Project: Enhancing participation of indigenous people to address discrimination and equity in health systems (106815-001).

This project was implemented by *Centro de estudios para la equidad y gobernanza en los sistemas de salud* (CEGSS) in Guatemala.

NARRATIVE FINAL TECHNICAL REPORT

December 2015

Abstract:

Indigenous peoples in Latin America face several barriers in accessing quality health care. Geographic and language barriers as well as ethnic and racial discrimination are some of the mechanisms of social exclusion impeding their access to good care. These factors also make it difficult for indigenous peoples to participate in the public sphere to influence policies and practices in health facilities. Guatemala has implemented progressive social reforms recognizing the right to health and promoting participatory governance of health systems. Novel strategies are however required to facilitate the participation of indigenous peoples, and break through the dynamics of inequity and ethnic-racial discrimination.

This project aims to strengthen the governance of the health system and enhance equity through active participation of indigenous communities. Teams of researchers are sharing their respective expertise to implement a rights-based intervention in rural Guatemala, and evaluate its impact on discriminatory treatment in health facilities. The intervention focuses on empowering the community with tools and strategies to monitor public policies and healthcare services in Guatemala. The impact evaluation will then help determine the effectiveness of the intervention in achieving enhanced community participation in health policies, and redressing discriminatory practices in service delivery. Several knowledge translation activities will be conducted throughout the project to share the process and results with health policy makers and managers at local and national levels in Guatemala. The findings will also be shared with various stakeholders in Ecuador, a country that is contemplating a similar intervention.

Keywords:

Guatemala, indigenous health, health rights, health system, participatory governance, citizen empowerment, impact evaluation

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I. Introduction:

This narrative reports relates to a) the intervention component led by CEGSS and Walter Flores as project leader and b) the knowledge translation component. The impact evaluation component was implemented by GRADE and lead by Martín Valdivia. The impact evaluation is reported separated by GRADE.

II. The Research Problem:

The exclusion of indigenous peoples in Latin America through various mechanisms has been widely documented in the literature. In addition, there are several studies in which the poor quality of health services for the indigenous peoples is discussed, from the arrival at the health facility to the actual consultation with the health professional. Nevertheless, the study of discriminatory treatment of indigenous people in health facilities has not been addressed rigorously.

In the proposed study, the research team will take advantage of a previously proven health rights-based intervention to explore not only the presence of ethnic-racial discriminatory treatment in health facilities, but also the impact of a policy intervention that can help reduce such practices and improve social inclusion and equity in health care. Therefore, this proposed project plans to strengthen the governance of the health system through the involvement of indigenous community. The project would operationalize the principle of governance by empowering the indigenous community through awareness of their rights and stronger capacity (understanding of concepts and tools) to monitor and evaluate the implementation of their municipal health programs and policies.

III. Objectives

The specific and general objectives of this project were:

General objective:

To implement a participatory health rights-based approach to citizens' empowerment for the monitoring of public polices and healthcare services, in about 20 new municipalities of Guatemala. This approach was developed by CEGSS in a previous project implemented in 6 municipalities.

Specific objectives:

- To implement the participatory health rights-based approach in 20 new municipalities of Guatemala. The municipalities will be selected based on a majority of indigenous population and high levels of poverty and social exclusion (as determined by national statistics).
- To establish a collaboration to transfer knowledge and skills transfer between

CEGSS and a group of researchers from Ecuador, interested in applying tools developed by CEGSS for the assessment of democratic governance in health systems (social participation, transparency and accountability).
- To link-up CEGSS collaboration with Ecuador and with MoH/PAHO through a community of practice.

IV. Methodology and Project Activities

This was a highly complex project to implement due to the participatory and flexible nature of CEGSS approach and the interest in evaluating the impact of the intervention through a rigorous methodology (randomized field experiment). Both project leaders (Flores and Valdivia) agreed that due to its complexity, there should be a common understanding and agreement on the nature of the intervention and the details of the impact evaluation before starting the implementation of field activities to avoid biases in the impact evaluation design. In order to reach agreement on the intervention and impact evaluation, both project leaders and their teams carried-out the following meetings:

In August 2012, Walter Flores-principal researcher from CEGSS took advantage of a visit he was doing to Perú and met-up with Martin Valdivia-principal researcher from GRADE. During this meeting, the two researchers discussed the general characteristics of the intervention and reviewed different literature on evaluation and impact evaluation of social accountability and community empowerment projects. Both researchers also agreed on a visit and workshop of GRADE researchers to Guatemala.

In the last quarter of the year 2012, Martin Valdivia and Jorge Aguero visited Guatemala to explore the feasibility of an impact evaluation design making an emphasis on discriminatory treatment based on racial traits. Both researchers met with CEGSS staff and CEGSS also facilitated meetings with health authorities and other research organizations in the country. After this visit, it was clear that there was still no clarity and agreement about the specific nature of the intervention and the design for an impact evaluation. A third workshop was planned for January 2013.

In this third workshop, Anna Dion, project officer of IDRC participated, together with CEGSS staff and both Martin Valdivia and Jorge Aguero from GRADE. The workshop lasted three days and after a detailed discussion of CEGSS intervention, GRADE presented the basic for an experimental design that would be used for the impact evaluation. Both teams, with the support of Anna Dion, agreed on the relevance of using a mixed methods design and the usefulness of prospective ethnography to document CEGSS intervention throughout the project. During the discussion, CEGSS also had the opportunity to clarify the specific characteristics of the intervention and the basis of the specific “theory of change” for the intervention was discussed.

As a follow-up to the workshop, CEGSS was left with the task of completing the

documentation of its “theory of change” and developing the database of municipalities form which the treatment and control municipalities would be randomly allocated. GRADE was left with the task of completing the experimental design for the impact evaluation and developing the questionnaires. These two task were taken in the remaining of the last quarter of year one of project implementation.

After all the above activities were completed, the project activities finally started only at the beginning of year two of project implementation. This means that the project started with one-year delay, which had implications for the implementation of activities that will be described in the final section of this report.

IV.a. Activities implemented related to project´s specific objectives of the intervention component

In this section, we are first reporting about specific objective 2 and 3 that could not be implemented as expected. For specific objective 2: *To establish a collaboration to transfer knowledge and skills transfer between CEGSS and a group of researchers from Ecuador, interested in applying tools developed by CEGSS for the assessment of democratic governance in health systems (social participation, transparency and accountability),* there were two limitations: a) as explained earlier, the project suffered one year delay in implementation due to the need of agreeing on both the intervention and the impact evaluation design. During this delay, Walter Flores communicated with the Ecuadorian colleagues and he was informed that team coordinator in the San Francisco University, had migrated to the USA. Although other university staff stayed at the university, they were either not interested or had no experience in health systems governance and participatory monitoring. Hence, there were no active counterparts in Ecuador. In addition to the above, by the second year of project implementation, it was becoming clear that the project was losing resources due to exchange rates. The projection of loss was around CAD 40,000, which would have a major negative impact on the project. For the work with Ecuador, the project had allocated USD 20,000. To continue with this activity and adding to the exchange rate loss, there would be an even higher negative impact for the project. Taking all the above into account and since there were not viable/interested partners in Ecuador anymore, the project leader decided to cut the activity with Ecuador and re-direct those resources for the implementation of the activities in Guatemala. The project leader informed about this decision to IDRC project officer (Chaitali Shina).

In relation to specific objective 3:*To link-up CEGSS collaboration with Ecuador and with MoH/PAHO through a community of practice,* this objective was also not implemented with Ecuador due to the reasons explained above. However, the community of practice has been promoted through the specific website that CEGSS created (www.vigilanciaysalud.com) to disseminate the findings of this project, not only in the 20 intervention municipalities funded through this IDRC

grant, but also the work in additional 15 municipalities that have been supported through a grant from Open Society Foundation. This is the reason why the website recognize the support of both donors: IDRC and Open Society Foundations. Through this website, CEGSS have been exchanging experiences with practitioners in Africa and Asia and also within Latin America, specifically with grass-roots organizations from the Amazon region in Perú and facilitating Civil Society Organization from the Highlands in Perú. In other words, although with different actors-the purpose of implementing a community of practice was still achieved and continues very active even after the IDRC grant concluded.

Below we report on the most important specific objective of this project: *To implement the participatory health rights-based approach in 20 new municipalities of Guatemala. The municipalities will be selected based on a majority of indigenous population and high levels of poverty and social exclusion (as determined by national statistics).*

Selecting the municipalities:

The municipalities were randomly selected from a list of over one hundred municipalities with a majority of indigenous population and high levels of poverty. This list was prepared using the official statistics in Guatemala. From this list, Martin Valdivia and his team did the random allocation of treatment and control municipalities. Martin and Walter agreed to add two more municipalities to the intervention in case there may be problems during implementation to the point that one or several municipalities had to be dropped out. The purpose was to retain as close as possible the target 20 municipalities for intervention. Once municipalities were selected, the project teams started the intervention component following the theory of change developed for this project (see Annex I).

Phase 1: Organizing process and initial appraisal study:

The initial appraisal involved a rapid analysis of local conditions in relation to access to healthcare services, availability of essential resources at healthcare facilities, power relations (trusts) and key characteristics of democratic governance (accountability, transparency and social participation). The appraisal also applied rapid ethnographic techniques (social mapping, document analysis, participant observation and in-depth interviews) to analyze and understand power relations and social organization at the local level. The initial appraisal was implemented in 22 municipalities. This initial appraisal was important to define the situation at the beginning of the intervention. From this appraisal, it was identified that out of the 22 municipalities for the interventions 3 municipalities (Palestina, Chiquirichapa and Cajolá) had non-favorable conditions for the implementation of the intervention due to a) tension and conflict among communities within the municipalities (due to access and use of river water and high political polarization) and b) municipal authorities were very negative towards the work to be implemented by the project and saw it as socially

destabilizing. Without the possibility of communities working together and municipal authorities perceiving the project as a threat, it was very unlikely that the project would have a successful implementation in these municipalities. Despite this situation, CEGSS continued engaging with these three municipalities hoping to be able to implement the intervention and avoid dropping them out of the project. In one municipality, despite several preparatory meetings, we could not continue the activities due to lack of agreement with community leaders. In another municipality, we managed to advance with the capacity building workshops but there was a high drop-out that made us to repeat the workshops several time with total new leaders. Once workshops were completed, community leaders dropped-out themselves from the field activities. In the third municipality, we were unable to advance due to the restrictions imposed by the municipal government. Due to this situation, CEGSS dropped those three municipalities and continued working only with 19. Annex VI has a detailed description of the conditions found in those three municipalities and the activities that were implemented in each of them before dropping them out.

Phase 2: Capacity building process:

The capacity building process include two main activities: one- day training workshops and a book compiling the most important laws study guides for participants to study at home individually and in groups within their communities. The workshops and study guides are based on popular education and adult learning techniques and cover the following themes:

- Legal framework for health and social participation in Guatemala.
- Public polices and the role and responsibilities of different actors.
- Participatory planning and monitoring.
- Implementing participatory monitoring for accountability.
- Strategies and activities to demand accountability of authorities and advocacy.

Each participant also receives a book compiling the most important laws in Guatemala. The book is in Spanish, however, in Alta Verapaz region there is a high percentage of monolinguals-being Maya-Qeqchi the mother tongue. Because of this, the project hire a Mayan Linguist to translate the full book into Maya-Qeqchi language to be distributed among community leaders from Alta Verapaz municipalities.

In total, the project implemented 154 one day workshops. In these workshops, there was a total participation of 1,902 females and 2,313 females, which indicates a percentage of 45% of females and 55% males. The distribution per each municipality is presented in table 1. Please note that since the levels of prior knowledge were highly heterogeneous in all municipalities, there was a need to adapt the number of workshop that were needed to cover all contents. Hence, the total number of workshops implemented among municipalities varied from 6 to up to 10.

Table 1.Capacity building workshops at municipal level

Capacity building workshops at municipal level

Municipio	Departamento	Total de talleres de capacitación implementados	Total de mujeres que participaron en talleres	Total de hombres que participaron en talleres
CONCEPCION SOLOLA	SOLOLA	10	106	142
COTZAL	QUICHE	9	128	242
FRAY BARTOLOME	ALTA VERAPAZ	9	114	132
IXCOY	HUEHUETENANGO	7	80	83
JOCOPILAS	QUICHE	8	37	97
LA TINTA	ALTA VERAPAZ	9	163	139
LANQUIN	ALTA VERAPAZ	9	87	112
S.B.JOCOTENANGO	QUICHE	8	36	129
S.B. AGUAS CALIENTES	TOTONICAPAN	10	117	108
SAN CRISTOBAL AV	ALTA VERAPAZ	6	99	83
SAN CRISTOBAL T.	TOTONICAPAN	6	19	191
SAN MARCOS LA LAGUNA	SOLOLA	9	142	98
SAN PABLO LA LAGUNA	SOLOLA	7	255	53
SANTA BARBARA	HUEHUETENANGO	8	121	147
SANTA CRUZ LA LAGUNA	HUEHUETENANGO	9	115	54
SANTA EULALIA	HUEHUETENANGO	6	81	156
SOLOMA	HUEHUETENANGO	8	41	93
TAMAHU	ALTA VERAPAZ	8	78	131
XECUL	TOTONICAPAN	8	83	123
GRAN TOTAL		**154**	**1902**	**2313**

Source: Project´s information system

In each training workshops, CEGSS provided subsidies for transport and food of community leaders. These subsidies were aimed to tackle barriers faced by these community leaders coming from extreme poverty contexts. Previous researched carried-out by CEGSS demonstrated that without subsidies, community leaders are unable to participate in capacity building processes.

As result of the capacity building workshops, community leaders learned about the legal framework and a general understanding of how public policies and services work and their relevance. Community leaders also developed skills to implementing the monitoring of public policies and services. They also learn and develop skills to implement advocacy plans to tackle the problems that have been identified during the monitoring.

Once capacity-building workshops were completed, we moved to the next phase, which was the monitoring rounds.

Phase 3: Participatory monitoring of public health policies and healthcare services: The citizens' vigilance process:

This stage involved the implementation of the participatory system to monitor whether public polices and healthcare services at the municipal level are addressing issues of access, reduce discrimination, improved allocation of resources, transparency and accountability. The monitoring system was implemented through three different methods:

- In-depth interviews during community assemblies aimed to identify families who had faced a health care problem, had gone to a public health care facility but did not receive adequate care. The in-depth interview collected information on resources used by families to pay for medicines, transport to a hospital, and also the number or working days lost to illness of parents or due to looking after a sick child .
- Health care facility surveys to assess availability of essential drugs, medical equipment/supplies and availability of human resources.
- Campaigns to collect complaints and audiovisual evidence: These were activities implemented in public parks or outside health care facilities and the purpose was to inform users of services about their rights and collect complaints for those cases in which users reported non-satisfaction with services. The campaigns also included collecting evidence and sending through SMS messages to the electronic platform (see next section in this report), photography and video.

The monitoring rounds were carried out by a steering committee of leaders that have participated in the training process. In each municipality, from the 30-40 leaders, about 7 are elected (by the rest of the leaders) to coordinate the monitoring work. The rest of the community leaders are involved in data collection and analysis.

The vigilance committee selected a purposive sample between 5 and 10 healthcare facilities for the monitoring. This included facilities that are close to the urban area of the municipality, facilities at intermediate distance and facilities that are remote. In each of the catchment area of the sampled facilities, leaders carried out community assemblies to ask about barriers in accessing local healthcare services and other complains. In the assembly, cases of families with a recent healthcare problem that was not adequate resolved are identified and between two or three of those cases are selected for in-depth interviews by community leaders.

In all municipalities community leaders organized themselves to carry-out the data collection. In some cases, particularly the most remote communities, the travel cost were high, then CEGSS provided subsidies for transport to reach those communities. This was done to avoid forcing community leaders to pay from their own pocket or that remote communities were not sampled due to the high transport costs.

Collected information was analyzed by community leaders with the technical assistance of CEGSS. A report was produced and findings presented to health authorities and municipal governments.

The three different methods for community monitoring were presented to trained leaders and also detailed explanations of time required, information and skills to implement each of the three methods. Since all community leaders are volunteers, they were free to decide whether they wanted to implement one, two or the three different methods for the community monitoring. As result, some municipalities implemented the three methods, other two and some only one. This variation was not a problem since the purpose of data collected through the monitoring is to elicit evidence of failings in service delivery and to engage with authorities. Hence, community leaders that felt data elicited through one methods was sufficient evidence to engaged with authorities were supported to move to the strategic advocacy stage. Other municipalities wanted to ensure that they collected enough evidence and implemented the three methods. Table 2 presents data on community monitoring round in each municipality.

Table 2.Community monitoring rounds at municipal level

Municipio	Departamento	Total de asambleas comunitarias realizadas para recoger información sobre vigilancia ciudadana	Total de rondas de vigilancia ciudadana realizada a establecimientos de salud	Jornadas de recolección de denuncias y evidencia
CONCEPCION SOLOLA	SOLOLA	1	0	3
COTZAL	QUICHE	1	3	1
FRAY	ALTA VERAPAZ	0	1	2
IXCOY	HUEHUETENANGO	2	0	0
JOCOPILAS	QUICHE	1	1	0
LA TINTA	ALTA VERAPAZ	1	0	0
LANQUIN	ALTA VERAPAZ	1	2	1
JOCOTENANGO	QUICHE	0	0	1
SAN BARTOLO	TOTONICAPAN	3	0	1
SAN CRISTOBAL AV	ALTA VERAPAZ	0	0	1
SAN CRISTOBAL T.	TOTONICAPAN	0	0	2
SAN MARCOS	SOLOLA	0	1	1
SAN PABLO	SOLOLA	1	1	5
SANTA BARBARA	HUEHUETENANGO	1	0	2
SANTA CRUZ	SOLOLA	0	1	1
SANTA EULALIA	HUEHUETENANGO	1	2	0
SOLOMA	HUEHUETENANGO	0	2	3
TAMAHU	ALTA VERAPAZ	1	0	0
XECUL	TOTONICAPAN	1	0	0
GRAN TOTAL		**15**	**14**	**24**

Source: Project´s information system

SMS platform to receive complaints from users of services:

Through a small grant from Open Society Foundation (2013-2014), CEGSS developed, field tested and piloted, an SMS platform to receive complaints from users of services and monitor the responses from authorities to those complaints. The piloting during 2014 was very successful and demonstrated that sending complaints through SMS messages reduced considerable the amount of time that community volunteers had to dedicate to the monitoring system. Piloting also revealed that since it was a real-time complaint, health authorities were more interested in responding to those complaints than complaints received through the pen and paper methods of written reports that included problems identified several months earlier. In addition, other public human rights organization in

Guatemala (National Ombudsman, and others) were interested in providing a follow-up to complaints that may have been related to discrimination and racism experienced by users of services, and corruption by health care providers.

Due to the success described above, the project decided to adopt the platform as a core component of our approach to accountability. The geographical information data for the 20 municipalities in the interventions component in this project were added to the platform database and community leaders from those municipalities were trained in the use of the platform, coding and sending of messages. Table 3 present the data on complaints received by the platform during the period February to September 2015. Please note that this data included also complaints from 15 additional municipalities that are supported through a grant from Open Society Foundation. An info graphic with the detailed process of how the SMS platform works is included in Annex II.

Table 3.Consolidated report of complaints grouped by category from 35 municipalities. Period February to September 2015

Category	**Number of complaints**
Lack of vaccines	44
Lack of drugs	431
Lack of equipment and/or supplies	91
Charging for services at health care facilities	6
Charging for emergency transport to patients using Ministry of Health(MoH) vehicles	20
Selling MoH drugs in pharmacies or private clinics	1
Denying care on the grounds of not having the necessary equipment and supplies	43
Denying care on the basis of ethnicity or language	12
Denying care on the grounds of not having a carnet	4
Denying care on the basis of gender, age or socio economic status	14
Lack of informed consent	3
Mistreating users	42
Unsatisfactory care received by in-patients at hospitals	7
Not giving users enough information about diagnosis and treatment	7
Health facility is closed	17
Absenteeism of mobile teams providing services at community level	2
Health facility infrastructure in bad condition	34
Others	40
TOTAL	818

Source: Project´s information system

The platform also included a color coded system to monitor the resolution of complaints (see annex II for details). By September, 4 complaints were already resolved by authorities. Although the IDRC project is finalized, the platform is still ongoing and it has generated the interest of other NGOs in Guatemala and abroad. Civil society organization monitoring food security have requested CEGSS the possibility of an alliance to expand the platform to monitor food security policies. CEGSS has also been approached by organization monitoring HIV treatment to monitor availability of drugs and compliance with HIV policies in the country. Annex V presents an information bulleting produced by CEGSS to disseminate the work of the platform.

Phase 4: Strategic advocacy actions:

Once evidence collected from the community monitoring is ready, community leader request a meeting with health authorities at local and provincial level and municipal authorities. Community leaders from some municipalities did a two stage process: a) a meeting to present the evidence of problems with the delivery of services and b) follow-up meeting to develop and agree action plans and monitor the resolution of problems. In other municipalities, community leader managed to develop an action plan with authorities in the same meetings in which evidence was presented. After that, they continued having meetings with authorities to monitor the implementation of the action plans and the resolution of complaints. Table 4 presents the distribution of advocacy meetings with authorities by each municipality. As it can be see in the table, most municipalities preferred to develop an action plan within the first meeting and went to continue meeting with authorities for monitoring purposes. A total of 116 meeting were implemented under this modality of advocacy.

Table 4.Advocacy meetings at municipal level

Municipio	Departamento	Total de reuniones con autoridades para presentar reportes de vigilancia ciudadana	Total de reuniones con autoridades para planificar mejoras a los servicios o monitoreo de avances en plan de acción
CONCEPCION SOLOLA	SOLOLA	0	11
COTZAL	QUICHE	0	5
FRAY	ALTA VERAPAZ	1	7
IXCOY	HUEHUETENANGO	0	7
JOCOPILAS	QUICHE	0	5
LA TINTA	ALTA VERAPAZ	1	3
LANQUIN	ALTA VERAPAZ	0	5
JOCOTENANGO	QUICHE	4	7
SAN BARTOLO	TOTONICAPAN	1	3
SAN CRISTOBAL AV	ALTA VERAPAZ	0	6
SAN CRISTOBAL T.	TOTONICAPAN	0	2
SAN MARCOS	SOLOLA	0	14
SAN PABLO	SOLOLA	3	17
SANTA BARBARA	HUEHUETENANGO	0	5
SANTA CRUZ	SOLOLA	0	2
SANTA EULALIA	HUEHUETENANGO	0	7
SOLOMA	HUEHUETENANGO	0	3
TAMAHU	ALTA VERAPAZ	2	6
XECUL	TOTONICAPAN	0	1
GRAN TOTAL		**12**	**116**

Source: Project´s information system

One of the main issues addressed during the meetings at municipal level was the fact that municipal health authorities did not have decision-making regarding

key resources such as procurement of medicines and medical supplies, petrol and spare parts for ambulance, and that they were totally dependent from Ministry of Health provincial authorities. Because of this, community organizations at municipal level elected representatives that would engage with authorities at provincial level. Table 5 presents the distribution of advocacy meetings that were held in each one of the 5 provinces that the 20 municipalities belong to. Due to distances from the municipalities to the provincial capitals, CEGSS provided subsidies for food and transport to community leaders that attended these meetings.

Table 5.Advocacy meetings at provincial level

Departamento	Total reuniones con autoridades para presentar reportes de vigilancia ciudadana	Otras reuniones de incidencia estratégica a nivel departamental
ALTA VERAPAZ	1	8
QUICHE	6	6
HUEHUETENANGO	2	8
SOLOLA	0	6
TOTONICAPAN	3	19
TOTAL	**12**	**47**

Source: Project´s information system

Public exhibits of audiovisual evidence

During the initial strategic advocacy meetings with authorities, it became clear that authorities were no longer paying attention to written reports, they specifically said that they doubted the data collected through pen and paper since it was prone to manipulation. Based on these comments by authorities, CEGSS together with community leaders decided to implement a strategy in which evidence would be collected through video, photography and voice recording of users complaining about the services.

To implement this strategy, CEGSS designed a participatory-action process aimed to a) develop skills of community members for eliciting audiovisual evidence b) transferring that evidence into different media communication (video, photography, radio and newsletters) and c) presenting the evidence to authorities. Annex III includes an info-graphic summarizing this process.

To implement the above strategy required purchasing over 40 video-cameras and 40 digital voice recorders and 10 computer laptops. Since the IDRC project did not have resources allocated for that type of equipment, CEGSS used resources from an Open Society Grant to acquire all the audiovisual equipment that would be distributed to community leaders.

The project was implemented from April 2014 to July 2015 and it was highly successful. A total of 75 community leaders were trained and developed skills to collect audiovisual evidence. All evidence collected by the trained community leaders was transformed into:

- 34 short videos
- 11 photo-essays
- 9 newsletters
- 9 radio programs

All the above material was presented to authorities, mass media, academics and the general public, through a public exhibit in Guatemala and 5 other exhibits in each one of the provincial capitals: San Marcos, Huehuetenango, Totonicapán, Quiché, Alta Verapaz. Annex IV includes an info-graphic summarizing the process of the public exhibits and the achievements.

IV.b. Knowledge translation component:

This component of the project had the follow general and specific objectives:

General objective: To implement innovative and systematic knowledge translation (KT) strategies to disseminate information, knowledge and evidence generated through the intervention.

Specific objectives: To disseminate CEGSS approach, and its lesson learned, to specific audiences as follows: s) Community based organizations: educational newsletters; screening of audiovisuals at town hall meetings, dissemination workshops b) General public: educational radio programs transmitted through community radios and c) Decision-maker and academics: policy-briefs, reprints of peer-review articles and research reports.

In terms of innovative communication and knowledge translation, CEGSS was very successful and implemented multimedia communication strategies as described in the previous section. In addition, CEGSS produced info-graphics to disseminate its findings to academics and policy makers. CEGSS also supported community organizations in some municipalities (12 in total) to implement an education campaign to community radios. Only those communities that were interested in pursuing a radio campaign implemented this campaign, hence it was not presented in all 20 municipalities. Tables 6 present the municipalities that implemented a radio campaign.

Table 6.Radio campaign right to health and citizens´ vigilance

Municipio	Departamento	Número de programas de radio o TV en el municipio
Cotzal	QUICHE	1
S. B. Jocotenango	QUICHE	1
Jocopilas	QUICHE	1
S. B. Aguas C.	TOTONICAPAN	1
San Cristobal T.	TOTONICAPAN	1
Santa Bárbara	HUEHUETENANGO	1
Soloma	HUEHUETENANGO	1
Tamahu	ALTA VERAPAZ	1
Fray Bartolome	ALTA VERAPAZ	1
Tinta	ALTA VERAPAZ	1
San Pablo	SOLOLA	1
San Marcos	SOLOLA	1
TOTAL		**12**

Source: Project´s information system

In addition to all the above, CEGSS developed a specific website (www.vigilanciaysalud.com) to a) disseminate all audiovisual evidence resulting from community monitoring b) accessing the SMS complaint platform and c) disseminating the project achievements, lessons learned and methods implemented.

V. Project Outputs

V.a 3 Infographics

Titles:

1) Public exhibits: Audiovisual Evidence of right to health violations

2) Audiovisual Evidence of Right to Health Violations

3) A community team for the editing and dissemination of audiovisual evidence

By: *Walter Flores and Julia Delgado*

Report Type: Infographic poster

Date: Published by: *July 2015, published by CEGSS*

Location: *Guatemala*

Number of Series part: N/A

IDRC Project Number: 106815-001**, IDRC Project Title:** Enhancing participation of indigenous people to address discrimination and equity in health systems Country/Region**:** *Guatemala*

Full Name of Research Institution: Center for the Study of Equity and Governance in Health Systems. **Address of Research Institution:** 11 calle 0-48 zona 10, edificio Diamond, oficina 504**.**

Name(s) of Researcher/Members of Research Team: Walter Flores**. *Contact Information of Researcher:** waltergflores@gmail.com

***This report is presented as received from project recipient(s). It has not been subjected to peer review or other review processes.**

Abstract: *Research outputs should include an abstract of 150-200 words specifying the issue under investigation, the methodology, major findings, and overall impact.*

Indigenous peoples in Latin America face several barriers in accessing quality health care. Geographic and language barriers as well as ethnic and racial discrimination are some of the mechanisms of social exclusion impeding their access to good care. These factors also make it difficult for indigenous peoples to participate in the public sphere to influence policies and practices in health facilities. Guatemala has implemented progressive social reforms recognizing the right to health and promoting participatory governance of health systems. Novel strategies are however required to facilitate the participation of indigenous peoples, and break through the dynamics of inequity and ethnic-racial discrimination.

This project aimed to strengthen the governance of the health system and enhance equity through active participation of indigenous communities. Teams of researchers shared their respective expertise to implement a rights-based intervention in rural Guatemala, and evaluate its impact on discriminatory treatment in health facilities. The intervention focused on empowering the community with tools and strategies to monitor public policies and healthcare services.

This info graphics summarized the participatory action research process

implemented through this project. The three info graphics describe the process to develop skills and knowledge to use audio-visual evidence to monitor public health care facilities and the specific team of community leaders who were trained to edit and disseminate this audio-visual evidence.

Keywords: participatory research, audiovisual evidence for human rights monitoring, right to health, indigenous populations, Guatemala.

V.b Poster describing the complaints platform

Title: ICT for the monitoring of right to health violations.

By: *Walter Flores and Luis Otzoy*

Report Type: final report product

Date: *July 2015, published by CEGSS*

Location: *Guatemala*

Number of Series part: N/A

IDRC Project Number: 106815-001**, IDRC Project Title:** Enhancing participation of indigenous people to address discrimination and equity in health systems Country/Region**:** *Guatemala*

Full Name of Research Institution: Center for the Study of Equity and Governance in Health Systems. **Address of Research Institution:** 11 calle 0-48 zona 10, edificio Diamond, oficina 504**.**

Name(s) of Researcher/Members of Research Team: Walter Flores**. *Contact Information of Researcher:** waltergflores@gmail.com

This report is presented as received from project recipient(s). It has not been subjected to peer review or other review processes.

Abstract: *Research outputs should include an abstract of 150-200 words*

specifying the issue under investigation, the methodology, major findings, and overall impact.

Indigenous peoples in Latin America face several barriers in accessing quality health care. Geographic and language barriers as well as ethnic and racial discrimination are some of the mechanisms of social exclusion impeding their access to good care. These factors also make it difficult for indigenous peoples to participate in the public sphere to influence policies and practices in health facilities. Guatemala has implemented progressive social reforms recognizing the right to health and promoting participatory governance of health systems. Novel strategies are however required to facilitate the participation of indigenous peoples, and break through the dynamics of inequity and ethnic-racial discrimination.

This project aimed to strengthen the governance of the health system and enhance equity through active participation of indigenous communities. Teams of researchers shared their respective expertise to implement a rights-based intervention in rural Guatemala, and evaluate its impact on discriminatory treatment in health facilities. The intervention focused on empowering the community with tools and strategies to monitor public policies and healthcare services.

This animated poster described the way in which CEGSS developed a platform to use ICT to monitor, together with communities, right to health violations in rural areas of Guatemala.

Keywords: participatory research, ICT for human rights monitoring, right to health, indigenous populations, Guatemala.

V.c Website (www.vigilanciaysalud.com)

Title: Sitio web de los Defensores (as) comunitarios del derecho a la salud

By: *CEGSS and Consejo de Comunidades de Guatemala por la Salud*

Report Type: e.g., *final product of project implementation*

Date: *May 2015, published by CEGSS*

Location: *Guatemala*

Number of Series part: N/A

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This website was specifically created to disseminate the audiovisual evidence of the health care services monitoring by community defenders. The site also includes short videso describing the achievements out of the vigilance work of citizens.

Keywords: participatory research, , right to health, indigenous populations, Guatemala.

V.d Informative Bulletin

Title: Boletín Informativo: Plataforma de Denuncias

By: *CEGSS and Consejo de Comunidades de Guatemala por la Salud*

Report Type: e.g., *final product of project implementation*

Date: *May 2015, published by CEGSS*

Location: *Guatemala*

Number of Series part: N/A

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Keywords: participatory research, , right to health, indigenous populations, Guatemala.

VI. Project Outcomes

Ethnographic data collected by the project revealed that by the end of September 2015 we had achieved the following

19 municipalities have active channels of engagement with citizens to discuss problems and implement solutions

10 municipal governments are allocating financial resources to improve local health services

In 12 municipalities, users perceive reduced discrimination and better responsiveness from providers

Achievements by the project continue to evolve even after the project concluded, hence CEGSS will implement detailed case studies in the first quarter of 2015 to document the achievements. In addition, community leaders produced their own short videos to document achievements in their municipalities. These videos are available at: http://vigilanciaysalud.com/logros/

VII. Overall Assessment and Recommendations

Based on the achievements collected through our ethnographic data and the amount of audiovisual materials, we can state that the project was successful. More importantly, the approach developed by CEGSS is attracting interest from other civil society organization in Guatemala and other countries of the region.

In terms of the impact evaluation implemented by GRADE, although we maintained good communication with the external impact evaluation team at GRADE, our perception is that an experimental design is not the best fit for interventions that are participatory and highly flexible.