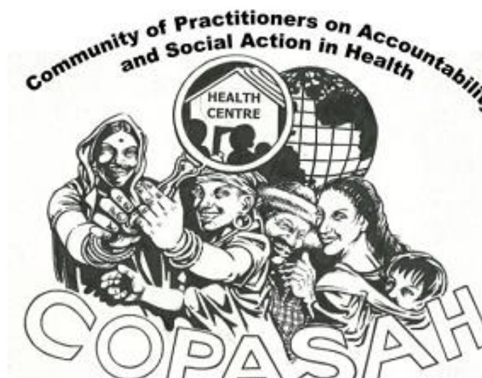
COPASAH SOUTH ASIA EXCHANGE AND STRENGTHENING MEET

ON

SOCIAL ACCOUNTABILITY IN HEALTH IN THE SOUTH ASIA REGION

DECEMBER 4-6, 2016; KATHMANDU, NEPAL



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The report though is not an exhaustive one but attempts to surmise the learnings and discussions from the meet

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INTRODUCTION

COPASAH - Community of Practitioners on Accountability and Social Action in Health - is a global community of practitioners who share a people –centric vision and human rights based approach to health, health care and human dignity (www.copasah.net). COPASAH'S mission is to nurture, strengthen and promote collective knowledge, skills and capacity of community-oriented organisations and health activists primarily in the regional nodes of South Asia, Latin America, East Southern Africa and Central Europe working in the field of accountability and social action in health, for promoting active citizenship to make health systems responsive, equitable and people-centred.

CONTEXT FOR THE MEET AND STRENGTHENING SOCIAL ACCOUNTABILITY IN SOUTH ASIA

In the COPASAH South Asia regional node of practice, synergy has been enhanced through different interactions in form of workshops, Facilitated learning exchange visits and through virtual communication on the communication platforms and the COPASAH Communiqué (newsletter).At country level this has deepened but there are very few opportunities for collective deliberations on the social accountability in the region in form of face to face meetings. With a view to understanding various approaches and experiences from a range of health rights organizations and health rights activists in different countries of South Asia (India, Pakistan, Nepal and Bangladesh), COPASAH South Asia envisaged a platform for discussion to contribute to strengthening the field of accountability in health in South Asia and to deepen and expand the regional base further of COPASAH through medium of a COPASAH South Asia strengthening meeting. The objectives of the meet were:

OBJECTIVES:

- To understand the eco-system of social accountability in health in the South Asian Countries
- To facilitate mutual sharing of experiences and learning from each other
- To strengthen South Asian solidarity to promote people oriented social accountability perspectives and perspectives.
- Explore opportunities for knowledge production from accountability practice in the region and its exchange in form of webinars, case studies and other mediums

SESSIONS OF THE MEET

COPASAH South Asia Exchange and Strengthening Meet, was convened in Kathmandu, Nepal from Dec 4 to 6, 2016 on a very participatory note. The meet saw significant participation from countries of Srilanka, Bangladesh, Pakistan and Nepal. The meet was facilitated by COPASAH Steering Committee (SC) member Renu Khanna, with co-facilitation support from COPASAH South Asia SC member Gulbaz Ali Khan.

DECEMBER 5, 2016 SESSIONS

SESSION I: MUTUAL INTRODUCTIONS, CONTEXT OF THE MEET AND COMMON EXPECTATIONS FROM THE MEET

Representing the COPASAH South Asia practice node Surekha Dhaleta set out the tone for the South Asia meet. Through a participatory methodology COPASAH SC member Renu Khanna steered the mutual introductions, wherein the participants shared the context of their work and affiliated organizations. Representing Srilanka Dr. Harishchandra Yakandawala and Asitha Punchihewa from Family Planning Association (FPA) of Srilanka; Tharindu Gunathilaka and Sanath Mahawtihanage from the Sarvodaya Sharmadana Movement of Srilanka, elucidated that Sarvodaya is the biggest Non-Government Organisation in Srilanka and the organisations including FPA and Sarvodaya have been instrumental along with other stakeholders in proposing Health as a Right and Srilanka may soon recognize health as a Right in its Constitution.

Participants introducing themselves

Representing Pakistan, Kanwal Iqbal from Community Uplift Programme (CUP) and Gulbaz Ali Khan from Centre for Inclusive Governance (CIG) highlighted that CUP has been amongst the forerunners in carrying out social accountability in Pakistan and both the organizations have experimented with use of community score cards in family planning, citizen report cards in the Khyber Pakhtunkhwa region of the country as well have had experience of experimenting with other strategies like that of budget tracking, Right to Information, Right to Public Services and developing manuals, guidelines etc. for health services providers also. Amongst the Nepal representatives, Narayan Adhikari from the Accountability Lab outlined that the organization is working towards accountability, health and migration in Nepal and is geared towards using Information Communication Technologies (ICTs) extensively with youth in Nepal. Post the April, 2015 earthquake in the country, the Accountability lab has set up citizen help desks to bridge gaps with local people on the ground and the organization has bolstered campaigns such as the Integrity Idol since 2014 to debate around the idea of integrity and demonstrate the importance of honesty and personal responsibility. Kedar Khadka from GoGo foundation in Nepal elaborated that GoGo foundation has been instrumental in conducting public hearings from village, district up to central level, and in developing social audit accountability tools which have been adopted by Ministry of Health education and other sectors also. Two participants from Nepal, Rakshya Paudyal from Beyond Beijing Committee (BBC) in Nepal pointed out the

BBC and Kapil Kafle, coordinator Men Engage Alliance South Asia joined the meet later in the day. Representing Bangladesh, Rowshan Ara and Maksuda Khatun from Naripokkho outlined that the organization is women's activist organisation working for the advancement of women’s rights and entitlements and building resistance against violence, discrimination and injustice. They delineated that Naripokkho was found in 1983 and since then has been involved in numerous activities related to Violence Against Women (VAW) in Bangladesh, which include campaigns, cultural events, training, research, lobbying and advocacy. It has also vast experience in monitoring government health care facilities and in increasing accountability of service providers amongst the key components of work on monitoring, they added.

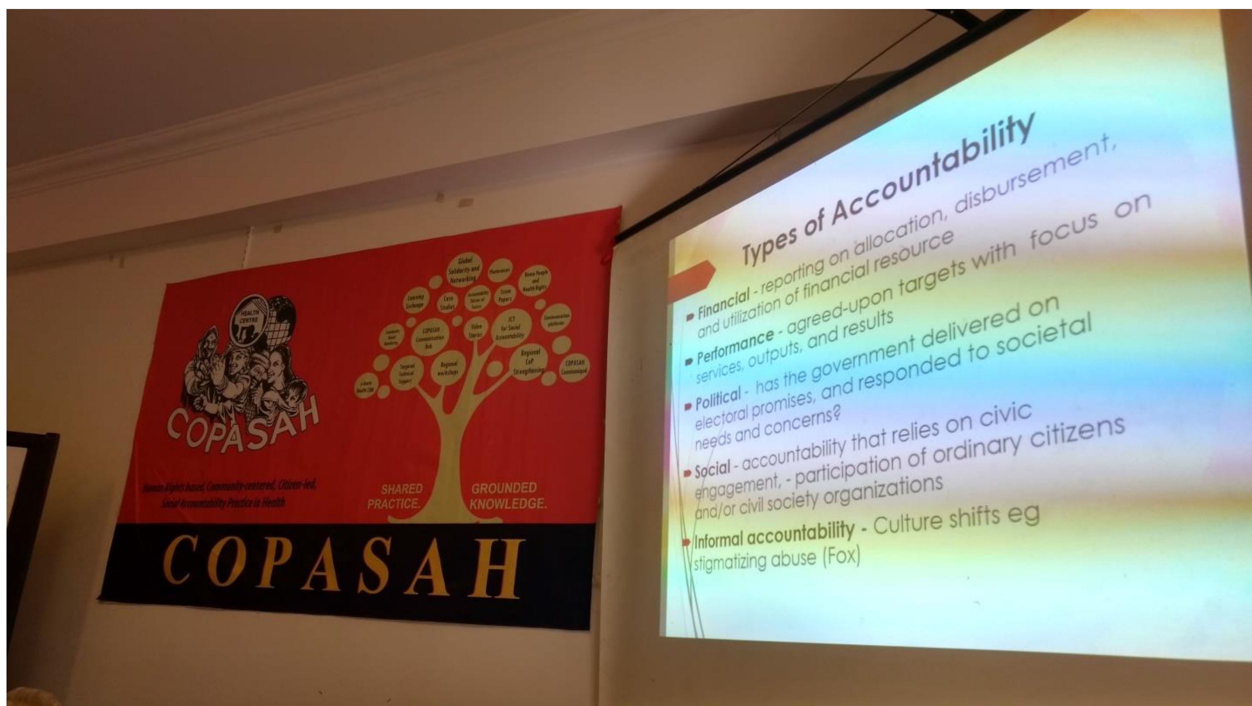
COMMON EXPECTATIONS FROM THE MEET

Advancing from formal introductions by participants around the context of their work and of their organizations, the schedule was elucidated by Renu Khanna, following which the participants outlined their common expectations from the meet. The potentials from the meet by the invitee participants were outlined, in terms of taking it as an opportunity to understand health related issue in the South Asian countries, besides exploring it as a platform of experience sharing on challenges and success of accountability practices, and learning from each other on accountability tools, as well taking it a prospective instance to know more about COPASAH, forge cross country alliances with different organisations, networks and strengthen the COPASAH network in the South Asia region.

COPASAH SC member Renu Khanna introducing the schedule of the meet

SESSION II: PERSPECTIVE- CONCEPT ACCOUNTABILITY AND SOCIAL ACCOUNTABILITY IN HEALTH; COPASAH PERSPECTIVES AND CORE VALUES

Providing an understanding of the conceptual framework of Social Accountability with insights on citizen-led and community- centred social accountability, COPASAH Steering Committee member, Renu Khanna, apprised the participants about the different types of social accountability and social accountability in health.



Presentation showcasing different types of accountability

She touched upon the different aspects of tactical social accountability as advocated by Prof. Jonathan Fox of American Research Centre and also highlighted upon, why there is an interest in social accountability reflecting citing reflections as the interest may lie to improve programme effectiveness, to improve social and economic development status of the poor and excluded, to reduce corruption, to improve aid effectiveness and efficiency of development/public sector investments or to increase democratization, to empower the marginalised or to challenge existing political relations/ formulations/ decision making in favour of the disempowered and marginalised. Apart from this, she introduced the role of COPASAH in strengthening the 'grassroots' practitioner for mobilising and empowering

‘citizenship’; moving beyond ‘tools’ to tactical and strategic engagement with state authorities with robust evidence through capacity building, and identifying and sharing ‘innovative’ grounded practices around accountability and empowerment through learning and knowledge building. In addition the advocacy role of COPASAH with focus on the dynamics of ‘power’ and participation in the formulation and implementation of health policies, was also brought to fore along with the communication role of COPASAH of active sharing – from the bottom up and across regions.

The session had participant members raising some pointers for discussion that largely social accountability of the system has been discussed upon, but we also need to talk about the responsibility. This further evoked discussion on the discourse of power and power differentials.

SESSION III: PRAXIS SHARE: LEARNING FROM COPASAH PRAXIS

The session on Praxis share: Learning from COPASAH Praxis chaired by Dr. Harishchandra Yakandwala, initiated with showcasing of a short film on what COPASAH is and the trajectory followed by COPASAH. The short film screening was followed with praxis sharing by participants who have been involved with COPASAH. Representative from Beyond Beijing Committee (BBC), Rakshya Paudyal shared the experiences of association with COPASAH, peer learning approach of COPASAH as affected through the South Facilitated Learning Exchange Visits (FLEVs) to India. She added that a major learning adopted by BBC in Nepal from COPASAH was that of Community Based Monitoring, as grasped during FLEV in Bangalore and other workshops of COPASAH. BBC incorporated the learning of the community monitoring in their work of focusing on safe abortions. With involvement of community, these learnings adopted from COPASAH led to duty bearers become more alert and accountable and the Primary Health Centres (PHCs) also started providing accessible services, she added.

Sharing his experiences of establishing COPASAH in Pakistan, Gulbaz Ali Khan from CIG, who is also COPASAH South Asia Steering Committee member highlighted that the aspect of reflecting practitioner’s knowledge and experiences (which are not documented largely) has been the encouraging factor to be part of the COPASAH network. Interaction with COPASAH network

members at various platforms He added that visibilising COPASAH in Pakistan as well reflecting social accountability initiatives of the region have been through several contributions in terms of writings for the COPASAH Communiqué on Primary Care Management Committees (PCMCs) (Health Department's community participation mechanisms), Public Information Boards in Basic Health Units (BHUs). Additionally, PCMC conference was held in held in Pakistan under the banner of COPASAH which was instrumental in expanding the outreach with different regional network in the country.

The reflections by the participants led to some questions being explored through discussions like monitoring system responsiveness is a challenging task and there is a need to think broadly about hybrid social accountability program through which different rights are negotiated. Other issues were also explored like is it the donors, NGOs or collectives, whose agendas get entry and which tools/ strategies work and who are the real decision makers.

Following the reflections, the initiative of COPASAH of using Information Communication and Technologies (ICTs) was shared by Surekha Dhaleta, from COPASAH South Asia Practice node. She outlined that initiative to use accessible Information Communication Technologies (ICTs) innovatively was experimented across six locations of India with capacity building of 30 selected

community level leaders who were already involved in community monitoring. Skill building on use of accessible and affordable technology, such as cell phones and basic cameras and follow up was done with community leaders for one year with three rounds of technical support workshops. Community leaders held discussions within their community on the priority health rights issues they faced, on use of technology to generate evidence, on their participation in the process and their consent to do so. Following these processes, digital evidence gathered in form of photostories, photo voices was then shared with the health system officials and committees related to grievance redressal in public health dialogues organized by community leaders. This initiative led to bridging the divides to facilitate quicker and efficient communication for meeting the community health needs and for prioritizing in health planning.

Following the sharing of the ICT initiative the participants were given a virtual tour of COPASAH wherein the website of COPASAH was showcased and details of the COPASAH regional nodes, COPASAH accountability practices, knowledge products (case studies, issue papers); praxis sharing and networking (COPASAH Communiqué, list serve); social media platforms were also shared in addition to the COPASAH peer learning and capacity building approaches.

SESSION IV: PRAXIS SHARE: LEARNING FROM COUNTRY SPECIFIC EXPERIENCES ON SOCIAL ACCOUNTABILITY IN HEALTH

Facilitated by COPASAH Steering Committee member, Renu Khanna and chaired by Narayan Adhikari from the Accountability lab in Nepal, the session saw sharing of country specific experiences on social accountability, wherein the different systemic contexts and introductions to the health indicators/health problems, socio-political contexts of countries were shared apart from the accountability mechanisms/structures and major actors/stakeholders in the countries**.** The country wise presentations are summarized as follows:

PAKISTAN

Outlining the socio-political, social accountability and health service context of Pakistan, Gulbaz Ali Khan (CIG) and Kanwal Iqbal (CUP) spelt that democracy is going through certain maturity in the country. Media and social media are growing in the country and transparency and

accountability have gained political support in the recent times. There have been recent legislations on guaranteeing public services, information, accountability, conflict of interest etc. Different accountability structures exist in the country in form of Public Accounts Committee, National Accountability Commission, Public Procurement Regulatory Authority, Auditor General of Pakistan, Tasks Forces of PM, CM and other officials, Anti-Corruption Establishments, Federal Investigation Authority and Independent Monitoring Units. Different Social Accountability mechanisms have been employed in the provinces as well since 1990s including the School Management Committees (SMCs)-1994, Parent Teacher Associations/Committees(PTAs/PTCs)-1994, Health Management Committees and Primary Care Management & Secondary Care Management Committees -2001.

Pakistan team members sharing country accountability context

Some of the key projects which have initiated accountability mechanisms include Citizen Voice Project (Strengthening citizen voice and public accountability) by Asia Foundation and FAFEN, funded by USAID. Under this project over 300 grants (including Health) were granted to civil society organizations in all four provinces of Pakistan. Similarly CESSD-Citizen Engagement for Social Service Delivery had projects by Cowater Intl which were funded by CIDA and Aus aid and

worked in basic health, water supply and primary education in 11 districts of KP province. Under this project PCMC were established as local support function to Basic Health Unit(BHU) administration and scorecards were used in addition to the use of Public Information Boards, Budget Tracking, Networking Committees, Right to Information, Right to Public services etc.

In the health domain, Health and Nutrition Innovation Fund (HANIF) has aimed to increase demand, accountability and supply of quality services in Reproductive Maternal Newborn Child Health (RMNCH). EVA-BHN (HANIF is the subcomponent of Empowerment, Voice & Accountability for Better Health and & Nutrition) and is a 5 million Fund. It has over 8 pilot innovations and 1 scale up in terms of Scorecard, and has done some propagation and adoption of innovations. Scaling up pilots for wider use and adoption by the various actors has been done to strengthen advocacy at District and Provincial level and leverage coordination with partners for learning integration.

CUP Pakistan has also been involved in citizen led performance monitoring of health and population service facilities through Community Score Card, improvement in Primary Health Care Services through Community Score Card and establishment of Joint Citizen Monitoring Committees at Cluster level(for monitoring and follow up) and in establishment of District Advocacy Forums. They added that the major stakeholders in the health sector include, Government which is the first line services provider; private sector (both in collaboration and independent) and charitable and autonomous bodies including Armed Forces.

Kanwal and Gulbaz added that despite devolution there are challenges in the health sector in the country, that health still touches the bottom in financing. For the political governments health has not been a priority and there are weak regulations despite establishing provincial bodies, besides other challenges.

SRILANKA

Spelling out details of the Srilanka context of health and health care services, the team from Srilanka comprising of Dr. Harishchandra Yakandawala, Asitha Punchihewa, Tharindu Gunathilaka and Sanath Mahawtihanage highlighted that Srilanka has free health and education

services and is credited with good health indicators in South Asia. The country has been able to eliminate malaria and filarial and Health as a Right is in the process of being included in the Constitution soon.

However despite overall health figures, there are huge variations within the country. Food security remains a huge issue with 1/3rd of children being malnourished. The ageing population is high and the country is witnessing socio-economic transition. The country is also observing an increase in the non –communicable diseases, amongst which 20% accounts for share in the non-communicable diseases and chronic kidney diseases form a major burden now in the country. The health services are delivered through an extensive network of primary-to-tertiary level health institutions and the Ministry of Health, Nutrition and Indigenous Systems is the central government ministry responsible for health, providing both allopathic and Ayurveda services.

Srilanka team presenting country context

The participants from Srilanka also outlined that there are different accountability platforms in the country. The private sector in health has seen an exponential growth in the last 10 years. 56% of the health services are controlled by the government and 44% of the private health care services are controlled by the Private Regulatory Council, provision of health insurance also

exist in the country. To pursue good governance roles, Srilanka has Open Government Partnership (OGP) and under the OGP, the National Action Plan affirms commitments to promote transparency, accountability and public participation in different thematic areas including health, education, anti-corruption, local government, right to information, women's issues etc. Different movements including the Patients Right Movements, People's Health Movement, Sarvodaya Movement etc. have espoused the concern for health in Srilanka. Attempts have been made for safe and affordable medicines for all and the lead agency controlling the price of the drugs is the Ministry of Health, currently 72 essential drugs are price controlled in the country. The spending on health is 25 % in public sector and 75% in private sector. HIV test is compulsory for every pregnant woman and is conducted every month of pregnancy, and regular audits are conducted on for maternal and neo-natal deaths. Fines for road traffic accidents have been increased and green tests are there for vehicles to control pollution. Inspite of the progresses made in the country, different challenges continue in the health services, they added.

BANGLADESH

Providing a background of the health service system and context of Bangladesh, Rowshon Ara and Maksuda Khatun from Naripokkho shared that Health is recognized as the primary duty and responsibility of the state in Bangladesh; however it is not a fundamental Right. Despite several government policies, there is poor implementation of government policy and programs and high maternal mortality in different geographical areas continues, women's access to local level health facilities is minimal. Social accountability has been fostered through mandated committees like Hospital Management Committees, Parliamentary Standing Committee on Health, Union Parishad standing Committees on health, education and Health and family welfare.

Naripkkho has worked with re-activation of Health Management Committees through CBO partners in 2001, as an existing accountability mechanism and provided motivation for regular meetings and action to improve the situation as well build up the relation with local MPs and

other members of the committee. A regular follow-up by Naripokkho and CBOs has been done and Naripokkho has trained CBO partners in monitoring and data collection from the health Accountability mechanisms have led to small but significant achievements like Committee members are now more proactive in identifying problems and taking measures to solve them and there is increased supply of diagnostic equipment's and medicines and doctors are more regular in reporting to duty etc. (For more details see Annexure 1). However certain challenges continue as HMC are not functioning everywhere, yet it is an officially recognised fora where local people and administration can sit together and discuss problems, identify solutions and take local measures. There is overload on secondary and tertiary facilities and provider's accountability is not ensured, besides absence of functioning referral systems and other challenges, the Pakistan team added.

NEPAL

Elaborating the context of Nepal, Kapil Kafle, Coordinator Men Engage Alliance reflected that accountability mechanism exist in Nepal. The Constitution, provisions of law are there however the social fabric of society which steeped deep in caste system and untouchability makes accessibility, availability of health, education and other services a distant reality.

The country specific sessions provided a context of the socio-political and social accountability context around health and other areas across the countries and provided a snapshot of the social accountability tools being used across different contexts, and the larger point that emerged was that sustainability of interventions is a big challenge and there is a shrinking space for the civil society in the current context in some countries across South Asia. The sessions for the day closed on an enthused note, with planning for the next day sessions.

DECEMBER 6, 2016: SESSIONS

SESSION I: SKYPE DISCUSSION ON PRIVATE MEDICAL SECTOR ACCOUNTABILITY

Steered by COPASAH SC Renu Khanna, the session for the day started with a skype discussion on accountability in the private medical sector with insights shared by COPASAH Steering Committee member Dr. Abhay Shukla (from SATHI, India) and senior health rights activist and gynecologist, Dr. Arun Gadre from SATHI, Maharashtra in India. Dr. Abhay Shukla enunciated briefly upon the social accountability of the private medcial sector initiatives being pursued in Maharashtra, India. He described the experience of the accountability of private health sector and said that it is a difficult task to fight for the health rights of patients and to bring in accountability in both public and private healthcare. Community monitoring has been carried on for more than a decade in Maharashtra, and it has yielded some good results in the public sector, where the marginalized communities have organized themselves, generated evidence of their own experience of receiving health services and used that evidence to argue for better deal for themselves. Some progress and innovations have been made towards accountability of the private sector and the learning from the work so far has been that learning that patient's rights in private sector is an initiating point. The Clinical Establishment Act is in the incipient stage. Describing from the testimonials of 78 doctors practicing in six states including those practicing traditional medicine, as collated in a book titled Dissenting Diagnosis, co-authored with Dr. Arun Gadre; Dr Abhay Shukla said that private medical health sector is entrenched with corruption and institutionalized unethical practices in medicine, involving prescription for unnecessary tests and medicines, or recommendations for unnecessary hospitalisation or surgery, either for commissions or to meet targets imposed on doctors by private hospitals. He added that private health care sector is largely unaccountable and unregulated, and driven by interests to maximize profits and by commercial pressures, it is often involved in various malpractices and exploitation of patients. The regulatory bodies are also feeble and have hardly been able to curb malpractices.

The discussion on the accountability of the private health sector brought forth some reflections and questions from the member participants for further dialogue:

- What kinds of tools have been used for accountability of the private health sector? Are they similar to those being used of the public health sector?
- How can patients be empowered for a platform to ensure accountability of the private health sector?
- Regulatory Commissions are exist in Punjab and KP provinces of Pakistan and have notified minimum standard for both public and private health sectors. There is maturing civil society but few think-tanks and there is a need to mobilise health consumers from the different provinces in Pakistan.
- The situation across South Asia countries is similar; the private medical care is expensive ridden with malpractices. For example in Nepal the cost of medicines and services is not homogenous across, there is no uniformity in rates of medicines of different brands. There are no regulatory and monitoring systems for private health sector in Nepal. Similarly there is no possibility of civil society monitoring the private health sector in Bangladesh.
- The private sector in health is a big business and commissions for unnecessary investigations, most of the times it has been observed that a certain section of consumers also push for expensive diagnostic tests and medicines.
- The regulations are top down and bureaucratic and corruption levels are high

It was highlighted by Dr. Abhay Shukla that the problems and framing of the accountability in accountability are quite different from the public sector. In the public sector the focus is on adequate human resource, facilities with adequate quality, whether standard inputs are being given or not and other aspects. However at least in India, there are no clear standards for the private sector. The tools for accountability have to be framed; the cases of private medical sector are largely taken as individual cases as consumers or taken in the Medical Council.

Responding to the reflections and questions of the participant members from Pakistan, Nepal and Bangladesh; Dr. Arun Gadre and Dr. Abhay Shukla delineated that though the initiatives and platforms like Citizen Doctor Forum which have been set up in two cities of Mumbai and Pune, India for ensuring accountability of the private health sector are in the budding stage, but these are exciting options, which bring together good citizens and ethical rational doctors and

medical activists. The focus is on the rational treatment protocols, where patients are not stuck in medical consumerism.

Participants seeking queries on private sector accountability on Skype

Dr. Abhay Shukla added that there are numerous good examples which can be mutually shared and adopted from within the South Asia context. For example Dr. Gobinda K C in Nepal has been raising voice against the corruption and play of power being used in Nepal in the private medical colleges. The Commissions in Pakistan and the Charters of Patients' Rights and Responsibilities also can be used by activists as platforms to foster accountability. He also added that Bangladesh has been a pioneer in raising the issue of irrational medicine use in and has strong civil society network and it is a good opportunity for inter-country collaboration to work on aspects of social accountability of the private health sector.

The session concluded on a very promising note of the all the country participants agreeing to collaborate for learning and sharing from each other and sharing experiences on the private health sector accountability.

SESSION II: PERSPECTIVE: STRATEGIES AND TOOLS FOR SOCIAL ACCOUNTABILITY IN HEALTH

COMMUNITY SCORE CARD: COMMUNITY UPLIFTMENT PROGRAMME (CUP), PAKISTAN

In the second session for the day accountability practitioners from Pakistan and Srilanka shared the accountability tools of community score card and Deshodhaya as being used by CUP, Pakistan and Sarvodaya Shramadana Movement respectively. Kanwal Iqbal from Community Upliftment Programme (CUP), Pakistan described the usage of Community Score Card as a social accountability tool. The service providers and the seekers work together on the ranking of the health services and it involves extensive engagement for ensuring participation of both users and service providers for a meaningful dialogue and probable solutions. The providers also do a self-assessment of the services against self-generated indicators and interface meetings are held between the providers and service seekers, where they compare and analyse the services, if gaps are there the providers develop an action plan in association with the community (service seekers) to fulfill the gaps. Kanwal added that it has been observed that the trust increased between the service providers and the community with the interface meetings. She added that the tool was used in Basic Health Units (BHUs) of 5 districts in the KP province and it was found that infrastructure was poor in the facilities and the construction was very old, besides there were poor drinking water facilities, no utilities, non –availability of medicines, and the attitudes of the service providers were problematic with a large number of dissatisfied users.

The description of the community score led to questions as was it done as a baseline and hwat were the indicators used? Responding to the query Kanwal elaborated that first score card is a baseline, and score cards are repeated on six month basis, as it takes 3-4 months to complete the entire process. The primary health care services were the indicators. She outlined, however, there are some issues beyond the facility and the district administration. Adding on the discussion on the community score cards, Gulbaz Ali khan from CIG, Pakistan added that score cards are different from report cards. Score cards can be used to fix small things like attitudinal changes, doctors' punctuality and through these users and doctors mutually arrive at

agreeable solutions. The score cards are ground testers to penetrate to the domain of the administrators. It was also pointed out that the tools don't work alone and there is need to supplement tools for example score card supported with expenditure tracking. Discussions were also held on the role of the donors in imposing indicators for the tools such as the core cards.

DESHODAYA MODEL - SARVODAYA SHRAMADANA MOVEMENT, SRILANKA

The second presentation on the accountability tools was done by Dr. Sanath Mahawithanage, from Sarvodaya Shramadana Movement. Elaborating the details of the Deshodaya Model of accountability he pointed out that 'Deshodaya' is a tool to facilitate citizen-state interactions, and the entry point is the village for it. He described that the word Deshodaya is a combination of two words, Desha (Any geographical entity) and Udaya (awakening). The Sarvodaya Shramadana Movement which is based on the Gandhian and Buddhist philosophy and it imbibes the meaning of awakening of all. The Sarvodaya Movement was found through Shramadana (Gift of time, thoughts, labor and energy) in one rural village in 1958, and has expanded to 15,000 villages throughout Sri Lanka. Currently, it is the largest embedded community-based development organization network in Srilanka and is working with 5,200 legally independent village societies in all districts including war-torn northern and eastern provinces. He added that Deshodaya model aspires for development i.e. participatory community development with spiritual – moral; cultural – social; and economic - political development to satisfy the basic needs of people and to preserve local values and respect local knowledge. It also has added the element of innovation and experimentation over six decades. Dr. Sanath said that the model fosters willingness and uplifting ability to seek government accountability among citizens and civil society through "GramaSwarajya" (village self-rule) model. This process involves going through different stages like psychological infrastructure development; social infrastructure development; satisfaction of basic human needs and institutional development; income and employment generating and self-financing and sharing with neighbouring villages, which into turn lead to social empowerment, technical empowerment, economic empowerment and political empowerment (self-ruling villages) respectively.

He added that the experience on social Accountability in health in relation to four critical factors associated with Social Accountability of the Sarvodaya Movement has been as of

1. **Facilitating citizen-state interactions:** Creating opportunities for information exchange, dialogue, and negotiation between citizens and the state through “Deshodaya.”
2. **Promoting transparent and responsive behavior:** Promote transparency and open information sharing, and constructive engagement among service providers and policy makers with citizens through engaging in policy formulating process

3. **Fostering willingness and uplifting ability:** To seek government accountability among citizens and civil society- Technical capacity building as well as mobilization, coalition-building, negotiation, and advocacy through “GramaSwarajya” model.

4. **Creating an enabling environment:** To create an enabling environment, within the policy, legal, and regulatory spheres for increased civic engagement through Sarvodaya Shramadana Movement and village level Sarvodaya Shramadana Societies (SSSs) by capacity building.

Citizen –State Interaction through Deshodaya

Elaborating on the facilitation of citizen-state interactions through Deshodaya, he added that there are different independent forums to facilitate various functions such as citizen-state interactions to communicate, discuss and solve community problems. Each forum comprises of 20-25 members and meets once a month or need basis.

Some of the selected initiatives under the interaction include:

- Find a solution together (2011-2014)-towards an active citizenship
- Our testimony to Lessons Learnt and Reconciliation Commission (LLRC) 2012
- Educating citizens on 19th amendment
- Transitional justice – a programme on peace and reconciliation

Some selected initiatives with other institutions include

i) Open Government Partnership (OGP)

- Improving public access to preventive and curative strategies to combat CKDU
- Transparent policy to provide safe and affordable medicines for all
- National Heath Performance

ii) Proposals for new constitution – “Right to Health” as a fundamental right

iii) Programme on safe food

An enabling environment is created through Sarvodaya Shramadana Movement and village level Sarvodaya Shramadana Societies (SSSs) by community capacity building which includes:

- Formation and registration of Sarvodaya Shramadana Societies (SSCs), Continuous training of officials, Societies Ordinance, Annual audits and other constitutional obligations providing other necessary facilitations through Sarvodaya sister organizations such as Sarvodaya Economic Enterprise Development Services (SEEDS)

SESSION III: LOOKING FORWARD AND STRENGTHENING SOLIDARITY

The third session for the day involved country wise group work and presentation to reflect upon the idea of taking COPASAH forward and strengthening solidarity in the South Asia region. COPASAH South Asia SC member Gulbaz Ali Khan, who facilitated the session, and elaborated upon three points for the participants to deliberate upon which included:

- How can COPASAH be expanded in your countries?
- How can you contribute to the learning network of COPASAH and the COPASAH Communiqué?
- How can we build a shared social accountability system in the region for public and private medical sector?

Team group work on way forward

The country wise plans and strategies came forth as:

NEPAL:

i) Nepal team presented their vision of expanding the COPASAH network and pointed out that they would explore new constituencies, outside the realm of governments in different Non-Government Organizations (NGOs) and within the Government also by engaging Champions and Integrity Idols. In addition they would be reaching out and networking informally health professionals, associations of women health workers and young technicians, educators and also involve them in developing ICT tools.

ii) The Nepal time also mooted the idea of country Secretariat to coordinate the country specific network of COPASAH. The team also raised the point of exploring new modalities to go ahead. Reflecting on the point of contributing to the learning networking, the team elaborated that they would share cases stories, best practices and lessons learnt.

iii) The team also detailed out, that the Nepal team would explore the idea of developing a booklet on tools of social accountability for Nepal and also develop a 'TOOL BOX' comprising of 15-20 tools which can be collated together for South Asia, for example the Integrity Idol (from Nepal) and the tool box can be circulated and share worldwide.

The facilitator for the session Gulbaz Ali Khan said that sharing is part of COPASAH and it will help to strengthen the work in Nepal. He added that there is need of creating incentives o learning.

BANGLADESH

i) Enthused by the discussion on the social accountability of the session on the private medical sector, Bangladesh participants reflected that they would be keen on collating more information on the private medical sector in the country.

Bangladesh team sharing the Plan for taking COPASAH ahead

ii) They also elucidated upon the prospect of holding joint workshops of Naripokkho with COPASAH, holding collaborative webinars and imbibing the learnings and shared practices from the COPASAH network in their project areas, besides sharing short stories for the COPASAH Communiqué.

SRILANKA

i) The Srilanka group elaborated that they would explore the establishment of COPASAH network in the country and Sarvodaya and FPA would be focal points. In addition the group would strategise on the team, plan, funds and places for expansion and networking.

ii) The group outlined that as a country specific strategy, the team would initiate

- **Mapping of Stakeholders** which would involve identifying existing players and their scope and would also strive to establish a national accountability forum
- **Conducting Rapid situational assessment** and review of existing documents and systems as well Opinion survey (service providers and public including political leadership)
- **Pursuing Advocacy at** policy level, public level and management level and involving politicians, President and Prime Minister also in taking leadership roles in advocacy
- **Developing country specific strategic** plan would include national consultative process, development of draft plan and consultation process to finalize the process as well developing monitoring and evaluation systems and developing and implementing tools.

iii) In line with country specific strategy the team proposed to boost the communication strategies by contributing to the Newsletter and supporting through video-voices and webinars

i) **For the South Asia level Regional road map** the group suggested for developing a South Asia specific common framework to integrate country specific plans with future directions and then synthesize the regional plan

Srilanka team deleiberating on the way forward

The team members also opined that health sector coalitions exist apart from health sector unions and are pursuing work on accountability, there is a need to bring them together.

COPASAH Steering Committee member, Renu Khanna also pointed out that issues such as the private sector regulation, malpractices in the private medical sector need to be mapped. The guidelines are there however there is a need to collate them and to get them used, like the Private Sector Regulatory Council. Besides there are COPASAH themes including the reproductive and maternal health rights accountability and indigenous people's rights and accountability.

PAKISTAN

The Pakistan team delineated that they would endeavor to expand the already existing network of COPASAH in the country. They added that different social accountability networks exist in the country which are working on social accountability and include a gamut of donors and numerous NGOs, for example PASN, EVA BHN (£5 million donor funded venture). The team added that these networks would be approached for interaction along with different stakeholders such as medical associations, consumer protection organisations and these would be linked with COPASAH.

Pakistan team sharing plans for way forward

Pakistan participants reflected that as a contribution to the learning network they would contribute short articles, and share tools of accountability. Besides the sharing of stories of accountability praxis from the ground they proposed to develop a theme specific case study surrounding on the theme of Private health sector accountability and how regulatory framework is helping in ethical practices in the provinces of Pakistan.

- The members said that the team would also explore linkages with academia and researchers in KP and Punjab provinces and explore the possibilities of webinars on chosen thematic domains along with opportunities of Facilitated Learning Exchange Visits and capacity building.
- Kanwal from Community Upliftment Programme (CUP) opined that currently CUP is implementing score card in the KP province in three rounds. Webinar can be organized for the 18 staff members on tools of social accountability and the score card. The staff members can also share about the process and challenges faced by them in the implementation of the score card
- Gulbaz from CIG Pakistan said that the COPASAH network in Pakistan would foster more linkages with practitioners, academics and researchers.

INDIA

- The team from India including COPASAH SC member Renu Khanna and representing COPASAH South Asia practice node, Surekha Dhaleta, shared that COPASAH Secretariat and COPASAH South Asia practice node would explore the opportunity of an edition of the COPASAH Communiqué focusing on the region of South Asia and would invite praxis sharing from the regional constituencies of South Asia.
- In addition webinars focusing on themes of inter-movement dialogue on maternal health anchored by Renu Khanna and on the themes of private health sector accountability and patients' rights respectively can be facilitated by the South Asia practice node.

The way forward session concluded on a constructive note with all the participants agreeing on a common point of contributing collectively to take ahead COPASAH in respective countries as well in the South Asia region. COPASAH SC member, Renu Khanna who facilitated the meet for the two days, acknowledged the involvement and contribution of participants in the South Asia meet.

FIELD VISIT -VISIT TO BEYOND BEIJING COMMITTEE (BBC) AND INTERACTION WITH BBC MEMBERS

Following the way forward session the participants visited the Beyond Beijing Committee (BBC) office in Kathmandu to interact with the members of BBC and understand more about the context of accountability in Nepal and more about the work of the local organization.

Rakshya Paudyal from BBC who was a participant in the South Asia meet facilitated the visit to the BBC office. Chairperson of BBC, Shanta Laxmi Shrestha greeted all the team members from Pakistan, India, Bangladesh and Srilanka. Following mutual introductions she vividly described the work of BBC and reflected upon the discriminatory gender practices against women in Nepal. She deliberated upon the genesis of Beyond Beijing Committee (BBC) and said that it was formed initially as loose network after the UN Fourth World conference on Women at Beijing, September 1995 and was given a formal format as network NGO organization in 1998.

BBC Chairperson Shanta Laxmi (centre)sharing about the context of Nepal

She added that BBC is an organization as well as a national coalition of leading women's rights and gender-justice organizations working to advance the status of women in Nepal and achieve gender equality, sustainable development and women’s rights. It has been lobbying from the grassroots level upto the district, national and international levels for gender equality, to advance rights through, advocacy and training on women’s rights and to enable women and girls to access quality services to enjoy their human rights.

The chairperson of BBC added that the Committee use multi-pronged approaches like policy advocacy, grass-roots advocacy, program development in partnerships and networking and alliance building to achieve its vision of a society where women and girls lead equal and dignified life. It has also been conducting research on women’s and girls’ issues and has been carrying on evidence based advocacy. BBC has worked towards strengthening interface between community women and health service providers through different tools. She said that apart from health BBC has also focused upon the community health education programme for education of children in Nepal.

Shanta Laxmi Shrestha highlighted that with continuous lobbying, advocacy of like-minded organizations alliances and networks, continuous engagement with media, government and Parliamentarians, Nepal could attain legalization of abortion services. She added that BBC has conducted a baseline study tilted Abortion Stigma and its Effect on Women in Nepal which is a complement to Women’s Health Rights Advocacy Programme (WRAHP) and highlights that there is continuation of stigma and negativity related to abortion in Nepal and the status of legal abortion does not guarantee that women have access to adequate and supportive abortion facilities, besides unsafe abortions continuing to be one of the major causes of maternal deaths in Nepal. She elaborated that BBC with networks and alliances in association with media advocacy is lobbying for separate safe Abortion Bill in Nepal.

Encouraged by the learnings and experiences on social accountability derived from the COPASAH South Asia Exchange and Strengthening meet in Nepal and as shared by participants during the interface at BBC office, the chairperson of BBC expressed keenness to partner with COPASAH in the context of strengthening civil society voice for reproductive and maternal health accountability in South

Asia. She elucidated that BBC would explore the opportunity to work with the COPASAH network on the Sustainable Development Goals (SDGs) and continue advocacy to address the specific health concerns of disadvantaged groups specially of women and stress for accountability of governments. She added that BBC was especially keen on the specific target (5.6) under the goal of gender equality (goal 5) to ensure universal access to sexual and reproductive health and reproductive rights.

The field visit to BBC concluded on an affirmative note with all the participants outlining that it was an opportunity to learn about the microscopic details of the legal status of abortion in Nepal and bout the advocacy work of BBC and its alliances.

CONCLUSION:

A common agreement among the participants in the COPASAH South Asia Exchange and Strengthening meet as reflected through feedback provided by the participants focuses upon forging cross country alliances with different networks, groups working on social accountability and on expanding the COPASAH network across the South Asia region, within the countries starting from local, provincial levels to national levels and at the larger regional level. All the participants expressed interest in exploring the Private health sector accountability theme besides sharing different tools of accountability. They expressed that the meet has opened up an opportunity for exploring and adapting different tools of social accountability like the score cards, Integrity Idol and the use of digital evidence and ICTs for social accountability. The participants from Pakistan, Bangladesh, Srilanka, Nepal and India delineated that the meet has set a platform for cross –country fertilization on the idea of developing a social accountability eco-system in the South Asia region and this synergy can be showcased by frequently sharing the praxis of accountability through different platforms of COPASAH.

Based on the feedback of the participants the meet was able to discern some progressive outcomes

- Strengthening of the concepts and perspectives on citizen-led and community-centred social accountability in health

- Understanding of the socio-political contexts and social accountability practitioners (processes and organisations) of different countries of South Asia
- Exploring opportunity for strengthening and expanding the COPASAH South Asia platform
- Shared and agreed upon ideas to continue communication, share experiences and strengthen solidarity in South Asia (Including joint action plan for strengthening COPASAH regionally and continuing community based practitioners networking, solidarity and bottom up knowledge generation and dissemination)

Annexure 1- Schedule

Time	Session	Description of the session	Expected outcomes
Day 1: 4th December, 2016			
	Arrival of participants	Informal introductions over dinner	Setting the tone for formal sessions
Day 2: 5th December, 2016			
9.00 – 10.00	• Getting to know each other • Getting to know COPASAH Overview of the schedule, expectations and objectives	Through a participatory methodology mutual introductions will be done. Sharing of the schedule and setting common expectations will be facilitated Sharing what accountability tools have been used by the participants **Facilitator: Renu**	Familiarising with each other and with the objectives of the meet
10.00-11.00	Perspective: Concept • Accountability and Social Accountability in Health • COPASAH perspectives and core values	The core concepts and COPASAH perspectives will be presented and discussed **Presentation: Renu**	The familiarising with the conceptual framework of SA and clarity on the citizen-led and community – centred SA

11.00 – 11.30	Tea Break		
11.30 – 13.00	Praxis Share: Learning from COPASAH praxis • Sharing COPASAH experiences • Introducing the regional practice nodes • Introductions to resources, web-portal and knowledge products • Communication hub and using of online	• Introductions to the structure and processes strengthening practitioners, usage of ICT platforms, knowledge and experience exchange will be done **Anchor: Surekha** **Co-presenter: Gulbaz, Rakshya**	Participants will be familiar with the praxis of COPASAH

	communication platforms		
13.00 – 14.00	Lunch		
14.00 – 18.00 **TEA BREAK- 3.30 – 4.00**	Praxis Share: Learning from country specific experiences on social accountability in health • Pakistan • Sri Lanka • Bangladesh • Nepal • India	• Each Country group will map the SA field in their country, map civil society and other actors (30 minutes) • Identify and discuss key issues of health and SA practice and processes • Identify and share key challenges for SA in health Any significant policies in health care which have positive and negative mass impact To take into consideration pointers about (Health System, Health Indicators, Accountability mechanism (like community based monitoring etc., socio-political context etc.) **Facilitator: Renu**	Each participant will be enriched with the experiences of SA practice in other countries Collectively, a South Asia mapping of SA field and practice will be discussed
Day 3: 6th December, 2016			
9.00-9.45	Skype Discussion on Private Sector Accountability	COPASAH Steering Committee member Dr. Abhay Shukla and Dr. Arun Gadra members from COPASAH India with participants sharing country experiences on private sector Facilitator : Renu	Understanding on private sector accountability
9.45– 11.00	Perspective: Strategies and tools for Social Accountability in Health	The various processes and strategies (and tools) will be presented followed by a discussion	Participants will have a critical understanding of diverse processes, strategies and distinguish them from

		Presentation& Facilitation: Renu **Co-presenters: TBD* (invited participants)**	tools
11.30 – 11.30	**Tea Break**		
11.00 – 13.30	Looking Forward and Strengthening Solidarity • Country- group discussion • Sharing and Consolidation • Plans to strengthen solidarity	Group discussion in country groups – for planning Each country will present for about 10 minutes A final synthesis on the presentations and ways of strengthening solidarity will be discussed **Facilitators: Renu and Surekha**	• The participants will discuss and propose their plans for strengthening the COPASAH learning and sharing • A coordination group with one or two people from each country • Plan for a SA Newsletter (based on presentations – write ups to be submitted)
13.30 – 14.30	**Lunch**		
14.30 – 17.00	**Field visit (in exploration)**	• Field visit to local organisation (to be finalized)	To develop specific observation questions on Right to Health and Health Care, Sexual and Reproductive Rights; Orientation by host/participant
19.00-20.00	**De- Briefing of field visit**		Understanding the local accountability context and organization work
20.00 onwards	**Dinner (Nepalese Dinner)**		

Annexure II

PARTICIPANTS LIST

COPASAH South Asia Exchange and Strengthening Meet

On

Social Accountability in Health in the South Asia Region

December 4-6, 2016; Kathmandu, Nepal

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