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Rights-Based Citizen Monitoring in Peru: Evidence of Impact from the Field

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Abstract

This paper discusses a human rights-based initiative developed in Puno, Peru, in which indigenous women seek to address problems with access and quality of care by monitoring their government-run health facilities. The evidence of impact presented here is based on a qualitative study of the rights-based monitoring initiative (53 key informant interviews in 2010–2011), corroborated by findings from a review of previous qualitative and quantitative assessments of the initiative. The research findings show that the citizen monitors are able to identify, document, and act on a set of persistent "everyday injustices" experienced by health care users. These can include illegal financial charges, abusive or dismissive treatment, extended wait times, and culturally insensitive care. These results suggest that citizen monitoring can lead to important changes at the health facility level, as well as in the lives of the volunteer monitors. It can also provide key information that can be used to put previously neglected concerns onto local and national health policy agendas. However, as this article explores, the citizen monitoring initiative faces several of its own challenges.

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Introduction

This article concerns an innovative initiative developed in Puno, Peru, in which indigenous women engage in monitoring activities in their government-run health facilities. These Quechua-speaking women and their communities have long experienced discrimination and exclusion within Peruvian society. For indigenous women, the health care system is a site where they commonly face cultural barriers, abusive treatment, and discrimination, in addition to other problems linked to the systematic neglect or mismanagement of their local facilities. The initiative draws on a human rights-based approach (HRBA) to health to address these challenges. Using an approach called "citizen monitoring" (*vigilancia ciudadana*), it brings together a series of local, national, and transnational actors, as well as ideas and organizing strategies.

In this article, we aim to contribute to the discussion around the use of HRBAs by presenting evidence of impact from the citizen monitoring of health service delivery in Puno, Peru. In particular, we seek to highlight how citizen monitoring can promote the detection, documentation, and sometimes resolution of "everyday injustices" that tend to escape more conventional mechanisms for human rights promotion. These types of injustices include forms of routine discrimination, poor-quality treatment, illegal fees, and a lack of availability of free medications. They violate people's right to health and foster mistrust in the public health care system.[1] The citizen monitoring initiative suggests that HRBAs can promote the right to health for marginalized populations by democratizing the mechanisms for naming and acting on health-related human rights violations at the local level. Ideally, this information can help inform health policymaking. However, as this article explores, the citizen monitoring initiative faces its own challenges and limitations.

The citizen monitoring initiative in Puno seeks to improve the quality of health service provision in local health facilities (including main hospitals, mid-sized health centers, and remote health posts) in two of the region's provinces, with a particular focus on reproductive and maternal health care. In this initiative, volunteers monitor service provision through direct observation and by conversing with health care users and health workers. The participants, called citizen monitors, work with allied actors to engage health officials in direct dialogue about their findings and to press for remedial actions where necessary.[2]

The idea for the citizen monitoring initiative was developed collaboratively by CARE Peru—the Peruvian affiliate of an international nongovernmental organization (NGO), CARE International—and a US-based NGO, Physicians for Human Rights. In 2008, Physicians for Human Rights funded a pilot phase of the project. The key allied groups involved in the pilot included CARE Peru, ForoSalud (Peru's largest civil society network on health), and the Puno office of the Defensoría del Pueblo (Peru's national Ombuds Office). These groups also had important linkages with a transnational epistemic community of scholars, practitioners, and activists promoting HRBAs to health. CARE Peru and ForoSalud subsequently secured further funding to continue the citizen monitoring initiative beyond the pilot phase.

This article draws on findings from a qualitative research study of citizen monitoring in Puno done through the University of Toronto, Canada. One of the co-authors conducted the University of Toronto study as research for her doctoral dissertation. The other co-author is the former director of CARE Peru's Health Rights Program and the former head of ForoSalud, both of which supported the citizen monitoring initiative in Puno. The study uses the methodological orientation of institutional ethnography.[3] An institutional ethnographic approach begins with an investigation of the work experiences (including voluntary work) of a particular group of local people. It is based on the premise that analyzing these everyday work processes can provide an important vantage point from which to also understand a broader set of social and institutional relations. This methodological approach is especially useful in helping draw out evidence of the impact of an HRBA and, in particular, how this impact pertains to people's daily lives. Fieldwork for the study was conducted in 2010–2011 and involved

53 interviews with key informants in Puno and Lima. Data were first collected through semi-structured interviews with 23 citizen monitors to explore their efforts to promote greater accountability in their local health facilities, including their use of an HRBA. To better understand the social and institutional relationships in which the monitoring process is embedded, further interviews were then conducted with 30 key informants. These included frontline health workers from eight local health facilities where citizen monitoring was underway, local health officials in Puno, national health policy officials in Lima, human rights lawyers from the Defensoría del Pueblo office in Puno, and other civil society actors involved with the project. Data were transcribed and then carefully and repeatedly analyzed for content. Through this analytic process, key themes and subthemes were identified. Interview data were supplemented by the use of textual data, including gray literature in the form of project documents, reports, and relevant health policies.

We have sought to corroborate the findings and analysis from the above study by also drawing on the evidence of impact identified in a 2013 report on the citizen monitoring initiative conducted by a research consultant commissioned by CARE UK and published by the European Union.[4] This report utilized qualitative methods (interviews with citizen monitors and other key informants) and a review of secondary sources—including qualitative and quantitative assessments previously commissioned by CARE Peru—to analyze the impact of the citizen monitoring project.

The rest of the article is divided into four parts. We begin by presenting the problem of social exclusion and inequality in Peru, particularly in relation to health care. Next, we describe the methods used in the rights-based citizen monitoring initiative in Puno and present evidence drawn from field research about its impact on health care provision. We then reflect on the importance of HRBAs in citizen monitoring and how they serve to expose the everyday injustices that socially excluded people frequently encounter when accessing publicly provided health care services. In addition, this section discusses the challenges and limitations of the citizen monitoring model and its potential contributions to health policymaking. We conclude by summarizing our findings and reflecting on lessons learned during our research.

Social exclusion and inequalities in Peru amid growing wealth

Peru has experienced strong economic growth over the past decade, at an average rate of 6.5%.[5] However, progress in national-level economic and social indicators masks persistent inequalities along gendered, racialized, class, and geographic lines. Poverty has diminished, yet over a quarter of the population (28%) remains poor, and the distribution of both poverty and extreme poverty is heavily tilted toward rural, Andean/Amazonian, and indigenous populations. Despite its ranking as an upper middle-income country, Peru places 13th out of 17 countries in the region on the Human Opportunity Index.[6]

Rosemary Thorp and Maritza Paredes stress that racialized and gendered inequalities in Peru are embedded within the country's institutions.[7] This is certainly evident within the country's health system. The contemporary Peruvian health system is highly segmented in ways that reflect and reinforce intersecting gendered, ethnic, and class divides.[8] Health services are provided by (1) the Ministry of Health and its regional counterparts, which serve the poorest segments of the population, (2) EsSalud, a national insurance scheme that covers salaried workers and their families, and (3) private health providers for the wealthy and (private) traditional healers in rural communities. The inequalities embedded in the health system can be seen in the spending on these different forms of coverage. In 2012, the Ministry of Health's public insurance scheme (described below) spent US$35 per patient per year. In contrast, the social security-based EsSalud spent US$196 per patient, and private insurance providers spent US$542 per patient.[9]

The Ministry of Health and Regional Health Directorates are the main health service providers in the country, particularly in rural areas and

small towns. Used primarily by informal workers and the poor, these state-provided health facilities suffer from substantial problems, including chronic underfunding, drug shortages, workforce shortages, labor unrest, poor workforce training, and weak management.[10] In the late 1990s, the national government introduced a public health insurance mechanism (today known as Seguro Integral de Salud, or SIS) that covers care in public health facilities run by the Ministry of Health or the Regional Health Directorates. As a result, health facilities are officially no longer allowed to charge user fees to SIS affiliates for services covered through the scheme. In 2009, the government passed the Universal Health Insurance Law, which focused on broad health sector reform. However, the government has not provided sufficient financial resources to implement the new law, making its implementation extremely slow.[11]

The inequality of these health care arrangements is reflected in the inequality of health outcomes in the country, especially concerning women's reproductive health. While Peru has the second highest maternal mortality ratio in South America, maternal mortality is unevenly distributed across the country. In 2000, for example, the ratio for the capital city, Lima, was 52 deaths per 100,000 live births, while in the poorer Andean department of Puno, whose population is largely rural and indigenous, the ratio was 361 per 100,000 live births.[12] In the Andean region, women who face problems in accessing health services have reported greater difficulties (particularly the absence of personnel and necessary medicine) than those in the national capital and the coastal region, and the rural-urban divide is also significant.[13]

Evidence of impact from the field: Rights-based citizen monitoring in Puno

Puno is a majority indigenous region located high in the Andean mountains. It is one of the poorest regions in Peru. The social exclusion historically experienced by indigenous women in Puno continues to be high. Despite a renewed focus since 2002 on decentralization and new powers afforded to regional-level governments, the process has thus far "failed to establish a coherent and orderly institutional framework for delivery of government services to its citizens."[14] It is within this context that Quechua-speaking indigenous women are carrying out rights-based citizen monitoring of their local health facilities, with a particular emphasis on maternal and reproductive health care.

Structure of the citizen monitoring initiative

The citizen monitoring initiative in Puno seeks out local women with an established track record in leadership positions in their communities. These women receive training from a technical team comprising staff from CARE Peru, ForoSalud, the Defensoría del Pueblo, and, more recently, from SIS, the public health system's insurance scheme. Training sessions cover a wide range of topics, including "human rights, health care rights, elements of democracy and citizenship, sexual and reproductive health and rights, the rights of SIS users, citizen participation and citizen monitoring, access to information, laws to protect citizen monitoring, ministerial norms on vertical delivery with cultural adaptation and the free issuance of certificates of live birth."[15]

In 2010–2011, the project recruited approximately 60 women to act as citizen monitors to conduct monitoring activities in seven health care facilities (hospitals, health centers, and health posts) in the district of Azángaro (in the province of Azángaro) and in the district of Ayaviri (in the province of Melgar).[16] Today, although CARE Peru no longer provides direct support to the initiative, there are approximately 80 active monitors in four districts in Puno, including Ayaviri, Santa Rosa, and Macari in the province of Melgar, as well as the district of Azángaro in the province of Azángaro. They continue to receive voluntary technical support from former CARE Peru health team members. The monitors visit 14 health facilities in their respective districts. The model has also inspired the implementation of similar monitoring initiatives in other Peruvian regions, including the Andean region of Huancavelica.

Using a human rights-based approach to enable citizen monitoring

The approach used by the citizen monitors in Puno draws in part on ideas generated by a family of accountability initiatives that have emerged in Peru since the early 2000s. These various initiatives, all of which use the name *vigilancia ciudadana* (meaning citizen monitoring or oversight), arose as a result of popular frustration with official corruption, misuse of power, and lack of responsiveness from public services. Proponents of citizen monitoring stress the need for active citizenship in order to observe and oversee the functioning of state institutions.[17] A fundamental challenge for such initiatives, however, concerns how to get state officials to agree to the oversight relationship implied by citizen monitoring.

To address the uneven power relations faced by citizen monitors, the initiative in Puno incorporated an HRBA to health into its design. Proponents of HRBAs argue that these approaches are important because they seek to change the power relationship between excluded populations and the state. The principal benefit of such a framework "lies precisely in identifying individuals as claims-holders and states and other actors as duty-bearers that can be held to account for their discharge of legal, and not merely moral, obligations."[18] It shifts the debate from a discussion of "technical health policy questions" into "matters of political and legal entitlement."[19] HRBAs view participation as fundamental to realizing the human right to health. They assert active political roles for citizens as rights-holders, overseers, and claims-makers, while emphasizing the international obligations of the state to promote, protect, and realize health rights, and to facilitate citizen participation and oversight of government action. Also central to a rights-based approach is an emphasis on equality and non-discrimination. The citizen monitoring model in Puno incorporates all of these elements into its design and implementation.

In Puno, indigenous women and other marginalized actors face the challenge of not being taken seriously in health facilities. Ideas drawn from rights-based approaches to health provide the initiative's participants with a number of resources for justifying their positions as citizen monitors. The training they receive frames the oversight of government activity as a citizenship right: the monitors have a right and a responsibility to carry out their monitoring role.

This framing is supported by changes in law and policy in Peru. Over the past decade, the Peruvian state has enacted a number of laws and policies that incorporate ideas drawn from human rights and citizen participation. The Ministry of Health has begun to demonstrate formal support for an HRBA to health, as reflected in key ministerial resolutions and strategic documents. Since the 2000s, ministerial resolutions have been enacted on the promotion of human rights, gender equity, and interculturalism in health; on vertical birthing (recognizing the right to give birth according to indigenous cultural norms with support from public health workers); and on approving a national plan on maternal and neonatal mortality. Ministerial resolutions passed in 2008 and 2011 recognize the right to citizen monitoring of public health facilities.[20]

The adoption of these laws and policies supporting citizen monitoring is a result of sustained advocacy in Peru by members of an epistemic community dedicated to promoting HRBAs to health.[21] The country's transition to a democratic government in 2000 created an opening for human rights activists. Collaboration between Peruvians and transnational activists, scholars, policy makers, and donors throughout the 2000s further supported this process. The rise of the health and human rights movement and the new democratic openings in Peru helped persuade the government to adopt pro-participation policies relating to health services introduced in the 1990s. Prominent examples are the 1993 Citizen Participation Law and the 1994 Shared-Administration of Health Services Law.

Although the operationalization of human rights and citizen monitoring norms by the Ministry of Health is still weak, the fact that actual laws and resolutions are in place provides an important foundation on which actors in the initiative can draw. As a result of their training, the women themselves often have greater knowledge of human rights-related national laws and policies than many of the frontline health workers and

administrators they encounter. The monitors are quick to use this knowledge as strategic leverage when carrying out their facility-level monitoring, and they speak with pride about their familiarity with the legal framework:

> *Our training [as monitors] around human rights was clearer and broader than before [referring to a previous NGO-led initiative from the 1990s]. This time we understood what our rights were and why we had them, about citizenship and citizen participation. Because before, there almost weren't any of these laws. It's a little like the authorities wanted to oppress us, no? They would say "Why do these women want to do these political things?" They'd even try to brush us off. But now … with the 1993 citizen participation law … —and there's another law about access to information which is law 27806—these laws protect us.*[22]

This monitor articulates a change in perspective and in her perception of her own authority that comes with knowing her rights and from her ability to position herself as an active, knowledgeable, political actor with an important role to play in the local health facility. To support their work, monitors now carry files with them that contain copies of the legal norms that relate to the oversight process, including those pertaining to vertical birthing, the issuance of birth certificates, and the right to citizen participation.[23] These national laws and policies make explicit reference to international human rights obligations, including the right to health. Since 2014, the citizen monitors have also benefitted from the dissemination and use of the contents of the Office of the United Nations High Commissioner for Human Rights' technical guidance on the application of an HRBA to the implementation of policies and programs to reduce preventable maternal mortality and morbidity.[24]

From observers to advocates: How citizen monitors create change

Officially, the monitors' role is to observe and report on health service delivery in their local health facilities. The monitors' observations are consolidated and presented at regular meetings with district health officials and other key actors. In practice, the monitors' activities extend beyond observation and reporting. Much of their work takes place on site and in the moment. When the monitors are concerned about something they encounter, they call their allies for backup and support. For example, they call the lawyers from the Defensoría del Pueblo if they feel there is a pressing need to intervene in an urgent care issue; they call SIS officials if there is an insurance-related concern; and finally, they call their NGO colleagues for more general advice on issues when they are unsure of how best to proceed. As a result, the monitors' on-site presence in the health facilities creates linkages to these broader networks of allies and can have immediate implications for the health and livelihoods of marginalized women.

The informal expansion of the monitors' role from observation to some degree of intervention and advocacy reflects the realities of how fluidly issues arise. As acknowledged by a lawyer from the Defensoría del Pueblo, although the monitors' official mandate is limited to observation, realistically it goes beyond that "because waiting until the Defensoría or another authority arrives to ensure that this right to health is respected can be very difficult or can happen very late."[25]

The importance of the monitors' advocacy role is especially apparent in relation to maternal health. In the most extreme cases, the surveillance and immediate actions by a monitor might save a woman's life. One monitor recalled an event while she was on a shift:

> *There was a patient who had been transferred from Macari. She was nine months pregnant and in grave condition. They couldn't do anything for her in the hospital here, even though she needed a Caesarean. They said there wasn't an anesthesiologist available. So she had to go to Juliaca. I went with her to Juliaca to make sure they did everything. At first in Juliaca, they told us there wasn't an anesthesiologist available there either. I said that I was going to complain to the Defensoría. … It was nighttime, but I had their cell number. So I called and they helped solve things. … That's something that we can do. And we also didn't pay anything, because I knew not to. They even tried to say to buy two units of blood. I said that you aren't going to make the patient pay for that! With her insurance and with the help of the Defensoría, all her medications were covered.*

> *If that woman had been here she would have died, her blood pressure was terribly high. … We made sure about her insurance, we went with her and the doctor in the ambulance, we never left her. That's how it is. We also save lives.*[26]

While the line between the monitors' official role as observer and their informal role as advocate is sometimes fluid, the overall approach to rights-based citizen monitoring focuses on building dialogue with health workers and health officials. The intention is not to antagonize workers but to stress the rights of users of local health facilities, although inevitably tensions sometimes arise between the two categories of actors. This was especially apparent in the early stages of the monitoring initiative, but has been improving over time.

Some health workers noted that despite initial misgivings, they began to see ways in which the monitors' presence supported their work. For example, the presence of and feedback from citizen monitors has been important for improving the physical conditions of hospital-based deliveries. A senior midwife from one of the district hospitals recalled her initial mistrust of the monitors' presence, followed by a realization that the monitors could actually help her improve service provision:

> *At first, not just me, all of the staff, we were saying, "Oh, they're going to come and watch how we work. Who are these people? They shouldn't be here." … But then, we've been able to have exchanges about problems that they have presented to us [the monitors], cases that patients wouldn't say directly to us. … We've been able to make improvements, and there are less complaints. And really, I'd say there are more patients [pregnant women] coming now.*[27]

The midwife went on to discuss an infrastructural problem that had been identified through citizen monitoring and subsequently addressed by her staff:

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

Studies of citizen monitoring in Puno suggest that monitoring is starting to change practices in some health care facilities.[29] Informants of all categories (monitors, health care workers, Defensoría del Pueblo officials, and NGO staff) commonly observed that discriminatory and abusive behavior diminished when monitors were present, as did incidents of illegal charges and culturally insensitive care. This may have translated into greater usage of local health facilities. A statistical study cited by Rosana Vargas compares change in the usage of maternal health services from 2007 to 2009 in facilities with citizen monitoring against a control group without monitoring. It found a significant increase in usage compared to the control group with regard to health facilities in Azángaro, but only a slight increase in Ayaviri.[30] Additional qualitative and quantitative investigation would be useful to more fully understand the impact of rights-based monitoring at the health facility level over time.

The initiative has also had an impact on the monitors themselves. Citizen monitors reported that their involvement in monitoring has increased their leadership ability, their confidence in dealing with officials, and their capacity to act effectively in the public sphere.[31]

In addition to on-site monitoring, regular meetings are held in each of the targeted districts between the monitors and their institutional allies (CARE Peru, ForoSalud, the Defensoría del Pueblo, and SIS regional officials). Together, they analyze the monitors' findings and create an agenda of issues to discuss in a formal meeting with senior district-level officials and health workers from the Ministry of Health. These include the director of the district health network; the director of the district's hospital; and doctors, midwives, nurses, and other health workers. Other officials—for example, municipal workers—have also begun to participate in the meetings, further expanding the circle. The

original objective of this meeting space was to create an institutionalized forum in which monitors' observations from their facility visits could be regularly shared with health officials, in the presence of their allies.

The meetings have been a work in progress. Over time, the monitors and their allies have been figuring out how to function effectively in this new space. As one monitor explained, small, concrete gains have been achieved by sharing concerns at a district level:

> *I reported that there wasn't enough staff, because in the health post there were only two. Even [the health post staff] asked me to do it. "Why don't you ask as a monitor, since you're reporting on everything we do here to the hospital director, right? And since you work with the Defensoría and SIS, why don't you ask that there be more staff?" Which worked, and they've increased the number. There wasn't a midwife, one came only once per week from the hospital. Now there's one here permanently. There wasn't a nurse, now there's a nurse technician. … Before, the doctor never came. Now one comes every Wednesday. Now the population know that there's a doctor here every Wednesday and also a dentist, which there wasn't before.*[32]

This woman's local health facility is a tiny health post in an especially remote area of her district. The addition of a permanent midwife and nurse technician, along with regular doctors' visits, is hugely important to women's reproductive health and the prevention of maternal mortality. It represents an important victory on the part of the citizen monitors and their allies.

However, victories of this sort are particularly difficult to achieve. Monitors and their allies often find it difficult to realize tangible gains through the formal district-level meeting process. In general, they have more success in addressing facility-level issues that concern forms of misconduct by health workers, such as unjust charges, patient mistreatment, and poor care. Problems caused by broader resourcing and management issues—such as the lack of equipment and supplies, lack of transport, and staff shortages—are more of a challenge. This reflects the political economic realities of governing macro issues within a micro-level space. There is usually only limited room for movement on labor or budgetary issues at the district level. These issues are not unique to Puno and are pervasive throughout the public health system, especially in remote areas.[33] While individual problems are addressed in some instances, it is difficult to resolve them at a more systemic level.[34]

Understanding the impact of rights-based citizen monitoring

Bearing witness to everyday injustices

Bearing witness lies at the heart of human rights practice. Addressing human rights abuse begins with collecting the testimonies of those who will name what they have witnessed. James Orbinski, Chris Beyer, and Sonal Singh explore this from the point of view of humanitarian health care practitioners.[35] They argue that for medical practitioners, "bearing witness, having first-hand knowledge of humanitarian and human-rights principles and their limitations, and systematically collecting evidence of abuse, can be instrumental in tackling the forces that constrain the realisation of human health and dignity."[36] Without this kind of work, abusive acts go unseen and are not named as violations of human rights.

Through their regular presence in local health facilities, the citizen monitors bear witness to the everyday injustices faced by indigenous women and other poor people—problems that are entrenched within the health care system. By everyday injustices, we mean those common acts of disrespect, disregard, cultural superiority, or discrimination faced by members of socially excluded groups.[37] In health facilities, these kinds of injustices can include illegal financial charges, abusive or dismissive treatment, extended wait times, and culturally insensitive care. Everyday injustices are hard to address using conventional human rights mechanisms. They can be difficult to prove. They may involve small amounts of money or invisible kinds of damage, such as emotional harm. They are perpetrated against members of society who are least able to make official complaints, and

against whom this kind of abusive treatment may be seen as normal. Human rights bodies, such as the Defensoría del Pueblo, are often not equipped to effectively detect or deal with these very micro kinds of issues. In contrast, the citizen monitors are able to identify and often act on these injustices through their regular presence in health care facilities and the lack of social distance separating them from health care users. Their training, ability to call on influential allies, and ability to bring matters to district-level meetings all help provide citizen monitors with the authority to address these injustices in the moment.

Our interviews with citizen monitors suggest that these injustices are very significant to those who experience them. All the monitors interviewed told stories of mistreatment and injustice within local health care facilities. They are clearly motivated by the desire to put an end to such practices, and they make sacrifices to continue their work as volunteer monitors.[38] In addition, the disconnection of health users from health care services that can result from these injustices may have serious effects. For example, they may perpetuate health inequalities and contribute to delays in reaching emergency care.[39]

We propose that the notion of everyday injustices represents an important addition to the literature on the evidence of impact of HRBAs to health. For marginalized groups, significant barriers to health equity and social inclusion are posed by discrimination, cultural insensitivity, unjustified wait times, illegal charges, and so on. The example of the citizen monitoring model in Puno suggests that the design and evaluation of HRBAs should include a consideration of how these kinds of problems are being addressed for socially excluded groups.

Essential elements and limitations of the model

What are the essential elements in the initiative that allow monitors to have an impact on service delivery in health facilities? First, the initiative ensures that monitors who are members of the vulnerable group of health users, and who have received human rights training, maintain a regular presence in health facilities. As peers, monitors are keenly aware of the position of marginalized health users, and their routine presence enables them to act as events take place. Second, the initiative provides monitors with important resources: it enables them to reference laws and policies that protect health rights and rights to public participation, and to call on support from influential allies (for example, officials from the Defensoría del Pueblo and SIS) when needed. Third, monitors have direct access to senior health authorities through regular district-level meetings. This empowers the monitors to become significant actors within their local health care facilities who cannot simply be ignored.

Any attempt to replicate the initiative would need to be adapted to the distinct circumstances of each new place. However, certain core principles could be kept in mind: the creation of spaces and opportunities for monitors from marginalized groups to not only observe and identify problems but also receive advice and advocacy support from influential allies; formal mechanisms that enable monitors to have direct access to health authorities and hold them accountable for health services responsiveness; and systematic opportunities for collective learning and the sharing of experiences among monitors, which allows them to strengthen their sense of agency in relation to HRBAs.

Another important feature of citizen monitoring in Puno is its articulation with national-level health advocacy efforts through the national health rights umbrella organization, ForoSalud. By providing information to advocates at the national level, citizen monitors may be able to help influence national social programs, as well as the creation and implementation of health sector reforms.[40] Currently, there is only anecdotal information demonstrating this articulation. Formal research investigation around this phenomenon of integration between local and national advocacy efforts would be useful in the future.

Citizen monitoring in Puno takes place in a complex environment where social exclusion and inequalities in health care have been deeply embedded over time. While an HRBA can challenge these entrenched dynamics, it is a slow and complicated process. The model used in Puno faces a number of challenges and limitations. As discussed above,

the initiative continues to face difficulty in consistently addressing issues whose root causes lie outside the control of local or regional health care officials. Facility-level problems are frequently linked to higher-level funding decisions or problems associated with the health sector's weak human resources policies.[41] These can be difficult to influence using the initiative's methods. Despite the fact that the Puno initiative is articulated with national-level health advocacy, influencing these kinds of broader issues beyond the facility level remains a considerable challenge.

In addition, the citizen monitoring model explored in this article is not linear; rather, it depends on a wide network of actors. The monitors themselves are important, but so is the availability of strong and committed strategic allies. In Peru, the initiative has benefited from its alliances with a network of experienced and influential groups committed to HRBAs, including CARE Peru, ForoSalud, and the Defensoría del Pueblo. However, these kinds of allies may be less available or accessible in other countries. Allied organizations in Peru also face their own internal difficulties. Access to funding has become precarious as foreign donors shift priorities away from Peru in light of the country's rapidly growing economy, and as national mechanisms have yet to be ready to replace these resources. This limits the time and human resources that allies can commit to supporting citizen monitoring efforts. Issues such as these would need to be considered as part of any attempt to expand or replicate this particular model.

Finally, it is essential to flag the initiative's reliance on volunteer labor from citizen monitors, most of whom are low-income indigenous women. According to the monitors, their role is important and valuable to them. However, they face significant burdens by taking on these tasks. When they volunteer their time as monitors, they must absorb trade-offs against their economic and other social responsibilities.

Conclusion

This article presents evidence of the impact of an HRBA through an examination of the citizen monitoring process in Puno, Peru. It finds that the rights-based citizen monitoring initiative enables socially excluded, mainly Quechua-speaking women to exercise a nascent oversight role in state-run health facilities in a context of vastly uneven power relations. As a result of their training, their regular presence in the health facilities, and their partnerships with key allies, monitors are able to witness, document, and address persistent forms of human rights abuse that affect their communities. These are "everyday injustices," forms of routine abuse and discrimination that limit users' rights to health.

Citizen monitoring as a model faces a number of important challenges and limitations. Monitoring is labor intensive and requires ongoing technical and financial support from partners and donors. It is also demanding for the volunteers who carry out unpaid monitoring work. Although a growing body of information is being amassed at the local level that can be used to inform national health policymaking processes, monitoring has so far had limited success in addressing problems originating from the broader health system or from national policy decisions. Further refinement of the model, as well as support and investment in the process, is needed for rights-based citizen monitoring to move beyond these obstacles.

Methodologically, we found the qualitative approach that produced the evidence of impact to be a useful way to understand the complexities of the citizen monitoring process. The narrative nature of qualitative data allows an in-depth, detailed picture of the monitoring process to emerge, including the areas where it has been more and less successful at promoting change. Our initial understanding of these impacts would be further strengthened in the future through the increased inclusion of quantitative measures. For example, a follow-up quantitative investigation with a statistically sig-

nificant sample size would yield useful additional data to measure the impact of rights-based citizen monitoring in key areas, including comparative changes in the level of usage and satisfaction with maternal health services.

We note that methods for evaluating the impact of rights-based citizen monitoring were not integrated into the initial project design. This is a lesson learned. Embedding evaluation methods into the design of an HRBA from the outset would allow for more systematic evaluation about whether and how an HRBA is producing positive changes. It could also help identify unintended consequences. Importantly, embedding a mixed-method evaluation process directly into interventions such as rights-based monitoring would allow for important comparisons over time. The financial, time, and human resource constraints at the field level, however, can make it difficult to systematically collect rigorous data demonstrating evidence of the impact of HRBAs.

Based on our research and practical experience with the citizen monitoring initiative in Puno, we see a need for long-term partnerships between research institutions and practitioners aimed at evaluating and researching the impact of HRBAs. Where such partnerships are established, participants would be able to engage in an ongoing cycle of reflection and learning about the complexities surrounding the use of HRBAs.

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