Community of Practitioners on Accountability and Social Action in Health

COPASAH Communique

Issue 5, Oct- Dec 2013

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COPASAH as a Global Learning Community

It is about two years since the idea of a community of practitioners on accountability in health emerged from an enriching discussion in 2011 held in Johannesburg (South Africa). The collective thinking process on the need of building learning from practice led to measures such as enhancing capacities of practitioners in citizen centric. accountability framework, promoting peer learning and producing literature based on practice. The processes of practice based knowledge building and learning are inbuilt into COPASAH's vision to nurture, strengthen and promote collective knowledge towards promoting active citizenship to make health systems responsive, equitable and people-centred.

COPASAH has now started to reflect on the value addition of its own knowledge building and learning trajectory. The framework for assessing value creation in learning proposed by Etienne and Beverly Wenger-Trayner could offer some valuable insights into this.[1] This evaluative framework is well suited for analysing the value addition in any given learning process. It offers number of variables to look at the value addition to the learning process in its components and also to the process as a whole. Each of the proposed variables such as immediate value, potential value, applied value, realised value and transformative value, itself could be taken up for an in-depth analysis for the value addition while the entire framework could also be used for such an evaluation.

Learnings of COPASAH

Immediate value:

This refers to significant events, projects, enquiries that are being undertaken in the process of learning. The practitioner oriented capacity building workshops of COPASAH, facilitated learning exchanges, events of technical targeted assistance to accountability practice in health has been of great importance in all the three regions of South America, Eastern & South Africa and South Asia. The collective thinking, meetings and brainstorming across continents in formal and informal forums as a community of practice would stand COPASAH in good ranking as far as the immediate value is concerned.

Potential Value:

The mix of tangibles and intangibles such as documents, insights, relationships, energy generated, hopes and promises are conceptualised as potential value in learning. The issue papers and the case studies, the newsletters, the communication platform that has been instrumental in anchoring all the learnings, exchanges through listserv and more importantly the collective energy generated by building relationships has offered new insights and promoting the shared value of human rights based community monitoring. All these collectively would make an apt case for the potential value that they signify. The practice based literature and exchanges have offered the possibility of an alternative discourse to the dominant expert driven frameworks of accountability which do not prioritise the potency and agency of the community. One could say the energy created by COPASAH and the relationships forged are an indication to a great potential value that COPASAH holds.

[1] Wenger-Trayner, Etienne and Beverly, *Evaluation Framework,* available at http://wenger trayner.com/resources/publications/evaluation-framework/ (accessed: 21 March 2014)

Realisation of the dream of being a community of practice depends heavily on creative leaderships, ownership of the idea and local (regional) initiatives to nurture the process beyond stipulated and formulaic projects.

Applied Value:

The new practice, collaboration, different approach or any change that has occurred through the learning process is considered an applied value. The discourse on citizen /community centric and practitioner based accountability practice in health has emerged as the common voice through COPASAH discourse foregrounding the centrality of the community to lead the accountability practice and the capacity to bring about the social change. This is an important contribution to the countervailing discourse in the era of knowledge and digital divide. Collaborative actions such as providing technical support to each other across cultural contexts, putting together an abstract for Health System Research Symposium (Sept 30-Oct 4, 2014), applying the tools of capacity building and community monitoring in different contexts illustrate the growing solidarity.

Realised value:

As an idea which is evolving, it would be a hard task to pin-point on any one or two standalone improved performance indicators or outcomes of COPASAH from the lens of the realised value. One of the important outcomes is the global presence of the community of practitioners in health with its unique contribution of well-grounded practice across countries. Learnings from challenges and failures form the integral dimension of learning as a realised value. The realisation of being a global community of practice of a subaltern perspective itself is a great learning for COPASAH. The predominance of English in the medium of communication is certainly a great challenge to reach out and learn from communities of different ethno-linguistic settings especially in the non-English speaking areas such as the Americas. While the best evolved technology of the internet is not able to give us a meaningful translation, South Asia in general and India in particular offers a lived solution to overcoming such challenges. The digital divide presents another uphill barrier across cultural and political settings between accountability practitioners and academics (researchers) in terms of access and reach to knowledge making and learning processes. Realisation of the dream of being a community of practice depends heavily on creative leaderships, ownership of the idea and local (regional) initiatives to nurture the process beyond stipulated and formulaic projects.

Transformative value:

COPASAH's emerging identity as a unique space for foregrounding community - centric accountability practice in health, with the praxis of continued learning and social action with a cross-cultural solidarity could be identified as a transformative value in this learning cycle. The community of practice has been able to provide a framework for challenging the dominant techno-centric accountability practice with a more grounded experience of community monitoring - social action and learning praxis upholding the agency of the community for empowerment and change. Through this perspective COPASAH offers a more grounded and bottom up discourse on accountability that could have a transformative breakthrough within the tensions of seeing accountability either from the lens of empowerment and democracy or that of governance and corruption.

As a global learning community, many challenging questions are before COPASAH. It is time for COPASAH to look at its own strengths, challenges and opportunities. Has COPASAH fully exploited the potential of collective strength and solidarity? Have we been successful in reaching out to various practitioners in specific regions to embolden and to enrich the community of health accountability practice? What are the challenges before us and what lessons do we draw from what has not worked? What is the intensity of the collective energy and what are our strategies to sustain this in the future? These and such other critical questions might help us to make this global learning community stronger and much more vibrant .

Article by: E. Premdas Pinto

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

NGO Kham Delchevo: Community Monitoring and Accountability in Health (Eastern Macedonia)

Summary:
NGO Kham Delchevo has been instrumental in introducing community monitoring and accountability and transparency in the health sector in Eastern Macedonia. Kham has addressed problems with delivery of adequate health care at the local, regional, and national level. The primary focus of Kham's efforts has been childhood immunisations, but Kham has also fostered community initiatives and activism for rights of patients and universal access to health care.

Childhood Immunisations:
The Open Society Foundations (OSF) awarded NGO Kham Delchevo funding to implement a project that would increase the level of immunisations of Roma children in three communities in Eastern Macedonia: Delchevo, Village Crnik, and Vinica.

To attain success, it was important that these three communities get involved and fully support the project. For this reason, the project goals were presented and discussed with Roma leaders in the three communities. The primary goal of the project was to increase the level of immunisation of Roma children to the same level as that of the majority Macedonian population. The first phase was community mobilisation, which aimed at strengthening the community's knowledge about immunisations, and about their rights to free immunisations for their children.

Advocacy strategy for each of the three target communities was developed and plans were discussed with the community. Health care professionals, local government officials, and social services officials from the Centre for Social Affairs were also contacted. Local health care providers were particularly eager for the project to be a success in order to protect a greater percentage of the population against diseases. A coordinative body of all stakeholders- community, health care professionals, local government, and social services was created. For the very first time, members of the Roma community were put in a position where they could sit at the same table with representatives of the institutions, and where they could discuss their own problems and help make the decisions about how best to solve them.

Kham led community mapping activities in Delchevo, Village Crnik, and Vinica to identify the children who were at an age to receive immunisations, held meetings to mobilise the communities and provide information about immunisations and the rights of citizens to receive them. Health care professionals (medical doctors) spoke at these meetings to explain the importance of immunisations to protect children against diseases and also explained the low rate of possible reactions to immunisations in order to overcome parents' fears. Officials from the Ministry of Health also spoke to explain the rights of children to receive free immunisations.

As the next step, surveys were conducted in all three communities to ask residents if they were receiving the necessary immunisation services. A "Score Card" was created to identify barriers to immunisation. Health care professionals and members of the community accepted the validity of the score card. At the same time, a separate request for public information to the health centres in the three localities was sent. It asked questions pertaining to the budget spending for immunisation of Roma children according to the governmental program for active health protection for mothers and children.

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Doctor speaking with parents about immunisations


Inauguration of Crnik Health Centre

In Delchevo one of the major barriers to immunisation was the failure of Pediatrician health care workers to pay house calls in the Roma community. They should visit homes five times per year, but they were not doing so and in many cases they did not know the location of the children they were supposed to visit.

Working with all the stakeholders, the coordinative body in each locality created an action plan to overcome the barriers to immunisation. Three separate action plans for advocacy were identified because the circumstances causing barriers to immunisation were different in each community. Barriers were identified at both the local level and the national level.

In village Crnik, the biggest barrier was the 15 kilometer distance between Crnik and Pechevo, the closest location where children could be immunised. Transportation to get children to Pechevo is irregular and expensive. To overcome this barrier, community leaders and members of the coordinative body organised the community to submit a petition to the Director of the Pechevo Health Centre calling for immunisations to be provided in Crnik. Nearly all residents of the village at the time signed the petition, as a result of which the Health Centre and Local Self-Government Office agreed to establish a health centre in Crnik and provide health care professionals to administer immunisations in Crnik village itself. Other barriers were the anticipated retirement of the pediatrician and the possibility that Crnik would be without a pediatric doctor and lack of a car to guarantee transportation to Crnik for patronage nurses to provide regular health care. Working together, the coordinative body and the health centre successfully applied for specialisation for a pediatric. They also received support from the local government to submit an application for Crnik to be recognised as a rural health area and to have a regular Doctor every working day during the week. Other activities included construction of a playground in the village, and a program to improve access of the Roma community to job placement.

In Vinica one of the biggest barriers to immunisation is the movement of the Roma population for seasonal work in countries outside of Macedonia. Families may leave for long periods of time and the children will not be at their residence to receive immunisations. Additionally, through community mapping it was found that many of the homes in the Roma community in Vinica are not properly numbered or maybe not numbered at all, so health care workers cannot locate the houses with children needing immunisations.

In Delchevo one of the major barriers to immunisation was the failure of Pediatrician health care workers (Patronage services) to pay house calls in the Roma community. They should do home visit five times per year, but they were not doing so and in many cases they did not know the location of the children they were supposed to visit. Another problem is the lack of a car for visiting families. In addition, the community had a lack of Pediatricians after the retirement of the former one. As a result of advocacy work undertaken the health centre successfully applied for specialisation for a new pediatrician.

In village Crnik and Delchevo another barrier soon became apparent: lack of a car, driver, and benzene to transport health care workers so they could administer immunisations. The Coordinative bodies for these villages pressurised the Ministry of Health to provide transportation for health care professionals. (In Vinica transportation for health care workers has been adequately funded.) The Ministry of Health agreed to provide and transport health care workers but said that it needs additional funding from the Ministry of Finance to do so.

A media campaign was organised with Radio Zora, which broadcasts to all of Eastern Macedonia. This campaign described and explained the problems that Roma children experience in obtaining immunisations and was a very important tool in the advocacy process. Kham staff, health care professionals, and members of the Roma communities speak on weekly radio broadcasts. This puts a pressure on health centers to work to overcome barriers for regular immunisation because they are obligated by government programs to do so. It is hoped that these broadcasts will create pressure on the Ministry of Finance to provide adequate funding to the Ministry of Health to pay for the necessary health care personnel and

transportation expenses to enable the immunisation of Roma children as required by law.

Community outreach workshops in Delchevo, Crnik, and Vinica were also sponsored by Kham to provide information and promote the "Rights of the Patients" and a "Week of Immunization." Making citizens better informed about their rights, and about the responsibilities of government towards the citizens, will force the national government to adequately fund its part of the childhood immunisation program.

The initiatives taken up by the coordinative body have consequently led to two Roma members of coordinative body being selected to political parties, and now they are members of the current Council for the next four years. They can be important resources for lobbying and advocacy in solving problems and overcoming barriers in the field of immunisation, Rights of the Patients, and other priorities of the Roma community.

Through community outreach and information/ education campaigns, residents of all three communities assumed ownership of the immunisation project. In the next phases of the project, the communities themselves will be the leaders of the project. They have become informed and empowered and will be able to advocate for themselves to ensure that they receive the health care benefits to which they are entitled by law.

Other Successful Kham Advocacy Efforts in Health:

1. Successfully lobbied the Mayor of Pechevo to provide assistance to the most vulnerable Roma families with newborn children. The Mayor distributed baby hygienic kits to 10 families in Pechevo.
2. Provided information at public meetings that vaccinations and vaccination certificates for young adults (up to age 18) should be provided at no cost. This effort has resulted in a reduction of health care facilities charging for vaccinations that should be free.
3. Provided information to the public and advocated for transparency in the prices charged for preventative dental services. Prices charged are now aligned with the official pricelist for dental services, and the fair price has resulted in more people seeking preventive dental care, development of health care policies at the local level.
4. Mounted a successful initiative to have the Municipality of Delchevo set aside 200,000 MKD in the budget for health care and development of health care policies at the local level.

Meeting of Health Care Professionals and Community Leaders

Through community outreach and information/ education campaigns, residents of all three communities assumed ownership of the immunisation project.

Article by: Zoran Bikovski and Romina Kajtazova

Zoran Bikovski and Romina Kajtazova are working with NGO KHAM Delcevo.

To know more about the work done by NGO KHAM, Delcevo, please **CLICK HERE**

SARTHI's Experiences on Women's Health and Rights Advocacy Partnership (Gujarat, India)

The female genital organs are considered "dirty" and something to be ashamed of. In general women are not considered as sexual subjects. They are not asked about their desires or sexual wants and needs. Instead they are supposed to be passive recipients of the male sexuality.

Background:
Social Action for Rural and Tribal In-Habitants of India (SARTHI) was established in August 1980 as a branch of the Social Work and Research Centre (SWRC), Tilonia, Rajasthan. SARTHI was registered as an independent organisation in July 1985.

SARTHI is a grassroots NGO, with 33 years experience in rural development and is working in the tri-junction area of Gujarat, Rajasthan and Madhya Pradesh. Bheel Adivasi, the tribal pockets in these localities, are generally poor and underprivileged groups, having been neglected, made vulnerable and exploited by society for many years. The status and experiences of women are traditionally severe, and they are often totally suppressed in a male dominated society. SARTHI, apprehending the situation, developed an approach oriented around the needs-based services of health, natural resource management (NRM) and women's empowerment in about 300 villages of 14 talukas of Panchamahals, Baroda, Sabarkantha, Tapi and The Dangs of Gujarat and Dungarpur of Rajasthan.

Issues:
The heavy work burden of the women directly affects their health. In combination with a small intake of food - that is non-nutritious in character - the women are often in poor health condition. Yet discomforts and maladies are borne without fuss. This is partly due to the fact that the traditional health care system is modeled after men, and therefore it has failed to see the different experiences and health needs of the women. They are not used to talking about their bodies and their symptoms. There is also a lack of understanding in the society for the health problems of women. During pregnancy women usually perform all their daily chores till the time of labour, and they do not normally take any nutritious supplements in their diets. The fact that women are defined through their body and physique adds to the ignorance of women's health. In society their appearance and beauty is being judged, and the main purpose of their bodies is to work and bear children. Inability to live up to these expectations due to a weak physique, is not tolerated. This gives the women another reason for keeping quiet about their health problems. The gynecological problems are particularly concealed. The female genital organs are considered "dirty" and something to be ashamed of. In general women are not considered as sexual subjects. They are not asked about their desires or sexual wants and needs. Instead they are supposed to be passive recipients of the male sexuality. The lack of opportunities for young women to receive sex education and HIV information leads them to accumulate unverifiable myths, social norms. Only encourage "innocent" womenies, a woman who is sexually naive until marriage, does not seek pleasure from sex, one who would willingly and actively participate in sex only for the pleasure of her husband. The women have a lack of control over their own bodies and health, and little room to value and analyse their experiences.


Group discussion during the VHSC training

As per the baseline survey report, the following issues have been identified:

1. Thirty seven percent deliveries are conducted at home
2. Forty percent pregnant and lactating women could get the regular check up and treatment
3. Fourteen percentage Female Health Worker (FHW) found irregular
4. Fourteen percent Female Health Worker (FHW) post are vacant
5. Thirty eight percent women are not getting the benefit of Chiranjivi and Janani Suraksha schemes
6. Twenty five percent Sub Centres are completely damaged (not usable)
7. Seventy nine percent Anganwadi are not regular
8. No food as per menu in any Anganwadi
9. No quality of food in any Anganwadi

10. No activities have been conducted in any Anganwadi (as per government plan)
11. No use of untied fund in community which comes through VHSC
12. The members from community for VHSC are not aware about their membership, role, responsibility, and their rights and about the untied fund also etc
13. Eight percent Anganwadi are situated at out side the villages
14. Zero deliveries at PHC level

Strategies:

SARTHI's involvement: The aim was to know the situation of the government health schemes, specially about the Mother and Child Health Care schemes and how it can be improved with the people's participation. 38 villages from two Primary Health Centres (PHC) were selected and before the survey activity; the VHSC members were identified and sensitised about the issues and their role and responsibilities. They were also motivated to actively participate in the baseline survey. Following activities have been conducted by SARTHI:

1. Training and orientation for staff members
2. Baseline survey
3. Training to Village Health and Sanitation Committees (VHSCs)-: A two days training program for all the 119 VHSC members was conducted (38 person were presidents of VHSC, 18 women leaders from villages, 33 person from village panchayat, 30 women from self help groups) The training covered following topics:-
   - Mother's Health (technical knowledge)
   - Available Government Schemes
   - Health Right
   - Advocacy (on issues identified by baseline survey)
4. Village level Orientation program: All together 114 village level orientation program have been organised by SARTHI in 38 villages and about 800 people participated in these program. We highlighted the health issues of baseline survey and also about the right to health and advocacy.
5. Raising issues in Gram sabha: The trained VHSC members and other village leaders raised many issues about the health in their Gram Sabha and also forced to panchayat to make some resolution such as made a complaint against irregular of female health worker, fill up the vacant post of FHW, to improve the quality of food in Anganwadi, institutional deliveries at PHC level etc.

VHSC training at Ukhareli

Monitoring process:

The entire project staff of SARTHI meets twice at head office level in each month to have discussions on the progress of project work and problems faced during the field works. These meetings provide the space to share their experiences, review and reflections. The entire staff members present the activities report and process on implementation. These meetings help us to monitor the progress of program as well as to provide a platform to learn from each other's experiences. We also prepare project wise yearly plan of action with staff and do the follow up in these meetings on it. Apart from the monthly meetings, we also organised the special meetings and workshop with staff to have discussion about the organisation level issues and its working strategies. SARTHI also giving opportunities to staff for attend various meetings, workshops and seminars etc which are organised by other likeminded organisations, which help them to get more knowledge on the concern issues.

Outcome:

1. As result of awareness, first time 15 deliveries have been conducted at PHC level. (During the project period).
2. Two new buildings for Anganwadi have been constructed at the middle of village, the community take responsibility for site selection and monitor the quality of construction.
3. VHSC members made the complain to the CDPO about the bad quality of food in Anganwadi centre and as a result all the Anganwadi are now proving good quality of food
4. Due to regular visit to the Anganwadi by the VHSC members, the entire Anganwadi centres are more regular.
5. Due to people's intervention, the CDPO

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Training to VHSC at Chitwa PHC

Government do not have any follow up program after one year and the NGOs are having limitations to continue it. So, it is suggested that these types of program at least two to three years should be planned by government

become more active and regularly visiting the Anganwadi centres and taking care about the good quality of food.

6. Due to the efforts and pressure of the VHSCs, the irregular FHWs were transferred
7. All the vacant post of FHW has been filled by the efforts and pressure of VHSCs .
8. Proper use of untied fund by the involvement of VHSC in all the VHSCs .
9. The VHSC also used the Right To Information (RTI) for untied fund
10. and made a pressure on the medical officer for recovery of the items which was not available at village level.
11. Due to RTI by one VHSC, the medical officer and FHW frightened and recover all the items in all the villages which was purchased under untied fund.
12. Due to awareness among VHSCs, the beneficiaries of Mamta Day increased.
13. Due to awareness among the VHSCs, the untied fund is now operated as per the new guide line but in most of other places is still operated by school teacher and FHW is not as per guild line of government.
14. Earlier the untied fund was used in PHC and Sub centre level administrative expenses but now due to awareness, this fund is only used for community health related purpose such as village cleanness, soakage pit at community level, purchasing the vassal for cooking food at Anganwadi etc.

Challenges:

1. Traditional midwives (dai) are most important resource at village level but government's attitude towards Dai is not favourable
2. Lack of people's participation for proper implementation of government health schemes.
3. Lack of health awareness among the community
4. Buildings quality of Sub Centre and Anganwadi centre is very poor.
5. FHW is not using the building of sub centre (no willingness to use)
6. Lack of proper monitoring system (government willingness)

Lessons Learnt:

1. At present under the Village Health Sanitation and Nutrition (VHSNC) program, we trained the community and VHSNC member to take the social responsibility on health issue but government do not have any follow up program after one year and the NGOs are having limitations to continue it. So, it is suggested that these types of program at least two to three years should be planned by government which help community to more empower and aware.
2. The government Fund for each VHSNC is fixed at Rs. 10000 for all the villages (big or small) which is not reasonable because in big villages, this amount is very negligible
3. In any Government program from planning to implementation stage, government should involve the VHSNC or Village Development Committee (VDC) or community which creates the social responsibility among community.
4. Due to these types of activities, both the level (community and government) increased the understanding level like their limitations and capacity and it can find out the solution with jointly efforts

Article by: Dhan Singh Rathore

Mr. Dhan Singh Rathore is working in SARTHI as a coordinator since 1987.

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

Experience in Community Monitoring of Health Services in Tribal-Rural Areas of Vadodara District of Gujarat, India (Deepak Foundation)

Strengthening community involvement in improving public health services through village health and sanitation committees (VHSC) was envisaged way ahead in India in 2005 as an important component of National Rural Health Mission[1]. However, the operational plan of its implementation was not defined. Hence, several civil society organisations (CSO) developed innovative models for community monitoring of public health services.

Deepak Foundation, located in Vadodara, Gujarat state of India, is one such CSO that undertook the responsibility of forming VHSC and building capacity of its members in Vadodara district. The objectives were three-fold: i) to develop an operational manual for strengthening VHSCs, as part of a CSO network Jan Swasthya Abhiyan (JSA), based on experiences from diverse socio-cultural regions- tribal, rural and semi-rural areas of the district ii) to provide support system to Accredited Social Health Activist (ASHA) in behavior change communication and iii) to sustain the large-scale intervention public-private-partnership project "Safe Motherhood and Child Survival" with the Department of Health and Family Welfare, Government of Gujarat (2005-2011). The project aimed at reducing maternal and infant mortality in Vadodara district comprising 1.9 million population.

The Foundation was the first CSO in the State to undertake not only the strengthening of VHSC but also to federate them at primary health center level[2] (75), at the block level[3] (12), and at the district level over a period of five years (2006 -11). Community contribution was solicited for opening bank accounts of VHSC and undertake health-sanitation related activities. The cost of formation and federating VHSC was borne by the foundation. The annual untied fund (INR 10,000) was transferred by the government in the accounts of the VHSCs. Simultaneously, collective effort was made with members of JSA for policy formulation and advocacy to engage CSO in strengthening VHSCs.

Village representative sharing issues at Jan Sanvad

The key highlights of the Foundation's efforts

1. 1494 VHSCs were formed and strengthened in 1548 villages of the district
2. 75 PHCs , 12 Blocks and 1 district level federation were formed and activated
3. More than 2000 written applications submitted per year regarding health and development issues to the government departments through the VHSCs
4. Health and sanitation activities at village level were undertaken through utilisation of untied fund and community contributions (cash and

Community contribution was solicited for opening bank accounts of VHSC and undertake health-sanitation related activities. The cost of formation and federating VHSC was borne by the foundation.

[1] Training and enhancing the capacity of *Panchayati Raj* Institutions (PRIs) to own, control and manage public health services and development of health plan for each village through Village Health and Sanitation Committee (VHSC) of the *panchayat* are the core strategies of the National Rural Health Mission (2005-2012) of Government of India

[2] A primary health centre is established to provide public health services to 30-50,000 population.

[3] Block is the administrative division of the district

55 public dialogues facilitated with more than 500 participants in each to improve transparency and accountability of the government system

kind)

5. From community contribution Rs.65,000 was received and utilised for health-development activities
6. Coordinated activities with Integrated Child Development Services Scheme (ICDS) and Water and Sanitation Management Organisation (WASMO)
7. 55 public dialogues facilitated with more than 500 participants in each to improve transparency and accountability of the government system
8. Development of 1132 village health plans, amalgamated to form 75 PHC level health plans, 12 block level health plans and a decentralised district health plan were submitted to district health officials with budget.

The collective policy advocacy with JSA resulted in implementation of the community strengthening process in all districts of the State. The foundation continues to build the capacities of VHSC and PHC level committee members as a joint activity with the JSA supported by Government of Gujarat.

Article by: Smita Maniar

Ms. Smita Maniar works as Senior Health-Nutrition Research Coordinator at Deepak Foundation. She is involved in community empowerment and promoting Community Monitoring of Health Services in tribal and rural areas of Vadodara. Apart from documentation of the community monitoring processes and she advocates Community Health Action for improvement of maternal and child health.

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

South Asia Region: Facilitated Learning Exchange Visit to Mahila Swasthya Adhikar Manch (Women's Health Rights Campaign) in Uttar Pradesh, India

Background

The first learning exchange visit under COPASAH (Community of Practitioners on Accountability and Social Action in Health) in the South Asia region was organised from December 17-19, 2013 in district Chandauli, Naugarh block, Uttar Pradesh, India with Gramya Sansthan as the host organisation. Gramya Sansthan is a grass roots level organisation working in Chandauli, Sonbhadra and Varanasi districts of Uttar Pradesh on the issues of health rights of women, violence against women, child rights, labourers' rights, right to food and rights of marginalised tribals. The organisation is working to mobilise and support women in Naugarh block of Varanasi on the issue of maternal health rights through the community monitoring work of the 'Mahila Swasthya Adhikar Manch' (MSAM)[1]. The three days learning exchange visit organised in Varanasi was envisaged to achieve the following objectives: (i) to provide facilitated learning opportunity to practitioners within the region through visit to a COPASAH member organisation and learn from their social accountability practice; (ii) to learn about a variety of accountability initiatives being undertaken by civil society organisations.

The group included 15 participants from Delhi, Madhya Pradesh and Uttar Pradesh .

Day 1: Understanding the Context

On the first day of this convening, the participants from different organisations shared their work and experiences of community monitoring practice with each other. The introductory session taken up by Rakesh Sahu, Support for Advocacy and Training of Health Initiatives (SATHI) comprised of discussions on the participants' understanding of community monitoring and social accountability. There are different government schemes, but many times systemic problems are ignored and therefore, the structural inequalities remain unchange. This leads to rights violation, which demands community monitoring in order to ensure that services are available. Empowering people with knowledge is impertinent to bringing about changes in governance. Once the people have been mobilised, organised political action is possible, and government is forced to listen.

Accountability follows a bottoms-up direction. When the users of services are aware of their rights and entitlements, they can raise their voice against inadequate and inefficient services. Community monitoring and accountability are two sides of the same coin and help in ensuring adequate and quality availability of services. Through monitoring, a community collects data that provides a perspective for undertaking advocacy for improvement of services. Community based monitoring seeks to provide regular and systematic information about community needs, provide feedback on fulfillment of entitlements, functioning of various levels of public health system and service providers, and identify gaps and deficiencies in services. It is visualised as a process wherein feedback and reports from various levels lead to appropriate action and intervention aimed at improving the quality of service provisioning by the public health system.

Jagdish Lal, from Centre for Health and Social Justice (CHSJ) followed this with a discussion on values and principles that are inherent to any community monitoring process. These include answerability,

Community based monitoring seeks to provide regular and systematic information about community needs, provide feedback on fulfillment of entitlements, functioning of various levels of public health system and service providers, and identify gaps and deficiencies in services.

[1] The MSAM is an organisation of 12,000 poor rural women spread across 10 districts of Uttar Pradesh that is committed to advocacy and monitoring of women's rights to health. Since its formation in 2006, the MSAM has enabled rural women to recognize their own entitlements as 'rights holders'.

transparency, equity and equality, constitutionality, community-centered and shared leadership. It was high-lighted that this list is not exhaustive or complete and includes the key features. The group could relate to many of these in the work they were engaged in and shared experiences from their practices where these have been implemented. Emphasis was also put on the essentiality of the components of equity and equality to any community based process. There is now an emerging collaboration between civil society and local government which would hopefully help in the citizens' voice being heard.

The MSAM membership badge has given them recognition and is a symbol of power and strength for all the members.

Bindu Singh, the Secretary and Director of Gramya Sansthan gave a presentation on the history, work and organisational context of Gramya Sansthan followed by a presentation by Sadiya Siddiqui from SAHAYOG, Lucknow on MSAM. Sadiya explained the key objectives behind formation of the MSAM: (i) to establish the right of every woman to health; (ii) monitoring the quality of health services available locally; (iii) advocacy at the local, district and state level for improvement of maternal health services in Uttar Pradesh. The key issues addressed through the MSAM platform are right to maternal health services, food security and nutrition, employment, social security, and protection against domestic violence. Under MSAM, the women leaders from the community are mobilised to demand accountability for their rights. Committees are formed at village, block, district and state levels and the representatives are selected by the members of the alliance. The women members are continuously provided training on various health-related issues, such as Janani Suraksha Yojana (JSY), Janani Shishu Suraksha Karyakram (JSSK), untied fund, village health and nutrition day (VHND) and facilities that should be available at the sub-center. These women then monitor the quality and type of different health services and collect data for reporting. Advocacy on these issues is undertaken through dialogues with service providers, public hearings and discussions with state ministry officials. The alliance has been successful in mobilising women to identify violation of their rights, demand services they are entitled to, pursue advocacy initiatives and participate in government functioning.

Day II: Field visit and experience sharing by leaders and members of MSAM

The second day of the learning exchange visit focused on discussing and learning from the experiences of MSAM leaders. The participants' visited three villages- Karwaniya, Majhgai and Dumariya; and got an exposure to the functioning of the Mahila Swasthya Adhikar Manch (MSAM). These women are well aware of their rights and entitlements and voiced their opinions confidently. The members and leaders of MSAM shared their stories of struggle with the participants. The MSAM leaders related that reaching this far has not been easy. They have had to struggle a lot and faced a lot of apathy. At times the resistance from the people in authority was to the extent that their families too had to bear the consequences. But now the things have improved and the change that they are now witnessing is motivating them to take this process ahead. The MSAM membership badge has given them recognition and is a symbol of power and strength for all the members. The discussions provided an insight into the struggle that they had to go through and also their tremendous willpower in

facing the odds. A visit to the Anganwadi center revealed that even though the ANM and ASHA are serving the duties expected of them, there is a lack of infrastructure to support them. The ANM said that MSAM women have been closely working with them and this has helped them to reach out to a greater number of women and children. However, there is still a gap between the demand and availability of essential supplies and infrastructure from the state system. Towards the end of second day, all the participants of the learning exchange visit were taken to Nainvat village, where MSAM is not active. Group discussion with residents of this village revealed the apathetic condition of services. Conversation with the women who assembled for the discussion made the contrast even more evident. The women narrated that they have to pay money to get the services and were not even aware of the free healthcare facilities they were entitled to. During hospital visits, they have to purchase medicine from outside and pay money for ambulance services. Even a substantial percentage of the Janani Suraksha Yojana money that they were getting for institutional deliveries was being taken away by the service providers as informal payments. A few women also said that they had to borrow money to pay for the services because without it they are not given any attention. ANM and ASHA visit the village only once every month. During pregnancy none of the ANC checkups are done and services are limited to immunisation. This further emphasised the role civil society organisations can play in mobilising and supporting the communities.

organisations can play in mobilising and supporting the communities.

Day III: Debriefing, Discussions and Reflections on Learning

On the third day the participants discussed the field visit experiences and shared their observations, learning and future plans to implement the learning in their own practice. The participants identified community awareness, knowledge and understanding about rights, shared leadership and ownership as the key strengths. Women are challenging the traditional norms and implementing a methodology that is community centred and strong evidence based. Women advocating as a collective rather than individually has provided strength and receptivity to the demands being made. This has resulted in changes and improvement in the quality of services being offered. Everyone agreed that the MSAM model is sustainable and with technical support from local CSOs it can be continued for a long time. This was followed by a panel discussion with the MSAM leaders with Neetu Singh as the moderator. The women leaders said that if any services are denied to the village people, the leaders and members go up to the service providers and demand action. They also seek to make the service providers accountable for their duties. The women shared their stories of struggle and the resistance that they had to face from the authorities as well as their families. But now that things are improving and people are receiving the services they are entitled to, they feel that their struggle is rewarded. Gramya Sansthan's association has been instrumental in creating awareness, mobilisation and providing technical support. The women told that they want the next generation of leaders to take forward what has been achieved so far and are preparing them for taking this movement ahead.

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Article by: Dr. Bharti Prabhakar

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To know more about COPASAH, please **CLICK HERE**

People at the Center: Citizen Monitoring to Propel Rights-based Health Services and Social Accountability in Peruvian Andes

Still rural, indigenous pregnant women refuse going to health facilities due to the service provider's lack of knowledge/ respect for people's cultural beliefs and practices.

In countries like Peru significant economic advances have been made but they are still entrenched in unjust inequalities. Consequently, improving the health of people living in poverty and excluded from development opportunities will not be achieved by allocating additional financial resources or technical interventions alone. Substantial and sustainable change will only be achieved if poor people and their leaders or representatives have a much greater involvement in shaping policies, practices and programs and ensuring what is agreed actually happens[1].

In 1998, following the success of Peruvian Ministry of Health's School Insurance, the first public insurance system for the poor families was established. This was actually a reimbursement mechanism to cover the cost of health care of public school children. It also established the Maternal Health Insurance, a public reimbursement to eliminate the financial barrier to access (1998), and is now called Universal Health Insurance.

Still rural, indigenous pregnant women refuse going to health facilities due to the service provider's lack of knowledge/respect for people's cultural beliefs and practices. There are frequent episodes of women's dis-respect, abuse, underestimation of women's rights and under-the-table-payments.

Teaching hospitals and people's invisibility

Since 2009, CARE Peru's Participatory Voices Project has propelled a model for citizen monitoring of health services quality. Working with an actors-based approach, it comprises of rural, indigenous women leaders' empowerment processes and the principles of human rights frameworks taken into practice. In Puno region (Peru), nearly 150 quechua and aymara women community leaders were selected by their communities and provided capacity building to monitor women's health rights, particularly their right to good quality, and culturally-appropriate and respectful maternal health services. On the basis of their direct interaction with rural women, who use the services and individual as well as collective empowerment processes, women leaders demand information and changes in health services through dialogues with local and regional authorities. The initiative promotes accountability from the public authorities and providers.

After attending a series of capacity-building workshops, each citizen monitor (named "vigilante" in Spanish) receives accreditation and they plan their visits to health facilities. They visit health centers' officers and explain the monitoring mechanism to health providers. After building a common agreement on the priorities to monitor based on what rural, indigenous women expect to find at a health service, women leaders visit the health facilities three times a week. They make direct observations and hold conversations with female patients in their native language . On the basis of their findings, they produce regular reports and analyse them monthly with the regional Ombudsman's office, ForoSalud (a Peruvian civil society network in health) and CARE Peru members. They prioritise the findings, both the good and the bad, and construct a "dialogue agenda" which is presented to the health care networks/hospital directors and the

[1] Frisancho, A., Goulden, J. (2008) Rights-based approaches to improve people's health in Peru . In The Lancet, Vol. 372, December 13th, 2008. Published Online December 10, 2008. DOI:10.1016/S0140-6736(08)61785-7

to agree commitments of improvement. Other important results obtained by this initiative are:

- Identification of practices that were deterring women from utilising services, such as unavailability of services at times of day most needed and charging for medicines and services that were meant to be free
- Space for a sustained, systematic dialogue on what women expect from the health care system and the achievements and pitfalls of health care delivery
- Commitments to improve health care (accesibility, quality treatment, information, language, culture appropriateness)
- Empowerment of women, community leaders
- Medical practitioners and health authorities become more accountable to people's needs
- Improvement in obstetric care, child care
- Increased demand of maternal health services and institutional delivery
- Increased general awareness of rights among health authorities and within patients and local communities

Advocacy and technical assistance:

Peruvian MoH has taken into account the design of the current Health Sector Reform Policy. Steps are being taken for promotion of social surveillance of its implementation and development, as well as promotion of citizen surveillance through National Health Quality Guidelines included under the 12th National Health Quality Policy.

Lessons learned

- Key partnership and alliances with public and private actors are important to increase women's agency and to address unequal power relations
- International human rights framework/ principles can be used at a local level in an effort to strengthen the quality of attention given in health service delivery

- Accountability based on dialogue and governance strengthening, not "name and shame" help build mutual understanding, confidence and credibility
- Poor quality and performance standards
- Weak local management of health services
- Discrimination (both individual and political)
- Medical schizophrenia/ High officers turn-over, lack of supplies, poor salaries, lack of a career path
- Lack of Accountability culture
- Unjust power relations

Conclusion

CARE Peru's initiative in alliance with Ombudsman office and civil society networks, has contributed with greater transparency, respect, cultural sensitivity in service delivery and increased demand of health services by rural women and children[2]. It has also contributed to the formulation of National Policies of citizen monitoring promotion. Citizen monitoring at Puno has been selected by United Nations amongst eight case studies on social accountability promotion and has been highlighted by the World Bank among successful examples of social accountability.[3, 4]

Accountability based on dialogue and governance strengthening, not "name and shame" help build mutual understanding, confidence and credibility

Article by: Ariel Frisancho Arroyo

Ariel Frisancho Arroyo is a medical doctor with a MSc on Health Policy, Planning and Financing at LSE/LSHTM. He is also national manager of Social Rights Programs of CARE Peru; member of Peruvian ForoSalud Directorate. He is also member of the Steering Committee of both COPASAH and IIMMHR (International Initiative on Maternal Mortality and Human Rights).

To know more about CARE, please **CLICK HERE**

[2] Frisancho, A. (2013) Citizen monitoring to promote the right to healthcare and accountability . In Maternal Mortality, Human Rights and Accountability (Hunt, P., Gray, T., edits). Routledge, pps. 13-30

[3] UN iERG (2012) Every Woman, Every Child: from commitments to action. The First Report of the independent Expert Review Group (iERG) on Information and Accountability for Women's and Children's Health. Pp. 27. http://www.who.int/woman_child_accountability/ierg/reports/2012/IERG_report_low_resolution.pdf

[4] World Bank (2013) Investing in Reproductive Health: Closing the Deadly Gap between what we know and what we do, p. 21.

Resource Pack for Community Monitoring

This Toolkit is available online in beta version. It is going to be updated and revised soon. The available resources can be used for community monitoring.

This Toolkit is available online in beta version. It is going to be updated and revised soon. The available resources can be used for community monitoring. *Please send us any relevant material that you have on community monitoring*

Abstract for the Third Global Symposium on Health Systems Research

COPASAH's abstract for the Third Global Symposium on Health Systems Research

COPASAH Steering Committee members have submitted an abstract for the "Third Global Symposium on Health Systems Research" to be held in Cape town, South Africa from September 30 - October 3, 2014. The title is *"Building people-centred health systems through the social empowerment of marginalized populations: Moving from theory to practice"*. It has been accepted for the Symposium.

Growing list of members of COPASAH—Organisational

Africa - 39 Members

Action Group for Health, Human Rights and HIV/AIDs (AGHA) Uganda
Aidspan
Africa Youth Leadership Development and Health (AYLDH) Initiative
Anti Corruption Coalition Uganda (ACCU)
Budget and Expenditure Monitoring Forum
Centre for Economic Governance and AIDS in Africa- CEGAA
Civil Society Legislative Advocacy Centre
Community and Family Aid Foundation
Community Working Group on Health- CWGH
Daraja Development
DBL- Centre for Health Research and Development
Friends of Christ Revival Ministries (FOC-REV)
Grey to Green Earth Organization (GGEO)
Health Promotion Tanzania (HDT)
Health Rights Advocacy Forum
Initiative for Social and Economic Rights (ISER)
Jesus Cares Ministries
KAPLET
Management Systems and Economic Consultants Ltd
Masculinity Institute - MAIN
Media and Training Centre for Health
National Taxpayers Association
Naretu Girls and Women Empowerment Program
Lusaka District Health Management Team - LDHMT
RAIN- Uganda
Reach the Youth Uganda
Shelter and Settlements Alternatives: Uganda Human Settlements Network (SSA:UHSNET)
Tonata PLWHA Network
Training and Research Support Centre- TARSC
The Institute of Social Accountability- TISA
Treatment Action Campaign- TAC
Uganda Debt Network
Uganda National Health Users/ Consumers Organization
Uganda Network on Law, Ethics and HIV/AIDS (UGANET)
Uganda National Association of Community and Occupational Health (UNACOH)
Volnteer Youth League
Young Women's Knowledge and Leadership Institute Burundi (YOWLI Burundi)
Zimbabwe Association of Doctors for Human Rights
Zimbabwe National Network of PLHIV

Europe - 8 Members

Association for Emancipation, Solidarity and Equality of women in Macedonia -ESE
Center Amalipe
Foundation Open Society – Macedonia (FOSM)
Health Education and Research Association - HERA
Healthy Options Project Skopje - HOPS
Immpact, University of Aberdeen
KHAM Delcevo
SHARP Project, Royal Tropical Institute

Latin America - 3 Members

Centro de Estudios para la Equidad y Gobernanza en los Sistemas de Salud- CEGSS
Foro Salud- Foro de la Sociedad Civil en Salud
Universidade Federal do Rio Grande do Sul

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Agrotech Development & Research Trust
Amhi Amachya Arogyasathi
Aneka
Baba Ramkaran Das Gramin Vikas Samiti
Beyond Beijing Committee
BREAD - Bureau of Rural Economical & Agricultural Development
Brij Jan Jagaran Samiti
Centre for Health and Social Justice
CHEER - Centre for Health Education & Entrepreneurship Reform
Child in Need Institute- CINI
Citizen Engagement for Social Service Delivery
Community Network for Empowerment -CoNE
Deepak Foundation
Dharti Gramotthan Evam Shabhagi Gramin Vikas Samiti
Gram Sudhar Samiti
Grameen Vikas Sansthan
Gramin Punarnirman Sansthan
Holistic Action Research and Development
Human Rights Council
ICDDR,B
International Center for Research for Women (ICRW)
Jan Lok Kalyan Parishad
Jatan Sansthan
Jawahar Jyoti Bal Vikas Kendra
Jeevan Jyoti Jan Kalyan Kendra
Kashtakari Sanghatana
Krishi Gram Vikas Kendra
Public Affairs Foundation
Maa Durga Rural Women's Udyog
Mahammed Bazar Backward Classes Development Society
Manavok
Manjari
Marathwada Gramin Vikas Sanstha
Naripokkho
National Integrated Development Association (NIDA)
Nav Bharathi Nirmana Sangham
Neharu Yuva Samajik Samarasata Sewa Samiti
SAHAJ- Society for Health Alternatives
Sahara Aids Control Society
SAHAYOG
SAHAYOG, Odisha
Samagra Vikas Samiti
Sangini
Sankalp Sanskritik Samiti
SARTHI
SATHI- Support for Training and Advocacy to Health Initiatives
Satyakam Jankalyan Samiti
Shaheen Women's Resource & Welfare Association
Sharda Sewa Sansthan
Shikhar Prashikshan Sansthan
Shikshit Rojgar Kendra Prabandhak Samiti
Shirkat Gah - Women's Resource Centre
Sisu Vikas Samiti
Social Empowerment Welfare Association
Society for Community Health Awareness Research and Action- SOCHARA
Sri Sachchidanand Sikshan Sansthan
Synergy Sansthan
Tarun Chetna Sansthan
The YP Foundation
Tribhuvandas Foundation
VARUN
Village Health Committee - Sahiyya Resource Centre

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Tsegaye Tewelde
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Deepa Jha
Hina Shehzadi
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Juned Kamal
Kerry Scott
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Ramesh Kumar
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Shahidul Hoque
Shirkat Gah
Sohail Amir Ali Bawani
Soumya Kanta Mishra
Sunita Singh
T. Sharanya
Tahera Ahmad
Tarun Kumar

Others - 5 Members

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Deyan Kolev (Eastern Europe)
Dr. Roy Tjiong (Indonesia)
Nguyen Nhat Anh (Vietnam)
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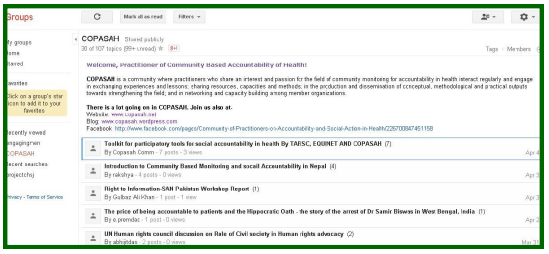

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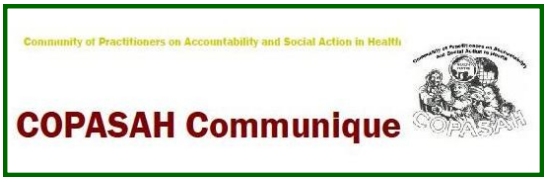

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