only because of its significance for health and wellbeing. It also influences sexual and reproductive freedom and therefore has implications for the political and economic lives of women, including their opportunities for work and education and the burden of care they may experience in the household (Doyal, 1995). However, women’s reproductive health care can also attract unique kinds of attention because of how it is implicated in broader political, social and ideological issues. Within the sphere of social reproduction, this can make reproductive
health—and the state’s involvement in reproductive health care—a particularly contested terrain.

Studies by historians and feminist scholars have shown that state intervention into reproductive health has often been guided by the priorities of nation-building or capital accumulation (Contreras, 2004; Necochea, 2014; Yuval-Davis, 1996, pp.18-9). This can involve promoting population growth among groups deemed to be desirable contributors to the labour force or favoured members of the nation. It can also involve efforts to limit demographic growth among groups identified as undesirable (Yuval-Davis, 1996, pp.18-22). Issues related to reproduction and sexuality are present in structures of gendered, racialized, class and ethnic stratification. Efforts to exercise controls over women’s sexuality are rooted in gendered relations of power and inequality (Doyal, 1995; Sen & Ostlin, 2008). These efforts often derive from ideological or cultural struggles to maintain gender subordination (Sen & Ostlin, 2008, p.5). Thus, reproductive health care can be embroiled in political issues related to the policing of sexual morality and the roles of women in domestic and public life (Htun, 2003). Gendered and other forms of inequality are also involved in the neglect of women’s reproductive health needs, particularly among excluded groups (Doyal, 1995).

The intersection of racialized and gendered oppression in reproductive health is particularly visible in relation to the population control movement. Both colonial and post-colonial states have sought to exercise controls over reproduction and fertility, particularly among marginalized populations. Studies of the population control movement, from its origin in the 19th century with
an emphasis on eugenics, to its role post-World War II and much beyond in the international development agenda, show the heavily gendered, class and racialized biases that have been embedded in population programs (Hartmann, 1995; Connelly, 2008). Hartmann critiques how, in the context of anti-Communism and the Cold War, the population-control movement constructed poverty, famine and environmental degradation as consequences of population growth, as opposed to problems rooted in patterns of deep social inequalities. She observes that family-planning programs carried out in the global south have often been coercive in their approaches and have not offered adequate contraceptive choice, follow-up services or counselling around family-planning options (Hartmann, 1995). Up until the mid-1990s, it was common for major donors such as USAID to tie development funding to the promotion of population programs, as a source of pressure on Global South countries to prioritize these initiatives (Connelly, 2008; Yuval-Davis, 1996, p.21).

In summary, different coalitions of actors may attempt to exercise controls over women’s reproductive health and health care for a wide range of reasons, including capitalist interests in reproducing the labour force, concerns over nation-building, the policing of morality, maintaining gender subordination, controlling undesirable populations or development-oriented population control (Morgan & Roberts, 2009; Yuval-Davis, 1996). Women who are struggling to increase their reproductive autonomy through access to reproductive health care may face different types of organized opposition. Conversely, social movements and other actors have sought to expand the control and autonomy of women over reproductive decisions. Local groups seeking to improve women’s reproductive health have found important allies among transnational movements promoting women’s rights and human rights (Morgan and Roberts,
Thus, the degree to which women are able to be in control of their own reproductive decisions and health needs is a site of struggle in which a whole range of power relations (gendered, economic, political, racialized, etc.) and actors may be implicated. For citizen monitoring, this means that the struggle to influence the state’s involvement in reproductive health care may be complicated by multiple and competing political projects.

2.4 Conclusion

This chapter has sought to create a theoretical and conceptual approach with which to understand and explore some of the diverse challenges involved in mounting a governance initiative aimed at governing state involvement in providing reproductive health services to marginalized communities. I have argued that the initiative is an instance of struggle by indigenous women in Puno in a larger battle concerning the distribution of the costs and burdens of social reproduction and the role played by the state. Conceptually, it is helpful to analyze the initiative as an example of governance “from below” in which members of a marginalized social group are attempting to shape how reproductive health care services are delivered to their communities. This analysis requires that particular attention is paid to how citizen monitors and their allies are able to negotiate the networks of power relations with which the monitors must contend in their efforts to govern health care service delivery.

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33 Morgan and Roberts develop the term “reproductive governance” to describe the ways in which different actors come together to influence reproductive behaviour (2009:12). They use the term to refer to “the mechanisms through which different historical configurations of institutions, churches, donor agencies and NGOs—use legislative controls, economic inducements, moral injunctions, direct coercion and ethical incitements to produce, monitor and control reproductive behaviours and practices” (Morgan & Roberts, 2009, p.12).
Chapter 3
Research Methodology and Methods

3.1 Introduction

In 2009, I spent three months in Peru doing exploratory research for this doctoral dissertation. During my stay, I was fortunate to have the opportunity to attend a workshop on health and human rights organized by ForoSalud, CARE Peru and a scholar from the University of Toronto. Over lunch, I sat next to and began an in-depth conversation with a woman from Puno who turned out to be the coordinator of CARE Peru’s citizen monitoring program in that region. I was fascinated by her account of their work and how the project was attempting to reshape citizen engagement with the Peruvian health system, in particular in relation to the role of indigenous women.

34 The workshop was co-organized by Dr. Lisa Forman from the University of Toronto and Dr. Ariel Frisancho from ForoSalud/CARE Peru. It was entitled “The Right to Health, Access to Medicines and Trade Rules: Rights-Based Policy Options For Accessing Medicines in Peru” (Canadian Institutes of Health Research, University of Toronto’s Comparative Program on Health and Society, CARE Peru. Lima, Peru, July 20-21, 2009).
My interest in Peru stems from long engagement with social justice issues there and, more broadly, in Latin America. I lived in Peru from 1999 to 2001 while I was working as a program officer for the United Nations World Food Program. This coincided with the final, tumultuous stages of the Fujimori regime and the subsequent democratic transition. Since that time, I have lived and worked in other parts of the world, but before 2009, I had not had the opportunity to return to Peru. During my exploratory research trip, I was struck by the many changes, both small and large, that had taken place during my eight-year absence. I noticed that some aspects of the public discussion concerning social exclusion in the country had changed. One interesting development was that human rights discourse was being increasingly used by both civil society actors and by government in public debates in relation to social issues. To be sure, human rights were previously invoked by civil society and government opponents, but chiefly in relation to civil and political liberties. Now, civil society groups were claiming new citizenship rights, including the right to oversee government administration as a way to ensure fairness and equity.

When I returned to Peru in early 2010 for further scoping work, these dynamics seemed even more pronounced. As I met with academic and activist contacts working on public health issues in Lima, the project in Puno kept returning to my mind. It seemed to represent a new kind of politics in the country, a politics aimed at developing practical strategies for addressing Peru’s deep divides. In Latin America, indigenous women have long suffered from exclusion and discrimination in health care. Here, the initiative in Puno seemed to be taking advantage of new political opportunities for making and enforcing claims against the state for inclusion.
My preliminary research also revealed a significant number of transnational connections underlying the project. These included interconnections relating to financing, sharing expertise and the spread of transnational discourses. These factors sparked my longstanding interest in global-local interconnections and collaborations and helped persuade me to focus my doctoral research on this initiative in Puno.

3.2 Methodological Orientation: Institutional Ethnography

In the sections that follow, I will outline my methodological orientation, research methods and research dissemination strategies for this study.

3.2.1 Overview

This is a qualitative research study that draws, in particular, on the methodological orientation of Institutional Ethnography (IE). Institutional ethnography was first developed by feminist sociologist Dorothy Smith. It is based on the premise that analyzing the experiences of a particular group of people can provide an important vantage point from which to understand a broader set of social and institutional relations (Smith, 2006). Researchers using IE begin locally in the actualities of people’s everyday lives and seek to explore how those actualities are brought into being, with specific attention paid to processes of management and administration (Church, 2002). Certain research methods, including participant observation, interviews and
textual analysis, are integral to an IE approach—although not all of them are necessarily used together. Campbell and Gregor conceptualize these methods as generating “entry level data” through accounts of everyday experiences in local settings, and “second level data” that help track relationships beyond the local settings (Campbell & Gregor, 2002, p.81).

Institutional ethnography involves three key components: (1) the identification of a core problematic that a researcher seeks to explore in the study, (2) attention to the daily work processes (or “work knowledge”) of a particular group of people that serves as the entry point for the study, and (3) an awareness of what Smith calls “ruling relations.” This term refers to the coordination between people’s daily work activities and the use of particular kinds of discourse and texts—for example, those found in government policy documents (Smith, 2006). I address each of these components and detail how they relate to my own study below.

3.2.2 Institutional Ethnography: Identifying a Problematic

Investigations that draw on IE focus on an initial “problematic”: a potential tension perceived in the daily activities of a targeted group of people that merits further exploration (Campbell & Gregor, 2008). Often, researchers drawing on IE as an approach begin with a loose idea of a problematic and further refine it as the investigation proceeds. This has been likened to grabbing a ball of string, finding a thread and then pulling it out (DeVault & McCoy, 2002).
My investigation begins from the standpoint of a group of predominantly rural, Quechua women and focuses on their oversight activities of local reproductive health service delivery in their districts’ public health facilities. These women are members of marginalized communities who face intersecting forms of discrimination. Complex power relations based on gender, ethnicity, language and class permeate the social relations that have traditionally shaped these women’s unequal engagement with their local health facilities. These same women are now seeking to play an oversight role as monitors in those health facilities. The initial problematic within my study concerns how the women navigate this monitoring process, given the tensions embedded in historically uneven power relations between themselves and those working in the public health system. Identification of this problematic helped me to shape my research questions and research design.

3.2.3 Institutional Ethnography: Work Knowledge

The concept of “work knowledge” is central to institutional ethnography (Smith, 2005, p.151) and integral to my methodological orientation within this study. Work knowledge moves beyond the idea of paid work to encompass “anything done by people that takes time and effort, that they mean to do, that is done under definite conditions and with whatever means and tools, and that they may have to think about” (Smith, 2005, p.152). Sociologist Marjorie DeVault explains that:

Institutional ethnographies are built from the examination of work processes and study of how they are coordinated, typically through texts and discourses of various sorts. Work activities are taken as the
fundamental grounding of social life, and an institutional ethnography generally takes some particular experience (and associated work processes) as a ‘point of entry’ (DeVault 2006a, p.295).

I use the notions of work process and work knowledge to help me explore and understand the work, roles and working relationships of the citizen monitors in Puno. I begin with an examination of the daily monitoring work done by this group of women to promote governance of reproductive health service delivery. I subsequently link how their work is coordinated with key national and transnational policy documents and discourses, especially as these relate to reproductive health and human rights.

3.2.4 Institutional Ethnography: Texts and Ruling Relations

Integral to an IE approach is an examination of the role that texts and discourse play in organizing people’s everyday activities. Texts such as legislation, government policies and instructions (for example, training manuals) are often highlighted when using institutional ethnography (Bisaillon, 2012). Texts and discourse are seen as a channel through which people’s activities in their local world are coordinated or linked with broader settings. In my

35 In her analytic glossary, *Institutional and Political Activist Ethnography*, Laura Bisaillon defines texts as “material artefacts that carry standardizing messages.” She explains “texts can include, but are not limited to, print, film, photographs television, mass and electronic media, and radio.” (p. 620). She uses Mykhalowksiy’s definition of discourse as a “systemic way of knowing something that is grounded in expert knowledge and that circulates widely in society through language including most importantly language vested in texts” (Bisaillon, 2012, p.610 from Mykhalovskiy, 2002, p.39).
own study, I focus in particular on key Ministry of Health policy documents related to reproductive health and citizen monitoring, as well as on discourse related to human rights.

Early writings by Smith on institutional ethnography highlight the importance of “ruling relations,” seen primarily as relations of domination, in shaping people’s everyday experiences and work processes. More recent studies by other authors using an IE approach have developed a more nuanced understanding of ruling relations. One scholar notes, for example, that actors can successfully challenge ruling relations in one setting yet be dominated by them in another (Kinsman 2006, p.143, from Murray, 2011). This is consistent with other strands of institutionalism that see relations between state and civil society in a more fluid and dynamic way than in Smith’s early work (Meyer & Rowan, 1991; Scott & Meyer, 1991). My own study takes this approach, as I explore the ways in which the citizen monitors both challenge existing rules, norms and procedures in some instances, and are simultaneously constrained by them in others.

### 3.2.5 Institutional Ethnography and Health Research

Over the past two decades, a growing network of researchers has drawn from IE to shape their investigations, including research related to health and health systems issues (McCoy et al., 1994; Mykhalovskiy & McCoy, 2002; Campbell & Gregor, 2008). While this approach originated in Canada, it has been increasingly applied in international settings. For example, in a recent article in the Latin American journal *Saúde & Transformação Social* (Health and Social
Transformation), the author uses an IE approach to draw out an “analysis of power relations that regulate the everyday practices in health institutions” through her focus on a maternal/newborn health program in Brazil (Véra, 2011, p.58). My own study, which applies IE within the context of participatory governance of reproductive health services, will add to this body of literature.

3.2.6 Institutional Ethnography and a Case Study Approach

Although I rely primarily on IE to orient my methodological approach, there are elements of my research design that are also consistent with a case study approach. Creswell identifies case study research as “the study of an issue explored through one or more cases within a bounded system (i.e., a setting, a context)” (Creswell, 2007, p.73). In my own study, I explore a particular set of issues—the monitoring of the delivery of reproductive health services—within a specific geographic context: two districts in Puno, Peru. In the Encyclopedia of Case Study Research, Bonnie Slade highlights a subtle difference between case study research and IE. She argues that, unlike traditional case study research, IE does not primarily seek to generalize from or compare local phenomena (Slade, 2009). Instead, IE research aims “to expose how larger power relations shape local experience” (Slade, 2009, p.462). This is what I intend to do in my study.

3.3 Research Methods

In this section, I outline the specific research methods that I used to conduct my study. I purposely began my research activities in Puno. This is consistent with an institutional ethnography approach, which focuses on grounding one’s research in the work processes of a
particular group (in my case, the particular work of the citizen monitors) and then tracing the work outward, to draw links with broader social processes (Smith, 2005).

In the following section, I will discuss my site selection, followed by the procedures I used for data collection, including how I conducted interviews and documentary data collection. I will conclude this section with a discussion of my data analysis procedures.

### 3.3.1 Site Selection

This study foregrounds the local as its point of departure. As noted earlier, however, in relation to the citizen monitoring initiative in Puno, there is a steady movement of actors, ideas and ideologies across national and transnational spaces. Although the primary actors (the citizen monitors) remain in Puno, the project has ongoing contact with other actors in the capital city of Lima as well as with transnational actors within the health and human rights community. As Gille and Ó Riain observe, “ethnographic sites are always and everywhere embroiled in an intermeshing network of multiple sites of social action, operating across multiple spatial scales and levels of social structure” (2002, p.286).

Initially, I intended to examine citizen monitoring in two departments of Peru: the initiative in Puno and another citizen monitoring initiative being implemented in the department of Huancavelica. CARE Peru and ForoSalud were also piloting the same citizen monitoring model in Huancavelica. Studying two sites would have allowed me to understand the design and
implementation of the initiatives in their different contexts. However, as I began to formalize my research design, it became clear that carrying on this work in two regions was beyond the scope of a doctoral study. Each region has its own specific, rich history and socio-cultural context that would have been difficult to draw out in the limited time available to complete a doctoral project. I chose instead to conduct a single field study, with a specific focus on the work in the provinces of Azángaro and Ayaviri/Melgar in the region of Puno.

3.3.2 Data Collection

3.3.2.1 Overview

Primary data collection for this study drew on research methods that were influenced by an institutional ethnography orientation (Campbell and Gregor, 2002; Eastwood, 2005; DeVault and McCoy, 2006; Smith, 2006). For my main data sources, I used interviews conducted with actors situated in a diverse range of social and geographic locations, along with document analysis of key texts. In total, I conducted 53 interviews during a one-year period between 2010 and 2011 (see Annex M). Twenty of these interviews were with active citizen monitors in the Puno provinces of Azángaro and Ayaviri, from June to August 2010. Three of the interviews were with inactive monitors. In March 2011, I interviewed three of the active monitors a second time, to further understand their perspectives and to see if there were any new developments with their work as monitors. The inactive monitors remained so throughout the study, so there was no need to interview them a second time. During the same month I also interviewed 20 key informants from Puno. These were a range of strategic stakeholders connected to the monitoring process, including local health officials, front-line health workers and civil society actors, as
well as staff from the *Defensoría del Pueblo* and the regional office of the National Public Health Insurance Program. In June and August of 2011, I interviewed 10 key informants in Lima. These were people who held senior positions within the Ministry of Health and civil society actors from national and transnational organizations involved in reproductive health and in citizen engagement.

Research data for this project were collected in four phases. Phase I took place from June through August 2010 and involved the collection of background information, the 20 interviews with active citizen monitors and the three interviews with former monitors. This was also an opportunity to immerse myself in the local context of Puno. When I had lived and worked in Peru in the late 1990s, I had done several brief trips to Puno but had not spent an extended period of time in the region. This study offered me a different field experience from any I had done in the past, and allowed for a particular space and context in which to consider my research findings.

Phase II took place in March of 2011 and consisted of my 20 key informant interviews with a range of actors in Ayaviri, Azángaro, and the city of Puno. I was also able to conduct three follow-up interviews with citizen monitors from Ayaviri and Azángaro. Phase III of my fieldwork took place in May of 2011, when I returned to Lima to interview six government officials in the Ministry of Health. Phase IV took place in July and August of 2011, also in Lima. There, I conducted an additional four key informant interviews with people connected to national and transnational civil society organizations and the United Nations.
I divided my data collection into these four distinct periods based on logistical realities that prevented me from spending one long, extended portion of time in Peru. The different time frames meant increased travel cost and time between my home base in Canada and my research sites in Peru. But it also offered some benefits. Distinct data collection phases provided time to do a rough analysis of my data prior to commencing the next round of interviews. Congruent with an IE approach, each level of data allowed me to identify key themes and determine whom best to interview in the subsequent phase (DeVault and McCoy, 2006).

3.3.2.2 Local Networks and Research Assistants

When I was still in the planning phase of this project, a senior anthropology professor at Lima’s Universidad Católica shared a useful piece of fieldwork advice with me. She had past experience conducting research in Puno and advised that qualitative research of the type I had planned was best done with the aid of “insiders,” a respected local person or people from the region who would be willing to open doors for me, help me to make initial research contacts and generally introduce me to the relatively small and tight-knit community. She felt that I would be far less successful if I tried to approach people on my own, without those initial introductions. I took that advice to heart and tried to listen and follow the cues from the knowledge and experience offered to me by a few of the local women practitioners in Puno. Two NGO practitioners in particular opened several important doors for me through their own networks. Through this approach, I was introduced to these people’s networks and was able to connect with a variety of actors situated in diverse locations and institutional circumstances in the
region. I eventually interviewed some of these people in my study, while others provided valuable assistance by helping me to identify and locate important background information and documents.

In order to support my data-collection process, I also hired two women from Puno as research assistants. Both were recent graduates from the local university and had experience conducting research interviews. Through a prior research project, they had conducted some survey interviews with the local women involved in the citizen monitoring process and had visited the local health facilities in Azángaro and Ayaviri included in this study. Based on the advice I had been given about the best ways to navigate qualitative research in Puno, I considered their prior knowledge and experience an important asset. These women played an important bridging role for me as insiders in the region, helping me to conduct my fieldwork. Both women were native Spanish speakers but also competent in Quechua. The citizen monitors were bilingual Quechua/Spanish speakers, but their first language was Quechua. Both research assistants signed a confidentiality agreement to ensure privacy around all aspects related to their interactions with the research participants. To my knowledge, the research assistants did not continue their conversations with the monitors after my departure from Puno.

I provided initial training with the research assistants by briefing them on the research project and discussing interview techniques. Together, we conducted some mock interviews with one another to practice using the semi-structured guide. One research assistant was present with me during each of the subsequent interviews with citizen monitors. This helped to ensure that we
found the prime locations across the two provinces, and that the interviewees understood the questions and were comfortable with the process.

### 3.3.2.3 Recruitment of Citizen Monitors

Soon after my arrival in Puno, I attended the monthly meeting of citizen monitors in Azángaro and in Ayaviri with the two research assistants. There, CARE Peru staff introduced me to the assembled group and I explained my research project and answered their questions. We recruited participants orally on a voluntary basis. The research assistants were integral to the recruitment process. After my initial presentation, we all made ourselves available to answer individual questions from women who were potentially interested in volunteering to be interviewed. The research assistants also helped to work out the logistics of the interviews, including scheduling times and negotiating locations that were convenient for the women.

The project had approximately 100 citizen monitors at the time of this study, with roughly 70 of them active in the provinces of Azángaro and Ayaviri. In my purposive research sample, I included 20 active monitors, 10 from Azángaro and 10 from Ayaviri. My sample took into account a mix of age, length of time performing monitoring activities, and a mix of different kinds of health facilities (hospital, health centre, health post) where they performed their monitoring duties. Together, the monitors covered a total of seven health facilities: two hospitals, one birthing centre, one health centre and three health posts.
In addition, I sought help from the Puno-based CARE Peru staff to identify women who were no longer active as citizen monitors. The research assistants were familiar with the women, and so we were able to approach them to ask if they would be willing to be interviewed for the research project. In total, I interviewed three inactive monitors to gain insight into the work they had performed and their reasons for discontinuing their involvement in the monitoring program.

### 3.3.2.4 Interview Process with Citizen Monitors

I prepared a semi-structured interview guide for the participant interviews (see Appendices A and B). This allowed me to explore local women’s involvement in the monitoring process and their linkages with other actors and broader structures. I drew on institutional ethnography to help me in the design of the guide. In particular, I focused on questions that would allow me to further understand the daily work of the monitors within the health facilities (for example, see questions #4 through #6 in *Citizen Monitor Interview Guide – Annex A*). Mapping how people’s everyday work is linked with the work of others in different social locations is central to helping conceptualize broader relations that coordinate local processes with external forces. This orientation suited my research questions. I also explored with the women their prior experiences with reproductive health service provision, as a way of better understanding their contemporary practice (for example, see question #2 in *Citizen Monitor Interview Guide – Annex A*). It was here that a historical perspective first emerged clearly and provided the basis from which to track down primary documents and reports from the 1990s and early 2000s.
Cross-cultural and translation issues can present significant challenges to this kind of research. I took various steps to mitigate these challenges. I prepared the interview guide in English and then had it professionally translated into Spanish in Lima (see Appendices A and B). I then vetted the guide with practitioners in Puno, as well as with the two research assistants, to ensure clarity and accuracy in the wording of the questions. As well, I ensured that the two research assistants had prior experience with qualitative interviewing and were able to communicate in both Spanish and Quechua.

One of the research assistants and I pilot-tested the guide by interviewing a citizen monitor prior to formal commencement of data collection. The test interview helped to refine and to further validate the guide. Some questions were omitted as repetitive, while the wording of some others was clarified or simplified. Results from the pilot interview were not included as part of the final study sample.

I conducted the actual interviews with the monitors over a six-week period in July to August 2010. This involved a great degree of travel between far-flung sites in Azángaro and Ayaviri. I would depart at dawn by public transport accompanied by one of the research assistants and return to the city of Puno late in the evenings.

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36 Given that all of the citizen monitors were bilingual Quechua/Spanish speakers, I chose not to translate the participant interview guide into Quechua. This allowed me, as a Spanish-speaking but non-Quechua-speaking researcher, more direct access to the research data and made data analysis more manageable than working between Quechua, Spanish and English. On occasion, one of the research assistants would orally translate a Spanish word into Quechua during an interview if a question needed further clarification.
The interviews with the monitors took place in various locations, depending on what was most convenient for them. Sometimes, I conducted the interviews in the monitor’s homes, but at times I used space in a public building, such as a room in the local municipal offices. Most of the interviews ranged from 45 to 90 minutes. I recorded the data and took notes during each interview. By the end of the 20 interviews it was clear that the data gathering had reached saturation, as many of the same themes emerged repeatedly.

Each citizen monitor interviewed in this study was offered a research honorarium. This was given as recognition of the time spent by the monitors during the interview process, including transit to the interview locations—time that otherwise would have been devoted to their many other responsibilities. The amount was based on factors such as honoraria paid in other studies that had been conducted in the region in recent years as well as on advice from local practitioners.

Once data collection was underway, I organized weekly group debriefs with the research assistants. This was always a fascinating process. When we discussed the week’s interviews, we talked over anything notable that stood out. We discussed aspects of the interviews that had

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Interviewees were informed of the honorarium prior to the start of the interview, as part of the consent process. They were also clearly told that they could terminate the interview at any stage prior to its completion and that this would not affect receipt of the research honorarium.
gone more or less smoothly. This group discussion helped to ensure consistency and quality control throughout the interview phase. It also served as a space in which I could pose questions and seek insights from a local Puno perspective. I took many field notes during those group sessions, and incorporated my impressions when I began data analysis.

3.3.2.5 Policy-Level Key Informant Interviews

I returned to Puno in March 2011, six months after my round of participant interviews, in order to conduct interviews with key informants. Based on a preliminary analysis of my interviews with citizen monitors in Azángaro and Ayaviri, I generated a purposive sample of key informants located in Azángaro, Ayaviri and the city of Puno. The entry-level data from the citizen monitors pointed to certain areas for further investigation and follow-up and helped me to determine whom to approach for interviews. These included a number of health workers of different levels and from different health facilities, some senior health officials, staff from the Defensoría del Pueblo, the Health Insurance Office (SIS), CARE Peru and municipal officials. I conducted a total of 20 key informant interviews. Recruitment was conducted through direct phone calls and the presentation of an official request by letter. In some cases, this process was also facilitated by a phone call from local CARE Peru staff. Their bridging role helped make it possible to access extremely busy institutional actors. Some recruitment was also done using a “snowball” technique, with one interviewee suggesting another potential informant.

The same research assistants who were involved in the first phase of the data collection process helped to arrange the logistics (scheduling and locations) for this set of interviews. I conducted
the key informant interviews on my own, however, as they were conducted completely in Spanish. Since the interviews took place during work hours, no research honoraria were provided to the informants, although they were given a small thank-you gift at the end of the process for their participation in the research process.38

In May and August 2011, I travelled to Lima, the capital of Peru, to interview national and transnational key informants. Based on initial analysis of my local data from Puno, my objective was to better understand the broader social relationships of national and transnational actors and how they mapped onto the citizen monitoring process in Puno. These interviews were anonymous, in order to create more space in which respondents could be candid. I conducted a total of 10 interviews in Lima. These included informants from the Ministry of Health, the United Nations and members of civil society organizations involved in reproductive health and citizen monitoring. I recruited informants either through direct request or by snowballing, with one informant contacting another and helping to arrange an interview for me.

3.3.2.6 Documentary Data

Texts are an important source of data within institutional ethnography. Texts are broadly defined and can include a range of sources. Some of the types of texts commonly used within an institutional ethnography approach include instructions, policies, regulations and formal legislation (Bisaillon, 2012). An important aspect of the analysis of texts in IE involves

38 The gift for policy-level key informants was a small box of Canadian maple candies.
understanding how they are “activated” by their engagement with people in local settings (Campbell & Gregor, 2002, p.33; Eastwood, 2005).

A challenge with the inclusion of documentary data is the danger of becoming overwhelmed with text. I chose my initial texts for inclusion carefully, based on the key issues that emerged through my entry-level interview data with the citizen monitors. These were supplemented with additional text as I proceeded with policy-level key informant interviews. I divided my selection of text into three categories. The first category consisted of text used as “tools” in the regular work of the citizen monitoring process. (Some examples include the reporting format monitors used after each health facility visit, as well as the official written badge they wore as “accreditation” to gain access to the health facilities). The second category comprised text stemming from a national law and policy context that had clear linkages with the citizen monitoring work in Puno. In particular, I focused on official policy resolutions from Peru’s Ministry of Health that were mentioned during interviews (for example, the Ministry of Health’s Resolution #598-2005: Technical Norm for Attention to Vertical Birthing and Intercultural Adaptation, as well as the Ministry of Health’s Resolution #040-2011: Policy Guidelines for Citizen Monitoring in Health). Finally, in the third category, I included key texts that linked the citizen monitoring work with transnational human rights discourse. Examples in this category include international human rights law documents pertaining to the right to health, such as the 2009 UN Human Rights Council’s Resolution on Maternal Mortality, as well as the 2005 report from the then UN Special Rapporteur, Paul Hunt, Right of Everyone to Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report on UN Special Rapporteur’s Mission to Peru.
I am confident that my choice of textual data was relevant and directly linked with my interview data. At the same time, as is the nature of institutional ethnography, I am also fully aware that there could have been other texts to include that would have led me in other directions. This is the nature of this type of investigation and as a researcher I needed also to base my decisions on what I believed to be a realistic amount of textual data to manage within a doctoral project.

3.3.2.7 Grey Literature

Grey literature in the form of project documents and reports also served as important supplementary material. To help with my historical chapter, I gathered many documents on the ReproSalud project available through the library of the Lima-based feminist NGO Movimiento Manuela Ramos, which had implemented the project from the mid-1990s to the mid-2000s. I also gathered documents from the USAID-funded Project 2000 program from that period. Project 2000 was initiated in 1993 and was intended to help strengthen the Peruvian Ministry of Health’s maternal and child health services (Coe, 1998). To further inform my understanding of the contemporary period, I looked at project documents from CARE Peru and public documents available from ForoSalud, the National Human Rights Ombudsman’s Office, as well as key Ministry of Health reports and action plans on maternal health and on sexual and reproductive health. I also reviewed key reports by transnational organizations that focused on reproductive and maternal health and rights, in particular those that looked at these themes in relation to governance and accountability.
3.3.3 Data Analysis

3.3.3.1 Working with the Data

Interview data were transcribed by the research assistants in Puno as well as by an additional assistant from the Catholic University in Lima who regularly works with social scientists involved in field research in Quechua-speaking areas of Peru. I also listened to all of the audiotapes myself, while simultaneously looking at the written transcripts, to re-familiarize myself with the data and check for accuracy.

In line with an approach to analysis used in institutional ethnography, I looked for “chunks of data” that would help me identify the way that work processes were coordinated and linked together between the local and the extra-local (Devault and McCoy, 2006a). I had already read scholarly literature on my topic area, as well as initial project documents and other grey literature to provide context for my research. From there, I began by delving into my first set of interviews with the citizen monitors. In particular, I made initial notes on the types of text the interviewees referred to when describing step by step their work as monitors in the local health facilities (e.g., report forms and badges). This helped me to create inclusion categories for the selection of my textual data and to begin to look directly at these key texts. I came to consider these as “tools” used directly by the monitors, often in strategic ways. They helped to organize the monitoring process by directly linking the monitors to other institutional actors. As I repeatedly reviewed my data from the citizen monitors, key themes and subthemes emerged; these were related to, for example, the monitors’ ideas about human rights and how they applied
these in their work as monitors, as well as themes and subthemes related to their experiences of exclusion and discrimination.

Analyzing the interview data helped me to identify particular historical events and circumstances that encouraged the indigenous women to be citizen monitors. I used that information as a way of tracing backwards, drawing on grey literature, government documents and scholarly sources to understand how these women’s involvement in the ReproSalud project in the 1990s and early 2000s laid the groundwork for their current work as monitors. Then I worked forwards, looking for the ways in which their daily activities as citizen monitors were coordinated with broader processes beyond those taking place in their daily interactions in the health facilities. As well, these first interviews with the citizen monitors helped me to identify the policy-level actors to interview. For example, the monitors’ frequent reference to the Defensoría made it clear that I should interview staff there, so that I could further understand the linkages. As well, reference to particular national Ministry of Health Resolutions helped me to narrow down the types of policy-level interviews to conduct with Ministry of Health staff in Lima.

In this way, my data analysis was an interactive process that gradually allowed me to create a narrative. I moved directly between chunks of interview data, textual data and back again, building my understanding of how citizen monitoring was organized. This form of data analysis, consistent with an IE approach, allowed me to build an understanding of the administrative and governance processes involved in the monitors’ daily work and to draw out the power relations
that are, in part, textually coordinated by their use of project report forms, key Ministerial policy guidelines and international human rights discourse. I also went back to my field notes and written interview notes to look for instances of body language, tone of voice and other nonverbal gestures that would be missed through the transcription process.

3.3.3.2 Quality of Data

The trustworthiness of the data and interpretation was enhanced through my use of interviews with a wide range of stakeholders located in different social locations whose stories corroborated each other’s experiences. An analysis of related texts pointed to the same themes. My own prolonged and consistent engagement with the research process and periodic debriefings with faculty and key stakeholders also helped to ensure the reliability of my interpretation.

3.4 Ethics Procedures

In compliance with University of Toronto policy, I submitted an ethics protocol that was approved by the Research Ethics Board of the university in 2010. It was renewed in 2011, 2012, 2013 and 2014 (see Appendix K). In Peru, the entry point for conducting this research is through CARE Peru. There is no formal ethics review mechanism within that institution. In lieu of an internal ethics committee, the CARE Peru’s Health Team National Coordinator was asked to
provide ethics comments on the dissertation proposal. Based on this consultation, CARE Peru provided a letter of endorsement of the research that was included in the submission to the University of Toronto’s Ethics Review Board (Appendix L).

Based on consultation with an officer from the University of Toronto’s Research Ethics Office and with researchers from Peru, I opted to ask for oral consent for interviews. As per my ethics protocol, I recorded oral consent in a notebook that I kept safely with my research transcripts. Participants were given a copy of a letter (in Spanish) for their own records that outlined the interview process and the consent procedure (see Appendices E, F, G & H). The identity of all participants has been kept confidential, and they are identified only using a code in the results presented in this study. To further enhance confidentiality, the research assistants from Puno and the person from Lima who assisted with transcription all signed confidentiality agreements prior to accessing the data (see Appendices I and J).

I sought advice on the appropriate use of incentives for research from researchers in Peru and from practitioners in Puno. Initially, I had intended to offer a small in-kind honorarium (food or goods) to the citizen monitors who participated in the study, in recognition of the time they committed to the study that they would have used for other activities. However, my advisors recommended that it was more appropriate to offer cash instead of in-kind goods. This allowed interviewees the flexibility to use the honoraria in the manner most needed. The set amount was based on suggestions from people in Puno, in line with best practice in the region. I offered these honoraria only to citizen monitors, since the policy-level key informants participated in the
interviews during their work hours. I explained to the citizen monitor interviewees that they could end the interview at any time and that they would still receive the full research honorarium. As noted earlier, I did give a small gift of to each of the policy-level key informants as a token of appreciation on completion of their interviews.

One area where I was especially aware of the ethical dimensions of my study was in regard to my relationship with staff from the NGO, CARE Peru. CARE Peru was the main institutional partner supporting the citizen monitoring program during the time of my data collection (although other organizations provided assistance as well). It would not have been possible to conduct my study without the access that CARE Peru facilitated for me. They provided me with program documents, allowed me to introduce myself to the citizen monitors during their group meetings and made themselves available for many fruitful and interesting, informal conversations concerning reproductive health and social inequality in Puno and in Peru generally.

To ensure the confidentiality and integrity of my work, I took a number of precautions. The nonprofit and health policy communities in Puno and Lima are both relatively tightly knit and it is likely that NGO staff would be familiar with many of the key actors that I would seek to interview. I was careful never to discuss interviews with the NGO staff, to maintain confidentiality concerning data collection at all times and to ensure that my research assistants understood the importance of this as well.
However, as part of my positionality as a student-researcher from a well-resourced university setting in the global North, I felt it was also important to me to “give something back” and to foster reciprocity with the NGO and its staff. I have worked extensively in non-profit organizations myself, and I am well aware of how external projects can take up scarce and valuable organizational time. One strategy I used was to share my initial broad impressions (without using names or institutions, and being careful to maintain confidentiality) at the end of each fieldwork trip. This was a way of providing feedback and early research results from my study that was relevant to the ongoing work of the NGO. I also arranged to make a joint conference presentation with one of the NGO staff at an international women’s congress in Ottawa that was attended by both academics and practitioners. This was consistent with my belief that reciprocity with those with whom we seek to collaborate is an important dimension in global health research. While I have written my doctoral thesis for an academic audience, I am also committed to discussing and working with the NGO after my dissertation is complete, in order to adapt relevant parts of my work into a document that would be of specific use to them.

3.5 Limitations of the Study

I am aware of a number of limitations in my study, some of which are related to the study’s scope. In order to make it a feasible project, I chose to limit the geographic scope to the region of Puno. It would have been interesting to compare developments in Puno with those of another region in Peru in which a similar program is underway. As well, I chose not to include participant observation and interviews with health care users within my data collection methods. Expanding the scope of my work in these various ways would have added to the depth and
richness of the data that I would have had at my disposal. A doctoral project is inevitably limited in terms of available time and resources, however, and I am confident that I was able to collect sufficient scope and range of data with which to effectively analyze and theorize concerning citizen monitoring of reproductive health service delivery in Puno. In future studies, it would be useful to compare the monitoring model in Puno to similar processes in other parts of Peru or even in other countries engaged in similar processes. As well, it would be interesting, if possible, to expand the scope of data-collection methods to include participant observation and interviews directly with health care users.

Another challenge that I encountered arose from the fact that much of my data collection took place during a time of political change within Peru. Regional elections were scheduled to take place in October 2010, a few months after my initial interviews took place in July 2010. My second round of interviews took place in March 2011. A new regional government was then in place, but things were still in flux in many of the institutions, including the Regional Ministry of Health. This meant that some public servants were reluctant to be interviewed.

The national political context also presented some challenges for my data collection in Lima. I conducted these interviews in two rounds, in May 2011 and August 2011. National elections were held in June 2011, right between these two periods. In May, I interviewed senior government officials within the Ministry of Health. Interestingly, I found that in the lead-up to the national elections, those informants were especially willing to be generous with their time. They were reflective about their experiences and relatively candid — far more than I had
anticipated given the timing. Nonetheless, upon my return in August 2011, there were other key informants in civil society organizations and government who were simply not available. For example, one prominent civil society actor had just taken a new key position within the Ministry of Health and was especially busy, while two others were unavailable due to their engagement in institutional planning processes. Each of these people suggested others for me to interview in their place, which I did, and I do not feel that this change significantly diminished the quality of my data, since I still had access to the written policy documents that I had intended to use as complementary sources of national-level data.
Chapter 4
Intersecting Currents: Participation, the State and Reproductive Health Care in Puno, 1990-2005

4.1 Introduction

In this chapter, I trace the developments affecting the field of reproductive health in Puno from 1990 to 2005, with special attention paid to the relations between indigenous women and publicly provided reproductive health services. The period from 1990-2005 is important for a number of reasons. During the 1990s, action by the state, international donors and domestic NGOs brought an unprecedented level of attention and investment in reproductive health oriented initiatives throughout Peru (Ewig, 2006; Rousseau, 2007). The period marked the first time human rights was introduced as an influential paradigm shaping ideas and practices related to reproductive health. Throughout the 1990s, reproductive health became an increasingly visible and contested arena in Puno. As well, new kinds of participatory spaces opened up for indigenous women, providing increased opportunities to engage publicly around reproductive health related themes.
Prior to the 1990s in Peru, multiple actors had been involved in reproductive health-related issues, often in tension with one another. For example, Necochea notes that the right-wing Belaunde administration of 1963-1968 was the first Peruvian government to officially adopt population control as a policy initiative, supporting USAID and foundation-financed family planning clinics. This approach was reversed by the subsequent government, led by left-wing military General Juan Velasco Alvarado, which adopted a pro-natalist stance and shut down family-planning clinics as a sign of resistance to U.S. influence in the country (Necochea, 2008:41). In tandem with the Velasco regime’s pro-natalist policies, however, the Catholic Church pursued its own unusual policy from the late 1960s through the mid-1970s, promoting “responsible parenthood” among families. This approach quietly allowed the use of modern contraceptives, including oral contraceptives, among its members (Necochea, 2008:41). During a similar period, from the 1970s onward, Lima saw the formation and rise of feminist organizations that advocated strongly for women’s health rights, including access to family planning and the prevention of violence against women.

These waves of activity were most visible in Lima and less evident outside of the capital, especially in the distant, systematically neglected region of Puno, more than seventeen hours by road from Lima. For example, in the realm of family planning, USAID channeled significant support through NGOs (Chavez and Coe, 2007). Yet one Puno informant noted that in her region, family planning and other reproductive health issues were not prominent on NGO agendas prior to the 1990s (Interview Anon 15, 2011). She did mention that the Catholic Church was a quiet protagonist, especially when foreign nuns who were Liberation Theology advocates arrived in the late 1980s and promoted some discussion among women about reproductive
wellbeing (Interview Anon 15, 2010). Traditional healers were another potential avenue of support for women’s health needs in their local communities. State-run health facilities, however, were scarce and were not sites that indigenous women commonly sought out for reproductive health care.

Several of the women interviewed in relation to the citizen monitoring initiative (examined in detail in chapter five) noted that they first started their public engagement with reproductive health in the new kinds of participatory spaces that began to emerge in Puno from the mid-1990s onward. This period was clearly formative for these women, and their experiences from that time inform their approaches to their current work as citizen monitors. My intention in this chapter is not to compare this earlier period with the citizen monitoring initiative that began in the late 2000s. Instead, my purpose here is to explore how many of the major themes of this study emerged and played out during this earlier period. This provides important insights that add depth to the analysis of the initiative. It also helps to explore the context and the learning experiences that led to the development of the initiative.

The chapter is divided into three time periods. During the first period, 1990-1993, reproductive health continued to be a neglected issue in Andean regions like Puno. The fragile public health care system provided limited services. Many indigenous women avoided public health care facilities due to experiences with cultural insensitivity, discrimination and abusive treatment. These matters were made worse by political and economic turmoil in the country. The new
president, Alberto Fujimori, introduced emergency austerity measures to deal with the country’s profound economic crisis, further constraining the quality of services.

The second period, 1994-2000, tracks a major shift as the state began to devote unprecedented attention and resources to reproductive health. Politically vulnerable at home and abroad, President Fujimori decided to champion women’s rights and to direct donor funds into reproductive health initiatives in an effort to build up both his international prestige and his popularity in rural areas. As well during this period, a Peruvian feminist NGO based in Lima secured international funding to launch “ReproSalud,” a major project intended to improve reproductive health among predominantly poor, indigenous women throughout Peru, including Puno. This project opened up new participatory spaces not only for urban, middle-class feminists but also for local indigenous women and recast issues related to reproduction within a reproductive rights paradigm.

The final period examined in this chapter, 2000-2005, begins with the fall of President Fujimori and his authoritarian regime in 2000. The transition to democracy brought a number of important changes and new opportunities for democratic citizen engagement. At the same time, the state continued its inconsistent and contradictory policies related to reproductive health. It further extended social welfare in relation to certain reproductive health issues, in particular maternal health, while curtailing access to other key services, in particular family planning. During this period, indigenous women involved in ReproSalud in Puno were recruited as volunteer maternal health promoters. They served as a bridge between their local communities
and health facilities, actively encouraging community women to utilize state-operated maternal health services. While there were some positive gains from the women’s participation as maternal health promoters, their enhanced contact with their health facilities shone further light on the deeply rooted legacies of discrimination, uneven power relations and severe structural constraints within the health system itself that continued to impede substantive improvements in the quality of reproductive health service delivery.

4.2 Reproductive Health Care in Puno 1990-1993: A Quiet But Profound Crisis

During the early 1990s, women’s reproductive health in Puno was characterized by three principal factors: (1) very limited access to public health services, (2) social silence regarding women’s reproductive health in general (and regarding issues such as contraception in particular), and (3) a climate of social exclusion that discouraged indigenous women from using public health facilities. While reproductive health issues were extremely important in the region given the troubling statistics, a combination of state neglect, social silence and marginalization of indigenous women helped to hide the crisis from public view.
4.2.1 Social Silence

One of the first things monitors noted in their interviews with me was that people did not talk openly about reproductive health issues. These were private topics that were most commonly dealt with in the home, among close relatives. In the early 1990s, family planning and related issues were not topics for public discussion in Puno. As one rural indigenous woman explained, “It was like a taboo. You couldn’t talk about it” (Interview Anon.3, 2010). While the reproductive health situation for women in Puno was one of the worst in the country, the problem was not addressed in public. This was just one of the barriers to effective action in dealing with the crisis.

4.2.2 The Crisis in Reproductive Health Services

During the early 1990s, the provision of reproductive health care services in Puno was in a profound crisis. Partly, this was due to the state’s longstanding underinvestment in social services and its particular neglect of “gray area” regions like Puno (O’Donnell, 2002, cited in Fleury, 2010). The problems associated with the uneven development of public health services in Peru were further exacerbated by two debilitating crises in the early 1990s. First, Peru was in the grip of a severe economic crisis brought about by years of mismanagement. By 1990, hyperinflation had reached a staggering 7,500 percent. The country’s GDP growth stood at negative 5.4 percent, while the value of real wages had declined by 79.6 percent. This had a

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39 I use the term “social silence” to refer to issues that are not talked about in public, despite their significance to people’s lives.
devastating effect on public health programs. In 1990, the Ministry of Health’s budget was only 15 percent of what it had been in 1980 (Ewig, 2004: 221 cited in Rousseau, 2007:100).

The effects of the crisis were further exacerbated by the radical structural adjustment policies undertaken under newly elected President Fujimori during his first years in office after 1990. A series of labour market reforms dramatically reduced workers’ rights and increased labour market flexibility. By 1991, social expenditures had hit a record low of 2.1 percent of GDP, the lowest level since figures began to be collected in Peru (Segura-Ubiergo, 2007:244). Meanwhile, large parts of the Peruvian population faced extreme economic hardship. From 1990 to 1995, average net wages dropped by 12 percent and the minimum wage declined by 30 percent (Segura-Ubiergo, 2007:251-251).

As well, during this period, political violence between the Shining Path revolutionary movement and Peruvian government forces was spiraling out of control (Stern, 1998). In Puno, the Shining Path was especially active in the northern, poorer and mainly indigenous Quechua areas of the region, while the southern, predominantly Aymara areas remained less profoundly affected (Interview Anon.15, 2011). The Shining Path had a strong presence in the two northern districts of Azángaro and Ayaviri, where the indigenous women interviewed for this study resided. By 1991, a state of emergency imposed by the central government in Lima was in place in several

40 For example, the Shining Path was responsible for the assassination of the mayor of Azángaro in 1989, as well as the destruction of the Catholic Church-run Rural Education Institute (Instituto de Educacion Rural “Waqrani”) in Ayaviri (Rénique, 1998).
northern provinces of Puno, including Azángaro and Ayaviri. Although a regional government had been officially installed by the Fujimori regime early in the decade, it was quickly evident that its political power was subordinate to that of the military command (Rénique, 1998).

These multiple crises dealt enormous blows to the public health care system. Rousseau estimates that by the 1990s, as many as half of the country’s 3,500 existing public health facilities “simply stood empty” (Rousseau, 2007:100).

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41 Peruvian historian José Luis Rénique notes the long and complex relationship between peasant communities in Puno and the central state. For example, in the mid-1980s, a vibrant regional movement of peasant groups opposed to the central government, but not aligned with the Shining Path, successfully held off the state’s imposition of a state of emergency, because they felt that it would give too much power to the military. They found valuable support for their position from Puno-based, Liberation Theology-oriented members of the Catholic Church (Rénique, 1998).

42 Amidst the profound economic and political chaos, longstanding patterns of social exclusion and discrimination particularly disadvantaged indigenous women. Women interviewed for this study cited instances of being called names such as “dirty pigs,” being kicked off buses and other racist practices as examples of the deep divides between themselves and more privileged members of Peruvian society. (Interview Anon.15, 2011). This discrimination was also reflected in the women’s interactions with public institutions. One interviewee recalled her own experiences in dealing with public services in the early 1990s:

I’ve struggled so much. I’m campesina [peasant] and I’ve been treated so badly, more than anything because I’m campesina. In the hospital and in the municipality they treated us terribly ... Women would be so sad when they’d go to an office. They wouldn’t serve us when we had on a [traditional] hat and skirt, they wouldn’t pay any attention to us. Other people would come, well dressed in their neckties – they preferred those people (Interview Anon.11, 2010).
4.2.3 Deep Patterns of Exclusion in Reproductive Health Care in Puno

During this period, indigenous women were deeply disconnected from the public health care system, particularly in the area of reproductive health care. Those who attempted to access the few available reproductive health services often encountered intense discrimination and poor treatment from the mainly mestizo, health workers who could have very different understandings of health, disease and culturally appropriate behaviour (Estrada, 2004). As I discussed in chapter one, these problems have a long history.

For example, one Quechua woman in Puno told me about her experience in a local health clinic in the late 1980s when she was trying to investigate her options around family planning. Her negative encounter not only resulted in her failing to receive appropriate care at that time, it also discouraged her from seeking state services for other reproductive health needs:

Even before Fujimori, they would just put things in you. That happened to me, because I went (to a health clinic). “I’m just going to examine you,” the nurse told me. After, she asked if she’d hurt me. I said no. “Well there, I’ve fitted you with a spiral [IUD]. Without my consent, without even consulting me!…”

Later, I went back to the clinic and I told the same nurse that my husband didn’t want it, that I wanted her to take out the IUD. “But your husband won’t notice,” she told me. “Just tell him you had it taken out.” I told her I couldn’t lie to my husband. She took it out and showed it to me. But she told me “don’t come back here saying you’re having another child. We’re not going to help you.” That’s why when I had another child I didn’t go (Interview Anon.10, 2010).
This woman’s experience reflects the paternalistic, discriminatory attitudes that indigenous women commonly encountered through their public health services. Coupled with structural constraints such as distance and cost, these were real barriers for indigenous women.

Cultural insensitivity was also a significant problem with reproductive health issues. This was a particularly the case vis-à-vis traditional indigenous birthing practices, which were not generally allowed in public health facilities. Official data estimate that throughout the 1990s, at least 90% of rural indigenous women in Peru gave birth in their homes, thus increasing the risk of maternal mortality, which at that time was the second highest in Latin America, after Bolivia (Mujica, Salazar & Cáceres, 2004). Birthing at home, however, allowed women to deliver their children in accordance with deeply held Quechua customs around childbirth. When going through labour and delivery at home, a woman would be accompanied not only by the birth attendant but also often by close family members. She would be given warm teas to help with labour, and herbs would be burned as incense. It was believed that darkness and warmth were important during labour and delivery, so light would be blocked off in the room by placing curtains over the windows, the woman would be given extra clothing and blankets to prevent her from getting cold, and a cloth would be placed over her head. A woman commonly delivered in a vertical position and a band was placed around her waist to help push the baby out. After

43 In the 1990s, “Peruvian experts identified two causes for high maternal and infant mortality levels: the low proportion of births taking place in health establishments, and the reluctance of and barriers faced by rural women regarding professional prenatal care” (Rousseau, 2007, p.109).
delivery, the placenta was given to family members to burn, as an offering to mother earth. The woman rested and was fed special warm foods, including caldo de cordero (soup made from lamb’s meat). After a period of rest, a family member would gently bathe the woman in warm, herb-infused water. These are healthful, traditional birthing practices (Estrada 2004; Davis-Floyd, 2000; Interview Anon. 2, 2010).

Despite the predominance of home births, some indigenous women did deliver in health facilities. In public health facilities, institutionalized practices related to childbirth were far different than those within rural indigenous communities. Indigenous health care users encountered a wide gap between their expectations and needs related to childbirth and the treatment they received from predominantly non-indigenous, bio-medically trained public health care providers, most of whom were from outside of Puno. Clashes often occurred. One Quechua woman from the Puno district of Ayaviri described her experiences of particularly rough treatment when she delivered her baby in the early 1990s:

One time I went to the hospital because I couldn’t give birth at home. And in the hospital they treated me terribly. As soon as they’d pulled out my son, they told me “Get up get up, you should be walking now. I got up and then I fainted. I don’t remember anything, only that I had oxygen in my nose and I was in bed again. They treated me horribly. I thought, how can they be like this? (Interview Anon 9, 2010)

Institutionalized birthing practices conflicted with those practiced in rural communities and left indigenous women vulnerable to mistreatment during childbirth in health facilities. Family
members were not always permitted to remain with women during labour. Since staff members were overburdened, labouring women would often be left alone for long periods. The buildings tended to be cold and drafty, light would enter through the windows, and the patient lacked privacy. Family members were not permitted to bring in their own blankets and clothing to keep the woman warm and block the light, as these were considered by many workers to be “dirty” (Interview Anon.2, 2010). Health care workers prevented families from serving the woman their traditional teas while in labour, and treatments were often administered without explanation, using cold metal instruments. Women were required to give birth in a horizontal position and not necessarily allowed to keep the placenta afterward. Soon after the birth, health workers would wash the woman in cold water. Family members were not allowed to bring in their own warm soups and the other traditional foods that were meant to nourish the woman after childbirth (Estrada, 2004).

These negative experiences were part of what influenced women’s decisions around where to give birth. One Quechua woman described her perceptions of women’s reluctance to deliver in their health facilities, and her interpretation of the attendant consequences:

In the 1990s some women would go to the hospital or health center to deliver their babies. But many more women preferred to stay at home because they were scared that they weren’t going to be treated well. That they’d be yelled at or that they’d be bathed in cold water. That they wouldn’t like the food, that it wouldn’t be like what was prepared at home. They had all these kinds of reasons why they didn’t go to the hospital — they didn’t want to go. That’s also why there were so many maternal deaths (Interview Anon.2, 2010).
This woman identified a massive gulf between the needs and expectations of indigenous women versus the realities they encountered in their local health facilities. She also understood that in the case of obstetric emergencies, this gulf had potentially life-threatening ramifications.

Financial barriers further complicated women’s decisions to seek care. In the early 1990s, in the midst of fiscal crisis, the national government had allowed local health facilities to introduce user fees in a desperate attempt to keep their doors open. Fee exemptions were possible, but the criteria for determining such exonerations were inconsistent and often applied in a piecemeal fashion (Ewig, 2006). The distance from rural communities to the limited number of health facilities further delayed women from receiving care. Women were also often responsible for other family members, and planning to deliver far from home entailed leaving them behind. Once a home delivery was underway, if an emergency occurred, reaching the far-away health centre in time was often no longer a feasible option.44 This situation was compounded by poor communication systems between rural areas and health facilities and a lack of an adequate number of functional ambulances.

These accounts from rural Quechua women help to explain why many women in their communities did not regularly seek reproductive health services such as family planning and maternal health. Some of these reasons related to the political economic realities facing the country and Puno at the time: there were few facilities, distances to clinics and hospitals were

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44 The main causes of maternal deaths in the 1990s and 2000s were obstetric emergencies, as well as complications from illegal abortions (de Carpio, 2013).
prohibitively far and the cost of services could be beyond most rural households’ budgets. Underlying this separation from the public reproductive health care system, however, was a consistent fear, often based on women’s first-hand experience, of culturally inappropriate, disrespectful, discriminatory and potentially abusive treatment in the health facilities. This fear reflected the deeply unequal power relations between the women and those in the public health system.

4.2.4 Women’s Public Participation

Given the lack of attention to reproductive health issues at the time, there were few if any initiatives in the early 1990s that sought to promote the participation of indigenous women in reproductive health policies and services in Puno (Interview Anon.15, 2011). During this period a great many efforts were being made to organize women’s participation in relation to other kinds of projects, however. From the 1980s onward, a growing number of NGOs, the Catholic Church, different political parties and some state agencies had turned their attention to

45 Influenced by proponents of social medicine and consistent with the 1978 UN Declaration of Alma Ata, the Peruvian state had made some effort to promote community participation in health in Peru in the 1980s, but with limited results (Reyes, 1987; Ewig, 2010). In rural Puno, there was little evidence of these initiatives, especially in the face of economic and political chaos that had crippled the public health system. One indigenous woman interviewed in this study noted that she had volunteered as a community health promoter with her local health facility in the late 1980s, with a focus on child health and malnutrition (Interview Anon 15, 2010). This kind of formal, participatory engagement with the public health system was uncommon for most indigenous women in Puno at that time.
fostering women’s participation in diverse types of projects in Puno (Oliart, 2007). For example, successive government administrations encouraged women’s participation in the delivery of state-sponsored social programs. Prior to Fujimori, the García government created *Clubes de Madres* (Mother’s Clubs), groups of local women in communities across the country that helped deliver programs like community kitchens, milk distribution and child feeding programs. Women’s participation in Mother’s Clubs provided a ready source of free labour for the delivery of these public programs, reducing the burden on the state (Francke, 2006). They were also used by each administration as a channel for building a political base in the countryside (Francke, 2006).

Development NGOs were also eager to establish participatory projects involving indigenous women in Puno. A Puno woman who had been employed with local NGO projects in the early 1990s explained that:

It was a “boom” in Latin America, this work with women. We were in the midst of proposals from Mexico +10 [1980 UN Conference on Women], so ten years from the decade of women. We were working with the women and they were finding that as a women’s group they could be part of an organization even

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46 Rural Quechua indigenous women have a long history of participation in Puno that predates the 1980s, including providing important logistical support in land struggles between peasant communities and the state in the 1970s (Rénique, 1998; Oliart, 2008).

47 *Clubes de Madres* (Mothers Clubs) were social organizations of community women officially set up under the García government in the 1980s. However, their antecedents are found in the independent community kitchen movement that emerged in Lima as a response to the economic crisis in the late 1970s (Francke, 2006).
bigger than the men’s groups because there were already campesino [peasant] organizations with men, but the women were not organized like that. So we started to work on the idea of an organization and what it meant, what it meant to be a leader, to be a representative of an organization, that kind of thing (Interview Anon.15, 2011).

Given that traditional Andean gender roles could sharply limit the ability of women to play a public role outside the household, the flourishing of this array of participatory initiatives supported by diverse actors was significant. These projects offered women additional spaces to gather, organize and build particular skills. Soon, these opportunities would become available to women in relation to reproductive health issues.

4.3 A New Focus on Reproductive Health Care, 1994-2000

The mid-1990s saw a dramatic break with the past in terms of the profile of reproductive health care in Puno. During this period, reproductive health became an important and contested arena in Puno, attracting significant attention from the state, international donors and Peruvian civil society. This was the result of converging forces involving both domestic Peruvian politics and

48 Nonetheless, local informants stressed that despite efforts to promote women’s agency, Andean women still lacked power in relation to men and, in particular, in relation to public authorities. For example, one indigenous woman explained how in spite of the new participatory spaces for women, they were not supposed to bring complaints directly to the authorities. If a woman had a complaint, it was supposed to be channeled through her husband (Interview Anon.10, 2010).
wider developments that reflected an increased global attention to women’s reproductive rights. With an influx of donor support, the state developed new policies and programs to promote reproductive health in rural areas. A Peruvian feminist NGO secured major international funding to launch an innovative project called “ReproSalud,” which opened up new participatory spaces and recast issues related to reproduction in a reproductive rights paradigm. However, the ramifications of the government’s ongoing neoliberal economic restructuring coupled with manipulation of its own reproductive health policies posed serious contradictions and challenges for those rural women who were struggling to improve reproductive health service provision in Puno. These opportunities and tensions are examined below.

4.3.1 The Winds Shift: Domestic Politics in Peru and International Developments

In the mid-1990s, women’s reproductive issues received considerable attention within the international community. In 1994, the UN International Conference on Population and Development in Cairo (the Cairo Conference) led to a significant shift on the global agenda away from the population-control approach dominant since the 1960s toward an agenda based on women’s sexual and reproductive health and rights. One year later, the 1995 UN Fourth World Conference on Women in Beijing (the Beijing Conference) further strengthened the outcomes from Cairo. As a result of these conferences, global discourse and policy agendas related to sexuality and reproduction began to be reframed within a human rights paradigm (Miranda & Yamin, 2010).
The timing of the landmark 1994 Cairo Conference and its resultant emphasis on reproductive health and rights converged precisely with a moment when Peruvian President Fujimori badly needed to bolster both his international and domestic support (Rousseau, 2007). President Fujimori’s moves to authoritarianism had bought him increasing criticism both domestically and abroad. In 1992 in league with the military, Fujimori had initiated a self-coup through which he dissolved Peru’s national Parliament and suspended the constitution to consolidate his own power (Murakami, 2007). The 1992 capture of the leader of the Shining Path rebels by government forces did help bolster his overall national support. However, when Fujimori sought public support for a new constitution in 1993 (which would allow him to run for another term), he was disturbed by the results of the national referendum. Although the constitution was passed by a narrow margin, the results showed deep divides in the country. While voter support for Fujimori was high in Lima, his popularity in the countryside was substantially weaker (Segura-Ubiergo, 2007). In Puno, Fujimori’s electoral support in the 1993 referendum was the lowest in the country, at a mere 17 percent (Grace & Kane, 1995, p.21, cited in Segura-Ubiergo, 2007, p. 255). This figure reflected the sense of disconnection experienced by people in Puno in relation to the central state.

Against this backdrop, Fujimori declared in his second inaugural speech in July 1995 that family planning would become a key government priority. Soon afterward, he travelled to Beijing to address the UN Fourth World Conference on Women; he was the only male head of state to do so. Fujimori swiftly embraced the post-Cairo discourse on women’s rights and reproductive rights when presenting his government’s new commitment to family planning. The Beijing Conference gave Fujimori a chance to shine on the international stage and proved to be both a
diplomatic and media coup. He garnered positive international press and had the opportunity to court potential donor support for his government’s bold promises of extensive new commitments to reproductive health issues in Peru (Rousseau, 2007).

On his return from Beijing, Fujimori announced far-reaching changes to the state’s weak family-planning services. He pledged that free services would be expanded and that service would especially be extended to underserved rural and remote areas across the country. Just prior to the Beijing Conference, and despite strong opposition from the Catholic Church, the government legalized “voluntary surgical contraception” (vasectomies and tubal ligations) and promised to make the procedures widely available through the public health system across the country.

These family planning commitments were later reflected in the government’s 1996 to 2000 Reproductive Health and Family Planning Program (PSRPF – Programa de Salud Reproductiva y Planificacion Familiar 1996-2000). The new program drew heavily on the agendas from the Cairo and Beijing Conferences, and stressed the state’s role in promoting reproductive health care, women’s reproductive rights and gender equity (Rousseau, 2007). Significantly, the PSRPF’s conceptual framework included as its stated goal “to promote the reproductive health of individuals, especially women” (Rousseau, 2007, p.107). The PSRPF also specifically included a commitment to “health services that will diminish the barriers that limit women’s access to quality care” (Ministerio de Salud, “Programa de Salud Reproductiva y Planificacion Familiar” Lima: Ministerio de Salud and U.N. Population Fund, 1996, 5, cited in Ewig, 2006b). Alongside family planning, the Plan outlined commitments to preventing
sexually transmitted diseases and gynecological cancers, as well as to providing pre-natal, natal and post-natal care (Rousseau, 2007, p.108).

The Fujimori regime’s expansion of reproductive health services in the second half of the 1990s was facilitated by new access to international donor support. Soon after Fujimori signed the final declaration at the 1995 UN Women’s Conference in Beijing, USAID invested heavily in the Peruvian state’s new family-planning program. Over the next five years, it financed 75 percent of the cost (Rousseau, 2007). Along with aid to the family-planning program, USAID also granted funding to the Ministry of Health through Project 2000 (Proyecto 2000). Through training and technical assistance, Project 2000 was intended to improve the quality of public health service provision, with a particular focus on maternal and child health services/reproductive health.

### 4.3.2 The ReproSalud Project

Fujimori was not the only Peruvian to make a mark in Beijing. Leaders from prominent feminist groups, primarily from Lima but also from other parts of the country, were actively involved in the Cairo and Beijing conferences. Their presence in these international venues provided

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49 In 1994, a targeted package of health services was introduced in the form of a primarily World Bank-financed program called Basic Health for All (Salud Basica Para Todos). Consistent with the orientation outlined in the World Bank’s 1993 World Development Report — *Investing in Health* — it entailed “necessary but minimalist government intervention” (Ewig, 2010b). The package included the provision of very basic services related to women’s reproductive health for the poorest segment of the population (Shepard, 2006).
opportunities to strengthen their networks with other civil society actors, international donors and the Peruvian state. This left these women’s groups well positioned to leverage support to expand their programming and advocacy efforts on sexual and reproductive health on their return home to Peru.

In 1995, a leading Peruvian feminist NGO with a strong record of work on gender and health issues, *Movimiento Manuela Ramos* (the Manuela Ramos Movement), along with a smaller Peruvian feminist NGO, *Centro de Investigación y Educación Popular Alternativa* (Centre for Popular Alternative Research and Education), was awarded a major grant from USAID to promote reproductive health. The project, entitled ReproSalud, focused on reproductive health and rights among poor, socially excluded women in Lima and eight departments across the country, including Puno. According to a *ReproSalud* document from this era, the project aimed to achieve three main results: “1) more equitable gender relationships between the women and their partners and families; 2) greater ability and willingness on the part of rural and peri-urban women to seek reproductive health care in the formal sector; and 3) effective participation of women and community-based organizations (CBOs) in the processes of designing policy proposals, adopting and monitoring reproductive health programs” (Manuela Ramos Movement, n.d).

50 The Manuela Ramos Movement was founded in the mid-1970s in Peru to work on development issues and gender equality. The NGO was named after an imaginary woman “Manuela Ramos” to “honor all women who, in their day-to-day lives, anonymously contribute the construction and development of Peruvian society” (Chavez, 2001:73). Manuela Ramos remains today a leading feminist NGO in Peru.
The ReproSalud project was groundbreaking in several ways. First, the sheer size of the grant was unprecedented within the NGO sector in Peru. Over the course of the ten-year project, ReproSalud received a total of approximately USD $38 million in funding from USAID (Shepard, 2002, cited in Stromquist, 2007, p.127). Second, the scope of the project was unique. Manuela Ramos had been working with women since the 1980s in low-income areas of Lima, supporting a variety of efforts including health promotion, legal advice and access to health, water and other basic needs. However, with the launch of the ReproSalud project, the organization was able to greatly expand its geographic and programmatic scope, working for the first time on reproductive health in some of the poorest and most remote regions of the country. Third, the methodology of the project was innovative. Firmly situated within the reproductive health and human rights agenda that emerged out of the Cairo and Beijing Conferences, the project used a participatory methodology to target some of the poorest, hardest-to-reach Peruvian women between the ages of 15 and 49. Outside of Lima, this included predominantly indigenous, rural and peri-urban women in geographic areas where health services were exceptionally weak.

Another significant aspect of the ReproSalud project was that it required Manuela Ramos to work more closely with the state. This was a standard requirement imposed by USAID funding. Manuela Ramos had played an informal bridging role since the late 1980s between low-income

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51 ReproSalud ran over two five year periods. It received an initial 25USD million grant from USAID for Phase I (1995-2000) and a further 13USD million for Phase II (2000-2005).

52 Anderson uses the ReproSalud project as an entry point for an interesting and useful investigation of the complex dynamics between rural women and health service providers with a geographic focus on the three departments of La Libertad, Ancash and Huancavelica (2004).
women and the state in advocacy efforts to improve health and basic services in urban poor areas of Lima. They were also strong advocates for legal reforms in the domestic violence sphere (Stromquist, 2007). The NGO had never before had a formal working relationship with the Ministry of Health, however, so this project marked the opening of new kinds of channels between Peruvian civil society and the state concerning reproductive health.

By 1996, just two years after the Cairo and Beijing conferences, the state appeared poised to expand significantly an aspect of social welfare that would directly benefit women: the provision of widely available, free reproductive health services. Buoyed by substantial international donor support, and consistent with the post-Cairo and Beijing conference agendas, the state pledged that these services would be widely available and grounded in human rights principles. At the same time, and with large amounts of international donor support, a leading national feminist organization, Manuela Ramos, and its local partners were poised to approach reproductive health through a participatory, human rights-based lens with marginalized, poor women in urban and rural areas across the country. The following section explores how this expanding and shifting reproductive health arena took shape locally in Puno.

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53 Although Manuela Ramos remained critical of the state, its newly formalized contact with the Ministry of Health through ReproSalud was part of a broader trend of closer collaboration between civil society and the state in the reproductive health arena. For example, during roughly the same period, the Ford Foundation sponsored a sexual and reproductive health project that involved six Peruvian women’s NGOs, called Consorcio Mujer, which also required direct contact with the state (Shepard, 2006). Meanwhile, Manuela Ramos and another leading group, Flora Tristan, along with the United Nations Population Fund (UNFPA) set up the Tripartite Roundtable (Mesa Triparte), a collaborative initiative between civil society, the Peruvian state and the international community intended to track progress toward implementing agreements from Cairo (Ewig, 2006; Rousseau, 2007). Together, these examples marked the opening of new kinds of channels between Peruvian civil society and the state around reproductive health.
4.3.3 Participatory Engagement in Puno through ReproSalud

To launch ReproSalud in Puno, the project hired two women from the region to act as coordinators. As an initiation into the project, the two women came to Lima for intensive training with the new coordinators from other regions (Interview Anon.15, 2011). The training workshops introduced these women to the project’s key themes including reproductive health, reproductive rights as human rights, gender equity and participatory learning. The training also helped to link the Puno coordinators into a much larger national (and transnational) network of women working on reproductive health issues.

One former ReproSalud staff person in Puno recalled the excitement of that period. She described hiring a small number of staff to work with her in order to implement the project. Instead of looking for local candidates with the longest experiences of NGO work, she noted that she looked for recent university graduates who were, in keeping with the principles of the project, fluent in Quechua, genuinely committed to the goals of ReproSalud, willing to learn its methodology and willing to spend extended periods of time in the rural countryside working directly with women in local communities (Interview Anon.15, 2011). By 1996, the coordinators were in place and ready to begin program implementation.\(^{54}\)

\(^{54}\) One was assigned to cover the northern, predominantly Quechua-speaking region and the other the southern, mainly Aymara-speaking region. In a later stage of the project, the two coordinator positions were merged and the coordinator for the Quechua region began to cover project activities throughout all of Puno. This research only covers two districts in the northern, Quechua region.
To recruit women to volunteer with the project, the coordinators contacted existing community-based organizations (CBOs) in rural communities, often Mother’s Clubs (Clubes de Madres). They provided information through the Mother’s Clubs and invited women in these communities to take part in a training course to become volunteer reproductive health promoters. Some of these women were already active in organizations in their communities, while others had little experience participating in local groups. All had experience with the reproductive health challenges they and those close to them regularly encountered, however. One interviewee remembered her own path to becoming involved with the project as a young woman:

My mother was part of the Club de Madres. There was going to be a competition and a training course for health promoters. I didn’t really know what it was about, but my mother suggested I go. I was around 26 or 25. I had never participated in any organization, I was very shy. I participated in a training, it was around, eight, ten days and then to select us we had to take an exam. I was so nervous. But I had had a friend who had just died when she was five months pregnant. Her parents were old and didn’t know she was pregnant. She died from hemorrhaging, her little baby died. So I told that story. And I was picked (Interview Anon.5, 2010).

Once they were recruited and trained, the women selected to be reproductive health promoters went on to conduct their own training sessions with women in their home communities. One former promoter recalls what it was like to conduct these workshops:

They gave us modules and we trained the women, bringing together whoever we could. For example, I trained 30 women in my community about the things I had learned, with the help of the training module….
Things like “healthy pregnancy and delivery,” “family planning,” “knowing your body.” How our reproductive organs work. At first the women thought this was rude, that we shouldn’t talk about this. But slowly they began to trust us. We had a little budget to prepare a meal and we promoters would prepare a meal and do the training with lunch. And we spoke in Quechua. These things helped to gain the confidence of the women during the trainings (Interview Anon. 6, 2010).

The participatory methodology and use of popular education techniques helped make the ReproSalud project accessible to women from diverse backgrounds, many whom had had minimal access to the formal education system. Facilitators led groups of women in a collective self-evaluation exercise in which the participating women identified the primary reproductive health problems in their communities, as well as the key barriers they faced when seeking reproductive health care (Chavez, 2001). Some of the main problems identified were: difficulties managing the spacing of their children (often they felt they were too close together), obstetric emergencies (such as hemorrhaging) and vaginal infections. They also identified a great many problems with their local reproductive health services. These included concerns with patient mistreatment, abuse, discrimination, a lack of respect for cultural norms, lack of medical supplies and long wait times (Estrada, 2004).

The project provided an opportunity for women to gather and to openly consider and jointly define their reproductive health issues in Quechua. It allowed women to share experiences on a topic that which they rarely discussed publicly, and opened up space to begin to develop a collective analysis of root causes behind their reproductive health problems. The results of these
self-evaluations were shared in meetings with local health officials, in an effort to improve the quality of health services (Estrada, 2004).

The project also revised the existing reproductive health education materials available in the country, which had not originally been designed with the needs and realities of indigenous rural women in mind. The materials were revamped to ensure that they were culturally and linguistically relevant, as well as accessible to those who often had had only minimal access to formal schooling (Murillo Hernández, 2003).

4.3.4 ReproSalud and Reproductive Rights

The ReproSalud project firmly situated reproductive health within an international human rights framework and ensured that this orientation was reflected in its training modules with community women (Chavez, 2001; Petchesky, 2003, p.209). ReproSalud has been cited as a “rare example of a large-scale donor-funded project that truly seeks to fulfill the spirit of the ICPD Programme of Action” (Coe, 2001, cited in Petchesky, 2003 p.209). The project’s human rights training offered women a new way of framing their reproductive health issues that resonated with the difficulties that they commonly encountered in that sphere. In Puno, the woman who earlier had described her poor treatment by health workers after she had fainted post-childbirth, recalled the importance of a human rights approach in terms of helping her to consider the quality of treatment to which she was entitled. She explained that soon after her negative hospital experience, a person from the ReproSalud project visited her community and
conducted training workshops on reproductive health and rights. This language resonated with her. “I started to know about my rights and how I should be treated,” she explained (Interview Anon 10, 2010). Later on, she also became a reproductive health promoter through ReproSalud.

4.3.5 Contradictions and Ruptures: The Coercive Sterilization Campaign

The positive developments that took place in Peru over the years that followed the Cairo and Beijing Conferences suggest that real gains were made in women’s reproductive health and rights. In reality, however, the situation was far murkier. Despite the commitments made to women’s reproductive rights in the government’s Reproductive Health and Family Planning Program, in 1996 evidence began to emerge that the government was involved in “a campaign of systematic sterilization often without full consent” (Physicians for Human Rights, 2007, p.30). The feminist NGO CLADEM (Latin American and Caribbean Committee for the Defense of Women’s Rights) collected testimonies in order to document human rights abuses carried out under the program (CLADEM, 1999). They identified cases in which women were coerced or pressured to accept the surgery. Sterilization procedures were sometimes tacked on to other procedures such as post-natal or post-miscarriage care. At other times, health workers convinced women to undergo the procedures through various forms of “coercion/intimidation and deceit” (Miranda & Yamin 2011, p.180). Surgery was often performed without proper sanitation, training or medical supplies. CLADEM’s investigation showed that at least 17 women died as a result of complications. A subsequent investigation by the Defensoría supported CLADEM’s findings (Defensoría Del Pueblo, 1998).
The emphasis on prioritizing surgical sterilization as a family planning method came from the highest levels of government. In contrast to feminist interpretations, planning documents generated in the offices of the President and the Prime Minister show how family planning was seen “principally as a tool for economic development, with little regard for the promotion of reproductive health or rights” (Ewig, 2006 p.643). These documents drew on neo-Malthusian logic that stressed permanent sterilization of poor, indigenous women as an integral component in the government’s efforts to reduce poverty. The number of women sterilized was explicitly used “as an indicator of successful poverty alleviation” (Ewig, 2006 p.644). Surgical sterilization was identified as the preferred outcome and the central government set strict quotas for the number of sterilizations that were required. Senior officials and even the President himself met directly with Ministry of Health officials to monitor and promote the achievement of quotas (Ewig, 2006 p.644).

The department of Puno was one of the many areas of the country where the coercive sterilization campaign was carried out. Interview informants from the districts of Ayaviri and Azángaro who had been reproductive health promoters during that period noted that they did

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55 Restructuring of the health labour regime that had been taking place since the early 1990s meant that many health workers had only short-term contracts with no job protection. They were also poorly remunerated for their work. Reaching sterilization quotas was directly linked both to incentives and to threats of dismissal or non-renewal of contracts (Ewig, 2010b). This placed many workers in a difficult position, as they found themselves acting as accomplices in practices that were in direct violation of women’s reproductive health rights (Miranda & Yamin, 2004).
indeed hear informal stories of abuses coming from some of the neighboring districts. However, they felt that the situation in their districts had been less coercive, in part due to the presence of the ReproSalud project and their own presence as reproductive health promoters:

Nobody used to say anything [about reproductive health]. They [health workers] just did what they wanted. With Manuela Ramos we woke up. We learned about our rights, how to make demands, how we wanted to be treated. We also learned about reproductive health, deciding how many children to have, how our body works, what (contraceptive) methods there were. We learned about all these things (Interview Anon. 10, 2010).

The former promoters argued that their ongoing dialogue and promotion of reproductive health rights with other rural women in local communities meant that these women were better informed about their options and less vulnerable to the potentially coercive practices they could encounter in their local health facilities.\(^{56}\)

The complex national reproductive health policy environment was reflected in the sometimes difficult interactions between local reproductive health promoters in Puno and workers in their local health facilities. One informant formerly linked with ReproSalud explained that:

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\(^{56}\) This reflects a tension that arose within the women’s community in Lima during the sterilization scandal. Some groups felt that organizations collaborating directly with the Ministry of Health were exacerbating the problems related to the forced sterilization. However, Manuela Ramos argued that their presence at a grassroots level was in fact a protective mechanism in the face of the abuse (Stromquist, 2007)
There was a lot of pressure from the Ministry because there was a big problem between them and us, they had to comply with the targets to provide contraception and to do vasectomies and tubal ligation, while at the same time we were teaching them about what were their rights, their rights around use of contraceptives, sexual and reproductive health. So some of the MINSA staff would tell us that we were misinforming the women. But in some health facilities they considered us their allies (Interview Anon.15, 2011).

The informant’s view highlights the potential for rivalries and alliances between government health workers and the reproductive health promoters during this period. Despite intense workplace pressure to meet sterilization targets, not all health care workers agreed with government policy. Some health care providers drew strength from the promoters’ work informing women about their reproductive rights and their family planning options.

The reports by CLADEM and the National Human Rights Ombudsman’s Office, concerning the coercive sterilization campaign caused a national and international scandal. Feminist organizations and the Catholic Church in the country allied to oppose the campaign and the government bowed to pressure and reformed its policies on surgical contraception (Ewig, 2006 p.647).
4.3.6 Participation in Phase I of ReproSalud, 1995-2000

This period marked the opening of new participatory spaces for rural indigenous women in the reproductive health arena. Through the ReproSalud project, women in rural Puno were recruited as volunteer health promoters to engage with their communities. Through training and self-diagnostics, these efforts spread awareness and intra-community dialogue concerning reproductive health issues and reproductive rights. Ironically, these participatory spaces opened up at a time when the Ministry of Health’s was implementing family planning policies that included coercive sterilization. This ran directly counter to the reproductive rights orientation of the ReproSalud project and counter to the human rights commitments articulated by the government. As a result, the health promoters had to navigate the complex dynamics presented by contradictory state social policies around reproductive health and neo-Malthusian population-control strategies presented within their local health facilities.

In the next section, covering the period from 2000 to 2005, I explore how amid dramatic changes in Peru’s political landscape, the participatory spaces used by the ReproSalud health promoters changed focus substantially. During this period, the promoters sought more formal and direct engagement with health facilities in order to address community issues with reproductive health care. Their volunteer work as maternal health promoters brought them into consistent contact with their health services. This enhanced the promoters’ analysis of the inequalities indigenous women faced around reproductive health care and catalyzed new struggles to try to address these issues.
4.4 Participatory Engagement with the State, 2000-2005

My goal in this section is to demonstrate how ReproSalud promoters’ increased contact with their local health services in Puno in the early 2000s led them to try new strategies to address the systemic problems they encountered related to the quality of maternal health care offered to indigenous women.

I begin here by briefly outlining the broader political and economic context in which the promoters’ struggles over reproductive health care in Puno were situated. In the remaining sections, I recount the women’s new role promoting maternal health, their strategies for trying to address the injustices they encountered related to state-operated maternal health services, and the barriers they faced when trying to directly address systematic problems with the quality of reproductive health care provision.

4.4.1 The Political Economic Context

In 2000, Peru was in the midst of tumultuous political change. President Alberto Fujimori fled the country amid scandals over corruption, abuse of power and electoral fraud within his regime. After a decade of increasingly authoritarian rule in Peru, the collapse of his government opened the way for a transition to democracy. An interim government led by Valentín Paniagua was set up to lead the country until formal presidential elections brought Alejandro Toledo to power in 2001. This period marked the beginning of widespread democratic opening after years of authoritarian, highly centralized rule.
At the start of the millennium, successive governments in Peru, backed by international donor support, directed increased focus and resources toward addressing maternal care. The Government of Peru had recently revised the objectives from its original World Bank PAR I funding package to concentrate more directly on improving maternal health care services. Meanwhile, the 2000 United Nations Millennium Development Goals (MDGs), endorsed by the Peruvian government, included Goal number five, which pledged to reduce the maternal mortality ratio by three quarters by 2015 (United Nations, 2014).

As well during this period, the government increased insurance coverage for maternal and child health care. In 1998, toward the end of the Fujimori’s regime, his government had introduced health insurance coverage for mothers and infants, followed the next year by insurance for school-age children. In 2002, the Toledo government consolidated the programs under the new Comprehensive Health Insurance, Seguro Integral de Salud (SIS) (Francke, 2013). These efforts were supported by a renewed donor focus on maternal health. Coverage remained fragmented and implementation was slow, but it did in theory reduce the financial barriers for low-income indigenous women to access maternal health services through their public health system. As Francke observes:

By law the SIS established the right of the poor and excluded populations to join the scheme and their right to receive free health services. However mechanisms to promote these rights do not exist or are very weak (2013 p.11).
4.4.2 Developments with ReproSalud

Amid the political changes sweeping through Peru, in 2000 USAID extended funding of the ReproSalud project for an additional five years.\textsuperscript{57} During this second phase of the project, the NGO Manuela Ramos entered into a closer relationship with the state. The NGO signed a formal agreement with the national Ministry of Health to provide technical support in areas related to reproductive health. At the same time, it also put greater focus on building local women’s advocacy capacity (Stromquist, 2007).

In Puno, this second phase of ReproSalud translated into new types of participatory opportunities for the local indigenous women active in the project. ReproSalud participants began to collaborate directly with their local health facilities as volunteer maternal health promoters. The goal of the maternal health promoters was to help reduce the number of maternal deaths in Puno. The inequalities in maternal death rates were still firmly entrenched, with the MMR in Puno: 362 per 100,000 live births compared to a rate of 52 per 100,000 live births in Lima in 2000 (Physicians for Human Rights, 2007). As maternal health promoters, the

\textsuperscript{57} An external evaluation of ReproSalud at the end of the 1990s noted positive results from the project. It found the impact of the project strongest among the women who were trained as reproductive health promoters. Results were weaker among women who were in contact with the project through the replication of trainings (Shepard et al 2002, cited in Stromquist, 2007).
participants were charged with encouraging women from their communities to use maternal health care services.

New insurance coverage for maternal care provided increased financial access for rural indigenous women; however, cost had not been the only deterrent. Many indigenous women also had reason to fear visiting the health facilities given past experiences of abuse and disrespect. In their new role as maternal health promoters, the ReproSalud participants became a link between local health facilities and pregnant women from their communities. In the words of one former promoter:

We would have community meetings and we’d see. We’d see somebody’s belly and we’d say, “are you going to your check ups?” And they’d say, “no!” So we’d say, “we’ll take you, when do you have time? And we’d take them to the health centre. They trusted us but they were scared to go for the check ups. They’d say, “I’m scared!” … So we’d take them; we’d say: “we’re going to go on this particular day, the bus is going to come at this time” (Interview Anon.1, 2010).

The promoters’ new bridging role between pregnant women and the health facilities represented a significant shift from their previous activities. In the first phase of ReproSalud, their primary task had been to work directly with CBOs in other communities to promote learning and dialogue about reproductive health and rights. Through the replication of training workshops, including self-diagnostics, they would work with women’s groups to building awareness reproductive health and rights. They facilitated self-diagnostics to help women identify their
most pressing reproductive health issues. During the first phase, the promoters met on occasion with their health facilities to communicate results from the communities’ self-diagnostics and to make recommendations for service improvements. After 2000, by contrast, the participants’ enhanced role as maternal health promoters brought them into much closer and consistent contact with their health facilities, since they would accompany pregnant women from nearby communities on their maternal health care visits.

The former reproductive health promoters expressed real concern about the high levels of maternal mortality in their communities. In particular, they explained their commitment to addressing what they saw as some of the ongoing, root causes of the problem: women’s lack of trust in their health workers and health facilities because of repeated experiences of insensitive, discriminatory or abusive treatment. One local woman explained her motivation for volunteering as a maternal health promoter:

We were worried about how we could solve this problem [maternal mortality]. This was the reason [we became maternal health promoters], so that mothers from both rural and urban areas would trust health workers, so they wouldn’t say that in the hospital they mistreat them, bathe them with cold water. These were the fears the mothers had, so they wouldn’t go. That’s why they would die (Interview Anon 11, 2010).

Former promoters expressed some satisfaction with their bridging role. They noted that community members respected them and sought out their advice. Some also said they enjoyed
collaborating with the health workers and felt a certain satisfaction with their more formal role (Interview Anon 1, 2010; Interview Anon 2, 2010).

Despite these positive aspects, the health promoters’ increasingly close and consistent contact with their health facilities also further reinforced their awareness of the poor treatment that indigenous women commonly faced when seeking out maternal health services. In particular, these included ongoing lack of recognition and respect of Quechua birthing practices, as well as the lack of basic supplies and equipment within the underfunded health system.

4.4.3 Lack Of Respect for Culturally Congruent Birthing Practices

Despite ReproSalud’s efforts in the late 1990s to sensitize the staff of health facilities by sharing the results of the community-based diagnostics identifying community concerns related to reproductive health and rights, many of these issues remained unaddressed. In particular, the lack of respect for Quechua women’s cultural norms around childbirth practices was a persistent problem. One promoter explained:

As Andean women, we have distinct customs. When a woman gives birth she eats her “chuma” soup, she covers her head, the spoon also needs to be wrapped in a handkerchief so that no cold penetrates the hand…. These are our beliefs, so these were the kinds of things we promoted. But the health workers were nearly always opposed. They hardly ever paid attention or accepted us. They’d ask us why we were always intervening, that we couldn’t, because they did things according to their laws from the capital (Interview Anon 11, 2010).
In these cases, when the maternal health promoters tried to intervene on behalf of the health users, the promoters found they often lacked sufficient power to have their voices taken into account. Part of this problem could be attributed to clashes in understanding between health workers trained in a Western, bio-medical approach and maternal health promoters with health knowledge based on a Quechua belief system. However, even health workers sympathetic with the views of their patients lacked a certain kind of power in these situations. The centralized structure of the health system meant that official norms from Lima dictated service guidelines for institutional deliveries. Health workers, often in precarious contractual positions, could make themselves vulnerable by agreeing to birthing practices that were not within the standardized norms. They may have feared being held responsible if complications had occurred. In this way, both the promoters and workers were part of an intricate structural web that ultimately left the expectant mothers as the recipients of poor quality treatment.

4.4.4 Consequences Of Underfunding within the Public Health System

When the promoters took on the bridging role between pregnant women in their communities and their local state-run health facilities in the early 2000s, it was not unusual for them to encounter first-hand the dire economic realities of the underfunded health system. One former promoter recalled her experience assisting pregnant women to deliver in her local health facility:
When we’d bring pregnant women in, or at the moment of delivery, we’d be there. We’d hear about it and we’d say, she’s going to deliver, she’s having these kinds of pains. Quickly an ambulance is needed. We even got a central telephone in the community for this. I forget what we called it. So we’d call for the ambulance, but sometimes they wouldn’t want to send us the ambulance. That it wouldn’t be there. Also, sometimes we’d get to the hospital and we’d have problems because we didn’t have any money. And what would happen? Sometimes there would be a complication, and they’d say to us: “go and buy this” — sometimes the nurses would treat us like that. And sometimes, mouths shut (quiet), we’d have to go ourselves and try to get the things (Interview Anon.1, 2010).

This health promoter’s experience reflects the chronic state of underfunding of the public health system in Puno and throughout Peru in the early 2000s. Ambulances, crucial for saving a woman’s life during an obstetric emergency, remained in short supply. Basic equipment needed in the event of birthing complications was not always on hand. The health promoter’s story indicates that perversely, in some cases, the cost of these supplies was passed on to the volunteer health promoters themselves (Interview Anon.1, 2010). Expectations by health staff that the volunteer promoters would absorb the financial costs associated with the facilities’ lack of basic supplies highlights both the underfunding of the state-provided health services as well as the uneven relations of power between the promoters and the health workers.

4.4.5 Organizing “Negotiations” with Health Care Officials

After 2000, the ReproSalud project put greater focus on advocacy as a means to improve reproductive health care services. In Puno, the approach was used to organize “negotiations” (negociaciones) with health officials and other authorities. In these negotiations, the maternal
health promoters, along with project staff, would identify what they felt were the main obstacles or issues keeping women from using the reproductive health services. A discussion would follow and a list of agreements was drawn up to try to address the problems.

These negotiations were a new type of public engagement for many of the reproductive health promoters. For the first time, they were sitting at a table in open dialogue with health officials and municipal authorities. The negotiations offered the participants an opportunity to identify problems and seek solutions in dialogue with officials. However, a former ReproSalud worker from Puno characterized the follow-up from these negotiation meetings as a situation in which “the women would fulfill all the agreements and the health facilities would fulfill few or none” (Interview Anon.15, 2011).

A former health promoter characterized the advocacy efforts in these terms:

They would meet with us....We would make agreements. Sometimes they (health workers and officials) would fulfill them, sometimes not. When they didn’t, we’d have to fight and fight. But if it didn’t work then it would just get left the way it was (Interview Anon.1, 2010).

In an attempt to advocate more formally, the promoters, with the support of project staff from ReproSalud, met directly with health officials to voice the problems they had witnessed related to maternal health care. Through these formal meetings, the promoters were now directly
struggling with the state over the quality of maternal health services. Their concerns were rarely taken up in a substantive manner, however. My interviews suggest that despite the promoters participatory engagement with the state, the advocacy strategy of negociaciones carried little weight in influencing reproductive health service delivery.

By 2005, USAID’s funding to ReproSalud drew to a close. This marked yet another time of change for the women involved as reproductive health promoters in Ayaviri and Azángaro. Despite the termination of the project and the loss of institutional support from Manuela Ramos, many former promoters in both Azángaro and Ayaviri remained active through their local CBOs. In the years that followed, these women continued to actively support reproductive health and other related women’s issues in their communities.

4.5 Conclusion

The years from 1990 to 2005 were groundbreaking in Puno for reproductive health. This is true not only in relation to how reproductive health emerged as a public issue in the region, but also in terms of how it became an arena of struggle between civil society and the state.

Events in Puno over this period support Kunz’s (2010) argument that we need to be careful about applying models developed in the global North to understand conflicts over the state’s involvement in social reproduction in the global South. As discussed in chapter two, Bakker and
Gill (2003) observe that neoliberal restructuring is forcing states to retreat from social welfare provision and to off-load social burdens, often onto women. The story in Puno over this period, however, is not one in which a social movement struggles against attempts to privatize the state’s role in social reproduction, specifically in the area of reproductive health. Instead, reproductive health care has long been predominately privately acquired in Puno. Then, from the mid 1990s forward and with donor support, the state’s public investment in reproductive health care services actually expands, even in a time of neoliberal restructuring.

The social struggles that do take place in relation to reproductive health care concern problems with how these services are organized and implemented. This is in line with Kunz’s other observation that it is important to pay attention not only to the quantity of state involvement in social reproduction but also the qualitative dimensions of the services that are delivered (Kunz, 2010). Thus, at a national level, lawyers and activists reveal and denounce the coercive sterilization program developed by senior figures in government. At the local level, the reproductive health promoters with ReproSalud attempt to address patterns of exclusion that are embedded in their local health care facilities. Both of these problems flow from what Quijano (2000) calls the coloniality of power: they stem from enduring notions of racialized and gendered hierarchies that situate indigenous Andean women as backward, problematic subjects to be controlled and excluded. When new resources flowed into expanded reproductive health programming, this also created new opportunities for these embedded inequalities to influence how services were organized and implemented.
One of the most interesting developments over this period concerns how the participation of indigenous women in the ReproSalud project set off important processes of collective learning, consciousness-raising and advocacy to challenge the influence of these embedded inequalities. In interviews, respondents who had been involved with the project made it clear how important they felt the project had been in raising their awareness about reproductive health and rights as well as in providing new opportunities for leadership. The indigenous women as well as former project staff in Puno who were interviewed spoke with real emotion and enthusiasm about their experiences with the project. It brought to the forefront reproductive health issues that had long been silenced. It opened up new spaces for women to engage with these issues in respectful, gender-sensitive ways, and to form a collective analysis concerning their reproductive health problems. Opportunities to act as promoters opened up new channels for indigenous women to engage with health professionals concerning reproductive issues, in particular those related to maternal health.

Ironically, however, closer engagement between the ReproSalud-supported promoters and their local health facilities also helped to lay bare the deeply embedded power relations within the public health system. Through their participatory activities and through their direct presence in the facilities as promoters, the participants saw first-hand the realities that were entrenched in the public health system and how that played out in the reproductive lives of indigenous women. In particular toward the end of the project, the promoters and the NGO staff struggled to create participatory spaces in the form of negociaciones (meetings) with health officials, in hopes that the promoters’ concerns could be heard and concretely addressed. But despite the best efforts of those involved in the ReproSalud project in Puno, only small gains were made through these
meetings (Anon.15, 2010). The promoters were able to encourage more women to use reproductive health services, but they lacked effective strategies to influence the quality of local reproductive health service provision.

Based on feedback from former promoters from ReproSalud, a human rights paradigm served as an increasingly important way of framing women’s individual experiences around reproductive health care in Puno from the mid 1990s onward and was actively embraced through community-based training around reproductive health issues. Nonetheless, despite their use of a human rights paradigm, reproductive health promoters encountered real barriers, including uneven power relations with health workers, when they struggled to address long entrenched problems with the provision of state-provided reproductive health services.

Nationally, human rights law and discourse did play a significant role in relation to reversing the coercive sterilization campaign. At first, the sterilization campaign in fact seemed to demonstrate the ineffectiveness of human rights commitments. The Fujimori administration was able to position itself as a champion of reproductive rights at the same time as it was promoting a sterilization campaign that grossly abused the rights of women. However, once the sterilization campaign came to light, the government’s very public commitments to human rights and reproductive rights left the administration particularly vulnerable to attack using “naming and shaming” strategies. The scandal galvanized Peru’s human rights community. As Miranda and Yamin observe:
The collective response to the sterilizations was one of the first times in which the Peruvian human rights community had so forcefully articulated claims, not just regarding individual instances of discrimination but also the government’s role in perpetuating and exacerbating converging patterns of exclusion based on race, gender and ethnicity (Yamin & Miranda, 2011, p.184).

Initial struggles with state health services by women from community-based organizations active with ReproSalud in Puno in the second half of the 1990s and early 2000s helped provide the scaffolding for new kinds of efforts by civil society to press state officials to improve the quality of reproductive health service provision that would emerge later in the decade. These efforts will be examined in the following chapter. Many of the former reproductive health promoters from Ayaviri and Azángaro, along with additional local women leaders, were recruited again to work with a new constellation of actors in a continuation of the struggles with the state over improvement of the poor quality of reproductive health care offered to them through their public health system. Drawing on lessons learned from their experiences between 1990 and 2005, and capitalizing as well on the increased visibility of health rights on the national agenda, the women and allied actors moved away from health promotion and instead began to focus on issues of participatory governance. Here, they sought to foster new forms of public accountability through direct monitoring of their local health facilities. In crafting a different kind of model for improving reproductive health service provision, the new team of actors paid particular attention to the realities of uneven power dynamics, and sought out creative strategies through which to address them.
Chapter 5

Rights-Based Governance in Practice: Citizen Monitoring of Reproductive Health Services

5.1 Introduction

In this chapter, I analyze the contemporary efforts (starting in 2008) of a group of women in the southern Andean region of Puno, Peru, to address problems with their public reproductive health services. They are mainly indigenous, Quechua-speaking women who have long experienced discrimination and exclusion in Peruvian society. Many of these women have considerable leadership experience in their local communities. Several have had extensive previous contact with their public health facilities through their earlier role as reproductive health promoters from the 1990s and early 2000s, as discussed in the chapter four. I examine their involvement in a local citizen monitoring initiative designed to oversee and govern the delivery of reproductive public services to their communities. This is done primarily through observation and reporting activities carried out at the facility level by trained volunteers. The citizen monitoring initiative has been made possible through the activities of a group of actors linking the monitors to national and international NGOs, government agencies and transnational epistemic communities. It draws upon notions of active citizenship, human rights advocacy, participatory
democracy and a national reform movement for citizen monitoring (*vigilancia ciudadana*). I will analyze the achievements and limitations of this form of citizen mobilization within the reproductive health arena.

This chapter is based on fieldwork conducted with local citizen monitors and key informants from 2010 to 2011 in the Puno districts of Ayaviri and Azángaro, the city of Puno and the Peruvian capital, Lima. It draws on interview data as well as an extensive document and literature review.

In the previous chapter, I explored how Quechua speaking women participated with reproductive health services in Puno from 1990 to 2005 through the ReproSalud project (1995-2005). Funded by USAID and administered by a prominent Peruvian feminist NGO, the ReproSalud project sought to promote improvements in reproductive health services in Puno and across other regions of Peru, especially among excluded populations. One of the outcomes of this project was the identification by project participants, most of whom were low-income indigenous women, of a systemic lack of respectful, culturally sensitive reproductive health care at state-operated health facilities. Direct efforts made by reproductive health promoters towards the end of the ReproSalud project to address problems with service provision by meeting with health facility officials met with only limited success, however. Similarities between the

58 It is difficult to find an exact English translation that fully captures the meaning of the term *vigilancia ciudadana*. The phrase “citizen monitoring” will be used in this study. Other suggested terms include “citizen oversight” and “citizen surveillance.”
ReproSalud project and the initiative examined here (e.g., the use of participatory strategies and a human rights paradigm) provide useful points for discussion that will be explored in this chapter.

Chapter four provided an account of the social context in Puno during the 1990s and early 2000s. Since that time, Puno has seen a number of important new developments, together with the continuation of older historical patterns. Since the mid-2000s, the Peruvian economy has generally experienced strong growth due to high commodity prices and a surging extractive sector. Successive governments (Alejandro Toledo, from 2001-2006; Alan García, from 2006-2011; and Ollanta Humala, beginning in 2011) have consolidated a neoliberal policy orientation that began in the 1990s, while also using the new influx of funds into state coffers to make certain increased investments in social benefits, including in the health sector.

Despite these developments, Puno continues to be one of the poorest regions in the country. From the perspective of the capital, Puno remains a distant region high in the mountains and far from the national agenda in Lima. A renewed focus since 2002 on decentralization and new powers afforded to regional-level governments has thus far “failed to establish a coherent and orderly institutional framework for delivery of government services to its citizens” (Tanaka & Vera, 2008). Puno remains a majority indigenous region in a country profoundly marked by gendered and racialized stratification. The social exclusion historically experienced by indigenous women in Puno continues to be high.
5.2 Development of the Citizen Monitoring Initiative

A number of influences came together in 2007 and 2008 to produce the citizen monitoring initiative. The initial idea for the project was developed collaboratively by CARE Peru and a U.S.-based NGO, Physicians for Human Rights USA (PHR). PHR had just completed fieldwork in Puno and Huancavelica with assistance from CARE Peru for a report on a human rights-based approach to the problem of maternal mortality in Peru (Physicians for Human Rights, 2007). The rationale for the citizen monitoring initiative drew on conclusions of the PHR report, which found that maternal deaths were linked to institutionalized discrimination and systemic underfunding of the health sector (Physicians for Human Rights, 2007). To address these problems, the initiative developed a citizen monitoring approach that borrows its name and some of its core ideas from Peru’s new vigilancia cuidadana (citizen monitoring/oversight) movement. Based on the notion of active citizen participation, the initiative has sought to develop a consistent presence within local public health facilities using volunteer citizen monitors, in order to track the quality of care provided to health users. Project staff present evidence gathered through facility-level monitoring visits to health officials at regularly scheduled meetings to promote constructive dialogue and improve service provision.

59 A year earlier, PHR, with field assistance from CARE Peru staff, had conducted an investigation into maternal mortality in Puno and Huancavelica from a human rights perspective. The PHR study analyzed a number of cases of maternal deaths among indigenous women in the Andean regions of Puno and Huancavelica through a human rights lens and concluded that the deaths were linked to institutionalized discrimination and systemic underfunding of the health sector (Physicians for Human Rights, 2007). A 2006 Amnesty International Peru report on maternal mortality in Peru had also identified systemic problems with the health system, including patient mistreatment and illegal charges for services, that violated poor and excluded women’s rights to maternal health care (Amnesty International, 2006).
monitors receive support from the project’s organizational partners: CARE Peru, ForoSalud (Peru’s largest health-focused civil society organization) and the Defensoría del Pueblo (Peru’s national Human Rights Ombudsman).

PHR funded an initial pilot of the initiative in 2008 to get the project going. Later in 2008, CARE Peru secured continued funding for the initiative through its involvement in “Participatory Voices,” a large-scale project funded by the U.K.’s Ministry for International Development on rights-based approaches to strengthening governance in health (Frisancho, 2013, p.19).

The active collaboration with the regional Defensoría del Pueblo office in Puno is an especially innovative characteristic of the citizen monitoring model developed in this initiative. The Defensoría is the National Human Rights Ombudsman’s Office in Peru. It was established in the 1993 Constitution, and finally officially launched in 1996 after much advocacy on the part of human rights groups (Youngers, 2006). Although the Defensoría has no power to directly sanction public officials, it is extremely highly regarded. It can also refer cases to the public prosecutor, if necessary. The Defensoría built its reputation in the Fujimori years, where it became known “as practically the sole democratic agent of accountability within the state” (Pegram, 2011 p.231). Now, within the context of a fragile democracy, the Defensoría still has a
high degree of trust from the public and maintains its role as a “key human rights defender in Peru” (Pegram, 2011 p.231).

When first approached by CARE Peru and ForoSalud representatives, the regional director of the Defensoría office in Puno signaled that she was very interested in the idea of her organization collaborating with the citizen monitoring initiative. She viewed the high rate of maternal mortality in Puno as a human rights issue. In addition to its other responsibilities, the Defensoría is charged with oversight of the provision of public services to citizens, including health care services. However, given the realities of limited staffing, Defensoría lawyers are unable to have the sustained contact with health facilities necessary to carry out this role in a proactive way. By working with citizen monitors the Defensoría could gain access to eyes and ears at a ground level in health facilities.

To get started, the initiative mobilized a network of indigenous women to work as volunteer citizen monitors. Many of the women recruited were former promoters who had worked on the

60 Nationally, the Defensoría has a strong track record in the area of defending sexual and reproductive health rights. As mentioned in the previous chapter, it played a key role, in collaboration with feminist NGOs and grassroots women’s organizations, in drawing public attention to reproductive rights abuses connected to the government’s sterilization scandal in the 1990s. In the early 2000s, it also helped draw attention to the reverse trend: the lack of contraceptive supply available in public health facilities. Since then, the Defensoría has spoken out against the alarming rates of maternal mortality in Peru, in particular in remote regions of the country.

61 Article 162 of the Constitution of Peru, 1993, reads: “It is the duty of the office of the Ombudsman to defend the constitutional and basic rights of the person and the community, and to ensure the enforcement of the state administration duties, as well as the provision of public services to citizens.”
ReproSalud project and now also formed part of the regional ForoSalud network. Others were female community leaders who were recruited through public announcements (Frisancho, 2013). One of the CARE staff, who had also formerly worked with ReproSalud, explained that she contacted women she knew through her network of former promoters to let them know about the new initiative. It had been nearly three years since the ReproSalud project had ended. She recalled that the women wondered if the idea was to continue with the same sort of approach.

I told them, “No, we are going to go further, we are going to make it better.” Negotiations were the way we did it before, but there needs to be somebody who says, “You haven’t done it” and “Why did you do it badly?” And that’s where the Defensoría came into things (Interview Anon.15, 2011).

For all of the positive achievements of ReproSalud, a critical lesson learned by women in the latter part of the project was that despite their new participatory spaces and their use of human rights discourse, they still had very little leverage when trying to raise concerns and problems with public health authorities. Partnering with the Defensoría was an innovative component within the new citizen monitoring model that was designed to lend additional leverage to the monitoring efforts of rural women.
5.2.1 Structure of the Citizen Monitoring Initiative

After the initial recruitment phase outlined above, the new citizen monitors receive training from a technical team comprising staff from CARE Peru, ForoSalud, the Defensoría and more recently, from the public health system’s Comprehensive Health Insurance plan (SIS). Training sessions cover a wide range of topics, including “human rights, health care rights, elements of democracy and citizenship, sexual and reproductive health and rights, the rights of SIS users, citizen participation and citizen monitoring, access to information, laws to protect citizen monitoring, ministerial norms on vertical delivery with cultural adaptation and the free issuance of certificate of live birth” (Frisancho, 2013 p.22).

At the time I collected data, the initiative had recruited approximately 60 women to act as citizen monitors to conduct monitoring activities in seven health care facilities (hospitals, health centres and health posts) in the district of Azángaro (in the province of Azángaro) and in the district of Ayaviri (in the province of Melgar). To conduct the monitoring, women work in pairs and are each asked to visit their designated public health facility approximately once or twice per week in order to observe health care delivery. Along with their regular monitoring visits, the women meet every two months with other monitors and the project team to discuss findings and prepare a collective report. Every few months, they present their findings to senior district health officials and other key actors in district-level forums.
Two regional NGO staff from CARE Peru and ForoSalud provide ongoing support and technical assistance for women engaged in daily monitoring activities. They also play a key role in report writing and supporting the presentation of results in district meetings with authorities. Technical support is also provided by staff from the Defensoría del Pueblo as well as by CARE Peru and ForoSalud national representatives when needed. Later in the project, staff from the public health system’s Comprehensive Health Insurance regional office (Seguro Integral de Salud – SIS), also joined the technical support team (Frisancho, 2013). In addition, the monitors are in regular contact with municipal workers in both Ayaviri and Azángaro. Meetings for the project are often held in the municipal buildings, and municipal staff members are familiar with and sometimes attend the formal district meetings with the health authorities.

While this formal structure is straightforward, in practice the initiative is quite complex. It involves a network of interrelated actors who interact across multiple layers of social relations of power. To support their authority in these actions, the monitors call upon their allies, participatory and human rights discourses, and key national laws and policies. Through CARE Peru and ForoSalud, the citizen monitoring initiative is connected to an extensive network of transnational allies. These include the other members of the international CARE family, as well as transnational epistemic communities of actors working on health governance, and maternal health and human rights.
5.3 Framework for Organizing the Presentation of Findings

The citizen monitoring initiative reflects a core tension discussed in the theoretical and methodological chapters and inherent in many efforts to promote social or political change through governance from below: The women who have been systematically marginalized and excluded from their public health system are now trying to hold this same system to account for the quality of its service delivery. The initiative is designed to reposition an excluded group so that its members are able to exercise influence over the quality of their reproductive health care. Are the organizing strategies of the initiative capable of changing the balance of power so that the monitors are able to do this? To what degree are these efforts successful in influencing the quality of maternal and reproductive health service delivery?

In the discussion that follows, I will analyze the citizen monitoring initiative as a governance initiative, drawing on the framework developed by Bakker and Silvey for examining governance. As I laid out in chapter two, Bakker and Silvey argue that governance initiatives have three interdependent dimensions: ideas, institutions and material practices (Bakker & Silvey, 2008 p.4). I will organize my discussion of the citizen monitoring initiative to look at each of these dimensions in turn. Doing so provides a useful way to explore different aspects of how the citizen monitors confront and navigate power relations in their attempts to influence reproductive service delivery. Attention to ideas provides an entry point for interrogating how concepts such as participation and human rights propose to reorient power relations within the
governance process. Examining daily practices\textsuperscript{62} allows me to focus on the influence of the practical and material activities of the citizen monitors and what impacts these have on power relations. Finally, considering the monitoring initiative from the perspective of institutions offers an opportunity to identify the role played by the formal sets of rules and practices that have been established among the participants. Together, all three dimensions provide a basis from which to consider the potential gains as well as the challenges associated with civil society struggles with the state for social protection and social inclusion in the reproductive health arena.

5.4 Dimensions of Governance: Ideas

This dimension of governance concerns those ideas that are used to justify and legitimate power within the governance framework established by the initiative. These are the ideas that are used to assert that the indigenous women volunteers and their allies are acting legitimately in their efforts to govern the delivery of reproductive health services in Puno. These ideas are intended to reposition the monitors within the existing networks of power relations and assert their authority to influence the governance of their local health facilities. As I discussed in chapter

\textsuperscript{62} In place of Bakker and Silvey’s term “material practices,” I am going to substitute the term “daily practices,” as it lends greater clarity in the context of my particular study. This term is consistent with my methodological approach of institutional ethnography. It begins from the standpoint of the everyday work practices of a particular group of local people (Smith, 2005), in this case the citizen monitors. At the same time, it still encompasses Bakker and Silvey’s conception of the practical actions that serve as (at times informal) sanctions and incentives for compliance within the monitoring process. It is thus a manner for identifying the concrete, tangible ways that participatory governance relates to reproductive health service delivery.
two, indigenous women are disadvantaged by what Quijano calls “the coloniality of power” where colonially-inspired hierarchies continue to influence power relations in modern society (Quijano, 2000). To exercise authority, the monitors must find ways to re-position themselves in the networks of relations that permeate their local health care facilities by using strategies to influence the micro-dynamics of power: the local, transitory and often contingent negotiation of power relations in the moment. The core ideas used to do this in the initiative are drawn from two sources: the international human rights movement, and the movement in Peru for a particular kind of governance called citizen monitoring (vigilancia ciudadana).

5.4.1 Citizen Monitoring

As set out in chapter one, the vigilancia ciudadana movement arose in Peru following the collapse of the Fujimori regime in 2000. The movement reflected profound public distrust engendered by revelations of systematic corruption and abuse of power. The term “citizen monitoring” is used to refer to a form of public participation in which citizens exercise an active oversight role over various forms of public administration (Barrientos & Alvarado, 2006, p.53, Benique undated, Gamero et al., 2004). At present, citizen monitoring is applied to a broad group of approaches in which citizen representatives assert the right to monitor and oversee government actions. This includes participatory municipal budgeting, oversight of the management of public finances and a citizen monitoring roundtable on sexual and reproductive rights.63

63 See, for example, www.unfpa.pe/intranet/aqv/informes/INFAQVOO15.pdf.
5.4.2 Human Rights-Based Approach to Health

As discussed in chapter one, over the past 20 years influential transnational and national epistemic communities have developed and promoted a human rights-based approach to health (Yamin & Miranda, 2011). This approach has become an accepted framework among UN agencies and many NGOs as a means of translating health-related human rights into relevant policies and programming.

Proponents of human rights-based approaches have argued that these approaches are important because they seek to change the power relationship between excluded populations and the state. The principal benefit of such a framework “lies precisely in identifying individuals as claims-holders and states and other actors as duty-bearers that can be held to account for their discharge of legal, and not merely moral, obligations” (Yamin, 2008, p.1). It shifts the debate from a discussion of “technical health policy questions” into “matters of political and legal entitlement” (Yamin, 2008, p.10). Thus, through a human rights lens, a public health problem such as preventable maternal mortality is re-framed as a violation of human rights.64

In addition, the rights-based approach incorporates participation as fundamental to realizing the human right to health. An official report drafted by the then UN Special Rapporteur on the Right to Health stresses the following:

64 In 2009, the UN Human Rights Council (HRC) Resolution 11 formally recognized preventable maternal mortality as a human rights violation (UN HRC, 2009).
a human rights-based approach requires that special attention be given to disadvantaged individuals and communities; it requires the active and informed participation of individuals and communities in policy decisions that affect them; and it requires effective, transparent and accessible monitoring and accountability mechanisms. The combined effect of these—and other features of a human rights-based approach—is to empower disadvantaged individuals and communities (UN Economic and Social Council, 2006, para. 25).

Ideas related to a rights-based approach to health and to citizen monitoring provide the participants in the vigilancia initiative with a number of resources for justifying their positions as citizen monitors. Both movements assert active political roles for citizens, either as rights-holders, overseers or claims-makers. Both emphasize the obligations of the state to facilitate citizen participation and oversight of government action. The training received by the citizen monitors emphasizes this framing. The monitors have a right and a responsibility to carry out their monitoring role. They are claiming universal rights of citizenship. A lawyer at the Defensoría in Puno described the results of the training given to monitors:

[The citizen monitors have been trained in what is the Right to Health] They know about how they are supposed to be treated from this normative framework. It isn’t something that they have invented (Interview Anon.23, 2011).

In the words of one of the monitors:
We received training from CARE Peru, ForoSalud, from the Defensoría…. [we were] Also [trained] about rights. That we have the right to be seen in private [during medical exams], that we have the right to information. Some of [the training] was like before [with ReproSalud]. But there were new themes. There were new themes we didn’t know. That we can monitor authorities, the Ministry of Health, that we have the right to denounce them to the prosecutor. That’s what we learned (Interview Anon.3, 2010).

This monitor articulates a change in perspective and perhaps authority that comes with knowing her rights and from her ability to position herself as an active, knowledgeable, political actor with an important role to play in the local health facility.

5.4.3 Opposing Ideas: Public Health as Charity, Rights as Too Western

As we shall see in the subsequent section, which discusses “everyday practices,” health workers initially opposed the presence of the citizen monitors in their facilities. A doctor interviewed in Ayaviri gave particular insight into the attitudes behind this opposition, which also helps to explain some of the roots of patient mistreatment. He argued that these stemmed from an ingrained perception among many health workers that public health is a form of charity, rather than a human right:
I think [these problems arise] because initially, health was seen as an act of charity. For example, here in Ayaviri, the hospital functions in a building that was the result of charity… Each city in Peru had its ladies’ groups, they’d raise money for health as charity. Most of our hospitals were created around that. And the staff, most of their medical training, even today, is fundamentally hospital-based, there’s very little emphasis on public health … That’s why, very often the attitude of health personnel is that they’re doing a favour for the person. And if they’re doing you a favour, then you can’t complain, no? And if someone complains, obviously they stop getting the favour. That’s the dominant conception. Even if it’s unspoken, it’s ingrained in our conduct (Interview Anon.17, 2011).

Others argued that the concept of human rights is sometimes unfamiliar to the citizen monitors. One key informant working with the initiative observed that, “The word ‘right’ is very western” (Interview Anon.15, 2011). She explained that during training with monitors, trainers look for common ideas found in human rights concepts and Quechua cultural practices, in order to build a conceptual framework rooted in the women’s own understanding. This approach mirrors findings from Molyneux and Lazar’s study of several NGOs’ use of rights-based approaches throughout Latin America in the 2000s (Molyneux & Lazar, 2003). NGO practitioners explained that when working with communities that are unfamiliar with rights, they would “find similar indigenous concepts and translate them into a language of human rights” (Molyneux & Lazar, 2003, p.89). They found, for example, that concepts of respect, dignity, justice and peace were effective places of commonality from which to begin conversations about rights (Molyneux & Lazar 2003, p.89).

In practice, many of the Quechua women trained as citizen monitors in Puno were already very comfortable with ideas related to human rights and use the concepts fluidly and strategically.
Some had worked with similar concepts within the ReproSalud project and readily took on the human rights framework on which the more recent citizen monitoring process is based. Other monitors interviewed reported also having participated in human rights training workshops offered through other organizations or through their municipality in recent years (Interview Anon.11, 2010).  

5.4.4 Legal Recognition of Human Rights and Participation in Peru

Over the past decade, the Peruvian state has enacted a number of laws and policies that incorporate ideas drawn from human rights and citizen participation. In particular, the Ministry of Health has begun to demonstrate formal support for a human rights-based approach to health, as reflected in key Ministerial Resolutions and strategic documents (Ministerio de Salud, 2011). The incorporation of these ideas within the bureaucracy, even if they are not systematically

65 In their own research on rights-based approaches throughout Latin America, Molyneux and Lazar also found many local communities were already familiar with human rights concepts, and argue that it reflects “the degree to which the language and practice of human rights has become a global reality” (Molyneux & Lazar, 2003:89). Nonetheless, the authors are careful to stress that this does not mean that rights are interpreted and taken up in the exact same manner in every location. Instead, the authors agree with legal anthropologist Sally Engel Merry, who argues that as “ideas from transnational sources travel to small communities they are typically ‘vernacularized,’ or adapted to local institutions and meanings” (Merry, 2006).
operationalized, lends further legitimacy to the use of human rights-based ideas, laws and policies as the basis for the citizen monitoring model.66

In 1994, President Fujimori passed a law on “participation and citizen control,” which establishes a number of mechanisms for enabling citizen participation, including procedures for recall and removal of public officials.67 During the Toledo administration that followed (2001-2006), participatory rights were expanded under a law that recognized the rights of citizens to participate in the implementation and oversight of state activities.68 Beginning in the Toledo years, a number of health-related national laws and policies have been passed that make explicit reference to human rights. These include Ministerial Resolutions on the promotion of human rights, gender equity and interculturalism in health;69 on vertical birthing (recognizing the right to give birth according to indigenous cultural norms with support from Ministry health

66 The participatory governance initiative in Puno is strongly linked to actors with deep ties in the right to health movement that has emerged in Peru over the past 15 years. ForoSalud, a large-scale umbrella network of civil society groups advocating nationally for rights-based health policies, emerged during the transition to democracy in the early 2000s. CARE Peru is a leader in ForoSalud and through its own programming has also been actively promoting the right to health and pressing for the incorporation of rights-based approaches in health policies within the Ministry of Health. Direct linkages with these national organizations that have institutionalized a rights approach in their own work lends important power and legitimacy to the use of a rights-based approach within the local governance model in Puno.

67 Ley N° 26300, Ley de los Derechos de Participacion y Control Ciudadanos (1994). The law was modified in 2009 by Ley N° 29313.

68 Art. 9, Ley N° 27658, Ley Marco de Modernización de la Gestión del Estado (2002).

workers);\textsuperscript{70} and on approving a national plan on maternal and prenatal mortality.\textsuperscript{71} Ministerial Resolutions 422-2008-MINSA\textsuperscript{72} and 040-2011-MINSA\textsuperscript{73} both recognize the right to citizen monitoring of public health facilities.

Although the operationalization of human rights and citizen monitoring norms by the Ministry of Health is still weak, the fact that actual laws and resolutions are in place provides an important foundation on which actors in the initiative’s participatory governance process can draw. A CARE Peru staff person recalls the early days of the initiative:

There was already law 26300 … it’s the law about citizen participation.\textsuperscript{74} … Once the women were trained, we presented ourselves to the health networks in Azángaro and Ayaviri, to explain to them and to present the monitors, to explain to the heads of the areas what the women were going to do. [Their reaction:] Rejection. Well, they [the health workers] didn’t know, they didn’t know it’s a law. They don’t know the laws, they don’t know anything like that. We told them that there’s a law that allows us as citizens to do monitoring … that we have voice and vote…. But in particular that in state institutions we’re allowed to intervene to improve the service to the users, that’s what the law says (Interview Anon.15, 2011).


\textsuperscript{73} R.M. 040-2011-MINSA, Aprueban el “Documento Técnico: Lineamientos de Política para la Vigilancia Ciudadana en Salud.” (2011)

\textsuperscript{74} Ley N° 26300, Ley de los Derechos de Participacion y Control Ciudadanos (1994). The law was modified in 2009 by Ley N° 29313.
The citizen monitoring project’s technical team has made sure that legal aspects related to the right to health care are included in the training modules. Frisancho notes that this includes case studies in which women consider “how rights were or were not respected in health care, what legal framework protects people in case of their rights not being respected and finally, to reflect on what role the monitors would have to promote quality and rights in health care services” (2013:23). To further equip monitors with strategic resources, project staff, together with the Defensoría, compiled a file for each pair of monitors to have on hand when conducting their monitoring visits. In the file are actual copies of the main rules and legal norms that relate to the monitoring process, including those pertaining to vertical birthing, the issuance of birth certificates and the right to citizen participation (Frisancho, 2013).

As a result of their training and hands-on learning as monitors, the women themselves often have greater knowledge of human rights-related national laws and policies (including those concerning participation, citizen monitoring and reproductive health) than many of the front-line health workers and administrators they encounter. The monitors are quick to use this knowledge and the framing ideas it contains as strategic leverage when carrying out their facility-level monitoring, and speak with pride about their familiarity with these laws and policies:

Our training [as monitors] around human rights was clearer and broader than before [in the 1990s]. This time we understood what our rights were and why we had them, about citizenship and citizen participation. Because before, there almost weren’t any of these laws. It’s a little like the authorities wanted to oppress us, no? They would say “Why do these women want to do these political things?” They’d even try to brush us off. But now … with the citizen participation law … – and there’s another law
about access to information which is law 27806—these laws protect us. We can get information, we can request a report from the authorities about something we want to know about and that we have doubts about … So the laws protect us, now that we know what they’re about…. Even today, the authorities don’t know, they don’t all know about these laws. They’re not really informed (Interview Anon.11, 2010).

While human rights are codified in laws and policies, they are not necessarily respected or implemented in practice. Some of the actors in the citizen monitoring initiative feel that there is still only a fragile acceptance of health-related rights on the part of many staff in the Ministry of Health.

Yes, the talk is there. But this is a norm, a standard, that each facility has to have posted somewhere visible, every office. Sometimes it’s there, sometimes not. (Interview Anon.15, 2011)

Political scientist Christina Ewig observes that there were different groups within the Ministry of Health bureaucracy in the 1990s and early 2000s, in particular between supporters of neoliberal versus human rights-based approaches, with the neoliberal faction holding more sway. She notes that there have been some recent shifts within the Ministry, with the rights-based supporters beginning to gain more traction. However, it is too early to know the real influence of that position within the organization (Ewig, 2010).

5.5 Dimensions of Governance: Daily Practices

Taking a “rights approach” to health demands that we engage with the messy, context-specific questions of how rights are made real, services are revised, policy makers and local authorities are convinced that
their practice must change, and affected persons act as if these rights can in fact underpin their actions and demands (Miller 2005, cited in Miranda & Yamin, 2010, p.199).

In this section, I will explore the daily practices used by the initiative to press for compliance and for rights to be “made real.” I focus on one primary feature of the initiative: the regular physical presence of the monitors as observers in health facilities. Through this practice, the monitors are able to play and move between a number of official and unofficial roles. They are observers, witnesses, sometimes promoters, sometimes advisors and sometimes advocates. Their presence in the facilities as direct observers creates an alternative form of oversight outside of the system of management maintained by the Health Ministry. Their presence also enables the monitors to choose between taking the formal route (recording events to be raised at a district-level meeting) and informal actions that can address problems as they are taking place. As we shall see, these informal actions involve the mobilization of strategic allies or direct negotiation with health facility staff. These actions serve as important persuasive practices that encourage a degree of heightened respect by (some) health workers for institutionalized rules, regulations, norms and standards that are supposed to guide their work.

I begin with a brief overview of the observation activities performed by monitors. Next, I examine the preliminary issue of how the citizen monitors gain access to health facilities to do their work: how they have negotiated relationships with health workers in order to carry out their responsibilities. Then I discuss the different ways that the presence of the monitors in the health facilities has material implications for patients in a number of important areas. These areas include: intercultural sensitivity, delays receiving care, mistreatment and economic issues.
Finally, I look briefly at the personal costs that monitors experience by carrying out their observation activities and maintaining their presence at health facilities.

5.5.1 Observation Activities

Citizen monitors are responsible for observing the provision of health service delivery, with particular attention paid to the quality of care provided to health care users. They are tasked with observing and reporting on both the interactions between health care users and service providers, and the general environment within the health facility. Monitors converse with health care users to find out how they feel they have been treated, and whether they encountered any difficulties or had any concerns. In particular, they find out whether people received treatment in their own language, if there were any financial charges, if they are registered for the free health insurance program (SIS) and other related topics (Frisancho, 2013).

Since this initiative was originally designed to improve maternal and reproductive health service delivery, the monitors have particular contact and relationships with the midwives, several of whom have been especially supportive of the monitors’ presence (Interview Anon.2, 2010). Monitors also cover a broad range of health delivery services during their shifts, including child health services.

At the end of their monitoring round, the women ask a senior health worker to sign a report form that proves that the monitor was present that day. The report is used in district-level
meetings between monitors, allies and senior health officials. The use of this reporting format will be discussed in more detail further on in the chapter.

5.5.2 Confronting Resistance to Facility-Level Monitoring

Before beginning monitoring activities, the senior staff from CARE Peru’s Lima office, along with the head of the Defensoría del Pueblo in Puno and the local citizen monitors, presented themselves and the initiative to the senior health directors in each district. They explained that they were responding to the frequent complaints by health service users about the patient mistreatment, illegal fees and other common concerns. They found that their alliance with the Defensoría provided important leverage in these initial meetings:

When we first went to Azángaro, they [the Health Ministry officials] were saying to us “Why are you doing this monitoring? Where is the signed agreement? Where does it say that CARE and ForoSalud are going to monitor?” And the Defensoría said that we don’t need it. Also, that there would never be a signed agreement between the Defensoría and the Ministry [because the Defensoría is mandated to monitor state institutions] (Interview Anon.15, 2011).

In fact, presence of the Defensoría aside, the women have the right to monitor health facilities as members of civil society. This right is recognized by the Ministry of Health itself in its own official policies, Ministerial Resolutions 422-2008-MINSA and 040-2011-MINSA. For

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example, the 2011 Ministerial Resolution: Policy Guidelines for Citizen Monitoring in Health, states that “citizen monitoring … allows for the exercise of the right to health (universal access to health) … promoting more efficient, transparent public management and good government practices” (MINSA, 2011, p.3).

To conduct their actual monitoring, the women work in pairs and visit their designated health facility an average of once or twice per week. Each monitoring shift lasts approximately six hours. On arrival, the monitors show their identification badge and present themselves as monitors to the senior health worker on duty.

The badges help us. The midwives say, “The women are here with their badges, they’re monitors.” That’s the way they identify us (Interview Anon.2, 2010).

The badges play an important role in helping the monitors obtain access to the facilities so that they can conduct their monitoring duties. Each badge bears the woman’s name along with the name and logo of the supporting institutions: CARE Peru, ForoSalud and the Defensoría del Pueblo. The name of the Defensoría carries particular weight in the accreditation process since it is a well-known state institution formally tasked with oversight of the public sector and

ensuring respect for human rights. The use of these badges by the monitors is another attempt to influence the micro-dynamics of power relations among the monitors and health workers. The badges confer symbolic authority on the monitors and they demonstrate the monitors’ endorsement by their allies at the Defensoría.

One Defensoría staff person noted:

We gave the women badges, because it’s a way that the women have something to back them up.

Hopefully there will come a time when a citizen, by virtue of simply being a citizen exercising her rights, will be able to do this without the need to count on an institution for credentials (Interview Anon.22, 2011).

Despite these preparations, the monitors still faced considerable resistance from health workers when they first began their monitoring work. Although the project had been presented to the hospital directors, it had not been fully communicated to health workers and many did not understand the objectives of the process or why the monitors were suddenly present in their work places.

The monitors bore the brunt of the initial backlash from many health workers. One citizen monitor recounted those difficult early days:

I didn’t want to go again after the first time. They [health workers] treated me badly. I didn’t want to go back. Even my husband told me, “This is going to make you feel badly.” I felt like they had lowered my morale, me who had had such high self esteem, they lowered it to the ground. “Why [are you here], don’t
you have anything to do?” they said to me. “You’re lazy,” they told me. That’s what they said. I felt badly … I told [NGO worker] about it. She told me, “No my friend. You have nothing to feel ashamed of. Little by little you’re going to get past this.” And it’s true, I have, I’ve gotten past it (Interview Anon.6, 2010).

The woman explained that, over time, the health workers in her small local health post noticed that she would speak to the health users in Quechua, that she would play with the children in the waiting room. Little by little the workers and the monitor began to form social relationships. The workers saw that she was also willing to assist them with translation when talking to health users, and other basics in their understaffed and under-resourced setting that actually facilitated their work (Interview Anon.6, 2010). One could question whether these kinds of new social relationships might jeopardize the objectivity of the monitor. Within the reality of a small, under-staffed health post, however, it would likely be difficult for a monitor to take a more formal and arms-length stance compared to if they were monitoring in a large hospital.

In the face of significant backlash, some of the monitors drew on their training and knowledge of laws, norms and policies to help them gain leverage. One monitor explained how she used her new knowledge in the very early days of the initiative to help her counter resistance from a doctor in her local hospital:

I told him, “Excuse me doctor, but this is a public institution, this is not your house or anybody’s house. I have the right to come here, the law allows me to,” I said to the doctor. The doctor said to me, “No, professional people should come here. Not people like you.” He said it to me like that. So I said, “Excuse
me doctor, but we are equals. The law is equal for everybody, that’s what the Constitution says. So you’re a professional and I’m not a professional, but we are equal before the law.” The doctor didn’t say anything then. He’d tried to scold me, but I wouldn’t let him scold me. I knew better, I’d been trained. According to the doctor he was humiliating me. But no, I didn’t let him humiliate me.… We talked about it more, later, with other staff, in a meeting. Now, that same doctor isn’t bad anymore. He’s good with us (Interview Anon.11, 2010).

Even when there is support from senior health officials for citizen monitoring, the staff reaction can nevertheless be fraught. One senior health worker explained that he was appointed to a management position just as the initial monitoring program was launched. He noted that there was strong backlash and a great deal of mistrust about monitoring among hospital staff. The issue was complicated by institutional politics related to the change of directors. Internal rumours circulated that the citizen monitors were in fact “spies” and that they were there to try to have staff members who were unaligned with the new hospital director fired from their posts (Interview Anon.17, 2011).

While resistance continues from some workers, in general the climate for on-site monitoring has improved over time. Recognizing the implementation gap, NGO organizers have made an effort to provide more detailed information about the purpose of citizen monitoring activities and have
also organized training with some of the health staff in Puno about the right to health; the training is co-led by a Lima-based Ministry of Health staff person.\footnote{One health worker who works especially with pregnant women recalls her own impressions of the monitors over time:  
At first I was a little angry, because it seemed like they [monitors] were asking more about patients’ rights and not the duties they should have. Later we talked about this, we met with all monitors. That’s when we understood that it wasn’t only happening here, that it was taking place all over Azángaro … (Interview Anon.27, 2011).  
This worker’s comment highlights the importance that health providers also place on the idea of patients’ “responsibilities.”}

Another senior health worker felt that it was also a process of relationship building, with both workers and citizen monitors learning about this new role:

They [monitors] have a different vision, and it takes some time to find a middle ground, through a process. I explained this to them, I said “the hospital is going to think you’re attacking them by monitoring, because this custom doesn’t exist here. But you are also going to have to understand that there are certain rules, certain hours…. We have to all go along adapting ourselves little by little, and finally we’ll arrive at a middle ground (Interview Anon.17, 2011).

The senior worker acknowledged that despite initial resistance, over time there has been a growing acceptance on the part of health workers about the presence and role of monitors.
5.5.3 Challenges Faced by Health Workers

The precarious labour context of many health workers (the ongoing legacy of 1990s neoliberal health sector reforms) adds a critical dimension to the practice of citizen monitoring. The health workforce in Peru is made up of a complex system of workers holding myriad types of contracts with vastly different labour arrangements. This creates health units in which workers of the same category (e.g., nurses) can be employed under vastly different labour standards, including job security and remuneration. One nurse spoke about her frustrations of having been on a series of temporary contracts for several years:

They [Ministry of Health] is always demanding that we promote health…. They tell us we need health families, healthy food. This is all good…. But more than anything, they forget about health workers. Who we are. That we’re very far away from our children, that we receive an absurdly low salary. They talk to us so much about health promotion, when health workers are so mistreated…. With our new contracts, they’re more or less telling us that we’ll never be permanent, we’ll never have stability. With these contracts they can fire you at any moment with no benefits. For example, I’ve given eight years of service, but none of it does me any good, because I’m contracted as CAS-PPR, you can’t do anything with that (Interview Anon.31, 2011).

Many health professionals have been brought into the health workforce on a series of fixed-term contracts, without ever being incorporated into the career structure (Urcullo et al., 2008). Workers under these contracts lack job stability, with contracts renewed periodically, sometimes as little as every three months, depending on the circumstances (Urcullo et al., 2008).
Health workers face further challenges given the health sector’s lack of an official salary policy. This creates health units in which the same category of worker can be employed under vastly different labour standards, including remuneration. Salary structures have been determined over time in the context of broader policies, especially fiscal austerity, as well as legislation around public employment (Urcullo et al., 2008). A complicated system of bonuses that lacks coherence has developed over the years and creates further confusion within the system. The Ministry of Health is apparently in the process of developing a comprehensive salary policy, but so far this process has not been completed (Palacios, 2013).

It is also worth noting that the increased demand for services on the part of health users now insured under SIS has not been met by equivalent increases in budgets to address the need for more health workers (Francke, 2013). This increased patient load further exacerbates health workers’ difficult labour conditions.

These labour conditions are hardly unique to Peru and are indicative of broader global trends related to neoliberal restructuring of the labour force. Highlighting the poor working conditions of health workers demonstrates the complex environment in which citizen monitors carry out their tasks. It also speaks to the careful balance that needs to be struck in order to forge effective working relationships between monitors and health facility staff. In some cases, this appears to be working well; in others, however, these social relationships remain tenuous. It also speaks to the complicated ways in which power circulates as marginalized women take on these new
positions that come with at least some degree of pseudo-authority. This is a new and unfamiliar
dynamic for both the health staff and for those women who act as citizen monitors.

5.5.4 “We Also Save Lives”: Moving from Observer to Advocate

In the following sections, I discuss some of the implications that the presence of the monitors
has for the communities that are served by the health facilities. I also examine how monitors
may move from an observer to an advocate role in order to address a pressing patient issue such
as a delay in receiving care.

While officially tasked with observation, in practice the monitors’ activities extend far beyond
that role and respond to the fast-moving nature of health service delivery. Much of the concrete
work done by the monitors takes place on-site and in the moment. When the monitors are
concerned about something they encounter, they call their allies for back-up and support. They
call the Defensoría del Pueblo if they feel there is a pressing need to intervene in an urgent care
issue. They call officials from SIS if there is an insurance-related concern. Finally, they are in
regular contact with their NGO allies for more general advice on issues when they are unsure of
how best to proceed. As a result, the on-site presence of the citizen monitors in the health
facilities creates linkages to these broader networks of allies and can have immediate
implications on the reproductive health and livelihoods of marginalized women.
The informal expansion of the monitors’ role from observation to some degree of intervention/advocacy reflects the realities of how fluidly issues arise. A lawyer from the Defensoría acknowledges that, although the monitors’ official role and mandate is supposed to be limited to observation, realistically they go beyond that “because waiting until the Defensoría or another authority arrives to ensure that this right to health is respected can be very difficult or can happen very late” (Interview Anon.23, 2011).

The importance of the “observation plus” or advocacy role adopted by the monitors is especially apparent in relation to maternal health. In the most extreme cases, the surveillance and subsequent immediate actions by a monitor might save a woman’s life. Monitors are regularly present in the health facilities, so they have the opportunity to see health service delivery in action. One monitor recalls a particular event while she was on a shift:

There was a patient who had been transferred from Macari. She was nine months pregnant and in grave condition. They couldn’t do anything for her in the hospital here, even though she needed a cesarean. They said there wasn’t an anesthesiologist available. So she had to go to Juliaca. I went with her to Juliaca to make sure they did everything. At first in Juliaca, they told us there wasn’t an anesthesiologist available there either. I said that I was going to complain to the Defensoría…. It was nighttime, but I had their cell number. So I called and they helped solve things…. The Defensoría helps because when we call them, they call the doctor, they call the Director, so that they’ll treat them [the patients] quickly…. They [health staff] are scared that those cases could be denounced…. If the Defensoría calls, they will treat those cases seriously. That’s something that we can do. And we also didn’t pay anything, because I knew not to. They even tried to say to buy two units of blood. I said that you aren’t going to make the patient pay for that! With her insurance and with the help of the Defensoría, all her medications were covered. If that woman
had been here she would have died, her blood pressure was terribly high…. We made sure about her insurance, we went with her and the doctor in the ambulance, we never left her. That’s how it is. We also save lives (Interview Anon.3, 2010).

In a widely cited 1994 *Social Science and Medicine* article, Thaddeus and Maine present a conceptual framework, “the three phases of delay,” that outlines key factors preventing pregnant women from receiving timely and adequate obstetric care and contributing to maternal deaths: (1) delay in decisions to seek care, (2) delay in reaching care and (3) delay in receiving care (Thaddeus & Maine 1994). The 2007 Physicians for Human Rights (PHR) report, *Deadly Delays: Maternal Mortality in Peru, A Rights Based Approach to Safe Motherhood*, builds on this conceptual framework and argues that the factors underlying the three delays are human rights issues. Interpretations of international human rights law stipulate that health care should be available, accessible, acceptable and of high quality for the whole population (UN CESCR General Comment 14, 2000). A lack of any of those dimensions can lead to delays for women in seeking, reaching and/or receiving care (Physicians for Human Rights, 2007). As well, underlying conditions such as anemia, malaria, HIV/AIDS and TB, each with their own human rights-related dimensions, can further complicate a woman’s health care needs and heighten her susceptibility to maternal mortality.

In the monitor’s anecdote above, the pregnant woman had sought and reached care. She then faced difficulties in accessing quality care, however. The monitor’s intervention with the help of the *Defensoría* ensured that the woman actually received appropriate emergency care in a timely manner and that she was not unfairly charged for health services that were officially covered
under her public health insurance coverage. Through their role as citizen monitors, women are becoming increasingly adept advocates vis-à-vis the public health system. This advocacy role will be explored further in chapter six.

Although monitors sometimes observe and address a crisis in a health facility as it occurs in the moment, their objective is not to place specific blame on individual health workers. Instances such as the emergency described above are also documented and shared through reports in periodic district-wide meetings with health authorities. These reports and meetings provide the monitors and their allies with an opportunity to identify recurring problems and flag systemic, institutionalized problems within the health system. This process will be discussed in further detail later in this chapter.⁷⁸

5.5.5 Promoting Respect for Intercultural Norms: Observer and Advisor

As noted earlier, progress has been made in recent years in addressing intercultural and human rights issues in the Ministry of Health. In 2005, the Ministry of Health passed a Ministerial Resolution on vertical birthing that provides for the cultural accommodation of indigenous

⁷⁸ I have no data on whether there were any repercussions for the front-line staff after their director was called by the Defensoría. This facet of the monitoring process would be interesting to explore in future research.
birthing practices. In 2006 the Ministry also passed a resolution that committed the organization to integrate human rights, gender equity and intercultural accommodations into the provision of health services.

The Defensoría in Puno, although constrained by its limited number of staff, has been slowly providing oversight of the Ministry of Health’s norm on the accommodation of vertical birthing and respect for cultural practices, and notes that its use in health facilities is still uneven and inconsistent. A staff member from the Defensoría’s office acknowledges the importance of the monitors’ presence in helping govern the implementation of those Ministerial rules that are designed to respect intercultural themes related to pregnancy and birthing:

We feel like a positive thing from this citizen monitoring is that treatment by the doctors, the nurses, the midwives has been changing. For example, in Azángaro around intercultural issues, the health workers were notorious. If women from rural areas came with their cloth and fleece to receive their newborn, they [the health workers] would reject it, saying “No, you have to buy these other things here, like these pampers [disposable diapers].” And often people didn’t like that. But I think with monitoring they’re [health workers] starting to get better (Interview Anon.23, 2011).

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In 2009, the government opened up a birthing centre that was attached to a local health facility in Azángaro. The centre is intended to provide a comfortable setting for women from rural communities to deliver their babies in accordance with their cultural traditions. Women from far away arrive at the centre two to three weeks before their delivery date. Those from the town of Azángaro generally arrive a few days before their due date (Interview Anon.27, 2011).

The citizen monitors regularly visit the birthing centre to observe whether Ministerial rules and norms are being met in terms of care and treatment within a Quechua-focused approach to birthing. Seemingly small details, such as the monitors’ identification of the need to provide wooden beds instead of standard-issue iron bed frames, help increase women’s acceptance and comfort level in their stay at the birthing centre, as well as build confidence among Quechua women around the idea of coming to the centre for future deliveries (Interview Anon.11, 2010).

As an alternative to the birthing centre, health workers also encourage women to deliver in either of the two district hospitals. If health workers consider a woman’s pregnancy to be high risk, the workers send the woman directly to the hospital for delivery, or she is transferred there from the birthing centre. The presence and feedback from the citizen monitors has also been important for improving the physical conditions for hospital-based deliveries. A senior midwife from one of the district hospitals recalled her initial mistrust of the monitors’ presence. But then she began to see ways in which the monitors actually began to help her improve service provision. She explained:
At first, not just me, all of the staff, we were saying, “Oh, they’re going to come and watch how we work. Who are these people? They shouldn’t be here.” … But then, we’ve been able to have exchanges about problems that they have presented to us [the monitors], cases that patients wouldn’t say directly to us…. We’ve been able to make improvements, and there are less complaints. And really, I’d say there are more patients [pregnant women] coming now (Interview Anon.28, 2011).

She went on to provide a concrete example of an infrastructure problem that had been identified by the monitors and addressed by her staff:

Our rooms here in Azángaro [hospital] are like in all places, made of cement. And with the cold, sometimes it gets to minus eighteen degrees below zero. Sometimes in the months of April, May, June, July, sometimes we have fewer deliveries here, because of the cold. That was one of the complaints of the monitors – that women didn’t come to deliver in the hospital because it was too cold. So we revised it all, we covered all the walls and all that. Now the rooms are a little warmer and we have more influx [of pregnant women]. And also, they bring the clothing that they’re going to use, their blankets, their teas. All of this has contributed to more women coming (Interview Anon.28, 2011).

5.5.6 Addressing Cases of Mistreatment

The monitors also strive to ensure that the overall quality of care provided to health users is respectful and appropriate. This can be a serious issue for Quechua women in Puno, with real ramifications for access to health services. One monitor talked about an interaction she had with a health provider around patient treatment:
One time I took my mother [to the health facility]. She didn’t want to go, “They’re going to tell me I can’t come more times this month,” she said. “OK, so I’ll go with you, since I know now about what kind of service they should give, because we have rights.” So I went, and it’s true, they were reprimanding my mother. So I said, “Miss, how is it possible? It’s her right, she’s coming for only the second time, not the third, no?” (Interview Anon.5, 2011).

The monitor was able to advocate for her mother and resolve the situation, but her experience speaks to the particular challenges that vulnerable groups face in trying to seek out health care.

Some real progress has been made in relation to quality-of care-issues since the beginning of the monitoring process. However, several monitors also note that improvements are inconsistent. Complaints concerning patient mistreatment continue to be high. Financial charges for services that should be covered by public health insurance remain a consistent problem. The monitors acknowledge that health users tell them that treatment is much better when the monitors are present, but that it often slides back to old patterns when the women are no longer on their shifts (Interview Anon.2, 2010; Interview Anon.11, 2010). This suggests that the impact of the governance process is very much a work in progress and that some sort of additional measures are potentially needed to embed these new patterns of behaviour more deeply within the health care system.
5.5.7 Economic Issues for Health Users: Insurance Coverage, Unjust Fees and Charges

Another important area in which the monitors’ on-site presence in the health facilities has material implications on the lives of health care users concerns the newly expanded public health insurance scheme, Comprehensive Health Insurance (Seguro Integral de Salud or SIS). As discussed in chapter four, limited public insurance was introduced to pregnant women and to school-age children in the late 1990s under the Fujimori regime. These schemes were amalgamated under President Toledo in 2004 and expanded with the passage of the Universal Health Insurance Law in 2009. The new insurance scheme is planned for progressive implementation and is intended to ensure that the poorest sectors of Peru will have basic health coverage (Ewig, 2010).

Despite the fact that public health insurance has been substantially expanded, in practice these benefits are not always accessible, especially for marginalized and excluded groups. At the time of this research, transition to this newest form of public health insurance was still in progress in Puno and there was substantial confusion among the public as to how to obtain coverage. Members of marginalized groups were often unaware of their entitlements under the new insurance system as well as how to complete the administrative paperwork necessary to enroll in the program. One monitor explained that she would periodically convene the women in her community and talk about the new insurance coverage. Then she would organize a trip to the appropriate office to assist everybody in completing the necessary administrative process to enroll in the insurance scheme (Interview Anon.3, 2010).
A senior SIS official in Puno explained that some of the difficulties associated with accessing health entitlements stem from the early days of the populist-based Maternal Health Insurance and School Age Health insurance schemes in the 1990s. This official felt that these generated certain kinds of conceptions associated with public insurance from both health care workers and the population:

Little by little it’s changing, but there’s been this idea that since everything was free, it wasn’t the duty of health staff to serve you, instead it was like they were doing you a favour. As though, “I’m doing you a favour, since I’m treating you for free, or I’m doing you a favour by registering you [for health insurance]” (Interview Anon.26, 2011).

In interviews, both monitors and their allies identified another frequent problem facing health users: that health workers would charge them to pay out of pocket for services or medicines that are in fact covered by public insurance. Citizen monitors, sometimes in collaboration with staff from the regional SIS office or the Defensoría, have been somewhat successful at resolving these illegal charges. They seem to be more effective when acting informally and in the moment at the facilities, and less successful at resolving these individual issues through the larger district meetings.

Sometimes the charges related directly to maternal health issues. For example, one monitor described her intervention, along with assistance from Defensoría and SIS staff, to ensure that a
woman did not have to pay for the caesarean she was being charged for, as the service was covered under SIS (Interview Anon.6, 2010). Monitors regularly speak with women in the health facilities that have recently delivered babies, to make sure that they have not incurred unfair charges, and to facilitate reimbursement if necessary.

One monitor recalled her frustrating efforts in assisting health users to obtain full access to benefits from the public health system. The process for accessing SIS is still complicated for many people trying to use health services. As well, she finds that health workers continue to charge patients for items that should be covered under the insurance scheme:

Since they’re in the middle of changing the insurance system, there are lots of problems. Some have the old insurance that should be good until October or November, but now they won’t accept it. The women don’t understand, since it says it’s still good. You have to update it or you have to pay. Still, more people come now because things should be free. They still always try to charge you for your bed when you deliver, for your food, all that…. Sometimes we present cases in the meetings [with health officials] about unfair charges. They want the receipts. Sometimes we can provide them. But other times, we can’t get receipts. They [health workers] make the patient pay 100 soles [35 USD] and we have nothing to complain with. We go to try and they deny it…. We make calls on our cell phones for more help…. And we get training about how to act, about what to do in cases, about how they should respect rights, that they shouldn’t charge unfairly, they shouldn’t abuse women who aren’t informed (Interview Anon.3, 2010).

A senior official in the regional SIS office in Puno noted that her office also tries to supervise the insurance implementation process, but that they simply lack the necessary human resources.
At the time of this study, the SIS office had five staff in charge of public health insurance coverage for 423 health establishments in the region. Although SIS had intended to eventually develop some kind of internal monitoring of the insurance system, nothing was yet in place in the region. The official explained that their own lack of internal monitoring capacity was a major factor in motivating them to partner with the CARE/Foro Salud citizen monitoring initiative (Interview Anon.26, 2011).

Difficulties around payments are further complicated by the structural limitations of SIS itself. Its budget comes directly from the Ministry of Economy and Finance, but it has never been well funded. In particular, budget increases have not kept up with the demand for services, nor with the expansion in the number of services it now covers (Francke 2013). Within this context, it is not unusual to find SIS backlogged with debts to hospitals and health networks (Francke, 2013). Unfortunately, too often, citizen monitors find that these structurally related financial problems are passed directly on to the health user.

Another unfair cost incurred by poor families is an illegal fee charged by health workers to parents when they try to obtain certificates of live birth for their new infants. These charges are especially common if the delivery did not take place in a health facility, thereby discriminating against women who, for myriad reasons, delivered at home. A certificate of live birth is an essential document. It is a prerequisite for obtaining a birth certificate and is supposed to be issued free of charge. Birth certificates are the primary piece of identification needed in order to be eligible for all sorts of other benefits of citizenship, including enrollment in public health
insurance. The denial of a certificate of live birth unless payment is received is therefore highly coercive. A 2006 study by Amnesty International Peru reported similar findings in other remote areas of Peru and highlighted it as an example of the ways in which poor and excluded women are denied their right to quality maternal and child health care (Amnesty International Peru, 2006).

Monitors in Ayaviri and Azángaro, in collaboration with the Defensoría, have helped to address the illegal charges for these certificates. One Defensoría lawyer recounted receiving a call from a monitor explaining that somebody had been charged unfairly for the cost of the certificate and given a receipt that did not stipulate the type of charge, but instead listed it as an “other service.” The lawyer called the senior official in the health establishment. When that failed, he called the director of the district health network, who investigated the matter and ensured that the woman was reimbursed. “Within three days they had returned the money and the citizen felt like her complaint had been paid attention to” (Interview Anon.24, 2011). Attention to these seemingly small details can be important in helping to build the fragile trust of traditionally excluded groups in the public health system.

One nurse interviewed explained that, in the past, she and her colleagues routinely charged money to issue a certificate of live birth, even though they understood that this was against the rules. She argued that the money collected did not benefit her or her colleagues personally. Rather, it was used as a small fund to pay for the ongoing, informal and unbudgeted costs associated with their positions. For example, she explained that they used it to purchase gas for
the centre’s motorcycle (which is used by the health extension workers). As well, following a safe delivery, it was common for health users to ask the nurses to be godparents to their children which requires that the new godparent give a gift to the family. The nurse explained that money from the common fund was used for those sorts of purchases, which otherwise would come out of the workers’ own pockets. She noted, though, that with the onset of citizen monitoring, she and her colleagues had stopped their practice of charging for the birth certificates, for fear of being denounced (Interview Anon.34, 2011).

Clearly, health workers should not be charging fees for these documents. However, this nurse’s story highlights important structural weaknesses in the health system. Essential operating supplies, large and small, need to be covered by institutional budgets. In this instance, costs related to the functioning of the health facility are being passed on to the health user. This case also highlights the irony that when some of the nurses and midwives who actually provide quality care and form positive relationships with health users may also encounter certain work-related social obligations (for example becoming godparents). These can come with financial implications that go unacknowledged in their daily practice. These sorts of costs are also not covered by institutional budgets and are not easy to repeatedly cover on health workers’ own low salaries.

Health users are also sometimes charged for medicines that are officially covered through insurance or are required to purchase part of their medications (described as “unavailable” through the public system) privately from local pharmacies. Some of these cases are simple
examples of corruption, especially when some of the health workers have direct links to certain private pharmacies. Other cases, however, are linked to systemic problems in staffing and in management of the supply chain for medications in the public health system. A Ministry of Health pharmacist told me in an interview that she had been the only member of her profession responsible for overseeing the pharmaceutical needs of all the health facilities in the district (hospital, health centres and health posts) for the past decade. This had made it extremely difficult to manage the drug supply system. She had only very recently received more staff. The pharmacist also observed that SIS is still slow to send the necessary reimbursement for medicines, which creates further delays in the supply chain (Interview Anon.30, 2011).

In addition, according to staff connected with the monitoring initiative, health users are often asked to sign a receipt certifying they received their full drug prescription when they only receive half. In these cases, monitors encourage health users not to sign the receipt. However, the monitors acknowledge that it is still difficult for health users to actually do this (Interview Anon.3, 2010). This puts the health user in a difficult position, since not signing the receipt might make it difficult to get even the half of the medication she should be allocated. She may have travelled far to come to the health facility and cannot easily return to it.

Sometimes monitors are able to help health users who may be charged very large, unfair costs. One monitor explained that there had been a death in the hospital and that health staff were making family members pay the related medical costs:
We quickly called the *Defensoría* and explained that there had been a death, and that the staff were making the family pay 200 soles [70 USD] [for an autopsy]. And what happened? The *Defensoría* immediately made a call to the [hospital] Director and the money was returned (Interview Anon.9, 2010).

Public health care facilities are a site for potential economic exploitation of health care users, as well as for other forms of mistreatment. The record of success reported by the monitors in obtaining reimbursements for health care users facing illegitimate or illegal charges in health care facilities highlights a particularly tangible benefit for people whose livelihoods are already precarious. It seems likely that the monitors’ ability to show concrete results by having money reimbursed contributes substantially to their reputation in their communities and may also help over the longer term to generate deeper confidence in the reproductive health services among systemically excluded indigenous women.

### 5.6 Dimensions of Governance: Institutions

The final dimension of governance identified by Bakker and Silvey concerns institutions, the sets of rules and practices “through which influence is stabilized and reproduced” (Bakker and Silvey, 2008, p.4). The institutional structure of the *vigilancia* initiative features two components that are designed to provide stability and consistency in its governance influence. The first component consists of the facility-level monitoring described above. The second component concerns a set of regular, official meetings that take place at the district level in which monitors and their allies share their findings with district health officials. The reports generated by facility-level monitoring are presented in the district-level meeting space.
5.6.1 Monitoring and Reporting at the Facility Level

The work of the facility-level monitors was explored in the preceding section. The observations and actions that take place at a facility level are critical to the governance process and much is actually dealt with and resolved on-site and in the moment. A seemingly simple reporting process is used to link the monitoring tasks performed in each health facility to higher-level, district meetings that are intended to produce opportunities for systemic change within the health facilities. Each monitor is required to complete a report form at the end of her monitoring shift. The form includes the name of the monitor, the facility in which she has performed her monitoring duties and any observations. On completion of her shift, the monitor is required to have her report form signed by one of the health workers on duty during that period.

In practice, for some monitors, the report form functions primarily as an attendance form, simply proving that she was actually present on a certain date at a particular time:

> After doing all my monitoring – usually I stay around three hours or so – after that I ask the midwife or the doctor to sign my form to show I was there. But I have another notebook where I note down everything that is happening in the hospital. Any observations I have, I have to write them down there. Because they [health staff] don’t accept that they’ve made any errors … so we note it down in our separate notebook (Interview Anon.2, 2010).
As a strategy for circumnavigating the uneven power dynamics with facility staff, this monitor omits critical findings on the report form that needs to be signed by the health facility workers. Details of her actual observations are usually written in a separate notebook or on different sheets of paper that the monitor keeps with her.\(^{81}\)

The actual observations made by the monitors are collected every two to three months in an internal reporting meeting held between the monitors and project staff from CARE Peru and ForoSalud. CARE Peru convenes these meetings in each district so that all of the monitors can come together to share their findings from the previous month. In the words of one monitor:

First we inform xx and xx [CARE Peru/ForoSalud members]. They listen to us. They note everything down, all of the details. Each monitor gives their information and we all listen to each other. They note down the dates, how we’ve helped, what we’re doing, how things are working with SIS, what the midwives are treating women, in other areas as well – not only with pregnant women. Monitor by monitor we give our reports. They note it down and afterwards they prepare a general report, a summary. Based on this we then request a date to meet with the Director and the health workers, the nurses and the midwives (Interview Anon.2, 2010).

NGO staff play a crucial bridging role in the reporting process. In particular, they record and synthesize the observations reported by the monitors. They create a meeting space in which the

\(^{81}\) Further investigation would be needed to understand how common it is for monitors to use this creative approach to reporting in the context of uneven power dynamics.
monitors share their information openly and listen to one another’s experiences. In an informal manner, each collective meeting acts as a learning forum both for the monitors and the project staff. There is ample discussion about the different cases, about what was done or should have been done, as well as discussion about proposed next steps if the situation was not resolved on-site. Staff use this information to produce a report, what the project refers to as a “dialogue agenda” (Frisancho, 2013:24) that identifies the current most important issues concerning quality of care in the monitored facilities. In an effort to foster a constructive conversation, the report highlights both the problems the monitors witnessed as well as the things they observed that were positive. This report is shared with their allies—the Defensoría and SIS staff—prior to the formal district meeting with health officials, so that the allies will be able to prepare any necessary supporting response.

5.6.2 District-Level Meetings

Regular formal meetings are held at the district level in each of the targeted districts. This forms a second major component of the institutional dimension of the citizen monitoring governance initiative. The district-level meetings are designed to bring together the monitors and their institutional allies (CARE Peru, ForoSalud, Defensoría) and senior district-level officials and health workers from the Ministry of Health. These include the director of the district health network (REDES), the director of the district’s hospital, and an array of doctors, midwives, nurses and other health officials. Other officials have also begun to participate in the meetings—for example, municipal officials—further expanding the circle.
The original objective in constituting this meeting space was to create an institutionalized forum in which monitors’ observations from their facility visits could be regularly shared with health officials, in the direct presence of their allies, including the Defensoría, SIS, CARE Peru and ForoSalud. Early on, the project’s technical team sought to set some basic ground rules in terms of how they would operate, in order to demonstrate good faith and build trust. First, they emphasized their intent to try to resolve issues at a district level, and not bring them to a higher, regional level unless absolutely necessary.

DIRESA [Regional Ministry of Health] doesn’t know much yet because what we want to present to the DIRESA are problems that are constantly repeated and that we can’t solve at the local level. That’s what we’ve talked to them about. We’ve told them that we’re going to try to solve the problems there [locally]. For me, I would want that if I have a problem, that we try to solve it directly with my own supervisor first, and if we can’t solve it and there’s no other option, then they would take it to the higher boss, so I wouldn’t feel bad (Interview Anon.15, 2011).

Second, they undertook not to disseminate the observations and findings from monitoring visits through local media channels. One of the members from the technical team remembers an early conversation with health officials:

We’ve told them in meetings: “Everything that we’ve seen here should be solved here.” None of us, not me, not the Defensoría, not the monitors – none of us are going to bring the issues to other spaces. We’re not going to bring them to the radios or the newspapers (Interview Anon.15, 2011).
The meetings have been a work in progress. Over time, the monitors and their allies have been working out how to function effectively in this new space. There are examples of small, concrete gains that have been achieved by sharing concerns at a district level. One monitor explained:

I reported that there wasn’t enough staff, because in the health post there were only two. Even they [the health post staff] asked me to do it. “Why don’t you ask as a monitor, since you’re reporting on everything we do here to the hospital director, right? And since you work with the Defensoria and SIS, why don’t you ask that there be more staff?” Which worked, and they’ve increased the number. There wasn’t a midwife, one came only once per week from the hospital. Now there’s one here permanently. There wasn’t a nurse, now there’s a nurse technician…. Before, the doctor never came. Now one comes every Wednesday. Now the population know that there’s a doctor here every Wednesday and also a dentist, which there wasn’t before (Interview Anon.6, 2010).

This woman’s local health facility is a tiny health post in an especially remote, rural area of her district. The addition of a permanent midwife and nurse technician, along with consistent doctor’s visits to the health is hugely important to women’s reproductive health and the prevention of maternal mortality. It represents an important victory on the part of the citizen monitors and their allies, and speaks to some of the potential that lies in rights-based governance.
5.6.3 Challenges Facing the Initiative's Institutional Structure

Along with victories such as the one detailed above, the monitoring and formal reporting process also sheds light on the deep-rooted structural challenges that shape the public health system. Monitors repeatedly bring forward issues involving forms of misconduct by health care workers (unjust charges, patient mistreatment, poor care). Broader resourcing and management issues arise as well, such as the lack of equipment, lack of supplies, lack of transport and shortages of staff. At the district-level meetings, the different stakeholders discuss the dialogue agenda. The monitoring team identifies key problems and notes positive developments. The health authorities sign official minutes and agreements are made to track progress and revisit the issue at future meetings (Interview Anon.15, 2011). In some cases, health officials will agree to implement a solution requested by the monitors and their allies; however, that does not always mean that the agreements are implemented. For example, the monitors and their allies have requested that all health workers be required to wear a photo ID badge. If this is done, health users will be able to identify health workers during treatment and will be more able to voice specific concerns or complaints. Officially, the Ministry has agreed to this request, but at the time of this research several months had passed and the issue was still on the table. The Ministry argues that it is a complicated logistical process to equip all their staff with photo ID and that they are working on it (Interview Anon.15, 2011; Interview Anon.23, 2011).

Observers note that it is often difficult to achieve tangible gains through the formal district-level meeting process. While budget and staffing issues are frequently brought to the arena, these issues are challenging to resolve at such a relatively low level. This reflects the political
economic realities of governance of macro issues within a micro-level space. There is usually little room for movement on labour or budgetary issues at the district level. These issues are not unique to Puno and are pervasive throughout the public health system, especially in remote areas (Physicians for Human Rights, 2007; Amnesty International, 2006). While individual problems are addressed in some instances—and more so with on-site monitoring in the moment—it is difficult to resolve them at a more systemic level (Interview Anon.24, 2011).

It has also proved difficult for citizen monitors and Defensoría lawyers to press for follow-up on more serious individual complaints. One problem arises from the structure of the complaint process within the Ministry of Health, which requires the formation of an internal “commission” made up of health facility staff to investigate the complaint. Both a former hospital director and a Defensoría staff person observed in interviews that it is especially difficult to convene such an internal commission, since workers rarely want to sit on them and risk going against “one of their own” (Interview Anon.22, 2011; Interview Anon.17, 2011).

Another major challenge to the effective operation of the initiative’s institutional structure is the frequent turnover of staff of all levels in the public health facilities. One of the project staff describes how this affects their work:

One imagines that they [the health workers] have their own spaces. That the head of nurses would call the nurses together and tell them that the monitors have raised this complaint. “Tell me what happened, because the Director is going to ask me for a report.” But when we go back three months later, the
Director is no longer there, the head of nurses is gone. We reread the agreement but it’s a new person, who doesn’t know anything. No documents have been left behind: we have to start all over again, informing them about the monitoring process. That’s our difficulty (Interview Anon.15, 2011).

The precariousness of employment in the health sector and the tendency for health workers to seek transfer to more desirable postings both contribute to frequent staff turnover. The political appointment of the Regional Health Director by the incoming Regional President (an elected position) is another factor influencing staff turnover. When a new Regional Health Director is appointed s/he tends to replace existing district-level directors with their own people. This leads to a steady turnover among the levels of management with whom the monitors and their allies are most often in contact. As a result, relationships with Ministry of Health managers need to be built again and again. One key informant connected to the government noted that, despite its positive aspects, decentralization of authority on health matters from Lima to the regions had contributed to greater instability within the health sector. She argued that with decentralization, more of the senior management positions were political appointments and therefore subject to the vagaries of the political machinery (Interview Anon.26, 2011). Relationships between health sector management and the health labour force are also fragile. Given the lack of a coherent salary policy for the health workforce, labour unrest is one of the few tools available to health workers to try to improve their working conditions (Urcullo et al., 2008). One health facility manager felt that the risk of frequent labour unrest in the health sector caused by a dissatisfied workforce can sometimes limit how often managers wish to be perceived as confronting their front-line staff (Interview Anon.17, 2011). This presents difficult challenges within the monitoring process in terms of the potential for concrete follow-up when complaints about specific health workers arise.
The patterns of misconduct that remain unaddressed are ultimately a reflection of weak management systems within the public health system, along with a lack of resources and other broader, structural factors. One senior health worker noted that effective strategies to address the deeply embedded problems in the public health sector remain elusive.

The monitoring is only following issues around the treatment of patients, but it isn’t going to the heart of the matter: why is there this mistreatment? Because there are deficiencies in implementation, deficiencies in buildings, drugs don’t arrive on time, there aren’t staff where they’re needed. Because there isn’t supervision, there isn’t good planning, there isn’t good execution (Interview Anon.17, 2011).

These deficiencies are acknowledged by some other staff within the Ministry of Health as well. One senior-level Ministry of Health bureaucrat from Lima explained his views on this:

I think that all of these things that we’re talking about with citizen participation, this theme, it’s about resolving things that have been left aside by the state … it’s because of the lack of presence of the state, so that citizens are doing the work that corresponds to the state. And this work is difficult, because we’re not talking about citizens with all the time in the world to dedicate to this. We’re talking about people who need to work, who need to study…. Citizen monitoring needs to exist because it’s necessary. But it’s more necessary that the state assume its responsibility (Interview Anon.37, 2011).
The institutional structure of the citizen monitoring initiative has real limits on its effectiveness. These limits are the result of systemic deficiencies within the governmental health care system. The citizen monitoring initiative does not have the leverage or reach to address these issues.

5.6.4 Monitoring and District-Level Meetings as “Conquered Spaces”

Despite these shortcomings, official district-level meetings still provide a space within which to continue to exert pressure on the Ministry of Health concerning serious issues and to remind them that others are watching their actions and reactions. The fact that the impetus for creating the meeting space has come from civil society and not public officials characterizes these meetings as a “conquered space” in the terminology developed by scholars using a spatial analysis to examine citizen participation (Cornwall, 2004b). Conquered spaces are those participatory spaces that are won as a result of civil society initiative. They are distinguished in this literature from “invited spaces” for public participation that are proposed and designed by officials (Cornwall, 2004b).

For the monitors and their allies, creating the participatory space produced by the initiative is a notable achievement. Despite the obstacles, the importance of this accomplishment should not be overlooked given the uneven power dynamics and relative marginalization of the citizen monitors. Interviews with the key informants involved in the initiative reveal some of their feelings about what they have done. One informant explains:
One thing for us that we feel is important that we’ve achieved is that we’ve managed to create this space. That they [health officials] give us their time and listen to what we’ve seen, even if they say it’s a lie, even if they say what they say…. This is a space that’s going to continue after we [the NGO/project] go, because they [the monitors] are going to do it. Because now it’s a space. That’s important. Also, they [health officials] see that this is a space where they are seen by outside people—whether they say it or not, they know that they’re being monitored around their quality of care (Interview Anon.15, 2010).

Although concrete outcomes are not easy to achieve through the use of this formal dialogue space, interviewees suggested that its very existence—the knowledge by health staff at a facility level that a formal space exists where their bosses gather to discuss the findings of monitors—could act as an informal deterrent of the kind of small-scale, daily improprieties that occur so readily at a local facility level. The existence of these district-level meetings confers a significant discretionary power upon the citizen monitors: It is their decision whether or not to produce a report that will trigger a meeting. Health workers have good reason to want to avoid being summoned to the district-level meetings along with their superiors in order to answer a complaint. Particularly in an environment with weak job security, health workers would rather not be identified with these kinds of problems. As a result, the ability of a monitor to choose whether or not to shift a dispute to a higher, more formal level also provides the monitor with a measure of informal power that can be exercised in the moment. It confers on the monitor the authority to switch roles from an observer to an advocate and potentially resolve an issue on the spot informally. The formal institutional structure of the monitoring initiative provides the monitors with a source of informal power that makes them into consequential actors within the health facilities that they monitor.
Finally, it is important to flag that the institutionalized dialogue space that has been created is not only a forum for highlighting the deficiencies within reproductive and broader health service delivery. The monitoring teams also use it as a venue to note achievements and to recognize positive work that is being carried out by health staff. They found that several of the midwives and nurses that they encountered, for example, were firmly committed to the delivery of respectful, high-quality treatment. Sometimes, public acknowledgement can have a ripple effect. This was evident in an interview with one nurse, who reported her surprise at having received a congratulatory phone call from her supervisor (Interview Anon.27, 2011). He had heard about her positive performance through a monitors’ district meeting and was following up to acknowledge the high quality of her work. In an extremely hierarchical system and a precarious labour environment, the value of this kind of acknowledgement should not be underestimated.

5.7 Conclusion

In this chapter I have presented my findings regarding the citizen monitoring initiative in relation to Bakker and Silvey’s three dimensions of governance: ideas, daily practices, and institutions. I have sought to explore the different aspects of how the citizen monitors navigate power relations in their attempts to influence how the state delivers reproductive health services. In the next chapter, I will bring together, analyze and discuss these findings in order to explore a number of cross-cutting themes.
Chapter 6
Addressing Everyday Injustices: the Potential and Limits of Citizen Monitoring

6.1 Introduction

In this chapter, I will discuss some of the tensions and possibilities concerning the citizen monitoring initiative that are revealed in my study. In the first part of the chapter, I focus on the inner workings of the initiative to consider the significance of five themes: (1) citizen monitoring and the micro-dynamics of power, (2) bearing witness to everyday injustices (3) the emergence of monitors’ advocacy activities outside of the initiative, (4) new kinds of alliances being made by the monitors and (5) citizen monitoring as a space for hands-on learning for human rights-based approaches to health. Each of these themes relates to the issues of social exclusion, political consciousness and the struggle to create practical strategies for pursuing progressive political and social change.

In the second part of the chapter, I consider the citizen monitoring efforts in Puno within the broader theoretical context of social reproduction. The citizen monitoring initiative is an attempt to govern how the state assumes the burdens of social reproduction through its provision of reproductive health care. I examine the capacity of the citizen monitoring initiative to address the problems identified by the monitors with their local health care services. I also discuss the
personal costs experienced by the women in carrying out their work as volunteer citizen monitors. In the third and final section of the chapter, I present some reflections on the politics surrounding proposals to scale up citizen monitoring across the national health care system in Peru. Through a brief discussion of a proposed alternative model, I set out some of the distinctive elements of the citizen monitoring initiative in Puno that underlie its effectiveness.

6.2 Struggling with the State through Rights-Based Governance: Emerging Themes

6.2.1 Citizen Monitoring and the Micro-dynamics of Power

In chapter one I first suggested that the citizen monitoring initiative had a central tension: it is an example of governance “from below” that relies on marginalized social actors to exercise influence over government officials. This influence is intended to be sufficient to affect how the state is involved in assuming the burdens of social reproduction, specifically by addressing problems with local reproductive health care services.

As I have shown in chapter five, the citizen monitors are able to exercise a governance influence in their local health care facilities. They do so using various strategies that alter the micro-dynamics of power in these settings. Together these strategies can allow the monitors to occupy more authoritative positions in the networks of power relations that surround their interactions
with the health system. The strategies are designed to make the role of “citizen monitor” a meaningful one within local health facilities.

In chapter five I set out first the ideas that frame the role and actions of the citizen monitors. The monitors appeal to human rights concepts to frame their role (as rights-holders with a right to fair treatment as well as a right to oversee the actions of public officials). These ideas are used to oppose competing conceptions within the health care system where poor and indigenous health-users may be regarded as the recipients of charity. The monitors’ rights-based framework is supported by certain laws and policies that confirm the right to monitor and the right to health.

The monitors’ regular presence in health facilities is a second important element of their influence. When they are monitoring, they are able to be present in the moment, to witness and to intervene if necessary. Their ability to intervene is supported by two other key elements. When they witness an urgent problem, the monitors are able to call on influential allies. Calls placed to the lawyers at the Defensoría for example can result in pressure on senior management to intervene and resolve the problem. In addition, the citizen monitors contribute to regular reports and participate in district-level meetings involving senior health care workers, Defensoría lawyers, and officials in the health care system. The ability of the citizen monitors to trigger these interventions has increased their status within health care facilities. It has increased their ability to address issues as they see them. Over time, they have been able to resolve issues without having to call on their allies.
Nonetheless, this newfound influence remains fragile and contingent. The monitors’ success at resolving problems in health care facilities can be inconsistent. While many workers take the monitors’ role seriously, the women still meet with resistance. In part the monitors’ influence depends on their ability to navigate power dynamics in the moment. However, as I discuss later on in the chapter, many of the problems monitors encounter in health facilities are rooted in deeper structural issues that are beyond the monitors’ reach. As a final point, I should note that, depending on how relationships between the monitors and the health workers develop over time, there could be the potential for co-optation of the monitors as health sector “insiders”. I did not see signs of this in my study, but it is a dynamic to be alert to as the initiative progresses.

6.2.2 Bearing Witness to Everyday Injustices

Bearing witness lies at the heart of human rights practice. Addressing human rights abuse begins with collecting the testimonies of those who will name what they have witnessed. Orbinski, Beyer & Singh (2007) talk about this from the point of view of humanitarian health care practitioners. They argue that, for medical practitioners, “bearing witness, having first-hand knowledge of humanitarian and human-rights principles and their limitations, and systematically collecting evidence of abuse, can be instrumental in tackling the forces that constrain the realisation of human health and dignity” (p. 698). Without this kind of work, abusive acts go unseen and are not named as violations of human rights.82

82 Dr. Bernard Kouchner and a small group of other French doctors promoted the concept of “witnessing” or témoinage when they founded the humanitarian organization Médecins Sans Frontières (MSF) in 1971. They stressed the need for témoinage as a response to what they perceived as the international community’s ineffective
Through their regular presence in their local health facilities, the citizen monitors bear witness in this sense to the everyday injustices faced in particular by indigenous women and that are entrenched within their health care system. By everyday injustices, I mean those common acts of disrespect, disregard, cultural superiority, or discrimination faced by members of socially excluded groups. In health facilities, these kinds of injustices can include illegal financial charges, abusive or dismissive treatment, extended wait times and culturally insensitive care. Everyday injustices are hard to address using conventional human rights mechanisms. They can be difficult to prove. They may involve small amounts of money or invisible kinds of damage such as emotional harm. They are perpetrated against members of society who are least able to make official complaints, and against whom this kind of abusive treatment may be seen as normal. Human rights bodies, such as the Defensoría, are not well equipped to deal with these micro kinds of issues.

Although everyday injustices may seem minor from one perspective, my interviews with the citizen monitors suggest these injustices are very significant to those who experience them. The monitors all tell stories of mistreatment and injustice within local health care facilities. They are clearly motivated by the desire to put an end to such practices. They all make sacrifices in order

response to the humanitarian crises that emerged during the Biafran war in Nigeria, as well as from floods and independence struggles in Bangladesh during a similar period (Redfield, 2006).
to continue their work as monitors. In addition, the disconnection of health users from health care services that can result from these injustices may have serious effects. For example they may help to perpetuate health inequality and contribute to delays in reaching urgently needed care (Thaddeus & Maine, 1994; Physicians for Human Rights, 2007).

Through their on-site advocacy or their participation in district-level meetings, the citizen monitors are often able to identify these everyday injustices as violations of rights. By doing this, citizen monitors contest the subordinate position that indigenous women occupy in power relations in these settings. Citizen monitors also contest this subordination by helping health users know about their health rights and by helping them try to solve injustices. Commentators have noted that fostering an awareness of health rights at a local level is important to support both individual claims and collective political action: “This lack of knowledge around health rights has also been identified by women’s health activists as a major obstacle to increased community participation around issues of health reform” (Observatorio de Equidad de Genero en Salud, 2006, cited in Gideon & Dannreuther, 2008, p. 858).

One of the most important elements of the citizen monitoring process is the systematic collection of detailed data by the citizen monitors over a prolonged period of time. The procedures associated with monitoring—observation, dialogue with health users, recording data in report forms and then collectively analyzing and collating the monitoring results within a human rights-based framework—provide a set of procedures for the regular collection of empirical data from local health facilities. Through the citizen monitoring project, the monitors
and their allies are amassing a formal evidence base in Puno that documents the state’s performance in relation to its duties to provide quality, available and accessible health services free from discrimination. This may prove to be an important platform from which to advocate for health users’ reproductive and other health-related rights.

6.2.3 Advocacy Outside of the Monitoring Process

In chapter five, I highlighted a number of times how monitors have informally been able to expand their monitoring role to act as advocates within their local health facilities. Increasingly, they are also applying these political skills outside of the monitoring process. For example, a number of the citizen monitors have become active in municipal politics since beginning their work with the initiative. Some have run for local office. Other monitors from both Azángaro and Ayaviri have presented proposals to their municipal councils to request money to fund projects through the local participatory budgeting process. The group of monitors in Azángaro was especially active in pushing their municipality to equip a new birthing centre in a culturally appropriate manner. A Defensoría lawyer observes:

83 Elson and Gideon note “Women in a growing number of countries are challenging this through gender budget initiatives that look at government budgets through women’s eyes and seek to change priorities and restore a sense of collective responsibility for human well-being” (2004, p.147). In Puno, citizen monitors have begun to participate in their municipal participatory budgeting processes. These women widen the scope of projects that are presented for funding. Instead of the heavy emphasis on infrastructure projects, they widen the scope to include, for example, childhood malnutrition.
They don’t just participate in the monitoring spaces…. There was a budget for the Birthing Centre and the municipality was going to buy equipment. The monitors intervened as an organization. They said, “We don’t want these types of beds, these frames made of iron. We want these made of wood, which are consistent with our customs.” They made all sorts of other changes too. I think it’s important, this theme of articulation, this strengthening of an organization. That it’s articulated with other state institutions, like the municipality for example (Interview Anon.24, 2011).

The monitors’ growing role as public and reproductive health advocates outside the boundaries of their local health facilities is an interesting phenomenon. Over time, monitors and their allies also are deepening their analysis of the broader structural factors that characterize their experiences with public health care. One key informant in Puno notes:

This is related to the politics of health…. All the health networks in the Andes and Amazon get the lowest budgets. The highest are in Lima and the coastal cities…. It is about exclusion, we’re excluded from having good health (Interview Anon.15, 2011).

The same respondent goes on to explain her deepening conviction (shared with other project participants) that action needs to be taken beyond the participatory spaces developed by the citizen monitoring initiative. She explains that they are planning to convene elected officials from the regional government in an effort to sensitize them regarding the politics of public health care. As she puts it, “we need to teach the congress people what the big problems are in health, because they don’t know. The regional government doesn’t know what the problems are in health” (Interview Anon.15, 2011).
One way to think about power and political participation is suggested by Yamin in her work on the adequacy of rights-based participatory initiatives (Yamin, 2009). She suggests that a liberal perspective on participation focuses on inclusion and the opportunities given to actors to express themselves. A second view examines the degree to which groups are involved in agenda setting and determining the content and issues that can be addressed in the participatory process. A third and more radical view concerns the degree to which participants are able to develop the political consciousness necessary to perceive and challenge the structural factors that underlie the forms of oppression that they face (Yamin, 2009:13). Involvement in the citizen monitoring initiative has clearly affected the political consciousness, as well as the leadership and advocacy skills, of many of the monitors. The public-advocacy efforts initiated by the citizen monitors outside of the monitoring process show the intentions of these women to take action on the more radical end of Yamin’s scale, through becoming involved in agenda setting and challenging structural barriers.

In the citizen monitoring initiative in Puno, the monitors and their allies have had to struggle for inclusion and to establish a governance process that can deal meaningfully with day-to-day issues regarding the treatment of indigenous women in public health care facilities. These are significant challenges. However, interviews with the monitors and their allies show that the monitoring process has made clear to these actors that while their efforts are important, further strategies are needed to push for changes to the underlying structural factors that shape their local health services. By bearing witness to the daily realities of reproductive health service delivery, by documenting and sharing these realities through meetings with one another, through discussion with institutional allies and by meeting with public authorities, the monitors and their
allies have started to establish a platform from which to develop a broader, more politicized analysis of the issues that underpin the poor health conditions in Puno, both in the reproductive health sphere and beyond (Interview Anon.15, 2011).

6.2.4 Building New Kinds of Alliances

One hopeful prospect emerging from the citizen monitoring experience in Puno concerns the possibility of forging new kinds of alliances between the monitors and health workers. Although the initial reception of the citizen monitors by the health workers was predominantly antagonistic, these relationships have largely improved over time. Some health workers commented in interviews that they now see benefits emerging from the monitors’ presence. One doctor recounted the assistance he received from monitors at a municipal meeting:

> When the Ministry of Health makes a request or a demand at a municipal meeting to all of civil society, the citizen monitors are our witnesses. They’re the ones who confirm our needs or who confirm the quality of attention that we’ve managed or not managed to provide. For us it’s a huge support. Personally, to me, the monitors are a huge support. For example, when we’ve made a request and the municipality wonders if we need this money, the monitors have helped us…. Due to their participation, since they are the [health care] users, in the end they’re the ones who are believed. The general population listens more to them in these meetings than to us (Interview Anon.29, 2011).

The doctor went on to explain that the support from the monitors helped to persuade the municipality to purchase a new ambulance for the health facility. Because of their regular
presence in the health facility, these monitors could speak with first-hand knowledge about the acute need for the ambulance. As well, they had developed enough of a working relationship with the doctor to feel they would support him in a public meeting. In line with the analysis of the Three Delays Model, the availability of an additional ambulance at this health facility is an important factor facilitating women reaching obstetric care and could have critical implications for the prevention of maternal deaths (Thaddeus & Maine, 1994). 

It is worth noting that these are new and fragile social relations. Power relations are complex, and more investigation would be needed to better understand the motivations of the women who supported the doctor’s ambulance request: whether they felt any kind of pressure on the part of the doctor, or whether they simply saw it as an opportunity to improve maternal health and health more broadly.

Promoting these kinds of alliances between health workers and the citizen monitors may turn out to be an important outcome of the initiative. London observes that alliances between health workers and health care users are crucial for confronting the structural constraints that underlie poor health systems. As he points out, “front-line health workers are frequently unable to

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84 For example, a senior health official in Ayaviri recounted a recent case in which a pregnant woman in crisis had nearly died while waiting on the side of the road near her home for an ambulance to get to the hospital. After being notified that the ambulance had not arrived, he was able to successfully intervene by insisting to the director of the neighboring health network to send their ambulance instead (Interview Anon.17, 2011). While that case was resolved, access to emergency transport remains a crucial issue in the districts where this case study is situated.
provide adequate access to care because of systemic factors outside their control and because of management systems that disempower them from acting independently and effectively,” and this can lead to a “fruitless antagonism” between health workers and users. This also can cause health workers to have negative feelings about human rights-based strategies that do not take these conditions into account (London, 2008, pp.8-9). Despite initial negative reactions about citizen monitoring by many health workers in Azángaro and Ayaviri, these nascent examples of cooperation between the workers and civil-society members suggest potential avenues for future advocacy efforts.

Since its inception, the initiative has depended on a series of key alliances among the citizen monitors, CARE Peru, ForoSalud and the Defensoría. Why do alliances among these organizations and groups seem to function effectively? Each of these alliances is based on mutual need and reciprocal benefits. All of the organizations involved in the initiative are operating in a (globalized) neoliberal environment with increasing demands being made on them concerning accountability, the ability to demonstrate performance and the need to make more efficient use of scarce resources. For example, a senior staff person interviewed at the Puno office of the Defensoría del Pueblo noted that she had just returned from Lima, where she and other Defensoría staff had received training by Canadian consultants on how to perform “results-based management” within their regional offices. She noted that she has no additional financial resources or staff to carry out these increased management and reporting functions.
The Defensoría’s involvement in the initiative allows it to report on its collaborative activities with monitors as evidence of “results.”

A Defensoría staff member in Puno notes frankly that the monitors perform an important function for the Defensoría and strengthen the institution’s efforts to fulfill its mandate (Interview Anon.22, 2011). As volunteer workers who are present in local health facilities and linked to the Defensoría, the citizen monitors extend the Defensoría’s influence into spaces that were beyond its consistent reach. This is of particular importance within the Defensoría. Although the Defensoría is a widely respected institution in Peruvian society, it has struggled over time to reach the most vulnerable members of the population, in particular women and indigenous communities (Pegram, 2011). In 2005, only 10.7 percent of all complaints to the Defensoría came from women, while only 4.8 percent were considered to have come from indigenous communities (Pegram, 2011: 234). Citizen monitors in Puno thus provide another sort of bridge between the Defensoría and local community members.

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85 Pegram notes that in recent years, the Defensoría has increasingly expanded its scope of attention “to interventions in policy debates, pushing for the redress of structural rights violations.” He argues that “a discourse that views public policy through the optics of human rights is a natural extension of the core protection functions of the office” (2011, p.245). However, he goes on to comment that this expanded focus might also place too much strain on the institution’s limited resources (Pegram, 2011, p.45).

86 Similarly, SIS (the comprehensive health insurance scheme) is able to perform its functions more effectively because of its involvement with the citizen monitoring initiative. A senior SIS (comprehensive health insurance scheme) official in Puno explained that plans were being developed for the SIS office to establish its own monitoring system for health insurance delivery, but that nothing was yet in place (Interview Anon.26).
As I have shown in chapter five, monitors gain much-needed support from their organizational allies, but they also perform important (and unpaid) institutional functions for their allies. Through their alliances with the monitors, the NGO allies are able to advance their broader agenda of promoting health rights in Peru. NGOs in Peru face their own considerable pressure given that donor funding is on the decline with Peru’s recent classification as an upper middle-income country. This has made transnational funding for health rights initiatives in Peru increasingly difficult to secure (Yamin and Miranda 2011). Examples such as the Puno initiative can be shared in transnational arenas both to increase knowledge of concrete local attempts to operationalize rights-based participatory governance strategies related to reproductive health, and also to draw attention that may help leverage new sources of donor support for these sorts of programs.

6.2.5 Hands-on Learning and Human Rights-Based Approaches to Health

Several monitors interviewed talked about how their involvement in the monitoring project had changed the way they viewed themselves and how they interact with public officials. Nearly all of the women who became monitors already had experience in community-based leadership positions. Their involvement in the monitoring project, however, provided them with new ways of engaging with public officials and new kinds of relationships with institutional allies. One woman talked about feeling like she now “knew how to speak with doctors and authorities” and that she was no longer afraid to go into any offices (Interview Anon.21, 2011).
Part of the hands-on learning in advocacy work and leadership achieved by the citizen monitors seems to have resulted from the role they played through their work. This point is perhaps best made by contrasting the monitors with the position given to health promoters under the ReproSalud project in the 1990s and early 2000s, which is discussed in chapter four. In many ways, the work of the promoters was similar to that of the monitors. The promoters had regular direct contact with staff at health facilities. They would accompany community women for services such as prenatal care and family planning consultations. Since their role was to act as a bridge between the community and the health facilities (to bring women in for care), the promoters were perceived as a kind of volunteer auxiliary worker—both by themselves and by health officials (Interview Anon.2, 2010). This put the promoters at the lowest level in the hierarchy of health workers. When they witnessed bad behaviour or noted shortcomings in the system, they had very little ability to protest or be heard. As noted in chapter four, the promoters did try to voice their concerns towards the end of the ReproSalud project through meetings with health officials, but met with extremely limited responses. One citizen monitor explained how she perceived the difference in her interactions with the public health system now, compared to her time as a reproductive health promoter in the late 1990s and early 2000s:

Before, things were run by the Ministry of Health’s rules, whatever they said. But now, so many things are changing. We also monitor. Now we know our rights, that nobody can force us to do things. So now, we also say “These things shouldn’t be like this, those things shouldn’t be like that.”… Now they pay attention to us, to our requests (Interview Anon.20, 2011).
The crucial part of this woman’s statement is her perception that the Ministry of Health now “pays attention” to monitors’ requests. In practice, there are significant limits on how often and to what extent health workers and health authorities actually do take monitors’ requests into account. It is also true, however, that monitors do have some success. This sense of achievement is reflected in this monitor’s personal perceptions of her degree of efficacy. Also interesting is her changing sense of rights. The citizen monitors who had been reproductive health promoters for ReproSalud also emphasized the importance of the project’s attention to human rights principles, in particular reproductive health rights. Monitors interviewed noted how a rights approach helped them to consider reproductive health issues within a broader structural framework.

In her article “Mapping the Middle,” legal anthropologist Sally Engel Merry considers whether and how human rights may shift subjectivities. She notes that she has at times witnessed a “conversion,” in which a person takes up a rights frame as a way of making sense of a particular set of circumstances in her world (Merry, 2006:43). Merry also argues, however, that more often women take up rights in a pragmatic, strategic manner. Whether or not people continue to use a rights frame depends upon the institutional response that their claims receive (2006:44). If they do not perceive a present or future benefit from engaging in rights activism, enthusiasm tends to drop off (Merry and Stern, 2005, cited in Merry, 2006:44).

Judging from the general commitment among monitors to human rights as a frame, their experience with human rights activism has been positive. It is unlikely that any number of
training workshops could take the place of the process of hands-on experienced by the women in their work as citizen monitors. Armed with the information they have obtained from their few formal human rights training sessions, the women see and feel both the openings and the limitations that are associated with this rights-based participatory governance approach.

6.3 Citizen Monitoring in Puno and the Global Crisis of Social Reproduction

6.3.1 Struggles Over the State’s Involvement: Quantitative and Qualitative Issues

In chapter two, I discussed how “social struggles” are important in relation to social reproduction. Bakker and Gill argue that these struggles can play a significant role in conditioning the degree to which the burdens of social reproduction, including those relating to reproductive health issues, may be distributed within society (Bakker & Gill, 2003). Writing in relation to a study conducted in the global south, Kunz cautions against limiting our analysis of the global crisis in social reproduction to focus narrowly on changes in the amount of state involvement. While the quantitative dimension of state involvement is clearly important, she argues that “it is essential to analyze changing forms of state involvement” in order to understand the “variety of ways in which the global crisis of social reproduction manifests in different locations” (Kunz, 2010, italics in original). The case I have explored in Puno reinforces
the importance of this qualitative dimension of state involvement in social provisioning. As we have seen repeatedly in the accounts provided by citizen monitors and knowledgeable key informants, indigenous women in Puno face real challenges when seeking reproductive health services in public health care facilities—including risks relating to abusive treatment, a lack of respect for indigenous cultural norms and discrimination. It also is clear from the accounts provided that these are very serious issues for the women involved. The interviews suggest that these types of problems can effectively limit access to health care with potentially highly damaging ramifications on women’s reproductive health.

Contesting the forms of state involvement in social provisioning (including institutionalized discrimination, weak management, etc.) may be particularly important for traditionally excluded populations. This can be true even when new resources are being extended to the health sector rather than being clawed back. An example of this can be found in the newly expanded public health insurance scheme (Seguro Integral de Salud/SIS) mentioned in chapters one, four and five. SIS was developed to extend coverage among the poorest members of Peruvian society for a wide array of public health services (including those related to reproductive health). This study suggests, however, that the expansion of public health insurance did not automatically translate into comprehensive health coverage for people from traditionally excluded groups. Despite the formal guarantees of coverage, citizen monitors repeatedly identified cases of overpayment and illegal charges to low-income indigenous women for reproductive and maternal health related services. Thus, even when new social rights are being extended and public spending on health care is increasing, the dynamics of social exclusion can complicate or reverse these gains.
The findings presented in chapter five suggest that informal measures taken by the monitors directly at a facility level can result in tangible gains for the qualitative dimension of state involvement in social provisioning. These are important successes. However, both the informal measures and the institutionalized, formal district-level meetings created through citizen monitoring have a more difficult time addressing the wider systemic issues that are identified by the monitors. These concern the need for the state to provide more health staff, including staff on longer-term, stable contracts as well as improved infrastructure, drug supply and equipment to many of the facilities in which the citizen monitors carry out their activities. It is the quantitative dimension of the state’s involvement in health care provision that is difficult to address with the mechanisms the monitors and their allies have created.

This situation relates directly to the realities of the Peruvian state’s provision of health services within a neoliberal context. Despite the expansion of resource allocation to the public health sector in recent years, the system remains seriously underfunded. The effects of years of sustained financial neglect, coupled with neoliberal restructuring in the 1990s, are still being felt at a local level. These are reflected in the realities of staff shortages, lack of equipment, poor infrastructure and insufficient drug supplies. Citizen monitors repeatedly identified problems in service provision that were ultimately rooted in insufficient health care budgets, lack of essential human resources and poor management systems. These problems are closely connected to the realities of social exclusion affecting indigenous people in Peruvian society. Inequality is embedded in the Peruvian health care system not only at the local facility level, but also at the highest levels of policy-making, system design and budgetary allocation. For example, the fact that SIS is chronically underfunded is likely linked to the fact that it provides insurance
coverage to the most marginalized members of society. In addition, neoliberal budgeting and prioritization practices, which emphasize clear and narrowly defined goals, favour targeted vertical programs. Consequently, in 2012, three vertical health care programs together had a budget that is three times greater than that of SIS (Francke, 2013, p.8). At the local level, unequal power relations help to translate organizational deficiencies into discriminatory treatment. Interviews with the citizen monitors suggest that the burdens of underfunding are often shifted to low-status patients (through illegal fees or extended wait times)—those least able to contest the treatment they receive.

In the end, therefore, both the quantitative and qualitative dimensions of the state’s involvement in health care provision for socially excluded groups are closely interrelated.

6.3.2 Privatizing Social Reproduction: The Personal Costs of Citizen Monitoring

The findings in the previous chapter identified several ways in which citizen monitors make material differences in the lives of health care users through their on-site presence and ongoing governance efforts. This work requires a strong personal commitment on the part of each woman involved in the initiative, and their involvement comes with its own associated costs. In this section, I would like to focus on the personal trade-offs that monitors make in order to fulfill their role, and how this issue relates to the ongoing privatization of activities related to social reproduction within a neoliberal economic order.
Each participant contributes her time as a monitor four to eight times per month (Frisancho, 2013:24). The goal is to have monitors present in facilities as frequently as possible. The actual number of visits varies from monitor to monitor, depending on her availability. Monitors also attend one meeting every two to three months to share their findings to the other monitors and the project’s technical team. Monitoring shifts are approximately six hours long (Frisancho, 2013, p.22). The monitors must plan and prepare in advance to make time to do these shifts. One woman explains how she gets ready:

Well, you see, I have this little business [a small kiosk]. So I have to plan a day in advance what I’m going to do, who I’m going to leave there. When I’m going to do my monitoring, I need to ask somebody to stay in the kiosk. And a day before, I need to prepare my food, get everything ready, organize everything in my house, so that I can go and do my monitoring…. Sometimes it’s hard for us, sometimes it’s hard to get here and we have to make sacrifices to get to the health facility. There are monitors who come from far away, who live in rural areas, who still do it. All so that they can make the quality of care better, so they respect our rights and our customs (Interview Anon.2, 2010).

Several of the women spoke of doing additional monitoring of health facilities, sometimes at unexpected moments. It is common for the monitors to be asked by community members or by relatives to go with them to a health facility, since they are seen as being able to negotiate the system. Even when visiting the hospital for personal reasons, some monitors will unofficially carry out their surveillance role. One woman explained:
Sometimes we go at other times too. I don’t only go when I’m doing my usual monitoring. For example, sometimes I go because I have a relative who has gotten sick. So I go to visit and they [the health workers] will ask me, “Oh, are you here to do your monitoring?” I’ll tell them no, and I don’t have them sign my report form or anything. But I’m still seeing what they’re doing, how it’s going, if they’re giving them the medicines and other things from SIS. I’m there so I still check with the patients, things like that (Interview Anon.2, 2010).

Along with their contributions to increasing health service accountability, the monitors also often carry out health promotion tasks. This can involve tracking pregnant women in their communities, convincing women to use the health system for prenatal care, accompanying people, especially pregnant women, to their appointments, etc. (Interview Anon.3, 2010; Interview Anon.9, 2010). There is little question that their unremunerated labour helps the public health system function more efficiently. This is part of an enduring reliance by health systems on women’s unpaid work both in the household and “as a mediator between the household and local health services” (Gideon, 2007, p.243). A 2010 report by PAHO and ECLAC has noted the gendered, invisible dimensions of women’s contributions to the caring economy in Latin America and the need for official measurement of this unpaid work, including within the health sector (PAHO, ECLAC et al., 2010). This call for measurement and recognition could equally apply to the work done by citizen monitors.  

Put another way, struggling with the state over its responsibility for social reproduction through citizen monitoring is itself another example of unpaid involvement in social reproduction by women.
Some scholars refer to the time women dedicate to caring activities outside the work they do at home and their paid work activities as the third shift (Boserup, 1970; Gerstel, 2000; Hochschild and Machung, 1989). For some of the monitors, this volunteer commitment is no longer feasible and some women cease to take part in monitoring activities. Based on interviews with inactive monitors, the most common reasons for inactivity were due to competing demands from household duties and paid labour (Interview Anon.1, 2010). This is a reminder of how the efforts of poor women to improve conditions of social reproduction, in this case by providing citizen monitoring of public health service delivery, are conducted within the realities of wider political economic conditions of poverty and unequal gendered divisions of household labour.

Citizen monitors can play an important role in identifying deficiencies in the public health system and pushing for their resolution. Ultimately, however, their efforts are needed because of the longstanding weakness of the state, as reflected in the inadequate health service provision. One senior Ministry of Health bureaucrat from Lima explained his views on this:

"I think that all of these things that we’re talking about with citizen participation, this theme, it’s about resolving things that have been left aside by the state … it’s because of the lack of presence of the state, so that citizens are doing the work that corresponds to the state. And this work is difficult, because we’re not talking about citizens with all the time in the world to dedicate to this…. Citizen monitoring needs to exist because it’s necessary. But it’s more necessary that the state assume its responsibility (Interview Anon.37, 2011)."
The health official’s comment recalls O’Donnell’s point, which outlined in the introductory chapter, about “low intensity democracies,” which feature “grey areas” characterized by low government presence, high inequality and social exclusion (2002). In the case of Puno, there has been increasing government presence in the 2000s, especially since decentralization. Nonetheless, high levels of inequality and social exclusion persist. As noted by the health official in Lima, given the state’s weakness, citizen monitoring is “necessary”. It is likely not a short-term measure, but it may be a medium-term measure. Monitoring will have succeeded if and when it is no longer needed because the state has more effectively assumed its role in the provision of reproductive health care that meets the diverse needs of the Peruvian population.

It is important to note that active monitors seem genuinely committed to what they are doing and that, despite tensions over time, they also speak of the perceived benefits they receive. These benefits include a sense of satisfaction in feeling that they are helping other women receive fair treatment, and a sense of respect they perceive from this new kind of position (Interview Anon.2, 2010; Interview Anon.6, 2010; Interview Anon.21, 2011). Even among the small number of inactive monitors interviewed in this study, none described themselves as having actually quit. Although they pointed to several constraints that made it impossible for them to continue their monitoring activities, all of these lapsed monitors described themselves as simply taking a break or a pause (Interview Anon.1, 2010). They still identified themselves as citizen monitors. This suggests the importance that playing this role has had for these women.
6.4 Citizen Monitoring of Health Care in Puno: The Politics of Scaling Up

In this last section of the chapter I want to tell a story linked to a broader political debate that was taking place within the Ministry of Health in Lima, the national capital, concerning the possibility of “scaling up” citizen monitoring to extend it throughout the national public health system. My purpose is to illustrate the diversity of ways in which actors can interpret core ideas about participation and human rights within a local governance model, and to provide a sense of some of the tensions present in trying to integrate a rights-based governance approach more broadly within the public health system.

In early 2011, the Ministry of Health released an official resolution approving its new *National Policy Guidelines for the Promotion of Citizen Health Monitoring* (Ministry of Health, 2011). This very thorough set of guidelines situates itself within an extensive law and policy framework, listing Peru’s commitments to relevant international human rights laws, national laws and other relevant Ministry of Health policy resolutions. The guidelines note that, among other things, “monitoring promotes proactive participation, allows for the exercise of health rights and contributes to transparency and accountability” (Ministry of Health, 2011, p.13). The guidelines also provide a short background on the current situation with citizen monitoring of health in Peru. The document characterizes the situation as “evolving according to the

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88 CARE Peru provided technical assistance on the drafting of the national policy guidelines, which drew heavily on the model used in Puno (Frisancho, 2013).
democratization processes and changes in relationships between the state and society” (Ministry of Health, 2011:16). It goes on to explain that “the implementation of citizen monitoring in health has not been a linear, continuous process, but rather a social construct characterized by relations of power” (Ministry of Health, 2011, p.16).

The policy guidelines have been strongly supported by some parts of the senior Ministry of Health bureaucracy. For example, one senior Ministry of Health official in Lima called the release of the guidelines “a historic act” (Interview Anon.25, 2011). 89 The policy guidelines are currently awaiting implementation, which is envisioned to take place in consultation and collaboration with local and regional governments and health authorities (Frisancho, 2013).

These developments are very promising. Action by the state to extend rights-based monitoring throughout the health system could be a critical investment in improving the quality of health services. Right-to-health expert Alicia Yamin writes:

89 “It’s a historic act, because it’s the first time that a document has come out that is not about … communities organizing themselves to bring people to the health facilities. No, this is about something else. This is about citizens, about calling for accountability, about feeling like a rights-holder. It is not about how I’m going to convene people in my community, or myself, to get vaccinated. No, it goes further than that, this exercise. It’s about universal rights and the frameworks for them, because there are a series of norms now…. There were some in the Ministry who had been fearful about the release of this document, scared that the population would be right there on top of them, demanding things and needing things. But no, on the contrary, when you work with the population, they want to help…. What they are going to do is not allow more theft, more injustices, which is different. They’re going to give support to those professionals, give support to those who are working for their health and wellbeing” (Interview Anon.35).
Implementation of international human rights norms relating to health at the national level must go beyond legislation, and beyond the traditional law-making and oversight bodies (such as courts and NHRI) into the ministries (including but not limited to health) which are charged with designing social policy, and executing and monitoring programs that affect health (Yamin, 2008, p.10).

Still, applying the vision articulated in the national policy guidelines is a complex challenge. As I will show below, there is a diversity of opinions within the Ministry of Health concerning the shape and role of citizen monitoring. These views are informed by quite different notions of rights and participation. Since widespread implementation of the 2011 national citizen monitoring guidelines has yet to take place, the field is still wide open in terms of the manner in which it will happen.

In Puno, I had the opportunity to interview staff at the Regional Ministry of Health office concerning the potential implementation or a “scaling up” of citizen monitoring through the Ministry of Health. This was an illuminating meeting that presented a very different vision of citizen monitoring than the one discussed in chapter five. The official interviewed was very interested in implementing the new national citizen monitoring policy guidelines. He interpreted these new guidelines from Lima as a natural extension of their domain (Interview Anon.25).

The official explained that the Regional Ministry of Health in Puno actually already had groups of trained citizen monitors active for the past year in two of the urban hospitals in the region,
and that it was in the process of recruiting and training additional monitors to extend coverage. Local men and women are chosen, recruited and trained by Ministry staff. They are provided with credentials, and assigned to a health facility to observe service delivery (Interview Anon.25).

The official’s account of the monitoring model being implemented by the Ministry contrasted with the Puno initiative I have been studying in a number of significant ways. The official explained his feeling that monitors’ actions needed to be tightly controlled. As he put it, the monitors “sometimes exaggerate a little. Possibly in place of helping they can impede some activities” (Interview Anon.25, 2011). The official also asserted that NGOs should not play a role in citizen monitoring of health care. Involvement in citizen monitoring is “work that doesn’t correspond to them” (Interview Anon.25, 2011). He argued that the Ministry of Health was the only appropriate entity to organize and lead citizen monitoring activities.

In contrast to the citizen monitoring initiative set out in chapter five, the model described by the regional Ministry of Health official left no room for monitors to interact with local authorities. Instead, in the official’s model, the Ministry’s monitors submit their reports directly to Ministry staff. The Ministry then manages the follow-up and decides when and how to act on the information provided by its monitors. The monitors themselves are not involved further in the process. The Ministry official stressed that it would be inappropriate to involve the monitors in any subsequent discussions:
It isn’t their responsibility. They go to monitor. What does this have to do with the authorities? That’s another level (Interview Anon.25, 2011).

Although I lack the data that would allow me to fully understand the workings of the nascent Ministry of Health Puno monitoring model, the preliminary description by the regional health official suggests that it lacks several of the elements that my own research highlights as being important to the successes of the citizen monitoring initiative that I studied. Specifically, the missing elements are those that seek to address the imbalance in power relations in the monitoring process and that provide citizen monitors with opportunities for autonomous action and knowledge building.

These missing factors are: (1) strategic support provided to citizen monitors from influential actors that are independent from the health system but still seek its improvement; (2) some flexibility about how the monitors’ role of “observer” is construed, allowing room for certain kinds of concrete interventions and resolutions to occur as issues arise at a facility level; (3) regular, internal group meetings with all of the monitors to discuss findings and engage in collective learning; and (4) direct contact between monitors (backed by strategic allies) and senior health authorities in district-level meetings to share findings, open up access to new participatory spaces for excluded groups and remind the health system that outside actors are watching and are invested in its performance.
By tightly restricting the role of the monitors to observation, it seems likely that they are less able to exercise the informal, discretionary influence used by the CARE Peru-backed monitors to help resolve issues as they arise. My research suggests that by producing tangible results in the moment (reimbursement of illegal payments, improvement of treatment, access to timely care) for members of excluded groups, the monitors improve the daily circumstances of these health users. They may also be fostering an increased confidence in the public health system, something that is profoundly lacking at present. Additional research would be necessary to explore these dimensions further. Given the persistent context of popular indigenous disconnection from local health facilities in Puno, building a sense of confidence and citizenship in relation to the health system is of enormous long-term benefit, with important ramifications for maternal and reproductive health.

Some civil society members in Puno voiced apprehensions about the Ministry’s nascent model in Puno, especially with regard to the monitors’ relative ability to observe with an unbiased and independent gaze. One civil-society respondent argued that the objective of monitoring “is not to defend your institution against a complaint, but rather to see what is going on. We’ll have to see up to what point public administration understands this” (Interview Anon.22, 2011). If citizen monitoring of local health care provision is scaled-up nationally in Peru, it is an open question as to how it will be structured. As Molyneux says, “the terrain of policy, whether social or economic, is always contested, and is shaped by different, sometimes competing politics and discursive fields as well as by existing institutional structures, governing parties and patterns of provision” (Molyneux, 2008, p.785).
In the case of citizen monitoring, comparative research is needed to fully understand how women’s involvement in the governance model examined in the Ayaviri and Azángaro districts of Puno and its outcomes are similar to and/or different than those of other citizen monitoring models within the health sector. That is beyond the scope of this current study. A different approach to monitoring can significantly diminish the opportunities for influence, collective learning, and consciousness-raising that monitors are able to experience in local rights-based governance processes. This can affect how monitors are able to realize rights or make effective use of participatory spaces. It influences the kinds of opportunities created for marginalized actors to take on roles of substance, and how monitoring might or might not affect reproductive and other health outcomes.

6.5 Conclusion

The discussion above reveals a number of tensions and contradictions within the initiative as well as its potential for promoting change. Through a combination of strategies, the citizen monitors involved in the initiative have been able to reshape the micro-dynamics of power in order to exercise a measure of authority over how the state is involved in supporting social reproduction through their local health care facilities. This can result in important kinds of positive change in how health care services are delivered. However, there are also real limits to what citizen monitors are able to accomplish within local health care facilities. Certain problems are rooted in structural decisions that are outside the control of local health care workers and local officials and are thus difficult to influence through monitoring. The citizen monitors have begun to identify these dynamics, however they lack mechanisms for exercising a governance
influence over higher-level aspects of the health care system such as policy-making or budgetary decision-making.

I also noted some hopeful developments that suggest that the initiative may help to promote future efforts to address these kinds of structural problems. Involvement in monitoring seems to have built up the capacity and politicization among the monitors who have increasingly become involved in political issues outside of their monitoring activities. The practices of documentation of injustices and the new space for collective learning created by the initiative may turn out to be particularly important in the future if they provide the basis for broader and more systemic political action. I have also noted the potential for alliances to be formed with health workers in a common interest for reform. There is of course also the potential for co-optation of the citizen monitors and their efforts. The independence of the monitors in Puno may be seen as threatening to some actors within the health care system. It is clear that the future development and legacy of the initiative remains open.
Chapter 7

Conclusion: Lessons Learned and Future Research

7.1 Social Exclusion and Reproductive Health Service Delivery

In the first chapter of this dissertation, I discussed the embedded inequalities and longstanding patterns of social exclusion present within the Peruvian public health care system. These legacies, together with the persistent weakness of the system, continue to undermine the reproductive health and wellbeing of women in remote regions of the country. What does this example of struggle over the health care system in Puno tell us about the complex relationship between social exclusion and the delivery of reproductive health care?

The experiences of the citizen monitors provide an important new insight about the problems of “social segregation” in health systems. Social segregation in health care is the practice, frequently seen in Latin America, of maintaining separate health care systems for different sectors of society (Cotlear et al, 2014). As we saw in chapter one, Peru’s health system follows the general pattern associated with this kind of segmentation. The social security health system available to salaried workers and their families is better resourced and provides higher quality services than the parallel public system administered by the Ministry of Health to serve informal
workers and the poor. Since 2000, Peru has sought to address this inequality by expanding its system of health care services for the poor, while maintaining the separation of the two systems.

As Cotlear et al observe, “Left to their own inertia, health systems in unequal societies tend to develop in a segmented way, leading to new forms of inequality and social segregation” (Cotlear et al, 2014, p.10). Once established, this segmentation is hard to challenge partly because it normalizes the divisions between different social groups. Health care systems that are targeted at socially excluded groups are prone to make narrower commitments to these groups: both in relation to the services that are provided or covered, and in relation to the resources that are committed to these systems. Despite the expansion of primary care in rural areas in Puno and coverage through SIS, services and coverage for rural indigenous women in Puno lag behind those available to higher-status groups.

The stories of the citizen monitors in Puno point to a second problem, however: that social exclusion is also related to a large gap between official health care commitments and their implementation. This gap can appear when necessary funds are not allocated, when discriminatory treatment in health facilities is not addressed and when the consequences of systemic failures are off-loaded onto those health users who are least able to complain. This situation results in abuses, large and small: the everyday injustices of social exclusion. This suggests that even improved versions of segmented health systems are problematic for excluded social groups.
The exclusion of marginalized populations from publicly provided health care services is hardly unique to Peru or to Latin America. It is a theme that resonates well beyond the region. In Canada, for example, discrimination and exclusion of Aboriginal people within the health care system is a stark reality. A 2012 report by the Health Council of Canada notes that:

> It is well documented that many underlying factors negatively affect the health of Aboriginal people in Canada, including poverty and the intergenerational effects of colonization and residential schools. But one barrier to good health lies squarely in the lap of the health care system itself. Many Aboriginal people don’t trust – and therefore don’t use – mainstream health care services because they don’t feel safe from stereotyping and racism, and because the Western approach to health care can feel alienating and intimidating (Health Council of Canada, 2012, p.1).

In another striking parallel to the situation in Puno, a 2011 study on Aboriginal maternal and child health in Canada points to many barriers Aboriginal women experience in accessing reproductive health care. These include distance and cost of transport from remote communities to adequate health facilities, the lack of culturally appropriate care, and a shortage of Aboriginal maternal and child health care workers (Health Council of Canada, 2011:21). The challenges that confront Canada’s Aboriginal peoples in realizing access to care, despite the country’s wealth and its strong health care system, suggest the common nature of the realities faced by indigenous women in Puno and by members of socially excluded groups across the globe.
Such concerns are currently gaining increasing attention at the global policy level. In a discussion paper related to the UN review of the ICPD (the International Conference on Population and Development) program of action, Gita Sen has recently argued that work on realizing sexual and reproductive health rights (SRHR) needs to address the “three main gaps” in the implementation of these rights. These are:

- the absence of quality in service provision; the fact of large and growing inequality; and the need for accountability. The criteria for the SRHR agenda moving beyond 2014/2015 should therefore be **Quality, Equality, and Accountability**. An approach based on these criteria would advance SRHR laws, policies and programmes towards respecting, protecting and fulfilling the human rights of the most disadvantaged women and young people, especially adolescent girls (Sen, 2013, p.7, emphasis in original).

The proposal to champion the themes of “quality, equality and accountability” for “the most disadvantaged” has been further elaborated by the World Health Organization in a 2014 position paper. The paper asserts that “to advance the sexual and reproductive health and rights agenda beyond 2014/2015, inequalities must be addressed, quality of care guaranteed and accountability enhanced” (WHO, 2014). Sen argues that a focus on these factors should also be central to efforts to include sexual and reproductive health and rights in the new Sustainable Development Goals, the agenda likely to replace the Millennium Development Goals post-2015 (Sen, 2013:7).

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90 Sen explains that her use of the term “Quality” is “short-hand” for Availability, Accessibility, Acceptability and Quality (AAAQ), four attributes necessary for health services, as identified by the Committee on Economic Social and Cultural Rights in its elaboration on the right to health in General Comment 14 (Sen, 2013, p.7).
7.2 Addressing Embedded Inequalities: Insights from the Citizen Monitoring Initiative

There is real resonance between the thematic focus for sexual and reproductive rights that is emerging in the international arena and the work already underway by citizen monitors in Puno. Through their involvement in rights-based governance efforts, the monitors are building accountability mechanisms to oppose entrenched inequalities in health care and improve the quality of service provision. Sen argues that in order to actually matter, “‘Quality, Equality and Accountability’ needs to become a slogan, but also to be more than a slogan” through translation into practical action globally and nationally (Sen, 2013, p.8). The experience of the rights-based citizen monitoring initiative in Puno provides a number of insights and reminders that are relevant to the international community.

First is the reminder that inequalities are historically embedded over time and reflected in institutions (Thorp & Paredes, 2010). Thus, strategies aimed at challenging inequalities in a particular locale require a historically grounded understanding of where and how these inequalities emerged, as well as the intersectional dimensions of these inequalities. Second, the involvement of members of socially excluded groups in accountability mechanisms (using participatory or “governance from below” strategies) is important in a number of ways. The everyday injustices experienced by socially excluded groups can often be relatively invisible to outsiders. Peers may be required to gain the confidence of health users, and to have insight into
their perspectives. As well, involvement in the governance process can help to build the kinds of knowledge, skills, political analysis and competencies among members of socially excluded communities that can serve as the basis for political action in the future.

Third, efforts to involve marginalized actors in meaningful ways in governance initiatives need to address the very real, uneven power relations that permeate these processes. In designing an initiative, those involved need to creatively consider what sorts of mechanisms can create stable and institutionalized conditions in which members of marginalized groups are able to reposition themselves in order to exercise greater power in settings where this has not previously been possible. Fourth, the monitors’ experiences in Puno are a reminder that problems with the quality of care in local health facilities are not only a product of micro-level dynamics. They are also often driven by broader political and economic injustices that structure the health system and are reflected in areas such as unfair employment conditions for health workers, inadequate funding of goods and services, and a lack of appropriate infrastructure.

Finally, the initiative in Puno reminds us of the importance of articulation across diverse kinds of spaces. The initiative depends on alliances across both geographic as well as social spaces with a human rights-based approach used as a set of organizing principles to guide local level actions. Ongoing transnational linkages (e.g., CARE International and the International Initiative for Maternal Mortality and Human Rights) and national linkages (ForoSalud and CARE Peru) lend extra support to alliances on the ground in Puno between the citizen monitors, NGO actors, human rights lawyers and even government officials, through staff from the
comprehensive health insurance scheme (SIS). It is a prime example of the complexities, contestation and struggle involved in local women’s efforts to tangibly improve reproductive health care.

7.3 Democratizing Reproductive Health Care

In chapter two, I discussed the “re-privatization of social reproduction” thesis: the idea that states under pressure from neoliberalism and globalization are offloading their responsibility for social reproduction onto women and communities (Bakker & Gill, 2003; Kunz, 2010). This thesis implies that social struggles by civil society should oppose these moves to “hollow out the state” in order to protect encroachment on social rights. But as Kunz has argued, the assumptions underlying the re-privatization thesis are drawn from the Global North and are not universally applicable. Many Latin American countries are in fact expanding social benefits. But the situation in Puno revealed by my study highlights some of the complexities underlying the state’s expansion of social welfare. It suggests that improving reproductive health care in Puno requires a deeper struggle, one that involves promoting the democratization of the state.

As we have seen, in Puno, the state has expanded its commitment to supporting social reproduction in relation to reproductive health care over the last two decades. State provision of reproductive health care services was minimal until the mid-1990s. Particularly since the 2000s, reproductive health care services for indigenous women living in rural areas in Puno have expanded significantly. However my study has shown that this increased state involvement has
not been straightforward. While public health care programs for the poor have grown, they have also exhibited deeply dysfunctional problems. Citizen monitors have documented abusive treatment and persistent discrimination. They have also identified substantial problems in the system caused by underfunding, mismanagement, and precarious employment practices.

Although the state has expanded social rights and dedicated new resources to reproductive health care for the poor, informal workers and their families, the impact of these reforms on health inequality is arguably less than it should be. The problems appear to be closely related to the fact that these programs are targeted towards populations characterized by intersecting inequalities (indigenous, Andean, female, rural, poor, informal sector, etc.). Quijano’s thesis of the enduring coloniality of power within modern society is supported by these developments (Quijano, 2000). Colonially-derived notions of social stratification appear to be at the heart of both the abusive behaviour and the institutional neglect. As a result, the expansion of social provisioning conceals a persistent form of inequality that continues to be embedded in health care services directed to the indigenous and the poor. The issue is not the “hollowing out of the state” but rather the state’s persistent undemocratic nature.

The citizen monitoring initiative is an attempt to challenge this. It is part of a broader movement of initiatives and efforts to further democratize states in the region as these states expand social rights. Across Latin America, states and civil society are confronted with the challenges of promoting inclusion in social provisioning (Gideon & Molyneux, 2012, p.294). The “good governance” reforms that accompanied neoliberal restructuring in Latin America since the
2000s have helped to create opportunities to democratize local governance and service delivery (Molyneux, 2008, pp. 781-4). As I set out in chapter two, these reforms are characterized by “a marked redefinition of state-society relations” in which some state functions are “devolved to the local level and exercised in some form of partnership with civil society” (Molyneux, 2008, p. 793). These regional developments help to explain the context in which the citizen monitoring initiative emerged. In Puno, key actors were able to take advantage of new openings to create a rights-based governance model that encourages new forms of citizen engagement with the state.

### 7.4 Areas for Further Research

Several avenues for further research emerge from this investigation:

1. **Continued Investigation of the Current Citizen monitoring Process in Puno.**

As citizen monitoring in Puno continues to grow and develop, it will no doubt continue to be a site of struggle and contestation over the state’s role in reproductive health care provision, and health care provision more broadly. It would be useful to understand specific dimensions of the process more fully—for example, how social relations between monitors and health workers continue to develop over time, including whether they are able to forge any substantive alliances to address systemic problems they encounter with health care provision.
2. Does Monitoring Contribute to Increased Trust in the Health Care System?

Ozawa and Sripad argue that trust plays a critical role in health care provision, since “the entire arrangement is largely relational” (2013, p.10). Researchers have linked trust to several important objectives related to health care, including access and quality of care. Trust also makes it more probable that health users will recommend services to others (Ozawa & Sripad, 2013, p.10). Access to health services and quality of care are crucial factors affecting reproductive health, so strategies to build trust in health services, especially among marginalized populations with histories of exclusion, are badly needed. Citizen monitoring may increase confidence in the health care system by remedying abuses and by creating an impression of fairness or justice. It would be useful to understand the perspectives and behaviour of health care users in relation to these points. As the project has now been operational for several years, there is likely rich data to gather on this dimension.

3. Comparison of Puno Initiative with Other Examples of Citizen Monitoring of Reproductive Health Care and Health Care More Broadly in Peru

The same rights-based governance model used in Puno is now underway in multiple regions in Peru. It would be useful to compare and contrast these experiences in a systematic manner.
4. Comparison of the Puno Experience with Examples from Other Countries

An investigation that compares the Puno experience with other local-governance efforts around reproductive health care, or perhaps health care more broadly, in other countries that have formally integrated the right to health in recent health care policies would offer further insight into critical factors that either support or impede the governance process. Sites could be selected both in Latin America as well as outside of the region. Chile and Brazil could offer interesting Latin American comparisons, while South Africa and India may have examples of local governance efforts in the reproductive health care arena.

7.5 Closing Reflections

Generations of exclusion and discrimination experienced by socially excluded women in Puno at the hands of their state-provided reproductive health services will take a long time to truly rectify. It is essential, however, to devise creative and effective strategies that begin to address these entrenched issues and to improve women’s experiences when seeking and receiving reproductive health care. An understanding of the rights-based governance initiative underway in Puno offers valuable insight into the complex struggles of marginalized actors with the state over its role in the provision of social benefits and the promotion of inclusive citizenship.
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Appendices

APPENDIX A:

INTERVIEW GUIDE - PARTICIPANT INTERVIEWS (ENGLISH VERSION)

GENERAL INTRODUCTION

Thank you for agreeing to participate in this interview. The study examines local citizen monitoring of reproductive health services in Puno, Peru.

Let me remind you that your name and exact job title will not be used in the study. Please feel free to speak openly about your opinions and ideas related to these questions.

You are free to skip any questions or end the interview before completion.

I. Citizen monitoring: general

1. What motivated you to be part of citizen monitoring for the reproductive health services? Could you tell me about how you first became involved in citizen monitoring?

II. Citizen monitoring: background

2. Before monitoring did you perform other similar activities?

(Probe: Who with? When was it? Could you tell me a bit about these experiences?)
III. Citizen monitoring: training

3. How did you prepare yourself for the tasks/role as a citizen monitor?

(Were there parts of the training that you felt were especially useful/not useful? Were the ideas in the training new to you/how? Could you give me an example of something that you felt was especially important in the training? Why?)

IV. Citizen monitoring: health facilities level

4. Could you tell me about the work done in one day when you go to do monitoring (from the beginning to the end of the day)?

(Probe: How does monitoring begin? What instruments are used? Who do you speak with? On what issues? How do you address the cases that arise (*give examples)? Are there sensitive areas (*give examples)? Are there cases that you are unable to resolve (*give examples)? What do you do in those situations? Could you tell me what you do with the information you collect during a monitoring visit?)

5. Could you tell me about your first experiences doing citizen monitoring of your local reproductive health services?

(Probe: How were you received at the health facilities? (Please describe the reactions of workers and patients towards you as a monitor)

How did you go about doing the monitoring? What was the most difficult issue for you in this first experience? What did you learn?)

6. Now that you have been monitoring your health facilities for some time, could you tell us how your experiences have changed?
V. Citizen monitoring: relationships with other institutional stakeholders:

7. What is the work you do with the institutions that support monitoring like? (*please, give examples/cases)

VI. Citizen monitors: relationships with other monitors and members from their own communities (peer and community support)

8. Do you meet with the other women in your group? With other monitoring groups?

(Probe: Could you explain what happens in these? What topics do you talk about and how do you use and apply the information obtained from these meetings?)

9. Do you meet with other stakeholders/organizations outside Puno to talk about your experience as monitor? (*give examples)

10. Could you tell me a little about what you bring from your experience as a citizen monitor back to your own community?

(Probe: How do other members of your community react to what you do as a monitor? Do you talk with other members of your community about reproductive health services issues? In your opinion could you tell me if people in your community have had a different idea regarding services and reproductive health since you started being a monitor?)

VII. Citizen monitors: personal perceptions/attitudes about how monitoring activities might affect reproductive health services and your own lives

11. What would you like to achieve as a monitor?
12. Based on your own experiences, what have been the limitations in doing citizen monitoring?

(Probe: Are there particular things that you find frustrating or challenging about monitoring? How much of your time does citizen monitoring take per month? Are there things that you would do that you maybe don’t do, because you are busy doing citizen monitoring? How do you feel about that? Do you receive any kind of payment for your work doing citizen monitoring? Could you talk about how you feel about that arrangement?)

13. Do you have any ideas about how you could be more effective in your work as a citizen monitor?

14. What are the things you like best about doing citizen monitoring?

(Probe: What is it you like best and what makes you feel good about monitoring? Could you give some specific examples? Are there particular things that you feel you have learned since you started being a monitor?)

15. Based on your experience, so you think there has been a change in the reproductive health services since you started monitoring your health centre? (*give examples)

16. Talk about how your monitoring experience has helped to achieve more citizen participation?

(*give examples)

17. Is there anything else about your role as a citizen monitor that you would like to tell me about?

(Jeannie Samuel/University of Toronto/July 2010)
APÉNDICE B:

ENTREVISTA GUIA - ENTREVISTAS DE PARTICIPANTES (VERSIÓN EN ESPAÑOL)

INTRODUCCIÓN GENERAL

Gracias por aceptar participar en esta entrevista. El estudio examina la vigilancia ciudadana local de los servicios de salud reproductiva en Puno, Perú.

Le recuerdo que su nombre y cargo exacto no serán utilizados en el estudio. Por favor sientase libre de expresar abiertamente sus opiniones e ideas relacionadas a estas preguntas. Tiene el derecho de pasar por alto cualquier pregunta o terminar con la entrevista antes que ésta sea completada.

I. Vigilancia ciudadana: general

1. ¿Qué fue lo que le motivó para ser parte de la vigilancia ciudadana en los servicios de salud reproductiva? ¿Podría contarme cómo es que comenzó por primera vez en la vigilancia ciudadana?

II. Vigilancia ciudadana: antecedentes
2. ¿Antes de la vigilancia ha realizado ud. otras actividades similares?
   (Indagar: Con quien? En que epoca? Podría contarme un poco de cómo fueron esas experiencias?)

III. Vigilancia ciudadana: capacitación

3. ¿De qué manera se preparo para realizar las tareas/funciones de vigilancia ciudadana?
   (¿Habían partes de la capacitación que considera que fueron de mucha ayuda o que no fueron de ayuda? ¿Las ideas expuestas en la capacitación eran nuevas para ud/como? ¿Podría darme un ejemplo de algún aspecto de la capacitación que considera de especial importancia? ¿Porque?)

IV. Vigilancia ciudadana: nivel del establecimiento de salud

4. ¿Podría contarme sobre el trabajo que realiza de un día cuando va a hacer la vigilancia (desde el principio hasta el final del día)?
   (Indagar: Como empieza la vigilancia? Que instrumentos utilizan? Con quien habla? Sobre que temas? Como resuelve los caso que se presente (*ejemplos)? ¿Existen áreas sensibles (*ejemplos)? Hay casos que ud. no puede resolver (*ejemplos)? Que hace ud. en esas situaciones? ¿Me podría contar lo que hace con la información que recoges durante una visita de vigilancia?)

5. ¿Podría contarme sobre tu primera experiencia realizando la labor como vigilante ciudadana de los servicios de salud reproductiva?
(Indagar: Cómo era recibida en el establecimiento de salud? (por favor describe las reacciones de los trabajadores/usuarios hacia ti como monitora)

¿Cómo realizó la vigilancia? ¿Qué fue lo más difícil para Ud? De esta primera experiencia, ¿Qué fue lo que aprendió?

6. Ahora que ha estado vigilando su establecimiento de salud por algún tiempo, ¿podría decírnos si/cómo sus experiencias han cambiado?

III. Vigilancia ciudadana: relaciones con otros actores institucionales:

7. ¿Cómo es el trabajo que realizan con las instituciones que apoyan la vigilancia? (*por favor dar ejemplos/casos)

IV. Vigilantes ciudadanas: relaciones con otras vigilantes y con miembros de sus propias comunidades (apoyo de pares y de la comunidad)

8. ¿Se reúne con otras vigilantes de su grupo? De otros grupos de vigilantes?

(Indagar: ¿Podría contarme un poco de esas reuniones? ¿Sobre qué temas conversan y cómo usan y aplican la información obtenida en estas reuniones?)

9. ¿Se reúne con otras actores/organizaciones afuera de Puno para hablar sobre sus experiencias como vigilante? (*ejemplos)
10. ¿Podría contarme un poco de lo que lleva de su experiencia como vigilante ciudadana de vuelta a su propia comunidad?

(Indagar: ¿Cómo reaccionan los miembros de su comunidad de su labor como vigilante?
Conversa con otras miembros de su comunidad sobre asuntos de salud reproductiva? En su opinión, podría contarme si las gente de su comunidad tiene una idea diferente sobre los servicios e salud reproductiva desde que usted comenzó como vigilante?)

V. Vigilantes ciudadanas: percepciones/actitudes personales sobre la manera en la que sus actividades podrían influir los servicios de salud reproductiva y sus propias vidas

11. ¿Qué quieren lograr con ese trabajo como vigilante?

12. ¿Según su experiencia, ¿cuáles son las limitaciones al realizar la vigilancia ciudadana?
(Indagar: ¿Hay aspectos en particular de la vigilancia que son frustrantes o desafiantes para ud? ¿Cuánto tiempo toma la vigilancia ciudadana? ¿Hay cosas que haría y que no las hace porque está ocupada realizando la vigilancia ciudadana? ¿Qué piensa acerca de esto? ¿Recibe algún tipo de apoyo por su labor de vigilancia ciudadana? ¿Podría contarnos lo que piensa sobre este acuerdo?)

13. ¿Tiene alguna idea de cómo podría ser más efectiva su labor de vigilancia ciudadana?

14. ¿Qué es lo que más le gusta de su labor de vigilancia ciudadana?
(Indagar: ¿Qué es lo que más le agrada y le hace sentir bien de la vigilancia?, ¿Podría dar ejemplos específicos? ¿Hay aspectos en particular que ha aprendido desde que empezó su labor de vigilancia?

15. ¿Según su experiencia, ¿cree que ha habido algún cambio en los servicios de salud reproductiva desde que empezó a monitorear su establecimiento de salud?

(Indagar: Si la respuesta es sí, ¿qué tipo de cambios? **ejemplos; ¿Cree que su vigilancia influye en esto? ¿Qué han sido otros factores? Si la respuesta es no, ¿por qué no? )

16. ¿Cuentame si/como su experiencia de vigilancia ha ayudado a tener más participación ciudadana? (**ejemplos)

17. ¿Hay algún otro aspecto sobre su rol como vigilante ciudadana que desearía contarme?
Appendix C:

Interview Guide – Key Informant Interviews (English Version)

Basic Interview Guide

General Introduction

Thank you for agreeing to participate in this interview. The study examines local citizen monitoring of reproductive health services in Puno, Peru. A series of interviews have already been carried out with approximately 30 community women who function as citizen monitors.

To better understand the multiple dimensions that make up the citizen monitoring process, I am also conducting interviews with 15-20 key informants who come into contact with the initiative. These people occupy different professional positions related to reproductive health service provision and policy-making, health and human rights, and civil society organizing around health issues.

Please feel free to speak openly about your opinions and ideas related to these questions.

Let me remind you that your name and exact job title will not be used in the study. You are free to skip any questions or end the interview before completion.
I. Citizen monitoring: background

1. Could you tell me about your own position and work responsibilities?

2. Could you tell me how you first became aware of the citizen monitoring of reproductive health services that is currently being carried out in Puno?

(Probes: have you had any contact in the past with other similar types of initiatives? If so, could you give details? Could you talk about any lessons you have learned from those earlier experiences?)

II. Citizen monitoring: current experiences

3. Could you talk to me about the kind of contact you currently have with the citizen monitoring of local reproductive health services? Please give examples if possible.

(Probe: In what capacity are you in contact with the monitoring initiative? What is your role in relation to them?)

4. Based on your knowledge and experience, do you have ideas about what happens with the information that is collected by the citizen monitors?

5. Could you talk about whether an international human rights framework forms part of the approach to citizen monitoring local reproductive health service delivery?

III. Citizen monitoring: lessons learned

6. In your opinion, are there benefits gained from the process of local citizen monitoring of reproductive health services in Puno?
7. Could you talk about what you feel are some of the biggest challenges to the process?

8. Do you have specific suggestions about ways to improve the citizen monitoring process?
Gracias por aceptar participar en esta entrevista. El estudio examina la vigilancia ciudadana local de los servicios de salud reproductiva en Puno, Perú. Algunas entrevistas ya han sido realizadas a aproximadamente 30 mujeres de la comunidad, quienes ejercen el rol de monitoras ciudadanas.

Para tener una mejor comprensión de las múltiples dimensiones que abarca el proceso de vigilancia ciudadana, también estoy realizando entrevistas a un grupo de entre 15 a 20 informantes clave que están en contacto con la iniciativa. Estas personas ocupan diferentes posiciones profesionales relacionadas con la prestación de servicios de salud reproductiva y la formulación de políticas, salud y derechos humanos así como la sociedad civil organizada en torno a asuntos de salud.

Por favor, síntase en libertad de expresar abiertamente sus opiniones e ideas en relación a estas preguntas.
Le recuerdo que su nombre y cargo exacto no serán utilizados en el presente estudio. Asimismo, tiene el derecho de pasar por alto cualquier pregunta o finalizar la entrevista antes de que esta sea completada.

I. Vigilancia ciudadana: antecedentes

9. ¿Podría hablarme de su cargo y responsabilidades de trabajo?

10. ¿Podría contarme cómo se enteró de la vigilancia ciudadana de los servicios de salud reproductiva que actualmente se llevan a cabo en Puno?

(Indagar: ¿anteriormente ha tenido algún otro tipo de contacto con iniciativas similares? Si así fue, ¿podría dar detalles? ¿Podría hablar sobre las lecciones aprendidas de aquellas experiencias pasadas?)

II. Vigilancia ciudadana: experiencias actuales

11. ¿Podría contarme sobre el tipo de contacto que tiene actualmente con la vigilancia ciudadana de servicios de salud reproductiva local? Por favor, cite algunos ejemplos si es posible.

(Indagar: ¿De qué forma está en contacto con la iniciativa de vigilancia? ¿Cuál es su papel en su relación con estos servicios?)

12. Según su conocimiento y experiencia, ¿tiene idea de lo que sucede con la información que recogen las monitoras ciudadanas?

13. ¿Podría decirme si existe un marco internacional de derechos humanos que forme parte del enfoque a la vigilancia de la prestación de servicios de salud reproductiva local?
III. Vigilancia ciudadana: lecciones aprendidas

14. En su opinión, ¿existen beneficios obtenidos del proceso de vigilancia ciudadana local de los servicios de salud reproductiva en Puno?

15. ¿Cuáles cree que son los desafíos más grandes en este proceso?

16. ¿Tiene alguna sugerencia específica sobre cómo mejorar el proceso de vigilancia ciudadana?
APPENDIX E:

INFORMED CONSENT LETTER - PARTICIPANT INTERVIEWS

Re: Local Citizen Monitoring of Reproductive Health Service Delivery in Puno, Peru – A Qualitative Case Study

[to be printed two-sided on Dalla Lana School of Public Health/UT Letterhead]

Dear________________:

I am a student researching the citizen monitoring of reproductive health services in Puno, Peru. I will be interviewing approximately 20 community women from the provinces of Azángaro and Melgar who currently volunteer as citizen monitors. I will also be interviewing approximately 20 other people, such as local health officials, members of civil society organizations, and officials from the National Human Rights Ombudsman’s Office. I will be asking questions about your views and experiences with the citizen monitoring process.

This research is being done for my doctoral dissertation, a large study that I will write for my PhD. I plan to publish parts of my research in academic journals. I will also share the
research with health care practitioners, policy makers and other organizations in Peru and outside the country who may be interested in helping to better understand the process of local citizen monitoring of reproductive health services,

I would like you to allow me to interview you. Your participation is completely voluntary. At no time will you be at risk of harm, and no value judgment will be placed on your responses. I would like to tape record our interview but you are free to say no. I will ask you to consent specifically to tape recording, below.

I expect the interview will last about 60-90 minutes. You will receive a research honorarium of 30 soles in recognition of the time offered for the interview process.

*Right to withdraw or refuse to answer:*

You are free to refuse to answer any questions you are not comfortable with, or to withdraw even after you have agreed to participate. The research honorarium will still be received if you withdraw.

*Confidentiality:*

I will not use your name or anything else that might identify you in reports, publications or presentations. Your interview will be completely confidential and will not be shared with anyone, beyond the researcher and the Research Assistants __________ and __________. The Research Assistants have signed a Confidentiality Oath swearing to keep the data obtained from the interviews in confidence.

I will destroy the tape recording after the research has been presented and/or published (up to five years after the data has been collected). Only the researcher, her supervisors and the Research Assistants will have access to the interview transcript or any information where you
can be identified. You will not be identifiable in the study. Data will be stored in a locked filing cabinet in my home and on a password-protected computer.

This research is being conducted at the University of Toronto’s Dalla Lana School of Public Health, under the supervision of Dr. Ted Myers, Professor, Division of Social and Behavioural Health Sciences. This research project has approval through the ethics process at the University of Toronto, protocol reference #25277. If you have any questions about your rights, you may contact University of Toronto’s Ethics Review Office at ethics.review@utoronto.ca or 001-416-946-3273. If you have further questions or concerns after leaving the interview, please feel free to contact me through the contact information listed at the end of this letter.

This letter is intended to outline the details of participation in this research study. It is for you to keep. If you agree to participate, please tell me so. Your consent will be recorded in writing by the interviewer in a private log book that is not shared beyond the research team and is kept in complete confidence. Thank you very much for your help with this study.

Yours sincerely,

Jeannie Samuel, Ph.D. Candidate
Dalla Lana School of Public Health
155 College Street
Toronto, Ontario
Canada M5T 3M7
001 416 822 7046
(Insert Peru telephone number)
Jeannie.Samuel@utoronto.ca

Dr. Ted Myers
Professor
Dalla Lana School of Public Health
155 College Street
Toronto, Ontario
Canada M5T 3M7
001 416 978 8979
Oral Consent Process

1. Along with the letter above, interviewees will be read the following consent section aloud and asked if they understand/agree:

   A. “I acknowledge that the topic of this interview has been explained to me and that any question that I have asked has been answered to my satisfaction. I understand that I can withdraw at any time, or refuse to answer questions, without penalty. I have a copy of the letter provided to me by the researcher and agree to participate in an interview for the purpose described.”

   B. “I agree to this interview being taped and transcribed.”

2. Oral consent (including the name and date) will be recorded by the interviewer in a confidential logbook to be kept by the researcher.
APPENDIX F:

UNIVERSITY OF TORONTO
DALLA LAN A SCHOOL OF PUBLIC HEALTH

INFORMED CONSENT LETTER - KEY INFORMANT INTERVIEWS

Re: Local Citizen Monitoring of Reproductive Health Service Delivery in Puno, Peru – A Qualitative Case Study

Dear ________________:

I am a doctoral student researching the process of citizen monitoring of local delivery of reproductive health services in Puno, Peru. I will be interviewing approximately 30 community women from the provinces of Azángaro and Melgar who currently volunteer to monitor reproductive health service delivery in their local publicly financed health facility. I will also be interviewing approximately 15 to 20 key informants who have contact with the work of the citizen monitors, for example local health officials, members of civil society organizations, and officials from the National Human Rights Ombudsman’s Office. I will be asking questions about your understanding and experiences with the citizen monitoring process.

These case studies will be part of my doctoral dissertation. I plan to publish parts of it in academic journals. I will also share the research with health care practitioners, policy makers and other organizations in Peru and outside the country who may be interested in helping to better understand the process of local citizen monitoring of reproductive health services,
I would like you to allow me to interview you. Your participation is completely voluntary. At no time will you be at risk of harm, and no value judgment will be placed on your responses. I would like to tape record our interview but you are free to say no. I will ask you to consent specifically to tape recording, below.

I expect the interview will last about 60-90 minutes. You will receive a package of school supplies (notebooks, pencils, pens) in recognition of the time offered for the interview process.

Right to withdraw or refuse to answer:

You are free to refuse to answer any questions you are not comfortable with, or to withdraw even after you have agreed to participate. School supplies will still be received if you withdraw.

Confidentiality:

I will not use your name or anything else that might identify you in reports, publications or presentations. The transcript [written record] of your interview will be completely confidential and will not be shared with anyone, beyond the researcher and the Bilingual Interviewers ____________ and ____________. The Bilingual Interviewers have signed a Confidentiality Oath swearing to keep the data obtained from the interviews in confidence. I will share my draft findings from the study through a workshop and distribution of a short written summary in the spring of 2011. You will have the opportunity during this preliminary feedback process to add to the findings or to make them clearer.

I will destroy the tape recording after the research has been presented and/or published (up to five years after the data has been collected). Only the researcher, her supervisor and the two Bilingual Interviewers will have access to the interview transcript or any information where you can be identified. You will not be identifiable in the study. Data will be stored in a locked filing cabinet in my home and on a password-protected computer.

This research is being conducted at the University of Toronto’s Dalla Lana School of Public Health, under the supervision of Dr. Ted Myers, Dean, Professor, Division of Social and Behavioural Health Sciences. This research project has approval from OISE/UT (####). If you have any questions about your rights, you may contact University of Toronto’s Ethics Review Office at ethics.review@utoronto.ca or 001-416-946-3273. Should you have further questions
or concerns after leaving the interview, please feel free to contact me through the coordinates listed at the end of this letter.

This letter is intended to outline the details of participation in this research study. It is for your records. If you agree to participate, please provide your consent orally. Your consent will be recorded in writing by the interviewer in a private log book that is not shared beyond the research team and is kept in complete confidence. Thank you very much for your help with this study.

Yours sincerely,

Jeannie Samuel, Ph.D. Candidate
Dalla Lana School of Public Health
155 College Street
Toronto, Ontario
Canada M5T 3M7
001 416 822 7046
(Insert Peru telephone number)
Jeannie.Samuel@utoronto.ca

Dr. Ted Myers
Professor
Dalla Lana School of Public Health
155 College Street
Toronto, Ontario
Canada M5T 3M7
001 416 978 8979
Asunto: Vigilancia Ciudadana Local de la Prestación de Servicios de Salud Reproductiva en Puno, Perú: Un Estudio de Caso Cualitativo

Estimado(a)________________:

Soy una Candidata a Ph.D. que está realizando una investigación sobre la vigilancia de los servicios de salud reproductiva en Puno, Perú. En 2010 y 2011 entrevisté a aproximadamente 45 personas en Puno, incluyendo mujeres de de las provincias de Azángaro y Melgar, quienes participaron como vigilantes ciudadanas voluntarias, funcionarios de salud local, miembros de organizaciones y funcionarios de la sociedad civil así como autoridades regionales de Puno. Ahora voy a llevar a cabo entrevistas con informantes clave de Lima. Realizaré preguntas sobre sus opiniones y experiencias en el proceso de vigilancia ciudadana o en las políticas vinculadas a este tema.
Estoy realizando esta investigación para mi tesis doctoral, un estudio amplio que escribiré para mi PhD. Pienso publicar partes de mi investigación en revistas académicas. También compartiré la investigación con profesionales de la salud, diseñadores de políticas y otras organizaciones en Perú y fuera del país que podrían estar interesados en ayudar a adquirir un mejor entendimiento del proceso de vigilancia ciudadana de los servicios de salud reproductiva local.

Me gustaría tener su permiso para entrevistarle. Estimo que la entrevista durará aproximadamente 30-45 minutos. Su participación es completamente voluntaria. En ningún momento estará en peligro y no se impondrá ningún juicio de valor sobre sus respuestas. Me gustaría grabar nuestra entrevista pero tiene la libertad de negarse. Solicitaré su consentimiento específico para la grabación, más abajo.

*Derecho a retirarse o a no responder:*

Usted tiene el derecho de negarse a responder cualquier pregunta en la que no se sienta cómodo(a) o a retirarse luego de haber aceptado participar.

*Confidencialidad:*

No usaré su nombre así como ninguna otra información que podría identificarlo (a) en informes, publicaciones o presentaciones. Su entrevista será completamente confidencial y sólo será compartida con el investigador y las personas contratadas para ayudarle a transcribir las entrevistas. Las personas contratadas para transcribir las entrevistas han firmado El Juramento de Confidencialidad por el cual se garantiza que la información obtenida de los encuestados será tratada de manera confidencial.

Destruiré la grabación al término de la presentación y/o publicación del estudio (hasta un tope de cinco años luego de haber recogido la información). Las únicas personas que tendrán
acceso a la transcripción de la entrevista o a cualquier otra información donde usted pueda ser identificada serán la investigadora, sus asistentes y sus supervisores. No podrá ser identificada en el estudio; la información estará guardada en un archivador bajo llave dentro de mi hogar y en una computadora protegida con una contraseña.

Esta investigación se lleva a cabo en la Escuela de Salud Pública Dalla Lana de la Universidad de Toronto, bajo la supervisión del Dr. Ted Myers, Profesor de la División de Ciencias de la Salud Social. Este proyecto de investigación está aprobado por la Universidad de Toronto. Si tuviera alguna pregunta sobre sus derechos, podrá contactar a la Oficina de Evaluación de Ética de la Universidad de Toronto ethics.review@utoronto.ca o al 001-416-946-3273. Si tuviera preguntas adicionales o inquietudes una vez finalizada la entrevista, no dude en contactarme.

El propósito de esta carta es dar a conocer en líneas generales los detalles de la participación en este estudio de investigación. Esta es su copia. Si decide participar, por favor hágamelo saber. Su consentimiento será documentado por escrito por el entrevistador en un registro privado, el cual será tratado de manera confidente por el equipo de investigación. Muchas gracias por su colaboración en este estudio.

Atentamente,

Jeannie Samuel, Ph.D. Candidata
Dalla Lana School of Public Health
155 College Street
Toronto, Ontario
Canadá M5T 3M7
001 416 822 7046 (Canadá)
0 991 224 789 (Perú)
Jeannie.Samuel@utoronto.ca

Dr. Ted Myers
Profesor
Dalla Lana School of Public Health
155 College Street
Toronto, Ontario
CanadaM5T 3M7
001 416 978 8979
ted.myers@utoronto.ca
Proceso de Consentimiento Oral

1. Conjuntamente con la carta arriba mencionada, se leerá en voz alta la siguiente sección de consentimiento a los entrevistados y se les preguntará si están de acuerdo:

   A. “Confirmando haber recibido una explicación sobre el tema de esta entrevista y que toda pregunta realizada por mi persona ha sido contestada de manera satisfactoria. Entiendo que puedo retirarme en cualquier momento o rehusarme a responder alguna pregunta, sin penalidad alguna. Tengo una copia de la carta, la cual me ha sido entregada por el investigador y acepto participar en una entrevista para los fines descritos anteriormente.”

   B. “Acepto que graben y realicen una transcripción de esta entrevista.”

2. El consentimiento oral (incluyendo nombre y fecha) será registrado por el entrevistador en un registro confidencial que será guardado por el investigador.
APPENDIX H:

INFORMED CONSENT LETTER – PARTICIPANT INTERVIEWS (SPANISH VERSION)

CARTA INFORMADA DE CONSENTIMIENTO (ENTREVISTAS A PARTICIPANTES)

Asunto: Vigilancia Ciudadana Local de la Prestación de Servicios de Salud Reproductiva en Puno, Perú – Un Estudio de Caso Cualitativo

Date

Estimado(a)__________________:

Soy una estudiante que está realizando una investigación sobre la vigilancia de los servicios de salud reproductiva en Puno, Perú. Estaré entrevistando aproximadamente a 30 mujeres de la comunidad de la provincia de Azángaro y Melgar, quienes actualmente son voluntarias desempeñándose como vigilantes ciudadanas. También estaré entrevistando a otras 15 a 20 personas entre oficiales de salud local, miembros de organizaciones de la sociedad civil y oficiales de la Oficina Nacional de la Defensoría del Pueblo. Realizaré preguntas sobre sus opiniones y experiencias en el proceso de vigilancia ciudadana.
Estoy realizando esta investigación para mi tesis doctoral, un estudio amplio que escribiré para mi PhD. Pienso publicar partes de mi investigación en revistas académicas. También compartiré la investigación con profesionales de la salud, diseñadores de políticas y otras organizaciones en Perú y fuera del país quienes podrían estar interesados en ayudar a un mejor entendimiento del proceso de vigilancia ciudadana de los servicios de salud reproductiva local.

Me gustaría tener su permiso para entrevistarle. Su participación es completamente voluntaria. En ningún momento estará en riesgo de daño y ningún juicio de valor será impuesto sobre sus respuestas. Me gustaría grabar nuestra entrevista pero tiene la libertad de negarse. Pediré su consentimiento específico para la grabación, más abajo.

Estimo que la entrevista durará aproximadamente 60-90 minutos. como reconocimiento y gratitud del tiempo ofrecido durante el proceso de la entrevista le haremos entrega de 30 soles.

Derecho a retirarse o a no responder:

Usted tiene el derecho a negarse a responder cualquier pregunta en la que no se sienta cómoda o a retirarse luego de haber aceptado participar, incluso siendo así se le entregara los 30 soles, antes mencionados.

Confidencialidad:

No usaré su nombre ni alguna otra información que podría identificarle en informes, publicaciones o presentaciones. Su entrevista será completamente confidencial y no será compartido con nadie más que el investigador y los entrevistadores: LINDA CINDY CORDOVA BURNEO y DOLLY RAQUEL AMBROSIO NEIRA. Los entrevistadores han firmado El Juramento de Confidencialidad en el cual la información obtenida de los encuestados será tratada confidencialmente. Compartiré las conclusiones del estudio preliminar en un taller
con las monitores ciudadanas durante la primavera 2011. Usted tendrá la oportunidad de discutir, complementar o aclarar los resultados.

Destruiré la grabación al término de la presentación y/o publicación del estudio (hasta un tope de cinco años luego de haber recogido la información). Las únicas personas que tendrán acceso a la transcripción de la entrevista o a cualquier otra información donde usted pueda ser identificada serán la investigadora, su supervisor y los dos entrevistadores bilingües. No podrás ser identificada en el estudio. La información estará guardada en un archivador bajo llave dentro de mi hogar y en una computadora protegida con una contraseña.

Esta investigación se está llevando a cabo en la Escuela de Salud Pública Dalla Lana de la Universidad de Toronto, bajo la supervisión del Dr. Ted Myers, Decano, Profesor, División de Ciencias de la Salud Social y del Comportamiento. Este proyecto de investigación está aprobado por la Universidad de Toronto. Si tuviera alguna pregunta sobre sus derechos, podrá contactar a la Oficina de Evaluación Ética de la Universidad de Toronto ethics.review@utoronto.ca o al 001-416-946-3273. Si tuviera preguntas adicionales o inquietudes luego de terminada la entrevista, no dude en contactarme por medio de la información brindada al final de esta carta.

El propósito de esta carta es dar a conocer en líneas generales los detalles de la participación en este estudio de investigación. Esta es su copia. Si decide participar, por favor házmelo saber. Su consentimiento será documentado por escrito por el entrevistador en un registro privado, el cual será tratado confidencialmente por el equipo de investigación. Muchas gracias por su colaboración en este estudio.

Atentamente,
Proceso de Consentimiento Oral

3. Juntamente con la carta arriba mencionada, la siguiente sección de consentimiento será leída a los entrevistados en voz alta y se les preguntará si están de acuerdo:

   C. “Confirme haber recibido una explicación sobre el tema de esta entrevista y que toda pregunta realizada por mi persona ha sido contestada de manera satisfactoria. Entiendo que puedo retirarme en cualquier momento o rehusarme a contestar alguna pregunta, sin penalidad alguna. Tengo una copia de la carta, la cual se me ha entregada por el investigador y acepto participar en una entrevista para los fines descritos anteriormente.”

   D. “Acepto que graben y realicen una transcripción de esta entrevista.”

4. El consentimiento oral (incluyendo nombre y fecha) será registrado por el entrevistador en un registro confidencial el cual será guardado por el investigador.
APPENDIX I:

CONFIDENTIALITY AGREEMENT (SPANISH VERSION)

JURAMENTO DE CONFIDENCIALIDAD

JURAMENTO de CONFIDENCIALIDAD

Entrevistador y equipo de Investigacion

Yo, ________________________, acepto tratar toda informacion relacionada al proyecto, Monitoreo ciudadano de Prestación de Servicio de Salud Reproductiva en Puno, Peru: Un Estudio de Caso Cualitativo (el Proyecto) de manera estrictamente confidencial. No discutiré ni revelaré informacion alguna relacionada a este estudio, sea escrita o verbal, con nadie mas que el equipo de investigación. Mantendré el anonimato de los participantes del estudio. Entiendo la necesidad de asegurar que los materiales confidenciales no estén a la vista o al alcance de otras personas. Recogeré e informaré de manera precisa toda información de acuerdo con el protocolo de estudio y seguiré el procedimiento de acuerdo a lo descrito en el taller de capacitación. No falsificaré informacion ni cambiare respuestas. Informaré a la investigadora Jeannie Samuel cualquier asunto que pueda tener un impacto negativo sobre el estudio. Entiendo que una violación de este juramento podría resultar en el retiro inmediato de este Proyecto.

______________________________  _________________________
Firma                          Fecha

______________________________  _________________________
Testigo                       Fecha
CONFIDENTIALITY AGREEMENT (ENGLISH VERSION)

CONFIDENTIALITY OATH

OATH of CONFIDENTIALITY

Interviewer and Research staff

I, ________________________________ , agree to regard all data related to the project, Citizen Monitoring of Reproductive Health Service Delivery in Puno, Peru: A Qualitative Case Study (the Project) as strictly confidential. I will not discuss or disclose any information pertaining to this study, whether written or verbal, with anyone other than the research team. I will maintain the anonymity of study participants. I understand the need to ensure that confidential materials are not left lying around for others to see. I will accurately collect and report all data in accordance with the study protocol, and follow procedure as outlined in the training workshop. I will not falsify data or change any responses. I will inform the researcher Jeannie Samuel of any issues that may negatively impact on the study. I understand that a violation of this oath could result in immediate dismissal from the Project.

______________________________                 ______________________________
Signature                      Date

______________________________                 ______________________________
Witness                        Date
APPENDIX K:

ETHICS APPROVAL

PROTOCOL REFERENCE # 25277

June 26, 2014

Dr. Ted Myers
DALLA LANA SCHOOL OF PUBLIC HEALTH
FACULTY OF MEDICINE

Jean Monica Samuel
DALLA LANA SCHOOL OF PUBLIC HEALTH
FACULTY OF MEDICINE

Dear Dr. Myers and Jean Monica Samuel,

Re: Your research protocol entitled, "Citizen monitoring of reproductive health service delivery in Puno, Peru: A qualitative case study"

ETHICS APPROVAL

| Original Approval Date: June 29, 2010 |
| Expiry Date: June 28, 2015 |
| Continuing Review Level: 1 |
| Renewal: Data Analysis Only |

We are writing to advise you that you have been granted annual renewal of ethics approval to the above-referenced research protocol through the Research Ethics Board (REB) delegated process. Please note that all protocols involving ongoing data collection or interaction with human participants are subject to re-evaluation after 5 years. Ongoing research under this protocol must be renewed prior to the expiry date.

Please ensure that you submit an Annual Renewal Form or a Study Completion Report 15 to 30 days prior to the expiry date of your protocol. Note that annual renewals for protocols cannot be accepted more than 30 days prior to the date of expiry as per our guidelines.

Any changes to the approved protocol or consent materials must be reviewed and approved through the amendment process prior to its implementation. Any adverse or unanticipated events should be reported to the Office of Research Ethics as soon as possible. If your research is funded by a third party, please contact the assigned Research Funding Officer in Research Services to ensure that your funds are released.

Best wishes for the successful completion of your research.

Yours sincerely,

[Signature]

Elizabeth Peter, Ph.D.
REB Chair

[Signature]

Daniel Gyewu
REB Manager

OFFICE OF RESEARCH ETHICS
McMurrich Building, 12 Queen's Park Crescent West, 2nd Floor, Toronto, ON M5S 1S8 Canada
Tel: +1 416 946-3273 Fax: +1 416 946-5763 ethics.review@utoronto.ca http://www.research.utoronto.ca/for-researchers-administrators/ethics/
APPENDIX L:

CARE LETTER IN SUPPORT OF ETHICS APPLICATION

April 28th, 2010

Office of Research Ethics
University of Toronto
12 Queen's Park Crescent West
Toronto, ON, M5S 1S8
Canada-

Dear Sir or Madam:

I am writing this letter with regard to the doctoral research project proposed by Jeannie Samuel entitled "Citizen Monitoring of Reproductive Health Service Delivery in Puno, Peru: A Qualitative Case Study". Ms. Samuel plans to conduct research relating to a citizen monitoring initiative that we are piloting in Peru. This initiative brings together community leaders who act as independent volunteer monitors of local reproductive health services. Ms. Samuel's research will contribute to further understanding of the processes involved in local level monitoring of these services in the country.

CARE Peru is a non-governmental international development organization. As such, it does not have a formal ethics review process that covers these types of research projects. However Ms. Samuel's proposal has been reviewed and found to be ethically sound from our perspective. The research design is culturally appropriate. It also features appropriate means for obtaining informed consent and provides appropriate protection of confidentiality of the research participants.

Yours sincerely,

Ariel Frisarcho
Health Team National Coordinator
CARE Peru
**APPENDIX M: TABLES OF INTERVIEWS**

1. Citizen Monitoring Interviews

In order to ensure anonymity of the interviewees, only the health facilities that the monitors are responsible for visiting are listed here. Health facilities are not listed by name within the study so as to avoid linkages with either citizen monitor-informants or policy level-informants.

### AZANGARO

<table>
<thead>
<tr>
<th>Health Facility</th>
<th>Number of informants interviewed who monitor the site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azangaro Hospital <em>(Hospital Azangaro)</em></td>
<td>7</td>
</tr>
<tr>
<td>Birthing Centre and Alliance Health Centre* <em>(Casa Materna y Centro de Salud Alianza)</em></td>
<td>1</td>
</tr>
<tr>
<td><em>These two facilities are located beside one another</em></td>
<td></td>
</tr>
<tr>
<td>San Juan de Salinas Health Post <em>(Puesto de Salud San Juan de Salinas)</em></td>
<td>1</td>
</tr>
<tr>
<td>Llachata Health Post <em>(Puesto de Salud de Llachata)</em></td>
<td>1</td>
</tr>
</tbody>
</table>

### AYAVIRI

<table>
<thead>
<tr>
<th>Health Facility</th>
<th>Number of informants interviewed who monitor the site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital San Juan de Dios Hospital <em>(Hospital San Juan de Dios)</em></td>
<td>9</td>
</tr>
<tr>
<td>Pueblo Libre Health Post <em>(Puesto de Salud Pueblo Libre)</em></td>
<td>1</td>
</tr>
</tbody>
</table>

Total number of health facilities covered by monitors interviewed in study: 7
(Two hospitals, one health centre, one birthing centre, three health posts)

Total active citizen monitors interviewed in Azangaro and Ayaviri: 20

Total number of inactive monitors interviewed: 3
### 2. Policy-Level Key Informant Interviews

#### AZANGARO

<table>
<thead>
<tr>
<th>Institution</th>
<th>Number of informants interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>MINSA Health Facilities:</td>
<td></td>
</tr>
<tr>
<td>i. Azangaro Hospital</td>
<td></td>
</tr>
<tr>
<td>ii. Birthing Centre <em>(Casa Materna)</em></td>
<td></td>
</tr>
<tr>
<td>iii. Alliance Health Centre <em>(Casa Materna y Centro de Salud Alianza)</em></td>
<td></td>
</tr>
<tr>
<td>iv. San Juan de Salinas Health Post <em>(Puesto de Salud San Juan de Salinas)</em></td>
<td>6 (nurse/doctor/midwife/pharmacist)</td>
</tr>
<tr>
<td>v. Llachata Health Post <em>(Puesto de Salud de Llachata)</em></td>
<td></td>
</tr>
</tbody>
</table>

#### AYAVIRI

<table>
<thead>
<tr>
<th>Institution</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MINSA Health Facilities:</td>
<td></td>
</tr>
<tr>
<td>Hospital San Juan de Dios Hospital <em>(Hospital San Juan de Dios)</em></td>
<td>6 (doctor/midwife/nurse/policy official)</td>
</tr>
<tr>
<td>Pueblo Libre Health Post <em>(Puesto de Salud Pueblo Libre)</em></td>
<td></td>
</tr>
<tr>
<td>Municipality of Ayaviri</td>
<td>1</td>
</tr>
</tbody>
</table>

#### PUNO (Regional capital)

<table>
<thead>
<tr>
<th>Institution</th>
<th>Number of informants interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARE Peru – Puno Office</td>
<td>2</td>
</tr>
<tr>
<td>Puno Regional Office of National Human Rights Ombudsman <em>(Defensoría)</em></td>
<td>3</td>
</tr>
<tr>
<td>Office of Comprehensive Health Insurance Plan <em>(SIS)</em></td>
<td>1</td>
</tr>
<tr>
<td>Regional Ministry of Health Office <em>(DIRESA)</em></td>
<td>1</td>
</tr>
</tbody>
</table>

Total number of key informants interviewed in Puno, Ayaviri and Azangaro: 20

#### LIMA (National capital)

<table>
<thead>
<tr>
<th>Institution</th>
<th>Number of informants interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARE Peru</td>
<td>1</td>
</tr>
<tr>
<td>PROMSEX</td>
<td>1</td>
</tr>
<tr>
<td>ForoSalud (former)</td>
<td>1</td>
</tr>
<tr>
<td>UNFPA</td>
<td>1</td>
</tr>
<tr>
<td>Ministry of Health</td>
<td></td>
</tr>
<tr>
<td>i. Health Promotion Directorate</td>
<td></td>
</tr>
<tr>
<td>ii. Health and Transparency Office</td>
<td>6</td>
</tr>
<tr>
<td>iii. Quality of Care</td>
<td></td>
</tr>
</tbody>
</table>

Total Lima: 10
Copyright Acknowledgements (if any)