Community of Practitioners on Accountability and Social Action in Health

COPASAH Communique

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Taking Stock of COPASAH

It is almost four years since the first meeting of practitioners was held in Johannesburg, South Africa.[1] Those of us present there realised that despite working in different geographical areas and very different contexts, we shared an explicit mandate to work with marginalised populations through principles of solidarity, human rights and social mobilisation.

Throughout these past four years, we have reinforced our shared principles and values that are being reflected in the Community of Practitioners on Accountability and Social Action in Health (COPASAH) regional training workshops. Also in the innovative processes and tools that we have implemented to share knowledge and skills among members (facilitated learning, cross-visits, mentorship) and the recently launched knowledge platform available within COPASAH's website. [2]

In addition, COPASAH has also expanded geographically as well as in the number of member organisations. We now have member organisations from the Balkans in Eastern Europe. Several organisations have expressed interest in setting a West Africa regional hub and in a recent visit to Indonesia several of us present there had the chance to meet up with colleagues interested in COPASAH.[3]

My feeling is that overall we are advancing well. However, based on our shared principles of solidarity and collective knowledge, I am convinced COPASAH still has so much more potential. In this, I agree with a recent analysis shared by Premdas through our listserve.[4] For the midterm, I would like to see stronger regional hubs innovating and implementing key learning processes. This also includes expanding and supporting new regional hubs. I also expect that within two year year's time, we would have accumulated sufficient learning and established innovative processes in place to have a global COPASAH meeting of practitioners. I encourage all of you, COPASAH members and friends, to continue our work and reach our collective goals.

Article by: Walter Flores, Global coordinator of COPASAH

Walter Flores is a Steering Committee member of COPASAH and also, Director of CEGSS, Guatemala.

To know more about the work done by CEGSS, please **CLICK HERE**

[1] http://www.copasah.net/practitioners-convening-at-johannesburg.html
[2] http://www.copasah.net/resources.html
[3] COPASAH and TALearn
[4] http://copasah.wordpress.com/2014/04/29/copasah-as-a-global-learning-community/

Empowering Girls Through Community Monitoring

Over 3000 adolescent girls mobilised into groups of *Kisori Samoohs* in Tarang project.

"It was a crisis situation when I first came to know that my parents were planning my marriage. I was not prepared for this yet and drawing courage from the discussions held in the Kishori Samooh (adolescent girls' group), I broached the topic with my mother. I told her that I wanted to complete my studies before getting married. Eventually my parents realised that marrying me this young would be harmful to my growth and development and decided to put off my marriage until I finished my education. I am a group leader (Sakhi) of Kishori Samooh (adolescent girls' group). We have discussions in our Kishori (adolescent) group on different issues like nutrition, education, gender discrimination, violence and child marriage. We also take steps aimed at eliminating these social evils."

In a conservative society like India and especially in rural Uttar Pradesh, early marriages are the norm. Girls are married as young as 13 years of age and child birth often follows within a year or two ending any dreams of education, vocational training and mobility. Burdened with responsibility of the household and child care at a tender age, these young girls often suffer from malnutrition and other health complications.

With the objective of empowering adolescent girls between 11 to 18 years by improving their nutritional and health status, upgradation of home-based skills, life and vocational skills the Ministry of Women and Child Development, Government of India introduced The Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG) –"SABLA". Through this scheme, it was visualised that adolescent girls would be equipped with information on health, family welfare, hygiene and guidance on existing public services through the scheme. The scheme also aims to mainstream girls who are school dropouts into formal or non-formal education.

Appreciating the comprehensive intent of the SABLA scheme, SAHAYOG, an NGO working on maternal health rights, planned to intervene in its implementation to contribute to its overall objectives of adolescent girls' empowerment. This was called the "TARANG project", in which SAHAYOG and its partners have mobilised 3071 adolescent girls in 100 Anganwadi-based groups called Kishori Samoohs across five districts in Uttar Pradesh and one in Uttarakhand. Each Kishori Samooh comprises a group of 15-25 adolescent girls who meet a few times each month.

Several capacity building trainings were organised to empower these girls on the issues of increased mobility, girl's education, improved nutrition, addressing the issue of violence, menstrual hygiene, gender and gender based discrimination, delaying age at marriage and first pregnancy, reproductive health and rights. These capacity building sessions have helped the girls to examine their situation and question the prevalent culture which gives more importance to education for boys and marriage for girls. Discussions in the Kishori Samoohs have helped some of the girls to start a process of negotiation with their families regarding their future. Kashibai, an adolescent girl from Digwar village, district Lalitpur in the state of UP was married at the age of 16 and six months later joined the Kishori Samooh of the Tarang project. Through the Samooh, she participated in discussions on the issue of nutrition, education, gender

तरंग परियोजना

(किशोरियों के स्वास्थ्य और अधिकारों के लिए एक साझी पहल)

चलो आओ देखें, कैसी मिल रही है किशोरी स्वास्थ्य सेवायें

समूह.................... ग्राम.................... ग्राम पंचायत.................... ब्लॉक....................

आंगनबाड़ी केन्द्र का नाम.................... जिला....................

सबला परियोजना के अन्तर्गत मिलने वाली सेवाएँ	त्रैमास.......... वर्ष..........			सुझाव व आगे के लिए कदम
	माह..........	माह..........	माह..........	
आयरन फोलिक एसिड की गोलियाँ मिल रही है कि नहीं।				
स्वास्थ्य जाँच, ऊँचाई, वजन, (बी.एम.आई.) माप की सुविधाएं मिल रही है या नहीं।				
पोषण, स्वास्थ्य, परिवार, कल्याण, बाल देखरेख पद्धति के बारे में जानकारी मिल रही है या नहीं।				
आंगनबाड़ी केन्द्रों पर समूह का संचालन सही से हो पा रहा है कि नहीं।				
खेल सामग्री, फ्लैश कार्ड, चार्ट आदि आंगनबाड़ी केन्द्र पर मिल रहा है कि नहीं।				
सार्वजनिक संस्थाओं (बैंक, डाक, थाना आदि) तक पहुँच हो पा रही है कि नहीं।				
आंगनबाड़ी कार्यकत्री, चिकित्सा अधिकारी, ए.एन.एम. आशा आदि किशोरी दिवस में पहुँच रहे हैं कि नहीं।				
किशोरी कार्ड भरवाया जा रहा है कि नहीं।				
क्या स्कूल से बाहर किशोरियों को पुनः नामांकन सखी सहेली और किशोरी समूह द्वारा कराया जा रहा है कि नहीं।				
11–14 वर्ष की ◆ किशोरियों को पोषाहार मिल पा रहा है कि नहीं। ◆ मिलता है तो क्या मिलता है।				
एन.एस.डी.पी. (राष्ट्रीय कौशल विकास कार्यक्रम) के अन्तर्गत व्यवसायिक प्रशिक्षण हेतु नामांकन की सुविधा उपलब्ध हो रही है कि नहीं (आयु 16–18 के बीच)				

सखी का हस्ताक्षर....................
सहेली का हस्ताक्षर 1....................
सहेली का हस्ताक्षर 2....................

संस्था प्रमुख का हस्ताक्षर....................
कार्यकर्ता का हस्ताक्षर....................
दिनांक....................

सम्पर्क परियोजना सचिवालय : ए–240, इन्दिरा नगर, लखनऊ–226016, (उ0प्र0) फोन :0522–2310747, 2310860 फैक्स : 0522–2341319
ईमेल – kritirc@sahayogindia.org वेबसाइट – www.sahayogindia.org

discrimination, violence, child marriage and its evil effects.

The discussions deeply disturbed her and she thought, “What should I do now as I am already married?” She discussed her dilemma with the members of the Kishori Samooh and the Tarang facilitator and decided that although she was already married she can delay cohabitation (called *gauna*) until she completes 18 year of age. She discussed this with her parents and they in turn convinced her in laws. Until she turned 18, she played an active role in group facilitation, campaigns and rallies.

In order to enhance participation of the adolescent girls in the implementation, monitoring and advocacy around the SABLA scheme, SAHAYOG developed a TARANG Monitoring Calendar. This calendar is designed with three columns for the months, to enable tracking the availability of 11 service components of the SABLA on a quarterly basis in their own Anganwadi. The monitoring calendar also provided a fourth column (titled “Suggestions and future actions”), which enabled the girls to analyse the findings and to devise action plans to advocate for the missing services. This community based monitoring by groups of 15-25 adolescent girls was done though a collective process in their Kishori Samooh meeting.

This process of monitoring and evaluation by the girls themselves has led to an increase in the confidence levels of girls who are now raising their voices in different platforms at village, block, district and state level. Take the example of the adolescent girl students of Government Inter College (GIC), village Mangoli located in Nainital district, in the northern state of Uttarakhand. The college has 324 students of which 165 are girls. Some of the girl students are also a part of the Kishori Samooh under Tarang project.

Adolescents writing a slogan on the wall during Kishori Jattha

During the Kishori meeting the issue of lack of toilet facilities and its impact on health and hygiene were discussed. The girls also discussed how the two toilets in college meant for them were always kept locked. This forced the girls to relieve themselves in nearby fields, which had an adverse impact on their health, especially during menstruation. The girls resolved to discuss the issue with the faculty and the principal after which the toilets are now being kept open, enabling the girls to use them.

These stories from the ground bring out the power of community monitoring by adolescent girls which is empowering them to challenge gender roles and the norms of a conservative patriarchal society. Although these are stories of small steps taken by girls in rural areas they have brought back a smile to their faces and have enabled them to break free from the bondages restraining the flight of their fantasy.

A specially designed Monitoring calendar helps in making action plans.

Article by : Ms. Y.K Sandhya

Ms Y.K. Sandhya is the Programme Manager for the women’s health and rights team, SAHAYOG, India. She oversees and assists the team and is also engaged in research. She also coordinates a national network called the National Alliance for Maternal Health and Human Rights (NAMHHR) that advocates for improved quality of maternal rights for the marginalised women in India. She was the recipient of the Indian Council of Social Science Research Doctoral Fellowship 2000 and the UGC – DSA scholarship awarded from 1994 - 1996.

To know more about the work done by SAHAYOG, please CLICK HERE

Sustained Community Vigilance For Accountability In Health Care

A core 10-member group of Dalit women in every village addresses injustice.

Background to Jagrutha Mahila Sanghatan (JMS)

The pocket of Hyderabad-Karnataka is a composite cultural unit of six districts in north Karnataka. It was under the rule of Nizam of Hyderabad for several years and was subsequently made part of the state of Karnataka under the reorganisation of states. Raichur district, bordering Andhra Pradesh and Maharashtra, forms part of the feudal history entrenched in caste discrimination, polarised land holdings and related social and economic inequalities linked to feudal agrarian communities. The movement triggered by the sense of alienation and backwardness has finally resulted in getting special constitutional status to this region under Article 371 of the Constitution of India. The painful experiences of constant discrimination and extreme forms of violence from within and outside their own community, both on the basis of being dalits and women gave rise to a process of collectivisation in 1999 in the district. This collectivisation aimed at addressing the gender and caste based violence resulted in the formation of Jagrutha Mahila Sanghatan (JMS) which also has become the symbol of the women's own empowerment to assert their rights and dignity. Struggle against injustice (sangharsh) and positive reconstruction (Navnirman) was the two-fold path employed by JMS in envisioning a just society for Dalit women.

The JMS women presenting memorandum and demanding improvement in Manvi sub-district (taluka)

The fight for dignity and well-being by Madiga (Dalit) women, their right to dignity in the backdrop of the extreme forms of discrimination experienced as Madigas (caste based) and as women (gender role based) included struggle for their basic rights and entitlements such as food-nutrition, water, health and medical care, education, participation in the local governance, wages, work etc. In a very hostile caste based society which is apathetic to their plight and unresponsive to their grievances, the sustained mobilisation and unrelenting struggle over the last 13 years has yielded results in making the service delivery systems accountable and responsive to them. JMS is active in 60 villages which are spread over adjoining Manvi and Sindhanur talukas of the district. They also form an important core group of the alliances of people's organisations in the district. The decade long sustained community vigil process which has become the part of everyday thinking and planning of the community are shared here.

How they function

In each village, ten member core group of women along with two leaders form a force and is recognised as Jagrutha Mahila Sangatan (JMS). This sensitised core group of women leaders formed through the process of community monitoring and leadership building, has been enabled to address the issues of injustice in the communities over a period of 12 years.

Vigilance groups in every village

The units of JMS in each Dalit hamlet of all the 60 villages hold weekly interaction with the village groups. This serves as an alert on issues of malfunctioning of Integrated Child Development Scheme (ICDS), Public Distribution System (PDS), gram sabhas (village meetings), health workers' visits etc. JMS has taken the lead and is an important constituent of the alliance of people's organisations at the district level which serves as the direct link between villages and the district.

What they do

The delivery systems of fundamental community entitlements such as ICDS, PDS (nutrition and food), schools (education and nutrition), health centres (health services), Mahatma Gandhi National Rural Employment Guarantee Act (MNREGA), food relief schemes (work and livelihood) and gram sabhas (decision making) are constantly monitored. The

[1] Madiga is the most discriminated ex-untouchable community known by different names in India – Arundatiyars, Maangs, Chambars etc generally associated with the jobs of tanning leather, scavenging. They are generally categorized socially as Dalits (which is not a constitutional term) and classified under Scheduled Castes (which does not stand for any socially specified caste – jati).

primary focus is on the entitlements of the Dalit communities as well as the community of the poor.

How they work

1. Continuous visits to public institutions in the village- ICDS centres, PDS shops, schools.
2. Activating the committees formed by the government such as PDS vigilance committee, Village Health and Sanitation Committees
3. Strategic use of right to information.
4. Use of technology: Since a number of people use cell phones among the labour community, it has been used as a tool to contact officials from the community itself
5. Intensive mobilisation during special occasions such as discussing community issues in gram sabhas and ensuring dalit community's participation in gram sabhas
6. Periodic issue based campaigns to revitalise energies in the communities. Issues taken up include right to food, right to health, violence against women, participation in gram sabhas etc.
7. Direct action by community and struggle against injustice and negligence (on issues of malnutrition, corruption and negligence in PHCs etc.)
8. Building up an environment of people's empowerment where bureaucrats are forced into dialogue and quick response. This is linked to direct action both at the local (village) level and district level
9. Documentation and network with the wider rights movement groups such as Jana Arogya Andolana, Karnataka (state chapter of the People's Health Movement), Right to Food Campaign, Dalit movement groups, Right to water campaign.

A Case Study

The MNREGA which offered 100 days of work to every rural household was implemented in the district of Raichur in its pilot phase in 2005 before it was legislated as a statute. Due to siphoning off resources, the communities could get on average only seven days of work till 2008 in the 15 gram panchayats of Manvi and Sindhanur talukas of the district, which by and large represent the reality of the entire district itself. Strategically, the community vigilance groups became instrumental in forming larger labour committees in each of the villages, which continued the engagement with the officers at the panchayat, taluka and zilla panchayat levels. The labour committees prepared the communities with the consciousness of labour rights and simultaneously struggled and continuously interacted with officials at various levels. The strategies of right to information, using cell-phones to contact officials from the field and photo and photo and voice documentation along with some militant struggles forced officials to do grievance redressal. This set in motion a process of monthly encounters at the taluka level between the labour committees and local officials. The process of continuous vigilance has resulted in achieving an average of 54 days per household and a number of households are actually realising their 100 days of work. The cycle of vigilance continues till the money is deposited in their bank accounts and restarts again with the application for further work. The vigilance did not restrict itself only to right to work. The vigilance groups intensified their pressure on ICDS centres, public schools, PDS shops and on health care, especially the care of expecting and nursing dalit women.

Outcomes

Fight for justice for the rights of Dalit communities and Dalit women is a constant struggle. The process of struggle for community entitlements has resulted in sustained community vigilance as well as fundamental sense of empowerment in the communities. The process has been sustained due to the emergence of different levels of leadership at different occasions. Though the first decade in the new millennium witnessed the decadence of public institutions and the rise of the private sector, the sustained community vigilance was able to retain a substantial leverage for dalit women and their space for negotiation to exercise their democratic rights. The recognition of JMS women as a monitoring body has been recognised by the administration and their presence in the public meetings changes the dynamics of the discussion. The power of information on health entitlements, the legislation (NREGA), the rules for the functioning of PDS – ICDS based on Supreme Court orders etc. has increased their bargaining power with the officials. The direct action and the constant follow up on irregular health staff, malfunctioning ICDS, quality of midday meals, unpaid wages under MNREGA etc has forced the officials themselves for a monthly dialogue. The leaders of JMS and other people's collectives are called for a monthly grievance redressal meeting at the taluka office, where the Executive Officer of the taluka panchayat summons the Panchayat Development Officer (PDO) of each of the 35 panchayats in the presence of women and is subjected to questioning. Similar, occasional meetings happen in the PHCs. Most of all, the response time by the administration to complaints, grievances and petitions has been shortened considerably. In 2002, filing of a FIR against molestation of dalit women took 3 months with a series of demonstrations before the police station. Now it gets done in an hour and the police appear on the spot on a phone call by any woman leader of JMS.

The JMS strategies of right to information, using mobiles to contact officials and photo documentations force officials into grievance redressal.

Hospital for maternal health services in Raichur district, Karnataka

Higher officials too are subjected to accountability in programme implementation.

Key Lessons Learnt

The challenges of systemic functioning still continue and it will require sustained energy to resist injustice meted out to the marginalised communities. Some key lessons, however, can be drawn from the decade long experiences of JMS for increased accountability and transparency in the community service delivery systems.

1. Continuous sustained vigilance: The process requires the elements of 'continuity' for sustaining pressure to alert the systems which are antipathic to marginalised communities.
2. Empowering the community: Building the process of empowerment of the community to do community monitoring is an element that is central to the process of continuity.
3. Conscientised key leaders in the community: A continuous hand-holding, discussion, capacity building of a core group around which communities are networked is very crucial. There is always an exit and entry of number of leaders at different occasions but a constant group assures continuity within the group itself.
4. Seeing beyond the project 'blinders': Community monitoring is a process which does not yield dramatic results overnight. As most of the support projects are short-visioned and short lived, it is very crucial to see beyond the project each time.
5. 'Be with the community': Responding to adverse situations: For larger community participation and real monitoring by the community, being with the community and solidarity especially during adverse situations plays a very positive element for sustainability of community monitoring.
6. Vigilance with critical support to the local implementers: Often people fight against the local representatives such as ICDS worker, ANM etc but let go of the higher level officials who are not visible but are important stakeholders in the chain of the malfunctioning of the system such as short supply of food and medicines etc. It is important to build solidarity with the front-line workers in the villages while subjecting them to constant monitoring. It is equally important to subject the higher officials to accountability in the implementation of the programmes.

Article by: E. Premdas Pinto, South Asia Region Coordinator, COPASAH

E. Premdas Pinto, co-initiator of the Jagrutha Mahila Sanghatan (Raichur, Karnataka – India) worked with JMS from 1999-2006. The Dalit Women's Collective is now led by local women leaders. From 2006 onwards, the author along with other friends continues to mentor the organisation.)

To know more about the work done by Jagrutha Mahila Sanghatan , please **CLICK HERE**.

Access to Healthcare Services for the Roma of Romania – Perceptions

According to data available in the European Union, life expectancy for the Roma is at least ten years less than that of the majority population. This data is in strict connection with their limited access to education and healthcare services. The lesser access to health care services by the Roma can be attributed to financial problem, availability of health care infrastructure as well as discrimination by the health care professionals toward the Roma ethnics.

Recent surveys conducted on the health conditions of the Roma population of Romania revealed issues of lack of information on the usefulness of inoculation, the reduced frequency of dentist appointments, inadequate nutrition, self-medication, difficult access to healthcare services because of the expenses that many Roma cannot afford and the low percentage of women who use prevention services for breast and cervix cancer. [1]

It is also highlighted that almost half of the Roma children have incomplete immunisation which they are supposed to get under the National Immunisation Program of Romania. 89.4% of the Roma females over the age of 15 years have never had any Pap smear for cervix cancer screening.[2]

The Institute of Public Policies (IPP) of Romania recently conducted an opinion poll to capture the clear picture of the access to health care services for both the Roma and the majority population. It highlights a series of aspects relevant for the current deficiencies and the priority sectors where the current situation can be improved.

Even though the initial premise of the research study was that the Roma population had a modest health condition and unequal access to healthcare services, over half of the Roma population who took part in the IPP poll carried out at the end of 2013 stated that they had a good and very good health condition (59%), whereas 24% said they had a poor and very poor health condition.

There are not any notable differences as compared to the majority population: 61% of the polled Romanians considered their health condition good and very good and only 9% considered it poor and very poor. However, these figures should also be interpreted in light of the low level of "literacy" of the Roma ethnic population in terms of the rights of the patient.

According to the IPP poll, 52% of the Roma ethnic did not have any healthcare insurance as compared to only 16% of the majority population. 15% of the Roma responded that the healthcare coverage they had was applicable to social cases only while for the majority, it is 4% only. The health insurance was paid by their employer for 55% of the majority population as against to only 18% for the Roma ethnic.

Even though the majority of the population (58%) stated that when they have a health problem they go to their family doctor first, number of Roma who go to their family doctor first was comparatively less (22%). 33% of the Roma people reported going to the emergency room first as compared to 12% of the majority population. The significant percentage of Roma who go to the emergency room is in direct connection with the high percentage of Roma who stated that they did not have any healthcare coverage and, therefore, could not register with a family doctor.

Another issue in health care of Romania is high percentage of self medication. Roma population lacks the knowledge and awareness and do not have access to the whole range of health care services in accordance to their need. The above mentioned report showed that 75% of Roma ethnics access pharmacists for medication as against 63% for general population, which is quite high in both the populations.

Life expectancy of the Roma is at least 10 years less than that of the majority population.

[1] Wamsiedel, M., Jitariu, C., Barbu, S., Cnab, T., Sănătate şi comunitatea romă. Analiză asupra situaţiei din România, (Health and the Roma community. A survey into the Romanian situation) Madrid,2009,http://www.romanicriss.org/Sanatatea%20si%20comunitatea% 20roma%20%20analiza%20a%20situatiei%20din%20Romania.pdf

[2] EVALUAREA PROGRAMELOR PENTRU COMUNITĂȚILE DE ROMI DIN ROMÂNIA, Agenţia Comunitară Împreună. (EVALUATION OF ROMA COMMUNITY PROGRAMS FOR ROMANIA, the Community Agency "TOGETHER"). The full version of the document can be accessed at: http://www.agentiaimpreuna.ro/files/publicatii/Evaluare_programe_romi.pdf

The local reality with the needs of vulnerable groups has been ignored in the National Health Strategy.

38% of the majority population and 26% of the Roma stated that they had been provided health-care services as outpatients (family doctor/ clinics). This shows the poor utilisation of preventive health care services by the population. When asked whether they felt excluded from accessing healthcare services, 78% of the Roma and 92% of the Romanians answered no; however, the high percentage must be also corroborated with the very low literacy level of the population with respect to healthcare education (for instance: pharmacists do not provide healthcare services).

The national health care strategy for 2014-2020 which is an essential document to increase the access of the vulnerable population to health care services was launched for public debate on 27th December 2013. The strategy sets out the main specific public policy directions, starting with the essential question "what do we want the Romanian healthcare system to look like in 2020," as the Minister of Health, Eugen Nicolăescu, stated at the launch of the document. When the National Strategy was drafted, the authorities declare that the starting point was the analysis of the relevant data concerning the demographic indicators, indicators related to the health condition of the population, the material, human and financial resources. Unfortunately the analysis did not take into consideration the information sent by the local authorities, which are the closest to the citizens and better know the local needs; consequently, the local reality was ignored. The needs of the vulnerable groups are very poorly reflected in this strategy – the only measure that is mentioned as specifically directed to the Roma communities is a potential intersectoral cooperation for a better health condition of the vulnerable groups, but the concrete indicators that are going to be followed-up/ monitored to discuss the quality of the healthcare act, the performance indicators and the indicators relating to an adequate response to the real healthcare needs are not specified.

Article by: Raluca Popovici and Elena Tudose

Ms. Raluca Popovici is Project Coordinator at the Institute for Public Policy (IPP) in Bucharest, Romania. She has a expertise in budget, health and parliamentary monitoring.
Ms. Elena Tudose is Program Director at the IPP. Her main fields of specialization are Qualitative and Quantitative Research Methods; Participatory democracy and Rights of vulnerable groups. Mrs. Tudose has coordinated more than 50 research and advocacy projects relevant to her areas of expertise at national/regional level.

To know more about the work done by Institute for Public Policy, please **CLICK HERE**.

An Insight Into The Lives of Domestic Workers (Housemaids) in Pakistan

Pakistan being a developing country has a large poor population due to which people grab any opportunity that guarantees money. The profession of domestic workers is one of them. Approximately 8.5 million informal domestic workers, including men, women and children, even under the age of 14 or above 60, work as personal maids and servants to the privileged class of our society to make both ends meet. However, the wages earned is not enough for their survival in this rapidly increasing inflation.

The majority of domestic workers in Pakistan, like other developing countries, are from rural areas. The nature of the job is decided by the consent of the hirer and the servant where it is made sure that the remuneration is less than the load of work to be done. Even the duration of work varies according to the need of assistance the hirer requires. Some of the workers work the whole day, while others are paid to work for few hours each day. Their usual pay scale is from 800 to 4000 rupees per month from which they have to cover their travelling expenses as well. However, some of the hirers provide pick and drop facility to their paid workers but that happens rarely.

Both the hirer and the workers have complaints against each other. Hirers usually complain against their workers for having light fingers; the house owners are often suspicions that their servants steal from them and also sometimes get involved in criminal activities as joining hands with the thieves under the table and assisting them in burglary and kidnapping for ransom. On the other side servants also complain that they don't have proper conveniences and are never trusted despite of how long they serve their hirers. They always face insulting and discriminatory behavior, and the salary as compared to their work load is always less. Moreover, they are made to work more than usual and not paid in case of working extra hours for a family gathering, party or other familial occasion.

If the problem is analysed from the perspective of both the parties, the need to establish a trusted and systematic network that ensures attending the concerns of both hirers and the paid servant, comes up. The need for government to intervene and establish such a system seems significant where the law makers' role stands vital. Currently there are no real penalties for exploiting their rights. Thus, there should be proper legislation for personal servants to protect their rights which must include their minimum wages under the wage ordinance of Pakistan 1961, working hours that must be between eight to ten hours a day, with a minimum of one day's rest per week, health allowance, maternity leaves, assurance of non-discriminatory behavior, dispute resolutions and provident funds in case of long term services. Admittedly, enforcement of working hour's legislation will be amongst the most difficult to monitor, however the government has to take a serious effort to resolve this issue.

Rokaiya is the bread earner for 8 family members

There are many other countries that have made proper laws and guidelines for housemaids and servants to reduce violence against domestic workers and accepted their rights like other labors as in Brazil.

Domestic workers are hired under a registered contract and have most of the rights as any other workers. In New York a government envoy has also unveiled plans to improve conditions

Currently, there are no real penalties for exploiting the rights of domestic workers.

SPARC reports 47 cases of violence from April 2010 to December 2013, with 16 children having died.

for domestic workers by regulating working hours, insisting on health care coverage and even allocating holiday time. In July 2011, the UN Convention also recognized domestic workers as workers with the same rights as other working class.

According to the Society for the Protection of the Rights of the Child (SPARC) 47 cases of violence against domestic workers from April 2010 to December 2013 have been filed, in 16 cases the child has died due to awful violence by the hirers. Moreover, there are many cases of sexual abuses of children and women by the hirers which often remain unreported due to socioeconomic and religious obstacles. According to a survey conducted by the Alliance against Sexual Harassment at Workplaces, in December 2007, 91% female domestic servants admitted that they face violence and exploitation of kind.

This part of our society is in dire need of attention for being completely deprived of their personal and professional rights. The constitution of Pakistan doesn't have any law that supports their concerns. Not even social activists pay any special attention in attending to their troubles and supporting their voice.

Further, the hirer should also inquire into the background of their workers before hiring them, such as checking their police record, carrying out a basic health test and also visiting or making calls to their old employers.

Civil society organizations and formal advocacy organisations need to bring government's attention towards establishing a complete legislation for their basic rights and to lobby for legal protection for domestic workers in Pakistan under the convention (No. 189) of the International Labor Organisation (ILO) which not only discourages violence against domestic workers but also protects their rights.

An 11 year old girl working as a housemaid which is a very common practice

Article by: Hina Shehzadi

Hina Shehzadi is a social activist, working since the past 5 years in various NGOs in Pakistan and is an active member of several right based organizations and networks. She is presently working with Shirkat Gah in Pakistan.

To know more about the work done by Shirkat Gah, please **CLICK HERE**.

Introduction to Community Based Monitoring and Social Accountability in Nepal

Beyond Beijing Committee (BBC) organised a half day introductory session on the basic concept of Community Monitoring and social accountability at Kathmandu, Nepal. Myself, Rakshya Paudyal, got an opportunity to be a part of the workshop, held in Mumbai, and second peer learning visit in Tumkur organised by COPASAH, and introduced the concept of Community Based Monitoring and Social Accountability in Nepal. The participants of the session were community based organisations from three different districts of Nepal along with some NGOs based in Kathmandu. There were altogether 19 participants as CBO and NGO representatives.

The objective of this session was to introduce to the community practitioners the concept of community monitoring and social accountability.

The session started with the introduction of community monitoring and social accountability in which the participants were asked about their knowledge on this aspect of community monitoring of health. The participants reported that the systematic process of monitoring in the field of health is not applied by any of them and even the concept of community monitoring is new to them. They said that the monitoring (with no systematic documentation) is carried out at the village level regarding utilisation of funds allocated for women. Thus the concept of community monitoring and social accountability was something different and interesting for them.

There were several important subjects that were discussed in the session:
- Essential features of community monitoring
- Why is it important in the context of Nepal
- The process of community monitoring
- Tools that can be used for community monitoring
- The impact of community monitoring, etc.

The participants were very interactive during the session and were delighted to be part of the discussions. They said that the concept was new and interesting yet challenging. The challenge have been mainly with regard to the political situation of the country.

Colour coded dustbins for waste disposal

After the presentations and discussions, there was a pictorial presentation of photographs taken in the Primary Health Center (PHC) at Kavadagalli in Tumkur, Karnataka, India that was visited during the second facilitated learning exchange visit. The presentation described how the community monitoring and advocacy done by the dalit community led to the transformation of the PHC and how the doctor in charge of the PHC could make a difference. The participants found this pictorial presentation very effective and found the work in the PHC exemplary. Some CBOs even took its picture so that they could show it as an example in their community. The picture, especially that of listing all the available medicines inside the PHC, was very catchy to the participants. They realised that they could start their advocacy even with a small change, which could be the listing of freely available medicines in the health facility. After a round of discussions, participants committed that they would start advocating for listing the medicines in the PHC of their community which BBC takes as one of the achievements of the session. The participants were impressed with the idea of community monitoring and they seemed very eager to apply that in their community.

Beyond Beijing Committee's session discussed tools for Community Monitoring and the impact it could make.

Article by: Rakshya Paudyal

Ms. Rakshya Paudyal is working as a Programme Officer in Beyond Beijing Committee (BBC), Nepal. BBC is an independent national network of organisations of leading women's rights and gender justice organisation persistently working to advance the status of woman. It was formed soon after the UN Fourth World Conference on Women, 1995.

To know more about the work done by BBC, please **CLICK HERE**

In conversation with Gulbaz Khan

"A PPP model in Lodhran, Pakistan produced such tremendous results that now it has been scaled up to all districts in Punjab"

Gulbaz Khan works on issues of accountability of health service delivery in Khyber Pakhtunkhwa in particular and Pakistan in general. Premdas and Gulbaz had extensive and detailed discussions on COPASAH and accountability in health when they met at the TA Learn annual workshop at Jakarta (Indonesia) during March 11 -15, 2014. The important excerpts of this conversation are below.

Would you share briefly about the accountability practitioners in health in Pakistan?
The community health management, monitoring, oversight and support has long been adopted with the advent of Private-Public Partnership in Lodhran, Punjab, Pakistan where a Basic Health Unit was contracted out (August 1999) to an NGO leading to increase in OPD, reduced doctor absenteeism, reduced operational expenses, reduced incidence of refusal cases, timely purchase and availability of medicines, enhanced citizen engagement through support group in daily affairs, and many more. This model was then picked up by the federal and provincial governments and adopted in selected districts while contracting out a section of basic health to selected NGOs. It produced tremendous results at grass root level and now the provincial governments tend to scale up (Punjab government has now awarded all BHU related services contract to a NGO) in all the districts.

What are accountability issues your organisation is involved with?
We are working in Khyber Pakhtunkhwa, conflict ridden area which is marred with multifarious problems including mismanagement, corruption, resource constraints, weak monitoring, gender inequality, vertical health management systems, weak data management etc. We work on two fronts, one is to support the provincial government to design, develop and implement pro-poor policies i.e. Supporting the health department in ongoing reforms agenda brought in by the Imran Khan led party, developing manuals, guidelines, resource books in a standard format for capacity development of provincial and district officials including at the facility level, help building M&E system, introduce social accountability including community driven management etc. and second is to create, revitalize and support local level structures enabling community engagement in health service delivery.

You have been interacting with COPASAH members in our communications. What do you think about COPASAH processes so far?
I think this is a wonderful experience to interact with COPASAH community members on areas of mutual interest. Though I am not an old member of this network, but I feel blessed that now I am engaged with wider community working on accountability in health sector. I have been receiving emails from members and also met a few in Jakarta TALearn community. However, we know that development practitioners do not believe in boundaries but it does matters on this globe and we all have to bear with this reality. I think we can have more discussions on Theory of Change, implementation practices, issue of context, political economy analysis, community engagement methods, what works well, if not, why?. We can have more exposure visits, webinars, case clinics, skype seminars, and many more.

We missed you at the South Asia Workshop in September 2013. However, do you think it is possible to build COPASAH forum in Pakistan?
Yes, I missed the opportunity but would like to get engaged with all future endeavours. Potential is immense in Pakistan to take forward COPASAH agenda and keep engaged with health practitioners and organisations who believe and practice community action in health. As I told that story is not new, so important, is how to tap this as INGOs, National NGOs, regional and local level organisations including CBOs are working strenuously in different dimensions of health.

Any thoughts and ideas on how we can take this forward ?
I believe that now COPASAH is growing exponentially and it is important to have focal person/ country facilitator in each country in South Asia with whom we can engage in regional steering committee meetings and country specific endeavours. More work is needed across the boundaries which we have to think innovatively to bring this forward and promote, propagate and practice community action in health sector. I think this is not a big deal, we jointly can do this.

COPASAH AND TALearn

Participants of TALearn workshop

The Transparency and Accountability Initiative (T/AI) hosted the second TALEARN Annual Workshop in Jakarta, Indonesia from March 11 to 15, 2014. The event was a space where donors, researchers and practitioners working on transparency and accountability (T/A) issues could gather to discuss key questions and challenges in the field. In addition, the workshop served as an invitation for participants to think about areas in which coordinated and/or collaborative actions, through the TALEARN community of practice, would allow those present to address some of the issues raised in ways that would not be possible for individuals.

The workshop was spread over 4 days and framed into roughly 3 phases. The first day and a half was devoted to raising questions and proposing ideas. This involved significant small group discussions, several panels, and a presentation from Twaweza, an East African organisation that has been very open about its own process of grappling with a set of questions and challenges around its work (including being highlighted in the blog of Oxfam's Duncan Green). Second half of the second day and entire third day opened a space for participants to consider what kinds of collective actions were being sparked by their engagement with the previously raised issues and with their fellow workshop participants. A number of themes emerged around which people clustered themselves, including:

- Improving Theories of Change
- Research and Evaluation Needs and Planning
- Social Movements and Accountability
- Organisational Learning
- Citizen Engagement, Transparency and Accountability Nexus
- Funder-Grantee Incentives that Enable and Constrain Learning

Each of these groups thought through a few actions they could take collectively that would add value to the work that they themselves and their organisations are doing, and which would address in more modest or ambitious ways, some of the challenges that participants had identified earlier in the workshop. Examples of actions proposed included organising virtual clinics to examine theories of change, webinars to address learning practices and incentives issues, and learning from cases of social movement activism around government accountability.

On the final day of the workshop, groups of participants visited several Jakarta-based organisations that had been involved in the event (FITRA, AJI and ICEL). These visits gave participants further opportunity to engage with local organisations and understand their context and approaches. Furthermore, it allowed local organisations to draw on the collective knowledge and experience of participants to get some new ideas on the challenges they face.

About 12 members and friends of COPASAH participated in the workshop and had interesting exchanges. A COPASAH meeting over lunch was held in which Cynthia (Director – AMHI- OSF, Walter Flores (Director CEGGS and Global Coordinator COPASAH), Premdas (COPASAH South Asia coordinator), Gulbaz Khan (COPASAH Pakistan) and friends from Indonesia, Philippines, OSF members from Bulgaria and Pakistan were present. The processes and stories of COPASAH were shared with them.

In the session on market place on accountability practices, COPASAH set up an information desk on the COPASAH knowledge products (issue papers, case-studies etc). The web-based tool produced for supporting practitioners on community monitoring in health, www.copasah.org was screened for the participants.

The 4-day workshop raised questions, proposed ideas and considered collective actions.

Article by: Walter Flores and Premdas

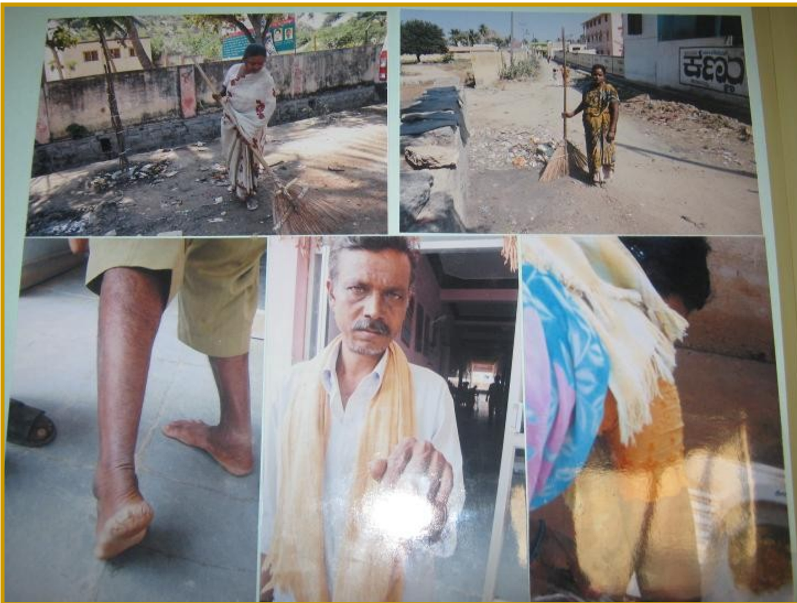
(Acknowledgment: Thanks to Brendan Holloran, TA Learn, for the inputs provided)
To get more information on the TALEARN workshop, please **CLICK HERE**.

Facilitated Learning Exchange Visit -2, Tumkur Karnataka, India

THAMATE has been working with manual scavengers for 20 years. Participants observed and learnt from the struggle they undertook.

The second facilitated learning exchange visit was hosted by THAMATE organisation in Tumkur a small town about 80 kms from Bangalore (Karnataka, India). Twenty two practitioners/ COPASAH members engaged in diverse accountability practices participated in this visit. The participants were from 8 states of India and one participant travelled all the way from Nepal to participate in this peer learning visit. The learning exchange visit focused on the accountability challenges in work with Dalit communities with rich discussions on history of Dalit struggle against oppression, the rise of Dalit movement, the issues the community confronted and the work on rights and dignity of Dalits. The host organisation, THAMATE works with Dalit communities with a special focus on the Dalits who are doing manual scavenging and still engaged as contract workers for sweeping streets, cleaning sewerage, and for cleaning dry latrines in towns and rural areas.

The visit gave the participants an insight into the circumstances and challenges face by this marginalised community and also helped them understand the efforts being undertaken to advocate for change in their lives and to ensure accountability of service providers and government for their welfare and dignity.



Photographs depicting the working conditions of manual scavengers (Source- Thamate, Tumkur)

DAY 1: Understanding the Context and Planning for Field Visit:

The three-day exposure visit was attended by practitioners from diverse accountability practices- rights and equity in the context of gender justice, working with men towards ensuring maternal health rights, human dignity and human rights of the marginalised, dalit communities and accountability challenge, ensuring accountability from government and society, community based monitoring of the health system, sexual minority, social exclusion, and role of men in children and adolescent health. The practitioners shared their experience and work with the marginalised communities, which was very enriching. This was followed by a discussion on the perspective related to the lives of dalit community and the importance of linking this perspective across different themes that the participants' are working on was highlighted. Advocacy work with the manual scavengers and dalit community started only recently and is particularly challenging, owing to the fact that this community has been oppressed for decades and this oppression has multiple layers- safai karmachari, manual scavengers, women's status, gender inequalities etc. THAMATE has been working with manual scavengers and dalits for over twenty years. The participants were asked to observe and learn from the struggle that the community has undertaken, the challenges that were faced around the issues of dalit community and the community monitoring initiatives that have been undertaken. The succeeding sessions discussed evolving COPASAH's perspectives on principles of social accountability, dalit communities and accountability challenge and monitoring development budget among SC/ST communities in Karnataka.

DAY 2 : Introduction to THAMATE's Work and Field Visit:

1. The second day began with an orientation to THAMATE's work and efforts to eradicate manual scavenging. The organisation has been part of the Dalit Movement for the liberation of Dalit communities from discrimination and untouchability. They identified the practice of manual scavenging as one of the darkest blot on the human dignity of Dalits. Thamate is working to empower, mobilise and organise the Madiga community which is primarily migrant in nature. The organisation works in 53 villages in 4 blocks- Madhugiri, Pavgada, Siri, Tumkur for eradication of manual scavenging, education of children, livelihood and

empowerment of youth. The community mobilisation is done at three levels-

1. For those over 60 years- social security and health schemes
2. Youth- motivation and skill development to take up alternative occupation through vocational training
3. Children (6-14 yrs)- compulsory education and ensuring that there are no dropouts by providing support through Bheemshalas.

The legislation in 1993 prohibited construction of dry latrines. It continues, however, in practice. The safai karmachari andolan (the movement of manual scavengers) have launched pitched campaign and struggle in the past years using all possible strategies which resulted in the Manual Scavenging Prohibition and Rehabilitation of Manual Scavengers Act 2013. THAMATE has been in the forefront of this struggle in the state of Karnataka.

Later the participants were divided in to three batches to meet the groups of manual scavengers at three different places- Y N Hoskote (125 kms), Pavagada (100 kms) and Madhugiri (50 kms). At these places interactions had been arranged with the mobilised community members and leaders from this community. The men and women from nearby villages and panchayats had gathered at these three centres. There have been several positive social changes in the community. Before THAMATE's work they were bonded labours in the municipality and the panchayat.

They were not paid regularly and were not respected. There has been a history of exploitation by the elected representatives. But a positive change has been that now they are sitting with the officers, putting forth their problems and discussing possible solutions.

DAY 3 : Debriefing, Discussions and Reflections on Learnings:

The third day of the exposure visit was marked with group discussions, presentations and sifting out learning from the accountability process.

The three groups formed for the community visits had discussion in their respective groups. The presentations by each group brought out rich learning experiences based on observation, discussion on the principles and analysing the lessons learnt. The challenges of accountability in the most marginalised communities of manual scavengers due to their poverty, caste related discrimination, caste related occupation of manual scavenging into which their life-circumstances have pushed them, non-recognition as workers even after 20-30 years of work as manual scavengers, challenges of women from this community

Interaction with children in Bheemshalas (coaching centers)

and the vulnerability of the community as a whole due to the caste, class, gender issues emerged as important challenges for the ongoing accountability processes. A discussion took place on the principles of community monitoring as part of the learning. It was explained that we have to look at accountability from the people's point of view, especially those who are socially deprived. Based on the experiences of visits and other citizen centric accountability practice, the principles of accountability process were discussed.

The common principles that emerged as part of the discussion and group presentation are the following:

Participation- through formation of groups, attending meetings, financial help for each other by savings in the cooperative, engagement with PRI

Empowerment- holding dialogues with authorities

Rights based- the community people have started recognising their rights and demand for protective equipments, health facilities, food, daily wages, provident fund etc

Capacity building- opportunities for learning, skill building training with the youth

Facts/ Evidence - collection through surveys, photo documentation, right to information, media sensitisation

Decentralisation- each year new men and women members are elected in the collective

Public official accountability- meeting and demanding provident fund from the district collector, official letter to panchayats for safety equipments

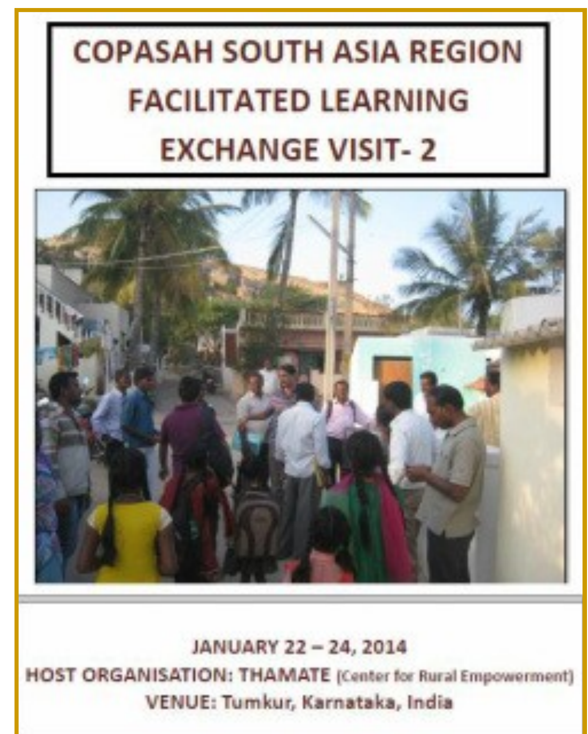
A discussion took place on the principles of community monitoring, that we have to look at accountability from the deprived people's perspective.

Participants said the visit was one of the most touching moments of their lives, providing insight into the dalit people's movements

The group got an understanding of the way advocacy has been carried and tide over the challenges faced by the marginalised communities. When certain development scheme is implemented under a policy it is very difficult to enforce accountability measures. However, when legislation is enacted, the responsibilities get fixed and consequences of inaction, adverse action are spelt out and this becomes very effective tool for accountability practitioners. The marginalised communities mostly become habituated to their living conditions and therefore it is necessary to build leadership among community people, ensure their participation at every stage, empowering them to ensure sustainability in the long run through capacity building, collection of facts and evidence (through surveys, right to information) and media sensitisation. Building and maintaining relations with public officials is equally important to ensure appropriate action and accountability.

CONCLUSION:

Participants from Nepal and about 8 states of India unanimously said it was one of the most touching experiences of their lives to learn about the struggle of this community. The three day visit was very thought provoking and provided lot of insights about the issues faced by the Dalit community. The whole of manual scavenging community, Devadasi system and the plight of the women suffering from this, Special Component Plan and its provisions, history of dalit struggle was an entirely different and new concept for the participants. The learning exchange visit showed the way how people's movements have taken place, how have been addressed, and the positive changes in the people's lives after that. Most of them indicated ways of incorporating the learning from this visit into the accountability work which each one is doing. The principles of accountability processes have been addressed, and the positive changes in the people's lives from the perspective of the marginalised communities were discussed in great detail during the visit. These are being evolved from the experiences of community monitoring of health systems in India. The hope, the determination to struggle, ability to cope with most adverse circumstances, a unanimous resolution to eradicate manual scavenging as an occupation of this community strongly indicated hope for the accountability process.



The detailed report of this visit

Article by: COPASAH Secretariat Team, India

To know more about the events oragnised by COPASAH, please **CLICK HERE**

COPASAH In The Health And Systems Research Symposium, Cape Town

The Third Global Symposium on Health Systems Research will build on the progress achieved by two previous, highly successful symposia held in Montreux (2010) and Beijing (2012). In line with the mission of the global health systems research society, the third global symposium will be organised in Cape Town, South Africa from 30th September to 4th October, 2014 on the theme 'Science and Practice of People-centred Health Systems'.

The specific objectives of the Third Global Symposium are to:

1. Share cutting-edge research addressing the development of people-centred health systems (including both conceptual work and the findings of primary and secondary research);
2. Identify and discuss approaches to research addressing this theme and to strengthening the rigour of this research;
3. Build the capacities of researchers, policy-makers, practitioners, activists and civil society organizations to conduct and use health systems research related to the theme;
4. Strengthen learning communities and knowledge-translation platforms working, to support people-centred health systems across disciplines, sectors and countries and, particularly, bridging practitioner, activist and researcher communities.

Number of members of COPASAH and the steering committee members in particular have sent in abstracts and have been accepted for oral presentations, poster presentations and for organised sessions.

1. Satellite Meeting on 29th September, 2014:

- ***Organisers:*** EQUINET, COPASAH and Rotterdam Global Health Initiative Erasmus University, for the participatory cluster in the SHaPeS TWG for Health Systems Global
- ***Title:*** New resources and opportunities for participatory research in health systems: Areas of focus for Health Systems Global
- ***Content:*** The satellite session will be convened by the three organisations leading the participatory cluster of the SHaPeS Technical working Group in HSR global. It will present and discuss with delegates interested in the cluster the issues, resources and capacities for the field and how these could

Third Global Symposium on Health Systems Research
Science and practice of people-centred health systems
Cape Town · 30 September – 3 October 2014

be developed through the TWG, and will make available work we have done to date, particularly through EQUINET and COPASAH. It will review the experience of using participatory action research (PAR), community monitoring and innovations in social media in transforming local health systems, the challenges faced and the areas for future participatory work in HSR. It will launch the EQUINET, AHPSR and IDRC methods reader on participatory action research and web tools from COPASAH. The session will identify field building inputs in terms of the resources, capacity building, methods and opportunities that need to be taken forward by the participatory cluster of the Shapes Technical working Group and the people who are interested in playing a role in the different areas of work.
- ***Speakers from COPASAH:*** Walter Flores and Abhijit Das

2. Organised Session

- ***Title:*** Building people-centred health systems through the social empowerment of marginalized populations: Moving from theory to practice
- ***Session type:*** Participatory session
- ***Field-building dimension:*** Original experience of learning communities and knowledge translation platforms engaged in strengthening health systems.
- ***Contributors:***
    - ◊ Chair: Edward Premdas Pinto
    - ◊ Contributor Africa: Geoffrey Oppio
    - ◊ Contributor Asia: Renu Khanna
    - ◊ Contributor Latin America: Walter Flores
    - ◊ Fish bowl moderator: Barbara Kaim

All the contributors above are members of the Community of Practice in Accountability and Social Action in Health (COPASAH) and also members of the participatory research cluster within the SHAPES group at Health Systems Global.

A satellite meeting to be organised at the symposium by COPASAH and others will review experiences and identify field building inputs

3. Presentations by COPASAH members at GSHSR (This list is not exhaustive and is based on the information provided upto 25 May 2014)

Name and Country	Type	Title	Other Forms of Participation
Abhijit Das, India	Oral	Community based monitoring improves informed choice and quality of care of family planning services	Speaker in satellite session
Edward Premdas Pinto, Abhijit Das, India	Poster	Open Learning Spirals : Pedagogical innovations for peer learning to facilitate knowledge translation and capacity building towards people oriented health systems in South Asia	Chair – COPASAH organised session
Renu Khana, India	Poster	Co-author with Sunanda Gunju	Speaker in organised session
Abhay Shukla, India	Oral	Communities reclaim the Health system, making services People-centred: Lessons from community monitoring and planning of Health services in Maharashtra, India	-
Barbara Kaim, Zimbabwe	Oral	Fish bowl moderator at the COPASAH organised session	Speaker in organised session and involved in post-GSHSR on Participatory Action Research
Ariel Frisancho, Peru	Oral	Inequities in health care for the indigenous and afro-descendant population in Latin America: Contributions of civil society organisations to assemble participatory governance in health care systems.	Speaker in another session at GSHSR
Geoffrey Opio, Kenya	Oral	Contributor from Africa	Speaker in the COPASAH organised session
Walter Flores, Guatemala	Oral	Exploring the governance of the Guatemalan health system: power relations affecting decision-making and its implications for equity	Speaker in satellite session and in the organised session
Jashodhara Dasgupta, India	Oral	Informed, organised and empowered: Poor rural women's negotiations for health and its social determinants in Uttar Pradesh, India	-
Idah Zulu-Lishandu, Zambia	Oral	Experience using photovoice in health system research transforming evidence and methods to share knowledge engage ,empower and act	-
MasumaMamdani, Tanzania	Oral	The Role of a 'Pay for Performance' (P4P) scheme in motivating health workers at different levels of the Primary Health Care (PHC) System in Tanzania	-
Y.K. Sandhya, India	Oral	Promoting Governance and accountability through active citizen participation: A case study of the Mera Swasthya Meri Aawaz project (MyHealth My Voice)	Sponsorship secured
Ameerkhan Kamalkhan and Rakhal Gaitonde, India	Poster	Community Action for Health - Community led evidence collection, planning and action to strengthen public health system	
Sunanda Ganju, Renu Khanna, Mahima Taparia, Neeta Hardikar, Pradeepa Dube, India.	Poster	Strengthening quality of Maternal health Care through Social Accountability mechanisms - Experiences from selected districts of Gujarat,India	
Elsbet Lodenstein, Marjolein Dieleman, Barend Gerretsen, Jacqueline E.W. Broerse, Netherlands	Oral	When and how does social accountability influence providers' and policymakers' responsiveness in health service delivery in developing countries?	
Sharanya Thanapathy, India	Poster	Perception of health system and community on a multi-faceted health system strengthening intervention in Dharmapuri, Tamilnadu	
Elsbet Lodenstein Marjolein Dieleman Barend Gerretsen Jacqueline E.W. Broerse, Netherlands	Poster	Inter-disciplinary research for people-centered health systems: How to overcome the challenges in practice?	
Anteneh Assefa, Ethiopia	Oral	Respectful and non-abusive care during childbirth in Addis Ababa, Ethiopia: A case from Saint Paul's Hospital Millennium Medical College (SPHMMC) and three Catchment Health Centers	

COPASAH Knowledge Products on Accountability in Health

Issue Papers

- Developing an Approach Towards Social Accountability of Private Health-care Services - Anant Phadke, Abhijit More, Abhay Shukla, Arun Gadre
- Ethical Issues in Community Based Monitoring of Health Programmes: Reflections from India - Renu Khanna
- How Do We Know We Are Making A Difference? Challenges Before the Practitioner of Community Monitoring Processes in Assessing Progress and Evaluating Impacts - Dr. Abhijit Das
- Who Are We To Care? Exploring The Relationship between Participation, Knowledge And Power in Health Systems - Barbara Kaim

Case Studies

- Citizen Monitoring to Promote the Right to Health Care and Accountability - Ariel Frisancho and Maria Luisa Vasquez
- Women in the Lead: Monitoring Health Services in Bangladesh-Sarita Barpanda, Samia Afrin, Abhijit Das
- Community Based Monitoring and Planning in Maharashtra, India-Abhay Shukla, Shelley Saha, Nitin Jadhav
- Claiming Entitlements: The Story of Women Leaders' Struggle for the Right to Health in Uttar Pradesh, India - Abhijit Das and Jashodhara Dasgupta
- Accountability and Social Action in Health - A Case Study on Solid Waste Management in Three Local Authority Areas of Zimbabwe - Training and Research Support Centre (TARSC)with Civic Forum on Housing (CFH)

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Open Society Foundation

Growing list of members of COPASAH

Africa—40

Europe—8

Latin America—3

South Asia—67

Individual members—74

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