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''LET'S BE CITIZENS, NOT PATIENTS!'': PROMOTING PARTNERSHIPS BETWEEN WOMEN'S GROUPS AND HEALTH SERVICES IN PERU

> 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. (Member of user committee in Cusco)
>
> What about my rights? Who is going to look out for me when I apply quality principles and they fire me for not meeting my quotas? (Doctor in Piura)

INTRODUCTION

In the traditionally hierarchical context of medical services, both health professionals and users are prisoners of unspoken assumptions and corresponding roles. The shift to a more democratic, horizontal system demands greater consciousness of and respect for users' rights on the part of providers, and both consciousness of rights and the capacity to demand respect for these rights on the part of users. Much effort in the public health and population fields has been devoted to working with reproductive health service providers to improve quality of care and respect for individual rights. Simultaneously, mainly feminist and some community health and development nongovernmental organizations (NGOs) have paid attention to working with users so that they recognize and demand their rights.

Program designers often don't recognize that in order to achieve this shift, an intense process of questioning of assumptions and attitudes on both sides is necessary. At the same time, within the health service, structural measures are necessary, such as changes in evaluation indicators of quality, mechanisms for user feedback and community involvement, and greater quality-related incentives. How can programs help users to construct their identities as citizens with rights so that they demand their rights and recognize violations of rights? How can programs help health providers respect these rights, and be more receptive to power sharing in an egalitarian relationship with users?

This case study of an innovative community participation program in Peru—implemented by a consortium of six feminist organizations called Consorcio Mujer—analyzes the experience of six diverse communities in Peru in which NGOs worked with both providers and users to improve quality of care and respect for users' rights. The sources of data for this study are: (1) reports and documents produced by Consorcio Mujer; (2) the author's personal knowledge of the project as a program officer for the Ford Foundation during the period 1993–1998; and (3) semistructured interviews conducted at the six sites with NGOs, health officials and providers, users' committees, and members of multisectoral committees during a two-week period in December 1998.

This study will describe the context in which the Consorcio Mujer project operated, focusing on developments in the health sector in Peru. The quality of care, citizenship, and users' rights principles that guided the project's interventions will be described, and the interventions and results of the main two phases of the project will be analyzed in detail. The chapter ends with a discussion of the factors that promote and pose barriers to sustainable dialogue between community women's organizations and the health sector.

THE CONTEXT IN PERU FOR THE CONSORCIO MUJER PROJECT

Health and the Health Sector

Peru is one of the poorest countries in Latin America.[1] At the time of the Consorcio Mujer project (1993–1998), 37 percent of its 26.1 million citizens lived below the poverty line, a figure that rose to 61 percent in rural areas, according to the National Statistics Institute (1999 and 2000). The statistics on access to the health system were also bleak. According to the 1998 Human Development Report, approximately 56 percent of the population had no access to health services, and one study showed that in the period from 1995–1997, of those with health problems who did not consult a health professional, for more than 60 percent the reason was lack of financial resources.[2] There are multiple barriers to access. For example, many

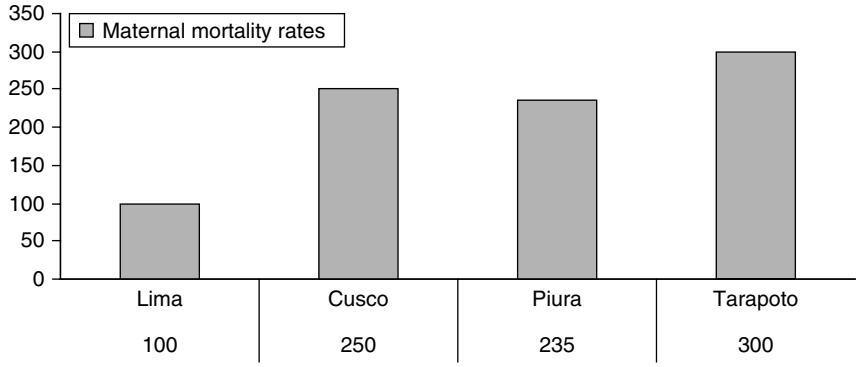

Figure 3.1
Regional Differences in Maternal Mortality Rates

service providers cannot easily communicate with the 27 percent of the population whose first language is Quechua, rather than Spanish.[3]

In 1997, maternal mortality was estimated at 265 maternal deaths for every 100,000 live births, one of the highest rates in Latin America.[4] The differences in health conditions and indicators between Lima and outlying departments[5] were (and continue to be) particularly marked, as Figure 3.1 shows.

The Peruvian government set an ambitious goal in early 1998 of reducing maternal mortality by 50 percent by the year 2002, but there were three important obstacles: lack of access in rural areas, failure to make childbirth services culturally appropriate, and the fees for childbirth expenses in hospitals. The last obstacle is believed to be an important factor in the low percent of women attended by health professionals in childbirth.

The level of unmet need for family planning services was also high, according to the statistics gathered in the 1996 demographic survey.[6] In rural areas, the observed fertility rate was 5.6, and the desired rate 3.1, while in urban areas, the observed rate was 2.8 and the desired rate 1.9. In 1994, one study estimated that 271,150 clandestine abortions were practiced annually in Peru, of which 47 percent presented complications.[7] Figure 3.2 on contraceptive prevalence and births attended by professionals shows the same regional disparities as for maternal mortality.[8] For this reason, the Consorcio Mujer program decided to work in three major cities outside of the capital.

Throughout the 1990s, the health sector in Peru suffered as a result of the constant reorganization in various health sector reform efforts. While the main thrust of all of these efforts was decentralization, along with a level of self-financing of the health system through users fees, in fact centralizing tendencies under Fujimori's authoritarian government[9] limited the decision-making authority of departmental health officials and their access to the income generated at the departmental level.

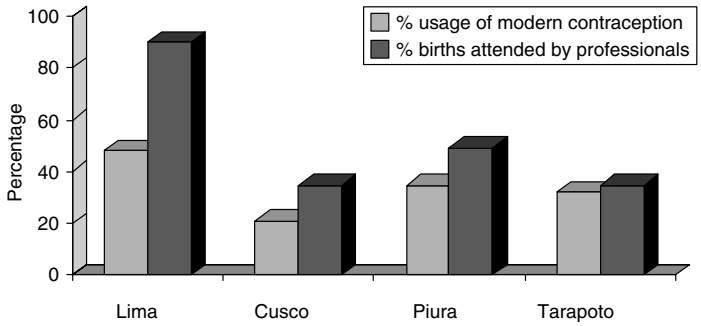

Figure 3.2
Regional Differences: Contraceptive Prevalence and Skilled Attendants at Childbirth (in %)

These tendencies of the Fujimori government undercut other democratizing initiatives in the health sector during this period. In 1992, when Consorcio Mujer conceived this project, there was little interaction between public health authorities and the women's movement. However, the time was ripe to initiate dialogue, because a new health sector reform was underway that mandated community involvement in setting priorities.[10] The reform restructured health facilities into networks of health posts reporting and referring to a secondary or tertiary-level facility. Some of these facilities were part of a pilot program: ''Local Health Administration Committees'' (CLAS), in which community representatives not only led needs assessments and helped set priorities, but also shared oversight of the facility with the director and other top staff. The CLAS were intended to be completely self-financed and autonomous. According to some informants, CLAS often had substantially higher user fees than the other health centers and posts.

As of December 1997 there were 548 CLAS scattered throughout the country. As is to be expected, CLAS generated mixed reactions based on both positive and negative experiences. In Lima, where the CLAS were not yet implemented at the time of this study (1999), providers spread negative rumors about community representatives representing political parties, and not users. Most relevant to this study is the ensuing atmosphere of apprehension surrounding the whole issue of community participation: the insecurity of mid-level management in Lima, which had not yet converted to the network system, and the anxiety among users about possible whole-scale increases in fees. These apprehensions mainly affected the pilot efforts in the three Lima municipalities in the Consorcio Mujer project during the years 1997 and 1998. In general, the results from this project were much more positive in the municipalities outside Lima, where decentralization and community oversight were already a fact of life.

Reproductive Rights Violations and Quality of Care in the Health System

In Peru in the late 1980s and early 1990s, both feminist organizations and established population and family planning institutions documented the nature and scope of problems with the quality of reproductive health care.[11] Feminist organizations in particular focused on widespread violations of users' rights.[12] In the early 1990s, partially influenced by USAID priorities, the Peruvian family planning program's preference for provider-dependent and long-acting methods led to an overly restrictive focus on provision of IUDs and sterilization.[13] Even though the HIV/AIDS epidemic was increasing in the country, provision of condoms was given low priority. Although significant proportions of indigenous women in Peru prefer natural methods, instead of helping women to use these methods more effectively, the public family planning program actively discouraged women from using them. After President Fujimori consolidated his hold on the government in 1992,[14] his strong focus on population control became increasingly evident, and exacerbated these tendencies.

At first, however, Fujimori's interventions seemed to favor women's rights and reproductive rights. Along with more than 180 other countries, the government of Peru signed the Programme of Action from ICPD without reservations in 1994, thus committing the Peruvian government to make individual well-being and reproductive rights—and not demographic targets—the axis of its population policy. Fujimori also gratified the Peruvian women's movement by appearing personally at the Beijing Conference (FWCW) in 1995, giving a speech that endorsed women's rights. Bucking the opposition of the Catholic Church, the Congress (controlled by the governing party) also passed legislation that relaxed the restrictions on male and female sterilization, thus expanding the range of contraceptive methods available to Peruvians.

The Peruvian government also implemented major policy and program initiatives to improve the quality of care and increase respect for human rights in the health system. In consonance with the goals of ICPD, during the 1990s, large multilateral and bilateral projects focused on improving access, infrastructure, and quality of care in reproductive health services, broadening the focus on family planning to include a major emphasis on lowering maternal mortality and on cervical cancer prevention. Some of these projects contracted women's NGOs to conduct key components designed to improve quality of care in health services.[15] Throughout the 1980s and early 1990s, these NGOs had worked closely with grassroots women community leaders in both health and community development efforts with a focus on women's empowerment. Therefore, they were very familiar with the day-to-day failures of the health services in quality of care and in meeting women's needs. Working on this issue that formed a central part of the feminist agenda

vis-à-vis the health system gave the NGOs a close link with the positive goals of the Ministry of Health (MOH) in the mid-1990s.

However, beginning in 1995, Fujimori pushed highly coercive initiatives in the family planning program aimed at population control, thus working at cross-purposes with all of these positive initiatives. The NGOs' close working relationship with the MOH at this point led to sharp divisions within the women's movement regarding when, whether, and how to denounce publicly the reproductive rights abuses.[16]

Throughout the history of the Consorcio Mujer project, even as the top decision-makers in the Ministry of Health and the president's office placed a positive focus on improving quality of care, they also followed MOH's traditional *modus operandi*, which emphasized productivity and efficiency, through target-driven campaigns for vaccinations and Pap smears. When this same modus operandi was applied to demographic targets and sterilization campaigns, the result was disastrous. Population control was publicly stated as a high priority for President Fujimori, who believed that it would help reduce poverty. Accordingly, from 1995–1997, the MOH implemented an intense campaign with the goal of sterilizing two million Peruvian women—supposedly the number of women in recent demographic surveys who wanted no more children and were not sterilized. According to most accounts, the president's office worked directly with the MOH to impose and keep track of progress on unofficial but inflexible monthly quotas for numbers of sterilizations at the regional level, descending to the level of each health facility and each provider within a facility. Providers and directors faced both threats and incentives to meet their individual and facility-level quotas. Given their low pay and, for many, lack of job stability,[17] few providers could afford to ignore these pressures.

This period in the history of the Peruvian health system was characterized by these contradictory trends—some of which protected and promoted rights while others led to rights abuses. During the height of the sterilization campaigns, the quality of care campaigns continued, and efforts to halt the rights abuses gained an important legal instrument when the Peruvian Congress passed the new General Health Law No. 26842 in July 1997, with a very progressive section on users' rights. The Consorcio Mujer NGOs built on this important policy advance, training both women and providers on users' rights as established by law, and disseminating widely a poster with a list of these rights.

THE CONSORCIO MUJER PROJECT—HISTORY AND FRAMEWORK

The project analyzed in this study was designed in the early 1990s by a consortium of six Peruvian feminist nongovernmental organizations (NGOs)[18]—Consorcio Mujer. Arising logically from the context of decentralizing health sector reform and quality of care initiatives, the several-stage

project empowered local women to advocate for and collaborate in the improvement of reproductive health services in their own municipalities.

Each of the Consorcio Mujer NGOs participating in this project selected a community; in five out of the six communities, the NGO had a tradition of work with both providers and local women's organizations.[19] Three communities were in the Lima, and one each was in the Amazonian jungle (Tarapoto), the Andean highlands (Cusco), and on the rural coast (Piura)—representing the main cultural/geographic zones in Peru.

The strategy was to involve both local women community leaders and service providers, first in assessing the quality of care, and then in training on users' rights, followed by direct dialogue about how to respond to the assessments. This project required profound shifts in attitudes of both providers and community women, so that both would recognize women as self-empowered citizens with the right to high quality health care.

Each community followed a several-stage process from 1993 through 1998:[20]

Phase I: Evaluation, Feedback and Dissemination

- Participatory evaluations of quality of services in a whole health district, involving health providers, the NGO, and community women's organizations.
- Multisectoral meetings to discuss the findings, and dissemination of the findings in a publication.
- A media campaign in each community on quality of care and users' rights.

Phase II: Pilot Interventions in Quality Improvement

- Simultaneous training of providers in one key clinic in the community and women community leaders from the clinic's catchment area in quality of care and users' rights.
- Identification of quality of care issues in the clinic by both providers and users, and development of concrete proposals for improvement by each.
- Workshops on quality of care and users' rights carried out by the trained women leaders among their community organizations.
- Meetings with trained providers and users to present their proposals for service improvements to each other, and develop a consensus work plan to address the quality issues.
- Formation of quality committees among providers and users' defense committees among the users to promote ongoing dialogue on quality issues. This component was designed to be the main mechanism to sustain the impact of the project once funding ended.

Citizenship, Users' Rights, and Quality of Care

Being citizens in our dealings with the health services means that we assume that health is a social right that we hold in order to achieve well-being. We strengthen our capacity to act with autonomy, knowing our rights as users of the health

services, and participating actively in decision making about our health, so that we assume responsibility for these decisions. We participate in the running of the health services, giving our opinions on the quality of care, presenting proposals and suggestions for improvement, and demanding these when necessary.[21]

Linking quality of care in health services to women's 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 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 (for example, occupational, political, economic, cultural, religious, and sexual). Women who enjoy full citizenship have the power, confidence, and appropriate channels for political participation in order to defend their rights in these spheres. 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.[22]

The citizenship model 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. A corollary is that the provider knows what is best for the user. Sensitive to past and current abuses, the consortium emphasized users' rights related to voluntary use of health care services, informed consent, nondiscrimination, and access to high-quality health care, regardless of ethnic group or socioeconomic class. Table 3.1 provides a comparison of the citizenship and paternalistic models of health care.

Table 3.1
Comparison of Two Models of Health Care Provision

Citizenship Model	Paternalistic Model
Users have rights of access to high-quality 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 or charity.
Community participation means that users are involved in setting goals.	Community participation means that community organizations help achieve providers' goals.
Horizontal relationships: Providers listen to users' concerns nonjudgmentally, and their responses consider these concerns.	Hierarchical relationships: Providers know what is best for the users, or "patients."

In applying this concept of citizenship to the health sector, Consorcio Mujer emphasized community participation and users' rights. To Consorcio Mujer, community participation meant that users should participate in setting goals for health care provision and in helping providers achieve these goals. Communities organizing for access to health care are more effective when they believe that they are fighting for entitlements rather than requesting charity. When providers believe that they are providing services as a favor, they react angrily when users complain about the quality of services, but when providers believe that these services are the right of all citizens, they are more apt to perceive quality complaints as legitimate. One quote from a health center director in Lima illustrates the paradigm shift that the Consorcio program 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.'"[23]

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 health care. 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, building on the quality of care framework developed by Judith Bruce for family planning programs. This framework recommends ample choices of methods, complete and appropriate information, respectful and high-quality provider-client interaction, technical competence, continuity of care, and access to a range of related services.[24] The users' rights framework used by Consorcio Mujer added the following principles:[25]

- Respect for users' rights is central to the concept of quality. User satisfaction is important but not sufficient. When women don't view themselves as subjects of rights, they blame themselves when they are mistreated, and don't express dissatisfaction with services.
- Major emphasis is placed on informed consent, freedom of choice and voluntarism, and respect for dignity of the person. The Consorcio's training highlighted the concept of freedom of choice to counteract coercive pressures on both providers and users in sterilization campaigns.
- Users have the right to privacy and confidentiality. Peruvian women complained about the presence of third parties without their consent, and about frequent intrusions into examining rooms.
- The right of users to express opinions and organize is a progressive feature of Peruvian General Health Law #26842, passed in 1997, and was a key axis of the Consorcio Mujer program.
- Nondiscrimination based on sex, religion, race, civil status, or location is enshrined in the Health Law. Consorcio Mujer added in their list of users' rights: nondiscrimination on the basis of economic status, age, and sexual orientation. (Discrimination on the basis of economic status was a frequent quality complaint in the six sites of the Consorcio Mujer program.)

- The right to culturally appropriate treatment and services is key for ethnic minorities. The Consorcio Mujer organizations believe that lack of attention to this right is an important factor in the underuse of maternity hospitals in Peru.
- The right of access to the widest range of services entails addressing barriers of geographical distance and cost. Cost became a major issue in Peru with the increasing users' fees.

Addressing these issues, Consorcio Mujer focused on the empowerment of users in three ways:

1. teaching women self-care, so that they are less dependent on the medical establishment for maintaining health;
2. educating them on gender and human rights issues to increase their view of themselves as bearers of rights; and
3. providing strategies to defend their rights as users of health services and as citizens.

PHASE ONE: PARTICIPATORY ASSESSMENTS OF QUALITY OF CARE

In 1994, Consorcio Mujer began gathering information within the six communities on how both users and providers viewed 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's evaluations included a dual focus on women's own perceptions of health care, and on the health services' quality, including the capacity to provide a 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 thirty 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?"[26]

The findings documented a range of problems:[27]

- *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 because of being rebuked or belittled by a provider. One user from the highlands testified: "I don't

go to the hospital because women are treated terribly, when they cry or scream with pain, the nurses ... insult them, 'Is this how you screamed when you were conceiving?' ... so I feel fear and shame.''

- *Providers' failure to greet users and introduce themselves.* The proportion of providers who greeted the client ranged from 15 to 60 percent. The project gave high importance to this indicator, which enables accountability. Women need to know the name of a provider who has mistreated them in order to lodge complaints.
- *Waiting time.* Waiting time was more than one hour for 48 percent of women. However, women tended to be resigned to the waiting time, but were outraged when they perceived that the ''first-come, first-served'' rule was violated.
- *Inadequate information.* Women complained of perfunctory and incomplete counseling. For example, they reported that providers did not explain diagnostic procedures 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 to 9 percent of providers explained Pap smears, and only 9 to 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'.''[28]
- *Interruptions, lack of privacy, and presence of third parties.* Women described frequent interruptions by other personnel while they were undergoing exams. Because of the presence of third parties (mostly medical students), 28 percent had no privacy during their exam; 8 to 19 percent felt shame because of this. Overall, 60 percent of women reported feeling shame at exposing their genitals. (Although 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 multisectoral committees—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.[29] 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 work plans.

The experience in Piura, the only rural area included in the consortium's project, exemplifies the challenges of having an impact on service delivery through this strategy. A daylong assembly was convened to review the outcomes of the quality of care evaluation.[30] Centro IDEAS, the NGO consortium member that had conducted the evaluation, other NGOs, the Rural Women's Network,[31] all of the midwives in the area, and municipal authorities attended.

Midwives presented findings from the provider interviews, and women from the community presented a summary of users' focus groups. In addition to deficiencies in service quality, women had highlighted the need to address neglected health problems such as domestic violence. Comments from both midwives and women from the community noted the need for more comprehensive services. However, when the midwives presented their work-plan 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 free sterilization. An NGO representative stood up and asked, ''Wait a minute. What does this have to do with everything we just heard?'' However, there was no possibility of adjustment; 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, in the Piura meeting, users complained that while the Pap smears provided through the campaigns were free, when women returned for their results, they were often told to pay a fee for the clinic visit. Not surprisingly, some women from this poverty-stricken rural 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. Second, the consortium redoubled its efforts to influence the quality-of-care evaluations at the central levels of the Ministry of Health, 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 in the consortium.

At a joint meeting, the Consorcio Mujer members reflected on the experiences in Phase One, and concluded that while the assessments and dissemination had served to raise consciousness about common quality of health care problems, more targeted interventions would be necessary to produce actual changes at the clinic level. They designed Phase Two of the project so that concrete improvements in quality of care at key clinics could serve a demonstration effect within each department.

PHASE TWO: COMMUNITY PARTICIPATION IN QUALITY IMPROVEMENT

The new strategy focused on: (1) collecting site-specific data regarding quality and capacity of participating health centers; (2) using the data in training courses with both clients and providers; (3) generating consensus on specific recommendations for improvements; and (4) creating sustainable mechanisms for dialogue between health providers and users.

As a first step in the new strategy, 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 in health sector reform programs.[32]

Quality Assessments in Each Clinic

As mentioned above, while the results of the 1994 user surveys were useful for diagnosing general quality of care problems in the health services in a geographic region, the sampling strategy did not provide any one center with a reliable assessment of quality of care. In 1997, Consorcio Mujer conducted new provider and user surveys on quality of care at each of the six pilot centers. The most common user complaints paralleled the findings of the 1994 evaluation: disrespectful treatment, long waiting time, lack of privacy, and inadequate information. A number of new complaints surfaced in the 1997 surveys,[33] however, including:

- *Pressure to be sterilized or accept intrauterine devices.* Overt and systematic pressure on providers to persuade users to be sterilized had not yet emerged at the time of the 1994 evaluation, but was evident in the 1997 surveys.[34] 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 rules."[35]
- *Lack of culturally appropriate services.* Failure to respect Quechua childbirth practices was of concern in all six sites.[36] The incompatibility between modern hospital-based childbirth practices and Andean customs (see Box 3.1) has long been common knowledge in Peru and is one of the main obstacles to increasing rates of hospital-based births.
- *Mistreatment and fee collection.* Ironically, the health sector reform's focus on achieving financial autonomy for local health services—potentially a significant barrier to access for low-income Peruvians—increased attention to quality of care in the public health centers and posts. However, certain perverse incentives in the policies also undermined quality of care. The collection of fees is a relatively new practice in the public sector, and the money collected is retained by health centers to purchase supplies and equipment, but most importantly to supplement the low salaries of permanent employees.[37] As a result, users at five sites reported problems with

Box 3.1
Traditional Andean vs. Modern Medical Birthing Practices

Andean women traditionally labor in a warm and dark environment among family members and/or traditional midwives. They ingest certain 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. The Western hospital model, with cool light rooms, enforcement of a prone position, and automatic disposal of the placenta, is particularly uncongenial to these women, and helps explain the low percentage of women whose births are attended by professionals. Indigenous women are often subjected to racist comments and mistreatment as well.[38]

providers charging for services that are officially free of charge. Furthermore, women at all six sites reported mistreatment of indigent women who requested fee waivers. Because every request for a fee waiver potentially reduced the salary of the person considering the request, it is small wonder that the requests generated ill will! 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."

The survey asked users to characterize good-quality treatment as well, and many willingly discussed positive experiences in the health system, again emphasizing the importance of personal interaction:[39]

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.

The Training Workshops

Consorcio Mujer developed separate but parallel workshops on quality of care, users' rights, and sexual and reproductive rights for providers from the pilot health center and women leaders from its catchment area. Direct service providers, auxiliary nursing staff, and, in some settings, the health center director attended the providers' workshops. For the users' workshop, the consortium NGOs invited leaders of community-based organizations (such as food committees and mothers' clubs) who also worked as health promoters.[40] Consorcio Mujer selected these women because they had

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. The goals for participants were to:

- understand the concepts of sexual and reproductive rights and users' rights, including the content in the new health law;[41]
- 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 identified in the surveys;
- generate new models of provider-client interaction through practical exercises in new ways of communicating and relating to each other;
- generate concrete proposals for improving quality at each health center.

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 was recorded during the 1994 evaluations (see Box 3.2). These participatory and intensive techniques built skills and enabled attitude change.[42]

The consortium training 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. Providers also discussed 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. The women leaders were also trained to conduct workshops on these issues for their community organizations, an outcome that was not expected of the providers.

Box 3.3 illustrates two training exercises, one for providers and one for users, which addressed central issues for each group.

In the final stage of the training, participants in both workshops developed specific proposals for improving services and formed implementation teams. After the training, the Consorcio NGOs coordinated a joint meeting between the two groups to develop a consensus plan for quality improvement. The expected result from the meeting was that the providers would form quality committees to implement these proposals, while the community leaders would form users' defense committees to promote their suggestions, with the two groups engaging in ongoing dialogue.

Box 3.2
Speaking to Deaf Ears: An Exercise to Analyze a Provider-Client Interaction[43]

The user is aged twenty-four, a high school graduate and a market vendor. She has come to the clinic because of a delayed menstrual period and received a positive pregnancy test result. The provider is a midwife with twenty years of experience.

Provider: Sit down, my love. [She asks the number of children (2) and the date of last period.] Little mother (*madrecita*), did you do a Pregnostic (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 here, little girl (*niñita*)?* Why don't you want to be pregnant?
User: (Laughs very 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, *madrecita*, 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 (*mi hijita*).
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.]

*Peruvian feminist NGOs have insisted that eliminating the common use of diminutive names such as found in this interview is an important element in the empowerment of the female user and in constructing more horizontal relationships. When challenged on this practice, providers typically respond that these labels are a sign of warmth and affection, and an important part of putting the client at ease. However, these labels clearly signal a vertical relationship; no one can imagine an indigenous woman calling a nurse "*niñita*."

Response to the Workshops[44]

Reactions Among Providers

The providers were committed to participating in the workshop. In many sites, the sessions lasted for several hours beyond the scheduled

Box 3.3
Sample Exercises from Providers' and Users' Training

Users Training Module: "YOUR DAY IN COURT"

Objective: To enable women to defend principles of reproductive rights in the face of arguments to the contrary.

1. Group discussion on the list of reproductive rights. The group chooses the right to choose what they think is most important to work on.
2. Three women become the jury, and the rest of the group divides into defenders of the rights and opponents. In the opponents' group, each woman is assigned a role with a card worn on the chest, such as bishop, neighbor, husband, *machista* [sexist man], scientist, chief doctor, etc. The defenders' group represents the community women.
3. After each group organizes its arguments, people from each group alternate by speaking for one minute.
4. At the end, the jury decides whether the right is approved or not.

Providers Training Module—Paper Boat Exercise

Objective: To encourage providers to examine the trade-off between quality goals and productivity.

1. The facilitator shows the group how to make a well-made paper boat, and gives each small group thirty sheets, with the instructions that they have three minutes to make twenty boats. The group that makes the most well-made boats wins the prize. Points are subtracted for torn or misshapen sheets.
2. In the next stage, the facilitator delivers thirty sheets to each group, with the instructions to make thirty boats in three minutes.
3. The judges compare the quality of the boats produced between the first and second stages. (Invariably, the second stage sees more quality problems.)
4. The group discusses the relevance of the exercise to their discussions on quality of care, and the productivity goals set by the ministry.
5. The group discusses the use of productivity goals to evaluate professionals or services. Messages reinforced by facilitator at this stage: improving quality may lower productivity in the short-term, but in the long-term, it results in less "waste," as in the discarded boats. Quality attracts more users to the center, and costs less when the problems of the users are adequately dealt with in one visit.

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.

In general, 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.

Providers' comments point to adjustments in their own attitudes, as well as to a realistic appraisal of the long-term nature of the change process demanded of them:

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 realized the problem that it is difficult to work on these issues with the community when we ourselves still have machismo inside us.

We learned that 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.

The focus on the "internal client" in the workshop seemed to be a powerful tool for change. One clinic director remarked:

They gave information on users' rights to us and to the users, thus initiating communication between us. Before this, we had problems, because 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.

In all six sites, the discussions on the tension between productivity and quality revealed providers' frustrations at feeling pulled between a concern for users' rights and institutional pressures to sterilize women. As one doctor in a Piura training session 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?"[45]

In analyzing quality problems in provider-client interactions, the providers also pointed to the anger and frustration that they feel when—in their opinion—users do not fulfill their obligations. One provider from Piura echoed sentiments expressed in most of the other sites as well: "And when the women know their rights, what about their responsibilities? For example, when they don't follow our instructions for treatment, or don't respect the clinic's schedule."

Reactions Among Users

The response among users was equally favorable. The training used participatory methods to support each participant's ability to "reconstruct oneself as a bearer of rights." Before the Consorcio project, the training provided by Peruvian NGOs with these grassroots women's organizations had focused on improving their effectiveness as community leaders, that is, on what the women could do for others. Consorcio Mujer NGOs viewed the linkage of personal issues in women's lives (for example lack of self-esteem and

recurrent RTIs) with their ability to organize with others for their rights as citizens as particularly effective.[46]

A trainer in Piura summed up this process:

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

This experience points out the limitations of traditional user satisfaction surveys. Women who do not view themselves as bearers of rights often do not express dissatisfaction. The user trainees in Consorcio Mujer's project 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.

I had decided not to 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.

The Experience of Replicating the Training

After the training, the community health promoters replicated the training in users' rights among the members of their organizations. In all six sites, this

was a new and empowering experience for these community leaders, and expanded the impact of the training. The manual developed by the NGO for the user training had to be adapted and simplified greatly for this purpose since many members of the community organizations have little or incomplete primary education. Even for the most experienced health promoters involved, this was their first experience in serving as trainers, that is, taking over the traditional role of the more professional NGOs.

All the promoters interviewed commented on how nervous it made them to assume this new role with their constituencies, on the one hand, but on the other hand, they revealed what an opportunity it posed for their own growth and leadership development. The leaders of the Salitral [Piura] network commented: "One just has to get over feeling nervous and learn to be strong, and capable of communicating new ideas to our groups. . . . We divided the work [for the training in each community] and each of us gave at least one of the sessions. [Q: And how did the workshops go?] Some women were very ashamed and timid, but as the sessions progressed they relaxed."

Consorcio Mujer hurried to implement this phase of the program because they felt such urgency about disseminating the message on users' rights effectively, to a broader audience, as the government's sterilization campaigns continued. Even though the campaigns officially ended in early 1998, it took some time for them to wind down and for NGOs and community organizations to verify this. Furthermore, the campaigns left a legacy of fear and distrust. Therefore, it was still urgent to convince community women that they were strong enough to defend their rights and to inform them of strategies that they could use in case of mistreatment or attempted coercion. The Consorcio hoped that given these tools, women would not deprive themselves of needed care at the health centers out of feelings of fear and distrust.

AGREEING ON SOLUTIONS

The results suggest that the Consorcio's intervention among providers and users was highly effective in producing concrete changes in the participating centers. In four of the six sites, providers formed quality committees and users formed user defense committees that were still functioning three to four months after their training ended. In five of the six sites,[47] the providers responded to the intervention process by instituting improvements recommended during the training workshops. However, only in the three sites outside of Lima were the changes implemented because of jointly agreed-on plans. The Lima sites only implemented ideas that arose in the provider training sessions. Several NGO trainers suggested that this difference is mainly due to the greater progress in devolving authority to departmental health officials outside of Lima; the Lima-based services tended to be still

mainly under central MOH authority at the time of the study interviews in late 1998. Table 3.2 summarizes the dialogue results at each site.

In the sites where the joint dialogue process was implemented as planned, the focus of post-training meetings was on reaching agreements to solve the quality of care problems identified in the health center. Each group came to these meetings equipped with a new perspective about the rights of users and with concrete suggestions to solve quality of care problems, developed in the final sessions of the training. In these follow-up meetings, the two committees communicated their suggestions to each other, and they reached agreement on a joint list of remedies, with a work plan to implement them in which quality and users committees shared responsibilities.

Although only limited evaluations of quality have been carried out since these measures were instituted, providers and users in all six sites interviewed in 1998 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 pointed to serious commitment to quality improvement, and to remaining areas of concern:

> 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. However, our basic problem is that we have few personnel and many patients. The problem of waiting time cannot be solved.

The following list includes solutions implemented at one or more of the sites.

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 because 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.
- Systematically enforce 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."

Countering pressures from the sterilization campaigns

- 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 fifteen-minute minimum consulting 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 antenatal visits to cover childbirth expenses (obstetric care is free but supplies must be paid for by the patient).

BARRIERS AND FACILITATING FACTORS TO DIALOGUE AND JOINT ACTIONS

Barriers to Dialogue and Partnership

Throughout the project, the relationship between health providers and community health promoters was fraught with tensions in five of the six sites in the project.[48] In the paternalistic model of "community participation"

in these communities, health promoters volunteer their time to coordinate with health centers and posts to help achieve goals set by the health sector. This lack of participation in setting goals combined with the MOH's strong focus on productivity and meeting targets, resulting in providers treating health promoters as mere agents to help them increase coverage. In return, the promoters were given no compensation, even for travel costs, no official recognition, and often, no respect. As one promoter from Lima stated: "When they cannot meet their goals for coverage, they call us." Many 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." Without a process of horizontal dialogue, community women were unable to sympathize with the often-untenable position of the poorly paid and overstressed health professionals, who were threatened with dismissal if they did not meet their targets. The Consorcio project was designed to promote just such dialogue, but in some cases, the tensions were not fully aired.

Difficulties also arose from providers' resistance to users' new status and sense of entitlement. In one site, providers did not appreciate having users' comments included in the performance evaluations of individual care providers. In another site, the users' committee tried wearing special aprons to signify a semiofficial status, and they 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 committee member 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."

Another factor posing an obstacle to progress was the division and lack of autonomy of many community-based women's organizations during the mid-to-late 1990s in Peru. In many communities in the 1980s and early 1990s, sharp divisions arose as the Shining Path and MRTA guerrillas infiltrated community organizations. Because the terrorists targeted community leaders for assassination, many community organizations—including the women's groups—weakened greatly during this period as their original leadership resigned or went into hiding, while Shining Path designated leaders who would support them. Once the threat of Shining Path diminished in 1993–1994, the patronage of the Fujimori government took over, and the women's organizations became dependent on the municipalities, which too often meant being dependent on the political party in control. As a result, there were parallel sets of community leaders in the ubiquitous "Cup of Milk" Program and among Mother's Clubs in some communities where the Consorcio Mujer project worked. The lack of a unified community women's leadership at the municipal or subregional level made dialogue difficult.

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 to facilitate the process of dialogue. The exception proves the rule. In Carabayllo, the Consorcio Mujer NGO CESIP 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. CESIP lacked sufficient history with these organizations to influence their stance and enable an effective dialogue. According to the providers, members of the users' defense committee arrived unannounced and sat in the waiting room observing. When asked what they wanted, the women said, "We're here to supervise you." These 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."

Factors in Successful and Sustainable Dialogue

In spite of these barriers to establishing a more horizontal working relationship, in five of the six sites the relationship between community leaders and providers remained friendly and cooperative after the workshops. An NGO 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."

This study's findings suggest that the post-training dialogues were most effective when the NGO had carefully negotiated and clarified the terms of the dialogue and prepared both groups in advance. In Cusco, the NGO and the Health Center agreed on how users would evaluate quality, and the promoters were well-received. The NGO also facilitated attitude change among the community leaders so that they could enter into this new kind of relationship. One leader from Cusco 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." Box 3.4 illustrates the potential for quality improvement when both providers and community members negotiate in this positive spirit.

The Role of Multisectoral Committees

In theory, the existence of functioning multisectoral committees should have been a key factor in facilitating dialogue between these community-based leaders and the health providers. In fact, Table 3.2 suggests that this is not the case, and the interviews brought out the reason: barriers to including community-based grassroots leaders in committees made up mostly of professionals—whether from NGOs or government agencies. Only in Tarapoto were community organizations routinely involved in the committee meetings. The results from Tarapoto make it clear that when such

Box 3.4
Negotiating Solutions in Piura—Male Involvement

In the users' workshop, the women connected their most-mentioned health problems to their ''triple role'' as spouses, mothers, and workers: vaginal infections, urinary tract infections, and headaches. Discussions about the vaginal infections led the participants to recognize the urgent need for the health center to do more to reach out to their spouses. . . . The providers were also concerned that almost 90 percent of the women attending the center had vaginal infections and their spouses refused to be treated, and so the problem was never resolved. Accordingly, both the women and providers proposed close coordination to plan outreach to the men in their communities.

Mentioned in the workshop document as causes of the problem were: ''machismo and low self-esteem of men, because when they come to the Center, it is seen as a sign of weakness'' and ''lack of dissemination about the services offered to the men.'' The women explained the problem: ''For the husbands, it is shameful to go to the Health Center with their wives. Their friends will tease them, saying, 'I see that she's ordering you around.''' By December 1998, the Center had organized three workshops for men on RTIs and STIs in three different villages and was about to hold a fourth, coordinating closely with the women so that the times would be convenient and the workshops would be publicized among the neighbors. The men of Salitral asked for another workshop. All locations indicated that the best time for workshops for men were the evenings or weekends.

Other plans and suggestions included: invitation for the spouse to be included in standard protocols for prenatal care and for STD/RTI treatment; and to take advantage of holidays and events planned by others such as Fathers' Day events, and sports events. The Quality Committee had already implemented the protocol suggestion at the time of this study.

The topic of male involvement arose again in another problem given priority: the providers' lack of acceptance of ''traditional'' (that is, culturally specific to this region) norms and health remedies. Specifically, the women asked that their spouses be present during childbirth and that herbal remedies be recognized and incorporated into the treatment regimes.

participation is successful, these committees can indeed facilitate dialogue between the community and the health sector.

In most functioning committees in this study, the health sector convened the meetings, with commitments from NGOs and other members to sustain the basic costs of coordination. In Salitral/Piura, rural women couldn't get to meetings in the provincial seat, partly because there were no funds for their travel. In San Juan de Lurigancho, the community health leaders didn't see the potential importance of attending meetings and assumed a more traditional role of cooperation with initiatives decided by the committee. The NGO members believed that the community women find their meetings ''boring.''

Table 3.2
Factors in the Long-Term Outcome of Dialogue Between Health Centers and Community Women

	Attitudes of Health Sector Leadership	Quality of Care Outcomes in Health Center	User and Quality Committees, and State of Dialogue	Representation of Community Groups on Multisectoral Committees
Cusco	Resistant at higher levels.	Changes implemented according to jointly negotiated plan.	User & Quality Committees established. Good informal coordination at Health Center level only.	Multisectoral committee disbanded; Committee on Violence sometimes includes community.
Piura	Very favorable.	Many changes in joint proposal implemented, and joint initiatives to reach out to men.	Unstable joint quality committee, with representatives from Health Center and women's network.	Well-functioning Reproductive Health Committee and others. Rural women don't attend.
Tarapoto	Very favorable.	Major improvements due to Consorcio and Project 2000.	Quality Committee and User's Defense Committees established.	Well-functioning committee with focus on women's issues. User's Defense Committee takes part.

LIMA: Carabayllo	High turnover in Health Center Directors. Distrust of community groups.	Improvements as result of provider training only.	Separate user & provider committees; history of antagonism and no dialogue.	No committee exists.
LIMA: San Juan de Lurigancho	Favorable attitudes at subregional level.	Improvements from provider training eroded by staff turnover.*	Promoters affiliated with NGO service. No stable User Defense Committee. Pilot provider training carried out before Consorcio project, with no Quality Committee as a result.	Well-functioning Health Committee. Community leaders don't attend meetings, but participate in actions planned by the committee.
LIMA: San Juan de Miraflores	Sub-regional officials antagonistic to project.	Improvements as result of provider training.	Informal but cordial dialogue at Health Center level. Promoters' group affiliated with NGO service. No stable Users' Committee.	Health Center Director taking first steps to convene the community to set priorities, as part of the health sector reform process.

*Much more time had elapsed between the initial training and the author's interviews in this site than in the other five sites. Centro Flora Tristan conducted the training at the Maternity Clinic in 1995–1996, while all of the other sites conducted the training in 1998.

These experiences suggest that multisectoral committees need to involve community-based organizations meaningfully in their deliberations in order to serve as a facilitating factor for partnerships and dialogue between the health sector and the community. Involving the professional staff of NGOs alone is not enough.

The evidence from this study suggests that the following factors might promote the sustainability of continuing dialogue between community organizations and the health sector:[49]

- *Support among high-level officials for community participation as part of health sector reform.* The new health sector reform in Peru was much more advanced in the provinces than it was in Lima. Peru's reform included a process of involving the community in setting health sector priorities and a transformation of health centers into self-sufficient entities with community oversight boards. In the provinces, the hard work of convincing providers of the benefits of community oversight was well underway, while the main attitude in Lima municipalities was one of anxiety and fear, fueled by rumors of instances where the process had gone badly elsewhere. To the extent that a ''culture'' of community participation deepens in Peru, the committees set up under this project—or some variation of them—would tend to continue into the future.
- *The presence of other large programs working on quality of care, including pilot health sector reform.* The World Bank, USAID, and UNFPA were all strongly pushing quality of care initiatives during the project period. In one case, in Tarapoto, the Consorcio Mujer training laid the foundation for a much more ambitious quality improvement initiative called Project 2000. As one provider said, ''After the training, Project 2000 fit us like a ring on a finger.'' In other cases, the Consorcio project was very complementary to the ''interpersonal relations'' training provided by a large World Bank project.[50]
- *The historical relationship between the health sector and the community.* In Carabayllo, CESIP would have had to work much longer and more intensively in this community to overcome the long-standing barriers of distrust. In contrast, there was a long history of cooperation between the Mothers' Clubs and the Health Center in Tarapoto, which helped make this one of the most successful experiences and facilitated the community women's inclusion in the multisectoral health committee.
- *The nature of the NGO's relationship with the community organizations and service providers.* In all of the Consorcio Mujer sites except Carabayllo, a long-standing relationship between the NGO, the women community leaders, and the health sector helped the NGO to play a catalytic role in setting terms and limits for the dialogue that were agreeable to all.

EPILOGUE AND FINAL REFLECTIONS

Consorcio Mujer did intensive work during 1999 to document the project's experiences, resulting in three publications.[51] These publications included an account of the experiences at each of the sites, as well as two

training manuals—one each for providers and community health leaders on quality of care and users' rights.

While the NGOs and health centers involved in Consorcio Mujer all still exist, the consortium no longer officially exists. The organizations joined forces to design, raise funds for, and then implement the project. In the absence of a follow-up study, one can only hope that the people involved in these experiences—from each NGO, Health Center, and women's organization—took the lessons from experience and applied it to their continuing work. In one case, the advocacy component of the much more extensive Reprosalud project in Peru, is directed by one of the Consorcio NGOs—Movimiento Manuela Ramos. Reprosalud supports similar dialogue on quality of care between community women and health providers.

This study highlights the role of NGOs in effecting meaningful improvements in the quality of women's health care through facilitating community participation. 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. The final Consorcio Mujer publication expresses concern about the sustainability of the dialogue process without this mediating influence. When aiming for systemic change, this points to the pitfalls of relying on NGOs, who mainly depend on short-term project funding to carry out their activities.

This study points to the effectiveness of Consorcio Mujer's strategy, which used a participatory process involving both users and providers to promote a system of health promotion based on citizenship and equality. An important element in the relative success of Consorcio Mujer's training strategy was that the participatory discussions and exercises led to the development of concrete proposals for improvements in service delivery and in 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 change strategy.

LIST OF ORGANIZATIONS IN THE CONSORCIO MUJER PROJECT

LIMA

CESIP—Centro de Estudios Sociales y Publicaciones
Lic. Silvia (Mina) Madalengoitia, Consorcio Mujer Project Director 1996–1999
Ida Escudero—Coordinator of Project in Carabayllo

MOVIMIENTO MANUELA RAMOS
Rocío Gutierrez, Coordinator of Project in San Juan de Miraflores
Rosario Cardich, Consorcio Project Director from 1994–1996
Fresia Carrasco, Representative to Technical Committee of Consorcio Mujer
CENTRO DE LA MUJER PERUANA FLORA TRISTÁN
Ynga Villena, Coordinator of Project in San Juan de Lurigancho
Ana Güezmes, Representative to Technical Committee of Consorcio Mujer

PIURA

CENTRO IDEAS
Puente, Pilar (coordinator through 1997)
Virginia Guero, Coordinator of Project in Salitral

CUSCO

AMAUTA—Centro de Estudios y Promoción de la Mujer
Rosario Salazar, Project Coordinator

TARAPOTO

CEPCO—Centro de Estudios y Promoción Comunal del Oriente
Maribel Becerril Ibérico, Project Coordinator.

NOTES

1. Most of the statistics in this section are cited to reflect the situation from 1995–2000, during and just after the implementation of the Consorcio Mujer project.

2. INEI, ENAHO 1995–1997 quoted in Ugarte and Monje 1999. ''Lack of financial resources'' could mean lack of funds to either pay the fees or travel costs.

3. United Nations 1995. ''Core document forming part of the reports of states parties: Peru,'' submitted to the UN treaty bodies. HRI/CORE/1/Add.43/Rev1.

4. Ministerio de Salud and USAID 1997, 11. The rate has since fallen to 240, according to the Population Reference Bureau,, *Women of Our World*, 2002. There is much uncertainty about maternal mortality rates because of underreporting from rural areas. The WHO estimates for 2000 a rate of 410 for Peru, and gives 230 as the low end of the range of uncertainty; accessed on October 2005: http://www.who.int/reproductive-health/publications/maternal_mortality_2000/.

5. The ''department'' in Peru corresponds to the main regional subdivisions in government administration. The data in Figure 3.1 is drawn from Consorcio Mujer 1998.

6. Presidencia de la Republica, 1998, 18–19.

7. Alan Guttmacher Institute, 1994. Delicia Ferrando was the researcher for the Peru study. A more recent study of abortion in Peru by the same author is available: Ferrando, Delicia, *El Aborto Clandestino en el Perú*, Lima, Perú: Centro de la Mujer Peruana Flora Tristán and Pathfinder Internacional, 2002. The study of 2001 rates

estimates 352,000 abortions, an increase in the abortion rate per 100,000 live births from 43 to 54.

8. Data in Figure 3.2 is drawn from Consorcio Mujer 1998.

9. 1990–2000. It is now widely recognized within Peru that his government was authoritarian and corrupt, but in the mid-1990s, he enjoyed high favorability ratings for halting hyperinflation and defeating the Shining Path and MRTA terrorist organizations. He was driven out of office by election-rigging and corruption scandals in September 2000.

10. For more information on reform of the Peruvian health sector implemented under the Fujimori government, see Ugarte and Monje 1999. At the time of the author's visit to Peru in December 1998, the pilot phase of the health sector reform was in full swing in various departments, and coming soon in the others. The pilot efforts were mostly in health regions (which group together several departments) outside of Lima, and involved restructuring mid- and upper-level facilities into autonomous and mostly self-financed ''networks and micro-networks.'' The author does not have updated (2005) information on this aspect of health sector reform.

11. Unfortunately, the bibliography of the Consorcio Mujer publications does not include most of these studies, which were evaluation reports. The author was familiar with the studies during the 1990s, because discussion of their findings was part of the process of negotiating the grant to Consorcio Mujer to conduct a quality of care evaluation. One is cited in Consorcio Mujer 1998: MINSA, HAMA, OPS 1993. ''Evaluación de las Condiciones de Eficiencia de los Servicios y Programas Materno Infantiles y Transmisibles.''

12. See Center for Reproductive Rights and CLADEM 1998 for a study of human rights abuses in the health system in the mid-1990s.

13. This emphasis was driven by the almost exclusive use of couple years of protection (CYPs) as the outcome indicator for USAID's family planning programs in the late 1980s and early 1990s. Long-acting methods give multiple years of protection, making the ''cost per CYP'' much lower than for provision of oral contraceptives or condoms, for example. In visits to Peru in 1992 and 1993, the author met with representatives of Pathfinder International and USAID. At that time, Pathfinder's program concentrated almost solely on IUD provision.

14. He dissolved the Congress, and then called a constitutional assembly controlled by those loyal to his party.

15. The Basic Health and Nutrition Project funded by the World Bank conducted community-based needs assessments, for which they contracted feminist NGOs. Project 2000, funded by USAID with Pathfinder International, aimed to raise the quality of care and user satisfaction in many services where it intervened. Most notably, Reprosalud, a USAID-funded $19 million project was awarded in 1994 to one of the largest feminist NGOs in Peru—Movimiento Manuela Ramos—to implement on a massive scale in low-income provinces a model community participation program in reproductive health and credit programs for women.

16. See Chapter 2 for a fuller discussion of how the Peruvian NGO networks met this challenge.

17. Many health workers were ''contracted'' as opposed to civil service (''de planta'') employees, and were hired with specific productivity goals. If these were not met, they could be fired, or transferred to an undesirable location.

18. The Consorcio Mujer members involved in this project included Movimiento Manuela Ramos, Centro de la Mujer Peruana Flora Tristán, and Centro de Estudios Sociales y Publicaciones (CESIP) 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. The Ford Foundation supported the project in two grants: the first of $100,000 and the second of $182,000, with a third grant in 1999 to produce the final publications. The Consorcio was formed in order to carry out this project, and was dissolved after the production of the publications in 2000.

19. The exception was CESIP's project in Carabayllo, a municipality in Lima. The outcomes reflected this difference, with less success in the dialogue between the community and the health providers.

20. Rosario Cardich of Movimiento Manuela Ramos directed Phase One of the project, and Silvia Madalengoitia of CESIP directed Phase Two.

21. From Consorcio Mujer's educational brochure for women leaders.

22. Hola and Portugal, 1997.

23. Except when indicated otherwise, the quotes in this study are from abridged transcripts of taped interviews during the author's 1998 visit to the six project sites.

24. Judith Bruce, ''Fundamental elements of the quality of care: A simple framework,'' *Studies in Family* Planning 21, No. 2 (1990).

25. Drawn from Consorcio Mujer's educational leaflet for women leaders: ''Let's Be Citizens, not Patients.''

26. 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.

27. All of these findings are summarized from Consorcio Mujer 1998.

28. Ibid., 42.

29. 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.

30. The author attended this meeting.

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

32. 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.

33. Consorcio Mujer 1998.

34. 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 higher-ups. When a midwife was under intense pressure to meet her monthly quota of sterilizations, she

in turn would exert substantial pressure on women. One United Nations professional described how in one village she visited, Quechua women fled into the hills whenever the public health midwife came to their village, because her pressures made them afraid of being coerced into being sterilized.

35. The sterilization campaigns ended abruptly in January 1998 when Giulia Tamayo of CLADEM Peru, a women's rights network, exposed related human rights abuses in the media; see CLADEM 1999.

36. There was widespread migration to Lima and other cities from the Quechua-speaking highlands in the 1990s; some were refugees from armed conflicts between terrorists and government troops. Others migrated for economic reasons.

37. Some health officials interviewed would not admit that fees are used to supplement salaries, while others confirmed that doing so is a widespread, but unofficial, practice. Health professionals interviewed in this study also pointed out that user fees are an incentive to improve quality, since attracting more users brings more income to the health service.

38. According to many informants in the Consorcio Mujer program, and in the Reprosalud project in the Andean highlands—from the author's interviews with staff and women leaders involved during the mid-term evaluation in 2002.

39. Quotes are from Consorcio Mujer 1998.

40. The health system in Peru, in concert with many international NGOs, has long trained community health promoters to carry out specific health promotion tasks in the community. These promoters are usually not paid for their time, or reimbursed for expenses.

41. The new General Health Law was passed in July 1997. Consorcio Mujer trainers gave participants in both workshop groups a poster with a list of users' rights as established by the law.

42. The training manuals were published in limited quantities. The participating NGOs and the author have copies.

43. Consorcio Mujer, 1998. This is an interchange documented during the 1994 evaluation.

44. The content of the following section is taken solely from the author's interviews in the six sites.

45. From interview with Centro Ideas staff in 1998.

46. From interview with Silvia Madalengoitia in 1998.

47. The one exception was an implementation failure. In San Juan de Lurigancho, the training by Centro Flora Tristán took place before the Consorcio had completed the modules, and the process was not the same as in the other sites.

48. This exception was Tarapoto, and may be due to methodology failure; it was the only site where the interview with the users' group was in a multisectoral committee meeting with health providers present.

49. Unfortunately, since Consorcio Mujer was a project that ended in 1999, carrying out a follow-up study would be difficult.

50. The Basic Health and Nutrition Project (*Proyecto de Salud y Nutrición Básica)*.

51. See three Consorcio Mujer publications from the year 2000 in the bibliography.