18

"Let's Be Citizens, Not Patients!": Women's Groups in Peru Assert Their Right to High-Quality Reproductive Health Care

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Problems with the quality of reproductive health care can be found throughout the world. In Peru, however, the nature and scope of these problems has been particularly well documented by both feminist organizations and established population and family planning institutions. Peru is one of the poorest countries in Latin America, with 37 percent of its 26.1 million citizens living below the poverty line, a figure that rises to 61 percent in rural areas (National Statistics Institute 1999, 2000). Maternal mortality is high, estimated at 185 maternal deaths for every 100,000 live births, one of the highest rates in Latin America (National Statistics Institute 2000). The differences in health conditions and indicators between large cities and outlying provinces are particularly marked. Furthermore, many service providers cannot easily communicate with the 27 percent of the population whose first language is Quechua, rather than Spanish (United Nations 1995).

In the early 1990s, a consortium of Peruvian feminist nongovernmental organizations (NGOs)[1]—Consorcio Mujer—conceived a project to enable local women to advocate for and collaborate in the improvement of reproductive health services in their own municipalities.[2] Its strategy was to involve local women and service providers in assessing the quality of care and engaging directly with health authorities in follow-up discussion about how to better meet users' needs. Unlike projects that invoke the term "community involvement" to mean perfunctory consultation, this project required community women to take responsibility as self-empowered citizens.

Linking users' needs to citizenship and sexual and reproductive rights was a logical and coherent step for the feminist consortium. As Latin American countries underwent democratization in the 1980s and 1990s, the concept of citizenship emerged within the

Latin American women's movement—especially in the regional meetings to prepare for the 1995 United Nations World Conference on Women in Beijing—as the theoretical and political foundation of discussions about women's status and empowerment. In order for women to exercise full citizenship, both the society at large and individual women would need to recognize female rights and autonomy in all spheres of life (e.g., occupational, political, economic, cultural, religious, and sexual) and be able to exercise such rights. A truly democratic society would thereby imply a shift from female dependence and submission toward equality and power sharing in governance and in the myriad decisions that affect women's lives (Hola and Portugal 1997).

In applying this concept of citizenship to the health sector, Consorcio Mujer aimed for a shift from a paternalistic model of interaction between providers and users toward an emphasis on community participation and users' rights. To appeal to goals that were already paramount in the health sector's agenda, Consorcio Mujer framed its project as one that would improve quality of care, a central concern in several national health projects funded by major agencies such as the Inter-American Development Bank, the World Bank, the United Nations Population Fund (UNFPA), and the U.S. Agency for International Development (USAID). To unite the concepts of quality and citizenship, the consortium placed users' rights and women's participation at the center of the concept of quality, while building on the quality-of-care framework developed by Bruce, which encompasses choice, information, provider–client interaction, technical competence, continuity of care, and access to a range of related services (Bruce 1990).

This approach stands in contrast to the paternalistic model, which is based on the belief that services for the poor are a matter of charity, not of the human right to health care. A corollary is that the provider knows what is best for the user. To Consorcio Mujer, community participation meant that users should participate in setting goals for health care provision and in helping providers achieve these goals. Sensitive to past abuses, the consortium emphasized users' rights related to voluntary participation in health care services, informed consent, nondiscrimination, and access to high-quality health care, regardless of ethnic group or socioeconomic class. Box 1 provides a comparison of the citizenship and paternalistic models of health care.

In 1992, when Consorcio Mujer conceived this project, there was little interaction between public health authorities and the women's movement, but the time was right to initiate dialogue. The health sector was being decentralized, resulting in the transfer of greater decisionmaking power to local officials. In addition, health-sector reforms mandated community involvement in setting priorities and in transforming local health centers into self-sufficient entities with community oversight boards.[3] With this in mind, each of the six Consorcio Mujer NGOs participating in this project

Box 1. Comparison of two models of health care provision

Citizenship model	Paternalistic model
Users have rights of access to health services, to freedom of choice, and to be treated with dignity.	Health services benefit users, and are provided to low-income people as a favor.
Community participation means that users are involved in setting goals.	Community participation means that community organizations help achieve providers' goals.
Equal relationships: Providers listen to users' concerns nonjudgmentally, and their responses take users' concerns into account.	Vertical relationships: Providers know what is best for users.

selected a community in which it had a tradition of work with both providers and local women's organizations: three were in the capital city of Lima; one each was in the Amazonian jungle, the Andean highlands, and on the rural coast.

DEFINING CLIENTS' PERSPECTIVES ON QUALITY OF CARE

In 1994 Consorcio Mujer began gathering information on how clients view quality of care. A number of studies had documented these issues in the past, but had concentrated on family planning; only two had incorporated clients' perspectives. Therefore the consortium focused its initial evaluation on women's own perceptions of health care, and on the full range of women's health services. The evaluation examined capacity for and the quality of basic gynecologic, contraceptive, and obstetric services, including the diagnosis and treatment of reproductive tract infections. In the six municipalities, the appointed NGO used standardized instruments to survey providers and at least 30 users and to conduct direct observations of provider–client interactions, with the clients' permission, in small health posts, larger health centers, and maternity hospitals. Some questions were specific, but many were open-ended, for example, "Was there any point during the medical visit when you felt ashamed?"[4]

The findings documented a range of problems:

Disrespectful treatment. Women reported being subjected to insults, angry shouting, and belittling. Nearly half (48 percent) suggested the need for improvement in providers' interpersonal skills. When asked which aspects of health care were most important for building trust, 57 percent highlighted "good treatment." In all, 17–30 percent of respondents in each municipality felt shame as a result of being rebuked or belittled by a provider.

Providers' failure to greet users and introduce themselves. The proportion of providers who greeted the client ranged from 15 percent to 60 percent.

Waiting time. Waiting time was more than one hour for 48 percent of women.

Inadequate information. Women complained of perfunctory and incomplete counseling. For example, they reported that providers did not explain diagnostic pro-

cedures and follow-up treatment. Many felt the explanations offered were not fully understandable. Only 17 percent of providers gave any explanations before or during vaginal exams, for example. In Cusco and Piura, only 8–9 percent of providers explained Pap smears, and 9–23 percent provided information on breast self-exams. According to Consorcio Mujer staff, "The information given to users is scant. . . . When users have vaginal infections, generally the professional says, 'It's inflamed'" (Consorcio Mujer 1998, p. 42).

Interruptions, lack of privacy, and presence of third parties. Women described frequent interruptions by other personnel while they were undergoing exams. Twenty-eight percent had no privacy during their exam because of the presence of third parties; 8–19 percent felt shame because of this. Overall, 60 percent of women reported feeling shame at exposing their genitals. (While one might expect that such modesty would lead to preference for a female provider, only 10 percent of respondents rated having a female provider as being of high importance.)

The findings were compiled into a report and discussed with local women's organizations, frontline providers, and municipal health authorities. These discussions often took place under the auspices of multi-sectoral committees that had been organized by the government in the mid-1990s to provide regular opportunities for communication between private and public actors involved in promoting health in a region or district.[5] The discussions were designed to reach agreement about courses of action to remedy the problems identified. There were difficulties, however, in attaining an adequate response from local authorities. Although the local women's groups and the frontline providers were dedicated to the process, they were not in a position to effect changes throughout large municipalities. The providers and users who had participated in the evaluation were from several health centers in the region, hence the findings could not be applied directly to improve services at any one center. Furthermore, because the decentralization of the health sector was still in its initial stages, central-level guidelines were still defining many municipal workplans.

The experience in Piura exemplifies the challenges of gaining consensus across a number of administrative levels. In Piura, the only rural area included in the consortium's project, a day-long assembly was convened to review the outcomes of the quality-of-care evaluation. Representatives of NGOs and the Rural Women's Network,[6] all of the midwives in the area, and municipal authorities attended, including representatives from Centro IDEAS, the member of the consortium that had conducted the evaluation. Midwives presented findings from the provider interviews, and women from the community presented a summary of users' input. In addition to deficiencies in service quality, women had highlighted the need to address health prob-

lems not traditionally dealt with by clinical services, including domestic violence. Comments from both midwives and women from the community noted the need for more holistic services. However, when the midwives presented their workplan for the year, it was as if these reports had never been made. The central authorities had already mandated two campaigns promoting and providing free Pap smears and two promoting and providing free sterilization. An NGO representative stood up and asked, "Wait a minute. What does this have to do with everything we just heard?" But there was little that could be done; funding was tied to directives from Lima.

While the municipal discussions led to frustration, the interaction between women and providers was generally viewed as valuable. For example, users complained that while the Pap smears provided through the centrally mandated campaign in Piura were free, when women returned for their results they were often told to pay a fee. Not surprisingly, some women in this cash-poor region went home without their results. These complaints helped providers grasp the frustration and distrust such campaigns generated in the community.

In addition to facilitating discussion, Consorcio Mujer used two other tactics to promote users' rights as the linchpin of quality of care. First, it designed a public media campaign with the slogan "Let's Be Citizens, Not Patients!" and distributed literature as part of the country's Safe Motherhood Day campaign. The consortium redoubled its efforts to influence quality-of-care evaluations at the central levels of the ministry and offered the ministry use of its research instruments and outcome indicators. These negotiations, initially promising, were truncated as controversy over the government's sterilization campaigns led to a growing rift between the ministry and some of the NGOs.[7]

A REVISED STRATEGY FOR COMMUNITY PARTICIPATION

Following the first set of experiments in provider–client dialogue, Consorcio Mujer decided it needed a new strategy, one that would have more specific geographic focus and build provider–client interaction around specific health center operations. The strategy would focus on collecting site-specific data on participating health centers and on training both clients and providers. The participating NGOs met with municipal health officials to select one health center in each project area. With an eye toward replicating the project beyond these pilot sites, the NGOs chose health centers that had been designated "network coordinators" as part of the national decentralization scheme.[8]

A NEW LOOK AT QUALITY OF CARE AT THE SIX SITES

While the results of the 1994 user surveys were useful for diagnosing general problems in a geographic region, the sampling strategy did not provide any one center with

reliable information. In 1997 Consorcio Mujer conducted new user surveys on quality of care at each of the six pilot sites. The most common complaints cited paralleled the findings of the 1994 evaluation: disrespectful treatment, long waiting times, lack of privacy, and inadequate information. A number of new complaints surfaced in the 1997 surveys, however, including:

Pressure to be sterilized or accept intrauterine devices. This type of pressure was reported in the three sites outside of Lima. In the early 1990s, the Peruvian family planning program's overwhelming emphasis on provider-dependent and long-acting methods focused mainly on provision of IUDs; overt and systematic pressure on providers to persuade users to be sterilized had not yet emerged at the time of the 1994 evaluation.[9] This significant change was apparent in the 1997 surveys, however. As a community health promoter in Carabayllo, Lima, reported in 1998, "Last year they made the mama tie her tubes, whether she wanted to or not, like a kid who has to obey the father's rule."

Lack of culturally appropriate services. Failure to respect Quechua childbirth practices was of concern in all six sites.[10] The incompatibility between Western hospital-based childbirth practices and Andean customs has long been common knowledge in Peru and is one of the main obstacles to increasing rates of hospital-based births.

Inappropriate fee-collection practices. Users at five sites reported problems with providers charging for services that are officially free of charge. Women at all six sites reported mistreatment of indigent women who requested fee waivers. The collection of fees is a relatively new practice in the public sector, and the money collected is often retained by health centers to purchase supplies and equipment and to supplement the low salaries of permanent employees.[11] A users' committee member in Cusco explained, "If we have money, they treat us well. . . . [Rural women] don't like to come to the city to give birth, because they have no money; the doctor ignores them and the nurses yell at them and insult them."

Users were also asked to characterize good-quality treatment, and many willingly talked about positive experiences in the health system, again emphasizing the importance of personal interaction:

> *She treats me kindly. I have a lot of trust and confidence in her and she is a good doctor. Several friends and I see her and we like her a lot.*
>
> *She calls me by my name, and doesn't say anything negative about my having sexual relations and not being married; in other places they scold you.*
>
> *She talks to me like a sister so that I'm not afraid during my labor; she helps me get off the bed and gives me advice.*

KEY TO THE NEW STRATEGY: THE TRAINING WORKSHOPS

Consorcio Mujer developed separate but overlapping workshops for providers and users on quality of care, users' rights, and sexual and reproductive rights. The providers' workshops were attended by the direct service providers, auxiliary nursing staff, and, in some settings, the health center director. For the users' workshop, the consortium invited leaders of community-based organizations (such as food committees and mothers' clubs) who also worked as health promoters. These women were selected because they would have enough health and leadership experience to replicate the workshop in the community. Most of these women were poor and had only primary-level education.

Each workshop consisted of four half-day sessions. Participants' goals were to:

- Define the concepts of sexual and reproductive rights and users' rights;[12]
- Critically analyze the attitudes and assumptions underlying the paternalistic model of health care;
- Reflect on their own experiences as users of health services, paying particular attention to problems that had been identified in the surveys;
- Suggest new models of provider–client interaction; and
- Generate concrete proposals for improving quality at their health center.

The consortium emphasized different issues in the providers' and users' workshops. Providers dealt first with their own experiences as users and with users' rights, and then concentrated on issues related to quality. These included the tension between quality and productivity, and quality-improvement strategies. Users dealt with self-esteem, rights, citizenship, and gender issues before they turned to the topic of quality of care.

Consorcio Mujer trainers used various communication strategies to promote reflection about quality-of-care issues and to stimulate positive role-playing. For example, participants analyzed an actual provider–client transaction that had been observed in one site (see Box 2).

In the final stage of the training, participants in both workshops developed specific proposals for improving services and formed implementation teams. The hope was that the two teams (called quality committees among the providers, and users' defense committees among the women) would engage in ongoing dialogue.

RESPONSE TO THE WORKSHOPS

What Providers Learned

Providers demonstrated openness to learning, recognized the need for quality improvement, and were aware of remaining obstacles, including a need for further training to deal with gender and sexuality issues. A provider in Piura said: "We learned that

Box 2. Speaking to deaf ears: An exercise to analyze a provider–client interaction

The user, a 24-year-old high-school graduate, is a vendor. She has come to the clinic because of a delayed menstrual period and has received a positive pregnancy test result. The provider is a midwife with 20 years' experience.

Provider: Sit down, my love. [She asks the number of children and the date of the user's last period] Little mother, did you do a [pregnancy test]?

User: Yes, doctor. [She gives her the lab report]

Provider: Who prescribed this?

User: I did. I came to the center and took the test, but I don't want to have more children now. I have many problems.

Provider: What's going on with this, little girl? Why don't you want to be pregnant?

User: [Laughs nervously] Things are not well at home, we are still building the house, and I have no money.

Provider: Do you have sons or daughters?

User: Two daughters.

Provider: So many little women? Now let's try for the little man. We're going to have this little child, the last one, little mother, because then we'll take care of you with pills or little tubes in your arm. Look, like these. [Shows the pictures of oral contraceptives and Norplant®] We won't do anything foolish, we'll respect this little boy child, and we'll love him very much as well.

User: I was taking Lo-Femenal, so why did I get pregnant?

Provider: You didn't take them correctly, my daughter.

User: *No.* I took them correctly.

Provider: But surely you forgot one.

User: No, I didn't.

Provider: I'm going to give you some pills so that you don't get nauseous. Next time you come, I'll do your analyses.

User: But, doctor, I'm not nauseous.

Provider: It doesn't matter, take them anyway, they'll be good for you. [She doesn't indicate how many times a day, or for how long]

Source: Consorcio Mujer 1998. This interchange was documented during the 1994 evaluation.

the users wanted us to ask them about sexuality. So now, we ask in a friendly way. But we still have some prejudices, and have asked Centro IDEAS for more training." Staff from the health center in the rural coast region commented:

> *They gave information on users' rights to us and to the users, thus initiating communication between us. Before we had problems. We saw things one way, and they saw them in another.*

> *The exercise where we put ourselves in the shoes of the users—[in which I was] remembering a time when I was treated terribly—influenced me. No one paid attention to me, and I got very demoralized.*

The course was very interesting. It allowed us to view ourselves objectively and see how we treat users. It was very useful to see their perceptions.

A comment from a clinic director in Lima exemplifies the change in attitude that the consortium's workshops aimed for: "Before, the providers were the authority, and the patients asked us to help them as a favor. Now we say, 'We are employed thanks to the patients.' "

In all six sites, the workshop also revealed providers' frustration at feeling pulled between a concern for users' rights and institutional pressures to sterilize women. As one doctor exclaimed, "What about my rights? Who is going to look out for me when I apply quality principles and am fired for not meeting my quotas?"

The providers were committed to participating in the workshop. In many sites, the sessions lasted for several hours beyond the scheduled time, sometimes until 10:30 p.m. In one site, an unsympathetic administrator scheduled an obligatory meeting to conflict with the workshop; the staff reacted by rescheduling the session for the evening, after work hours.

What Users Learned

The response among users was equally favorable, particularly with regard to the focus on rights. The previous training provided by NGOs to these grassroots women's organizations had focused on improving their effectiveness as community leaders, and did not link personal issues in women's lives such as lack of self-esteem to their ability to organize for their rights as citizens. Latin American feminist organizations—in their programs to promote citizenship among grassroots women's organizations—have learned the importance of participatory training methods for women in groups to support each participant's ability to "reconstruct oneself as a bearer of rights." The user trainees in Consorcio Mujer's project underwent this process to enable them to demand respectful and safe services. Participants voiced pride in their increased ability to ask questions, complain about mistreatment, resist coercion, and engage in discussion with providers on quality issues.

We didn't know about self-esteem. We learned to love and value our bodies and ourselves. Before, we let ourselves be mistreated, but no longer.

The concept of users' rights was new; it fit us like a ring on a finger. . . . We had complained before but without legal grounds.

Now we understand that human rights include the right to health. This caused us to think deeply. Why do we let them mistreat us? Why aren't we capable of reacting or asking for what we want?

The emphasis on self-esteem was important. We learned we can say no. We give and give, always for others. . . . Women always feel guilty.

The women's own views of what they deserved evolved over the course of the workshop. This process was summed up by a trainer in Piura:

What is new about the module is the concept of citizenship and rights. While the women already had some idea of these concepts, they were able to internalize them. The women reflected deeply. At the beginning of the training, they said that the quality of the services was just fine. Then, as we probed more into the different aspects of users' rights, the incidents of violations emerged—having to do with lack of privacy, inadequate information, mistreatment. . . .

At the beginning, I didn't think that the women were going to open up, but I was wrong. Little by little, they began to talk about everything they had left unsaid, and to express it with all their emotions. One woman wept as she described how she had been humiliated.

The providers understood about users' rights much more easily than the users. . . . [For the users] it was difficult to grasp the concept, because they only envision themselves as users and not as bearers of rights.

AFTER THE TRAINING: STRIKING A BALANCE

After the training, the two groups came back together. Throughout the project, the relationship between health care providers and community health promoters struck a balance between cooperative goodwill and tension. For example, community health promoters fiercely resented continuing to receive peremptory commands from health care providers as the predominant style of interaction: "Bring us 30 women on Tuesday for Pap smears." Difficulties also arose from provider resistance to users' new status and sense of entitlement. In one site, providers did not appreciate having users' comments included in the evaluations of individual care providers. In another site, the users' committee tried wearing special aprons to signify a semiofficial status, and joined the staff when they opened the waiting room suggestion boxes and reviewed users' comments. Although this action was negotiated by Consorcio Mujer and both sides agreed in principle, it did not work in practice. A user explained, "One woman went to the meeting to discuss the complaints, but she found that the language they used was too sophisticated. The women from the Mothers' Club didn't want to go any more, and the providers felt invaded."

In another site, according to the providers, members of the users' defense committee arrived unannounced and sat in the waiting room observing. When they were asked what they wanted, they said, "We're here to supervise you." Providers refused to negotiate directly with the users' defense committee, explaining, "This community is

very combative. We were afraid to enter into a formal relationship with them, because we don't have the means to live up to their expectations."[13]

In spite of these difficulties, in five of the six sites the relationship between the two groups remained generally friendly and cooperative after the workshops. A trainer in one site observed, "We have not noticed a negative reaction from the providers to women's participation. They view the women as allies." A user at another site remarked, "We had a positive attitude . . . that we were there to help them reach the people most in need. Before, we just criticized and didn't offer to help."

SHARED SOLUTIONS

The focus of post-training meetings was on solutions. Equipped with a new perspective about the rights of users, users and providers negotiated remedies for the various problems that had been identified. Most of the following solutions were implemented at particular sites; in some cases, however, several sites arrived at similar plans.

Promoting Respectful Treatment

- Rotate staff who treat users well into positions requiring public contact. In one Lima site, for example, a friendly cleaning woman was promoted to admissions.
- Establish procedures for firing, transferring, or disciplining personnel who are consistently the focus of mistreatment complaints. A doctor in the same Lima site lost her post as clinic director as a result of community pressure.
- Provide follow-up training to address assumptions and attitudes underlying rude behavior.

Ensuring that Providers Introduce Themselves

- Require providers to wear name badges.

Reducing Waiting Time

- Create chart retrieval routines to limit waiting time for women who arrive without their health cards.
- Post someone to direct clients to their proper destination.
- Establish procedures to serve clients in the order in which they arrive.

Protecting Privacy

- Establish a private area in which a user can state the reason for her visit.
- Place signs on examination room doors indicating whether the room is "free" or "occupied."

Eliminating Pressure to Be Sterilized

- Establish a waiting period between the counseling visit and the sterilization procedure. (This practice, originally instituted in one site, has now become part of the Ministry of Health's guidelines.)
- Conduct a community survey to prove to officials that there is no unmet need for sterilization to decrease pressure to fulfill unrealistic quotas.

Counseling

- Enforce a 15-minute minimum visit time to compel providers to spend more time offering information and counseling.

Promoting Cultural Sensitivity

- Introduce selected elements of natural childbirth and allow women to give birth in the squatting position with family members present.
- Use Quechua-speaking auxiliary staff to translate for users during visits.

Ensuring Access and Appropriate Fee-collection Practices

- Enforce guidelines on free services.
- Establish a savings plan during each antenatal visit to cover childbirth expenses (obstetric care is free but supplies must be paid for by the patient).

Although only limited evaluations of quality have been carried out since these measures were instituted, providers and users in all six sites have testified that services, while not perfect, have improved. Follow-up training of providers has consolidated some gains, while staff turnover has eroded others. Providers' comments point to adjustments in both the technical aspects of clinic operations and in their own attitudes:

> *We have to be realistic. We have been raised a certain way and consciously we know how we should be, but we can't live up to it. We have raised the problem that it is difficult to work on these issues with the community when we ourselves still have machismo inside us.*

> *We made the changes needed and applied a second survey, and we saw improvements in satisfaction with admissions, the cashier, and the first aid room. But our basic problem is that we have few personnel and many patients. The problem of waiting time can't be solved.*

> *Above all, the change has been within us.*

Users have also found changes "within themselves." Comments from women who had participated in the project indicate an increased ability to assert their rights as users:

> *Now we can complain and denounce mistreatment. We communicate with the superiors.*

> *I had decided to not get my tubes tied, but then one day a very angry nurse came to my house and asked, "Why would you want more children if you can't feed them?" I replied, "Miss, I'm not going to do it and no one can make me." Because if I want to, they can tie them, and if I don't, they can't force me. The nurse came for the second time, but I didn't want to meet her. . . . I had already been trained, so I told her that no one could make me, that this is my right and my body.*

CONCLUSION: THE NECESSARY ELEMENTS FOR CHANGE

Consorcio Mujer developed both a framework and a process of dialogue that challenged a paternalistic health care system and advanced a system of health promotion based on citizenship and equality. Clients, both individually and in groups, had to internalize the conception of themselves as bearers of rights. Providers had to begin to respect users' rights and to view respectful service delivery as a duty rather than a charitable function. Promoting such change required participatory training methods and time.

Another element in the relative success of Consorcio Mujer's training strategy was that its rights-based framework for change was followed by discussions and workshops to develop concrete proposals for improvements in service delivery and by actions to carry out the proposals. The combination of intensive interventions for attitude change, immediately followed by an opportunity to put these new principles into action, was a powerful strategy. While this strategy guided the process, some combination of the other facilitating factors was also necessary for success. Exceptional structural supports were in place through which the consortium was able to prod the system most effectively in some sites. These included:

- The availability of well-functioning, government-sanctioned multi-sectoral committees to serve as a forum for dialogue, pool resources on joint initiatives, and coordinate work. The existence of these committees was probably the single most important factor influencing success in some of the sites;
- Donor and government support of large-scale parallel and complementary projects designed to improve the quality of care;[14]
- Generally receptive attitudes among health officials toward community oversight, because of the introduction of such oversight mechanisms as part of health-sector reform; and

- A long-standing and trusting relationship between the Consorcio Mujer NGOs and local service providers and community-based women's organizations.

Consorcio Mujer did intensive work during 1999 to document the project's experiences, resulting in three publications (Consorcio Mujer 2000a, 2000b, 2000c), an account of the experiences at each of the sites, and training manuals for providers and community health leaders on quality of care and users' rights. According to the project coordinator, the demand for these publications has been lively. Only a more rigorous long-term evaluation could begin to take account of the ripple effects in the communities and elsewhere in Peru.

This chapter highlights the role of NGOs in effecting meaningful improvements in the quality of women's health care. Community oversight of quality of care in the provision of health services can be a delicate process; it is helpful to have an external entity managing it and monitoring the dynamics. The NGOs heard the views of both sides before bringing them together to engage in discussions and negotiation. Because users and providers speak different languages and operate from different places in the system, the NGOs played the role of mediator.

Finally, this chapter provides evidence of the ability of a rights and citizenship framework to stimulate collaborative partnerships between health care providers and the people they serve. The goal of democratic participation can only be realized when the less powerful actors in a system gain more power. Reaching this goal involves simultaneously promoting changes in people's attitudes and devising organizational, political, and economic structures that stimulate power-sharing and mutual respect.

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Notes

1 The Consorcio Mujer members involved in this project include Movimiento Manuela Ramos, Centro de la Mujer Peruana Flora Tristán, and Centro de Estudios Sociales y Publicaciones in Lima; Centro de Estudios y Promoción de la Mujer Amauta in the Andean highlands; Centro IDEAS in the rural coast zone; and Centro de Estudios y Promoción Comunal del Oriente in the Amazon region.

2 The documentation of the project presented in this chapter is based on reports and documents produced by Consorcio Mujer, on my personal knowledge of the project as a program officer for the Ford Foundation during the period 1993–98, and on semistructured interviews I conducted at the six sites with NGOs, health officials and providers, users' committees, and members of multi-sectoral committees during a two-week period in December 1998.

3 For more information on reform of the Peruvian health sector, see Ugarte and Monje 1999.

4 Such questions proved much more productive than asking a general question about a client's level of satisfaction, the answers to which tended to indicate falsely high levels of satisfaction.

5 The committees, organized in the mid-1990s with the encouragement of the Ministry of Health, included representatives from the health sector, other ministries, municipal officials, NGOs, and, occasionally, community organizations. The ministry hoped that by institutionalizing such communication, the resources of all institutions active in health promotion in one geographic area could be directed toward common goals and strategies.

6 The Rural Women's Network is an organization of peasant women in the Piura area with district-level subnetworks of more than 1,000 women.

7 The sterilization campaigns, which began in 1995, led to rights abuses throughout the country. During the campaigns, health care providers were given monthly quotas for numbers of sterilizations, which were enforced with both threats and incentives from the Ministry of Health. Given low pay and lack of job stability, few providers could afford to ignore these pressures. The campaigns ended abruptly in January 1998 when related human rights abuses were exposed in the media by Giulia Tamayo of CLADEM Peru, a women's rights network.

8 In the decentralization scheme, each network might include the maternity hospitals, health centers, and health posts in a health region. The institution designated as the coordinator of the network was in a key position to implement new programs and guidelines.

9 The levels of intimidation of users differed among the six project sites, depending on provincial fertility rates and on the willingness of regional, subregional, and health center directors to resist pressures from above. One United Nations professional described how Quechua women began to flee into the hills whenever the public health midwife came to their village, because they were afraid of being coerced into being sterilized.

10 Andean women traditionally labor in a warm and dark environment among family members. They ingest hot broths and teas, and the customary position when giving birth is to squat with the use of a birth pole. Postpartum practices include a restricted diet and burial of the placenta.

11 Some health officials would not admit that fees are used to supplement salaries, while others confirmed that doing so is a widespread, but unofficial, practice.

12 The new General Health Law, passed in July 1997, included a section on users' rights. Consorcio Mujer trainers gave participants in both workshop groups a poster with a list of users' rights as established by law. Ironically, the law was passed in the middle of the sterilization campaigns.

13 In most sites, the NGOs had a long history of work with both the health center and the local women leaders and could build on previously established trust. In this site, however, the Consorcio Mujer NGO was reaching out to a completely new geographical area, one in which the local women's organizations had had a confrontational relationship with the health system. It lacked sufficient history with these organizations to influence their stance and enable an effective dialogue. Based on the author's analysis of interviews at the six sites and interviews with the project director, it appears that the dialogues were most effective when the NGO had carefully negotiated and clarified the terms of the dialogue and prepared both groups in advance. This was easiest where there was a historical working relationship.

14 The World Bank, USAID, and UNFPA were promoting infrastructure improvements and quality-of-care initiatives during the project period.

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