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Citizen monitoring to defend maternal health rights in Peru

PHIL BORGES/CARE

Eugenia, right, a citizen monitor in Ayaviri, talks to a young mother

Executive summary

Poverty is as much about poor access to services and a denial of rights as it is about economic deprivation. In Peru, at the beginning of the past decade, the Ministry of Health estimated that one in four Peruvians lacked access to healthcare when it was needed (Ministerio de Salud del Perú, 2002: 14). This is not simply a story of inadequate investment; it is also an issue of deeply-rooted social inequality that has historically left poor indigenous rural women behind. In 2006, only one in five rural women was attended by a doctor for the birth of their child, compared to two out of three women in urban areas (ENDES, 2006). As a result, the maternal mortality rate in some poor rural Andean regions was nearly double the national average.

CARE believes that public health services should be available, accessible, acceptable and of good quality *for all*. Ensuring this requires more than technical fixes. It means developing efforts to make sure that citizens themselves participate in defining healthcare quality. Over the last seven years (since 2007) we have developed a model for citizen monitoring of health services to allow citizens to voice their concerns, hold service providers to account, and promote dialogue between them to constructively improve the quality of services. This briefing paper presents learning from our experience of implementing the model in the Peruvian highlands.

We found that citizen monitoring can have an important impact on the quality of service delivery. Beyond empowering monitors themselves, the citizen monitoring model has

Key points

CARE's experience in Peru shows that citizen monitoring can have an important impact on the quality of service delivery

Indigenous women in Peru face a number of obstacles and barriers which limit their ability to access maternal healthcare

improved transparency in health facilities, ensured greater respect for users' preferences in birth delivery, and helped reduce corruption; and this improved quality has generated greater demand for health services. Moreover, in comparison with other social accountability models such as Community Score Cards, the mobilisation of community monitors means that there is regular community engagement to check that whatever promises are made by service providers are met.

However, building demand for accountability through citizen monitoring also raises users' expectations for better quality provision, and these raised expectations may not be matched by improvements in the quality of services unless the incentives are right for service providers. Too much focus on the demand side can be counter-productive. We have learned that we need to highlight both failings and successes, ensuring that meetings are about dialogue and don't become a 'blame game'. Further, in order to address the root problem of discrimination, it is also important to intervene earlier, working to improve the training of human resources in the health sector so that we address incentive problems at their source.

Introduction: Health rights in political context

In 2001, the Peruvian government unified its public health insurance programmes (tax-funded reimbursement mechanisms) into so-called Integral Health Insurance (SIS) with the aim of eliminating cost barriers to access to health services. The hope was that this would increase the use of health services, particularly among the indigenous population. However, universal access on paper does not necessarily translate into universal access in practice or, for that matter, ensure quality health services for all.

In 2007, Physicians for Human Rights carried out a study to analyse the factors that perpetuate maternal mortality in Peru (Physicians for Human Rights, 2007). They argued that state financing in the sector was inadequate, and as a result health insurance failed to provide vital medicines or cover necessary health examinations or tests. Staff were hired on short-term contracts and tasked with onerous productivity targets which demotivated them and reduced the quality of patient care.

Further, corruption at the point of service use was rife, with a series of charges for medicines, examinations or certificates that should be free. They found serious problems of mistreatment and lack of respect, particularly towards indigenous women, and in many cases health personnel were unable to communicate with patients as they did not speak the local language. Moreover, many rural indigenous women have little knowledge of their rights, entitlements, the services provided or which services are free, and often choose not to use maternal health services or delay that choice because they feel mistreated or disrespected by health professionals.

The local context also makes a crucial difference in service delivery. In Puno, over half the department's population live in rural areas (INEI, 2007). This means that distances to health services are greater, the quality of facilities is generally lower, and doctors are generally reluctant to work in the poorest areas. Most rural women speak mostly Quechua or Aymara and therefore struggle to communicate with staff who speak only Spanish. One in five women in Puno is illiterate, making it difficult for many to understand written information in facilities. Two-thirds of the population live below the poverty line, meaning that many cannot afford to pay for health services.

These demographic issues are further undermined by institutional constraints. Political representation in the department of Puno is highly fractured. In the 2010 regional elections, 21 political parties participated. Many of them developed electoral strategies that sought to co-opt various women's organisations and health sector personnel. And yet, no candidate achieved enough votes, and this forced new elections.

At municipal level, the story is much the same. The Mayor of Azángaro, for example, achieved only 17.3% of the votes, considerably fewer than the number of invalid votes (30.6%). This all generates incentives for clientelism and corruption within the health sector. Personnel are appointed as much because of their political affiliation as their professional competence, and this also leads to high staff turnover as individuals fall out of political favour.

In 2011, CARE carried out a qualitative assessment in Melgar and Azángaro which found a number of rights violations:

- users had to pay for drugs that should be free under health insurance;
- parents had to pay for birth certificates, which should also be free;
- there was poor information on entitlements under public health insurance (eg the right to auxiliary examinations);

- rural women were treated with disrespect and called "dirty" or "stupid";
- providers did not respect cultural preferences (eg vertical birth delivery).

All of these contributed to a low use of health services by indigenous women and a maternal mortality rate roughly double the national average.

On the other hand, the introduction of participatory budgeting has provided greater opportunities for citizens to voice their preferences at local level, and a legislative framework which includes the requirement to institute social accountability mechanisms provides a supportive environment to achieve change.

Since 2010, CARE has carried out a number of studies to evaluate the quality of health services in Puno and the impact of the citizen monitoring model in improving service quality. We carried out action research with 118 people in 2010, a qualitative and quantitative assessment in 2011, a user satisfaction survey in 2013 and a systematisation in the same year. The following section will explain the model, and then we will look at the impact of the model in improving service delivery, and finally, there will be a discussion of what worked, what didn't and why.

Social monitoring of health services

CARE's model has four stages: organisation and planning; capacity building and planning; health facility visits; monitoring and evaluation (see diagram below).

Planning and capacity building

From the outset, CARE Peru partnered with ForoSalud (the country's largest civil society health network) and the Ombudsman's Office. Together, they defined what training was required for monitors and the support that public agencies required. Roles and responsibilities for each body were also defined in the monitoring process.

The project made an open call for participants within a number of targeted provinces through the radio. Radio provides one of the few sources of information for the public in unofficial languages – this is the principal medium for poor rural women who are often illiterate and do not speak Spanish. So, throughout the project, CARE and ForoSalud supported the monitors to develop brief radio programmes once a week for an hour in Quechua and Spanish to disseminate key messages around users' rights, preventing maternal mortality, citizen participation and the role of monitors in improving the quality of service provision.

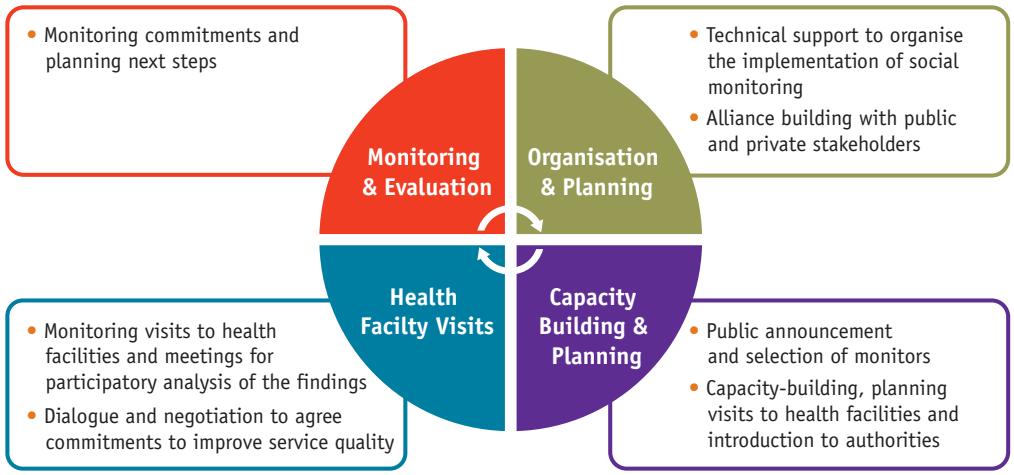
Working in partnership

ForoSalud has been integral to monitoring operations and also a key partner in national-level advocacy efforts, increasing the initiative's reach and representativeness. The Ombudsman has the mandate to protect citizens' rights and supervise the provision of public services and thus ensures state endorsement of the monitors' actions. The Departmental Office for Integral Health Insurance (ODESIS) also participates in meetings, strengthening coordination and helping to resolve gaps in service provision.

Given low numbers of personnel, public agencies have limited supervision capacity. The monitors therefore act as antennae for rights abuses, providing timely and detailed information around the quality of provision in health establishments.

CARE developed a model for social monitoring of health services, working in partnership with the civil society health network ForoSalud, the Ombudsman's Office, and local women's organisations

Social monitoring stages and processes



Monitors act as an intermediary between staff and patients, to help increase awareness on both sides about the availability and quality of treatment

Rather than starting from scratch, CARE reached out to health promoters in the department of Puno who were part of the ForoSalud network, and to local women's organisations (eg Las Manuelas in Ayaviri) as they had received some training previously in reproductive health and family planning. The monitors, CARE facilitators and the Ombudsman's Office chose two provinces: Azángaro and Melgar, where there were extremely high rates of poverty, maternal and child mortality and a history of user complaints regarding the treatment of poor indigenous women in health facilities.

Training contents were adapted to the needs and interests of participants and conducted in Quechua or Aymara, and case studies were analysed to apply practically what was learned. This included sexual and reproductive rights, the organisation and operation of healthcare services, SIS entitlements, social monitoring, access to information, and legislation that covers these areas. Monitors were chosen based on their availability, proximity to health facilities, knowledge, interest and level of commitment. Monitors were then shown how best to introduce themselves and address patients and service providers and were given an ID accredited by the Ombudsman. A monitor from Azángaro said:

When I went to the doctor at the hospital, he said: "What is all this about monitoring? We work hard here. Would you like me to come to monitor you at home?"

I told him, "Excuse me, doctor, we are healthcare promoters and have been trained by the Ombudsman and ForoSalud in monitoring. We know our rights. You cannot go to monitor my house, because it is private, but I can come to monitor the hospital, because it is a public institution, it is state-run. And here are my credentials."

"OK, come right in," he told me.

Citizen monitors

150 women have been trained and accredited to monitor health facilities and service delivery.

A study in Melgar found that the majority of monitors were previously community leaders who had completed either primary or secondary education and had some prior training in sexual and reproductive health rights and family planning. Quechua was their native language, but most understood Spanish. Many of the monitors were members of ForoSalud and of the Las Manuelas' organisation.

Health facility visits

The monitors visit health centres in pairs and generally carry out two to three visits per week, each of roughly five hours. They discuss issues with female patients in their native language about how they were treated, how long they had to wait to be attended, whether personnel complied with working schedules, and whether they were provided with information in their own language. The monitors document this in a register and they produce regular reports including both positive and negative findings, and these are analysed monthly with the regional Ombudsman's Office, CARE Peru and ForoSalud members. At the end of the visit, monitors ask the staff present to sign a monitoring form as proof of their visit and to help corroborate or challenge their findings.

Older staff from hospitals tend to have stricter procedures and a clearer hierarchy and are thus more resistant to changing their practices. A doctor in the Ayaviri hospital, for example, claimed that:

People who come [here] don't know how a city is, and how treatment is in a hospital. There is a cultural and language barrier. It affects them because they don't have experience living in the city and they see this as mistreatment. A hospital would never allow the family to be next to the patient; here we even let them sleep under the bed. We're taking a big risk… They have very deep-rooted ideas… We've got to find a way that the system can sensitise them to what attention in the hospital is like.

Monitors act as an intermediary between staff and patients, to help increase awareness around the quality of treatment and to inform patients about their entitlements and safe health practices. At first, monitors were looked down on by staff as they are not health 'professionals'. However, staff increasingly see them as playing a positive role. The Ombudsman's Office and ODESIS found that most health teams were unaware of the regulations, norms and laws that protect users' health rights, so a file was prepared for the monitors with copies of the main rules and legal norms (eg vertical birth delivery, free birth certificates, citizen participation, and health insurance benefits). As one monitor from a recent workshop put it, *"health personnel have realised that the monitors are a support to the health facility and they [now] have more respect for our work."*

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Primitiva, a citizen monitor in Ayaviri, talking to a mother at the health post

The aim is to ensure better communication and understanding between healthcare users and providers and jointly identify ways to improve the quality of healthcare

Agreeing commitments to improve service quality

Every three to four months, monitors meet with CARE Peru, ForoSalud facilitators, the Ombudsman's Office and ODESIS to discuss and analyse findings from the monthly reports, and identify trends of good and bad practices and performance at facilities. Based on this information, a 'dialogue agenda' is proposed for a meeting (*audiencia*) with the directors of health micro-networks, provincial hospitals, the head of the health establishments and their teams. In these meetings the monitors express their concerns and issues that need to be addressed locally. Until social monitoring was established, there was no space for users and providers to discuss the quality of services.

Crucially, this is not a 'blame game', but rather a concerted effort to ensure better communication and understanding between healthcare users and providers and jointly identify ways to improve the quality of services. At these meetings, both positive and negative aspects of service provision are discussed, and thus the space both gives the monitors the opportunity to question service providers on behalf of patients, and allows staff the opportunity to explain to the monitors why problems arise in the facilities. Although these spaces were initially resisted by various healthcare professionals, they are slowly becoming institutionalised as various members of staff see them as an internal control mechanism – a place to express their own grievances to their bosses as well as a place to inform users about the nature of services.

Equally, the Ombudsman's representative in Juliaca argued that *"at first one could feel the rejection of personnel… they are not accustomed to external oversight from civil society. [Now] the doctors have said that they can see it from another perspective, because before they only presented the negative cases and now they feel recognised, and this motivates them."* Without a balance between negative and positive elements, monitoring runs the risk of becoming an 'inquisition' and this encourages staff to externalise the blame.

Monitoring commitments

Monitoring and evaluation is conducted based on the minutes signed by the authorities present in the consultation meetings. CARE and ForoSalud regularly meet with staff and monitors and visit facilities to chart progress against the commitments made in the *audiencias*. Monitors themselves make the fundamental contribution, as the eyes and ears of the community, and their monthly reports are the main input to track success or failure.

Citizen monitoring has contributed to greater transparency in health facilities, greater respect and cultural sensitivity in service delivery, and increased demand for services

Impact of citizen monitoring in service delivery

Many monitors themselves feel a greater sense of confidence and self-worth in their household. One monitor noted after the training: *"In our houses our husbands and children now value us more, as they are impressed by our capacity to talk face-to-face with health providers, authorities or even participate at the participatory budget in the local government."* They have improved their knowledge and now have greater confidence to participate in public spaces.

Monitoring has contributed to a number of changes in service provision. Firstly, it has contributed to **greater transparency** in health facilities. All patients surveyed in Azángaro and Ayaviri in 2010 (30 in Azángaro and 40 in Ayaviri) reported that they had received information regarding the benefits of SIS, including which services and medicines should be provided free of charge, and the overwhelming majority said they were notified about the fact that birth certificates are free. Most doctors now wear name tags; their working hours and availability are published in a doctors' roll; the price of medicines and which medicines are in stock are published in a visible location; and a recommendations box has been introduced in many health posts. This has translated into greater respect for service hours by medical staff.

The intervention has also contributed to **greater respect** and **cultural sensitivity** in service delivery. There has been a decline in the number of reported episodes of disrespect to healthcare users. The survey showed that over nine out of 10 users felt that the attitude of personnel had improved. Monitoring has also reduced the frequency of other abuses such as under-the-table payments for birth certificates, and receipts are now provided for all user payments for medicines.

However, various providers do not recognise issues of discrimination and mistreatment and instead focus on issues related to organisation and service management which are not their direct responsibility. Some attempt to justify problems such as user mistreatment by referring to their own poor working conditions – low salaries, inadequate infrastructure and equipment, and under-staffing.

Notwithstanding, staff have generally become more receptive to users' demands. A qualitative survey in 2011 showed that now many staff allow women's partners to be present during delivery. Many facilities now allow women to bind their heads (a customary practice related to the unity of the head) and fewer mothers' genitals are washed with cold water (understanding the necessary hot/cold balance in the Andes). Also, fewer medical students enter birth delivery units without permission from the patient. There has also been a two-fold increase (from 194 births in 2008 to 437 in 2009) in the number of vertical birth deliveries (the preferred method of many rural indigenous women). All women surveyed in 2010 argued that there was an improvement in the quality of attention. Monitors' efforts in participatory budgets further achieved an extension of maternal health services with the construction of birthing houses (*casas maternas*) where rural women can stay before delivery in Azángaro and Melgar (construction cost 50,000 Soles, or approximately US$18,500, each).

Greater confidence in the quality of care has translated into **increased demand for services**. CARE's quantitative assessment in 2010 (comparing data between 2007 and 2009), comparing micro-networks with control facilities in Azángaro, found an increase in:

- pre- and post-natal controls;
- women's access to laboratory exams;
- institutional birth delivery;
- the proportion of women affiliated with SIS.

In Ayaviri, improvements were found only in women's access to laboratory examinations. This difference is largely attributed to greater problems in the quality of attention in the Ayaviri hospital, related to a greater staff rotation than in Azángaro.

The paradox of user satisfaction

Findings from a user satisfaction survey in 2013 showed, paradoxically, that health centres where social monitoring mechanisms were introduced generally had higher levels of dissatisfaction than in health centres where social monitoring was not introduced. Ostensibly, one might think that this means that the monitoring has not improved the responsiveness of service providers to citizens' complaints. However, the reality is rather more complex.

Lower satisfaction can be explained, in part, by the chronically low expectations of users in rural areas. In many parts of rural Peru, citizens are accustomed to view poor quality services and mistreatment by service providers as normal. In the absence of social monitoring mechanisms, they are often unaware of what

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Eusebia, a citizen monitor in Ayaviri, explains the processes developed to implement monitoring

services and treatment it is their right to receive. The data from the survey demonstrate that in health centres where social monitoring was introduced there was four times higher awareness of complaint mechanisms. Equally, where social monitoring was introduced, the percentage of users with complaints was twice as high. Social monitoring has driven both a rise in expectations and an improvement in the quality of services, but not at the same rhythm or pace.

A bridge between citizens and public policy

From the beginning, CARE recognised that if change was to be sustainable at local level we had to engage at district, regional and national levels to ensure that social monitoring was recognised, valued and institutionalised. In order to achieve this, CARE decided to form a strategic partnership with ForoSalud and the Ombudsman to carry out advocacy at these respective levels.

Towards the end of 2007, the Peruvian Ministry of Health consulted civil society organisations regarding the modification of the Co-management and Citizen Participation in Health Law (No. 29124). In the same year, CARE commenced our pilot in social monitoring in Puno, Piura, and Huancavelica. In May 2008 the Minister of Health met the monitors in Azángaro and saw their work. In 2008, the Ministry of Health passed a Resolution to Recognise Citizen Monitoring Committees.

Since then, the initiative has been a key reference point for health policy in social monitoring. In January 2011, the National Policy Guidelines for the Promotion of Citizen Health Monitoring were promulgated, and Article 9 of the Regulations of the Law for Universal Health Insurance (Law 29344) highlights that the Ministry of Health is responsible for establishing spaces and mechanisms for citizen participation in the framework of Integral Health Insurance.

At regional level, lobbying from CARE and ForoSalud helped ensure that Puno's Regional Health Council promulgated an ordinance which recognises citizen monitoring of health services through the *audiencias*. Work with the Regional Health Directorate (DIRESA), and within the Consultation Council for the Fight against Poverty and other bodies in charge of public spending within budget by results, allowed them to develop a Regional Ordinance (No. 04/2012) which ensured that action plans to implement citizen monitoring of health services were included in activities.

The experience has also been hailed as an example of best practice at international level. The first report produced by the UN Commission and the World Health Organisation for information and accountability regarding the health of women and children – Independent

The initiative has become a key reference point for including social monitoring in national and regional health policies

Successful social monitoring involves monitors drawn from the local community, partners with local relationships and credibility, and a commitment to constructive dialogue among participants

Expert Review Group (iERG) for Information and Accountability for Women's and Children's Health – in September 2012 included eight examples globally of how to promote citizen participation and accountability; CARE Peru's experience with social monitoring in Melgar and Azángaro was one of the case studies.

What makes the difference?

Enablers

Agents for change: Community monitors can play a crucial role in social accountability, offering *community-driven* rather than INGO-driven oversight. The monitors are the authentic eyes, ears and voice of their peers in a way that INGOs are not. The majority of monitors were previously community leaders with some prior training in sexual and reproductive health rights and family planning and citizen participation. They were members of local women's organisations and thus had legitimacy to advocate for community needs and concerns. Quechua was their native language so they were able to effectively communicate with service users, but understood Spanish and thus were also able to engage with health personnel. Taking advantage of existing local knowledge and skills and 'decentralising voice' in this way meant that results could be achieved faster and in a more sustainable way.

Choosing the right partners: CARE Peru recognised that to build its legitimacy at local level, it had to change its way of working. CARE established relationships with like-minded actors in local spaces and this set a platform for a mutual agenda. We decided to ally with ForoSalud which shared our rights-based approach to health and had a broad-based constituency at local level. This allowed CARE to take advantage of local capacity over an existing institutional base rather than duplicating efforts, and meant that policy proposals that were made locally and nationally had credible support from a broad civil society base.

Accountability based on dialogue, not naming and shaming: Ensuring early buy-in from the Ombudsman helped build an accountability bridge to other state actors. At the "intersection between state and civil society" (Pegram, in World Bank, 2014) the Ombudsman played a crucial role certifying monitors' credentials and accompanying the process. This meant the project had a state sponsor of civil-society-led efforts throughout. A focus on dialogue in the *audiencias* meant that both citizens and providers had a fair chance to openly discuss opportunities and constraints, and highlighting successes as well as failures helped generate a climate for positive incentives. Indeed, the Consultation Council for the Fight against Poverty and participatory budgeting processes helped state and civil society actors to engage in a multilateral space, where problems beyond the discretion of frontline service providers, such as a lack of birthing houses, can be presented in a shared agenda as a 'collective action solution'.

Barriers

Political will: In a hierarchical system such as the health sector, if rights or citizen participation are not part of the political discourse, or political priorities at the top, managers in the middle and personnel at the bottom will see them as optional. Managers will not establish incentives to promote them, find resources to make them real, or be accountable for delivering them. No INGO can go it alone. Overcoming this bottleneck requires a consistent effort to mobilise a coalition of civil society actors to convince political actors at both regional and national level.

Lack of performance-related incentives: Some of the health personnel interviewed did not recognise any problems in terms of mistreatment, discrimination, lack of privacy, or lack of respect for indigenous culture. They mentioned only the lack of medicines as a problem, one that was out of their hands, and that they do "as best they can" given the circumstances.

Poor human resource management: Constant rotation of personnel is a major issue. Certain short-term hiring practices (eg Administrative Service Contracts – CAS) have generated instability within health networks. When staff have short-term contracts, they often resort to malpractice or to clientelistic relationships with network directors. These directors are generally elected by their peers and thus have few incentives to hold their staff to account for malpractice. Equally, there is a lack of discretion from regional bodies to ensure training (eg on vertical birth delivery) or supervision which would improve the quality of provision.

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A midwife assisting a patient at a health clinic in Vilcashuaman

Supervision without sanctions:
Even though there are state agencies charged with the supervision of health services, the health sector has no authority to impose sanctions for non-compliance with norms. Complaints should be sent directly to the Police Complaints Commission (*Fiscalia*), but this does not always happen. As an ODESIS representative in Puno put it, *"there is supervision without sanctions."* Given the lack of authority within the Ministry, the Regional Government or managers of health networks to impose sanctions, commitments made in the *audiencias* are difficult to follow up on.

Conclusions and recommendations

Citizen participation in the design and implementation of health policies and programmes is a key element to ensure a better response from services to the needs of the population. The citizen monitoring model has put emphasis on empowering citizens and promoting greater awareness of the exercise of rights and establishing spaces for dialogue to address rights violations and other institutional issues related to service quality. The model has contributed to the personal empowerment of citizen monitors in their communities, ensured more transparent information about services, generated greater respect for users and cultural sensitivity in service provision, and achieved a reduction in under-the-table payments; all of this has generated greater demand for health services. So, overall, we can say it helps generate more responsive and better quality healthcare.

Two aspects particularly merit further consideration. On one hand, the oversight role of the monitors and the accountability bridge of the Ombudsman. Empowering community members as monitors and advocates can add a great deal of value to any NGO-led social accountability process. Many other approaches (eg Community Score Cards) focus very much on organising forums where communities appraise, score and comment, but very little on the spaces in between. This means, typically, that there are limitations in tracking how outputs from meetings (commitments) become outcomes (service delivery changes). Monitors can play a crucial third-party role to fill this gap. Secondly, as the World Bank's Jeff Thindwa has put it, Ombudsman agencies "are gateways for citizens into governments" (Thindwa, in World Bank, 2014). This intersection between state and civil society is a crucial but poorly understood area which requires further research.

Yet the model also raises questions about how to generate better incentives for improved service provision, as user satisfaction does not increase at the same rhythm as the demand generated from social monitoring. Increasing demand for accountability and generating

The citizen monitoring model puts emphasis on empowering citizens and promoting greater awareness of the exercise of rights

Translating policies into budget allocation and human resources requires sustained civil society pressure at provincial and national levels

spaces for dialogue are crucial to defend health users' rights, but we also need to help ministries to impose sanctions and ensure better follow-up when commitments are not met.

Recommendations

Beyond the enablers mentioned above, we can recommend the following to help overcome some of the key barriers:

Multi-tier engagement: It is clear that local-level social accountability actions at the bottom require greater attention to management structures in the middle, and advocacy on policy and financial resourcing at the top. With policies on citizen monitoring at national and provincial level, it is no longer a discretionary option. However, translating policies into budget allocation and human resources requires sustained civil society pressure at provincial and national levels.

Investing in people, earlier: Discrimination and mistreatment typically stem from hierarchical attitudes of medical staff towards patients and a lack of performance-based incentives for staff to improve the quality of care. This means INGOs and other agencies ought to help provide rights-based training of medical staff before they finish their medical studies rather than waiting till they arrive in poor rural areas, by which time prejudices have already formed and are harder to change. Actions should also focus on establishing protocols within the Ministry of Health to impose sanctions for malpractice, thus strengthening the authority of the Ministry to protect users' rights.

Accountability bridges: The Ombudsman played a crucial role in opening the door for the citizen monitors, but with low staffing, narrow technical capacity, and no legal authority to impose sanctions, it is worth analysing which other state agencies need to play a role to keep that door open and respond more meaningfully to the demand for the right to available, accessible, acceptable and good quality healthcare for all.

All voices are welcome, and comments should be sent to Tom Aston at aston@careinternational.org

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Melgar health network

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