COPASAH'S APPROACHES TOWARDS CAPACITY BUILDING

SYNTHESIS REPORT OF PRACTICE OF CAPACITY BUILDING IN THREE PRACTICE NODES OF COPASAH

Prepared By

CENTRE FOR HEALTH AND SOCIAL JUSTICE

COPASAH

With Support From

OPEN SOCIETY FOUNDATIONS

COPASAH'S APPROACHES TOWARDS CAPACITY BUILDING

SYNTHESIS REPORT OF PRACTICE OF CAPACITY BUILDING

IN THREE PRACTICE NODES OF COPASAH

Prepared by

COPASAH Global Secretariat and South Asia Regional Node
Centre for Health and Social Justice
Basement of Young Women's Hostel No. 2
Avenue 21, G Block, Saket,
New Delhi-110017

With Support from
OPEN SOCIETY FOUNDATIONS

Contents

I.Introduction to COPASAH 3

II The Need for Capacity Building in the Field of Citizen-led Accountability in Health..... 4

III. COPASAH's Perspective towards Capacity Building..... 5

IV. Thematic Domains for Capacity Building..... 6

V. Methodologies Adopted to Build Capacity of the Community of Practitioners 8

VI. Reflections and Learnings..... 10

VII. Concluding remarks 12

Annexure A: Report on Capacity Building Activities Undertaken by COPASAH-South Asia 13

Annexure B: Learnings from COPASAH's approach to Capacity Building – ESA region..... 26

Annexure C: Capacity building process in Guatemala, Latin America 31

I. Introduction to COPASAH

COPASAH is a Community of Practice (CoP) where practitioners who share an interest and passion for the field of community monitoring for accountability in health interact regularly and engage in exchanging experiences and lessons; sharing resources, capacities and methods; in the production and dissemination of conceptual, methodological and practical outputs towards strengthening the field; and in networking and capacity building among member organizations. This CoP was established as result of a three day "Practitioners Convening on Community Monitoring for Accountability in Health" organized by the Accountability and Monitoring in Health Initiative (AMHI) of the Open Society's Public Health Program in July 2011 in Johannesburg, South Africa. Thirty-nine practitioners from thirty organizations and twelve countries actively participated in this convening. All participants overwhelmingly expressed the need for establishing a CoP and form the initial core member base for this CoP.

In its first phase (from July 2011to December 2012 and henceforth, COPASAH I), COPASAH focused on establishing the CoP and concentrated in collating and developing knowledge-outputs addressing the key conceptual and methodological questions confronting the community monitoring practitioners. In the second phase, i.e. 2013-1, COPASAH concentrated its efforts in strengthening its membership base and in developing and implementing different practitioner-focussed and peer-led learning strategies. These learning strategies included formal training workshops (one each in South Asia, Africa and Latin America); hands-on/ practical learning support offered through targeted technical support to practitioners (three in South Asia and one in ESA region); facilitated learning exchanges to communities based on the peer learning model of learning (four in South Asia and one in ESA region). The membership of COPASAH expanded from around 25 to nearly 200 and the listserv to close to 350 subscribers, many of them representing their organisations. The approach was dynamic and open, based on partnership and promoting mutual learning and aimed at consolidating solidarity among practitioners. COPASAH, in its short existence of over three years, has created a global presence with acknowledgement from various practitioners, academicians and donor communities. The knowledge products and the processes of learning from practice have received encouragement and appreciation.

II. The Need for Capacity Building in the Field of Citizen-led Accountability in Health

Community based accountability mechanisms, often called social accountability mechanisms are emerging as an important imperative for increasing demand for public services, improving program efficiency as well as promoting public program accountability. These methods have emerged from a deep frustration of marginalized people to hold public systems accountable at the local level, even as their 'states' kept making tall and sometimes empty promises through ineffective and inefficient policies. Experiments in diverse contexts of Latin America, South Asia and Africa have shown that 'states' can be compelled to honor their promises using various methods of generating and collating evidence and arguing through these. Over the last few years some experiments have also emerged in the domain of public health generically known as 'community monitoring', where 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. At this point in time it is necessary that the practice of community monitoring and the framework of accountability and active citizenship that it is predicated upon, become robust so that such monitoring can become the bed-rock of accountable and effective health services, and of a rights based approach to health care.

Further, reflections and mapping of resources by the key actors in the field of social accountability in health and the growing group of experienced practitioners, have highlighted that community monitoring is an evolving field with few documented initiatives across the world and the great need for exchange of experiences and lessons across initiatives; for sharing resources, capacities and methods; for addressing conceptual and methodological debates on community monitoring; and better documentation and dissemination of community monitoring results.

In addition, as these approaches become popular there is a real risk of the community monitoring for accountability being routinized into a set of tools and methods. While methods and tools are important, the practice of community monitoring is anchored on a vision of community empowerment and active citizenship where marginalized communities are organized, share a common vision and work towards engaging the state to discharge its constitutional functions.

There is, therefore, a need to establish and promote a community monitoring that is firmly anchored to processes focused on community empowerment and active citizenship around health rights and to develop a body of shared repertoire of

resources: experiences, stories, methods, tools, case studies, documents, and ways of addressing problems—in short a shared practice.

Community monitoring for accountability in health aims at the "systematic documentation and review of the availability, accessibility and quality of health services against specific government commitments or standards by actual beneficiaries of services, for the purpose of doing advocacy with providers and policy makers to improve the services". It is a bottom-up approach sustained by participatory processes. The documentation and analysis is carried-out by citizens themselves. Through advocacy and engagement with public officials, monitoring results are used to demand concrete actions to bring about changes in service improvements and equitable distribution of resources. Since community monitoring is carried-out within and by socially excluded populations, it adds legitimacy to equity concerns and to specific demands for more responsive and people-centred health systems guided by rights-based approaches.

COPASAH's focus on capacity building emerges from the following factors:

- As citizens, especially those from the marginalised communities, are grappling with the issues of their human rights violations, the community leaders and those who facilitate mobilisation also require inputs and handholding to be able to document the experiences of violation and those of unaccountability of the health care providers and authorities.
- The usual technocratic and inputs-oriented capacity building based on the assumptions that the practitioners are able to absorb dense concepts and documents in a class room setting, more often than not, have little application value, though it adds to information dissemination. Grassroots practitioners need a different approach for them to be able to understand concepts, frameworks and processes and apply them to their own contexts and realities.
- Hence, a more participatory approach that builds on their experience and is applicable to their practice, is required. Capacity building should be a continuous process, with sufficient handholding and peer support as a key avenue for learning.

III. COPASAH's Perspective towards Capacity Building

Given the needs of practitioners and the philosophy underpinning social accountability practice, capacity building activities of COPASAH have adopted certain universal principles. First, all content of capacity building must be participatory. This allows for practitioners to truly engage with subject matter and reduces the trainer-trainee hierarchy. Second, the process must be organic and iterative. It must be responsive to

the learning needs of practitioners, and flexible to incorporate their concerns and interests. Third, capacity building must be experience-based, in that there must be sufficient opportunity to build skills and apply them hands-on. Fourth, peer learning and support is of utmost importance as the practitioners themselves bring with them several years of experience which can make the learning process rich. Peer support also helps in building solidarity and mutual encouragement to take work forward.

Keeping these perspectives in mind COPASAH adopts various approaches towards achieving these goals, including documentation of innovative practices, sharing experiences and reflections among practitioners through newsletters and a listserv, disseminating/making visible this perspective in the global accountability space through participation in conferences and dissemination of materials, as well as various capacity building initiatives. COPASAH's capacity building approaches aim to

> (1) expand and improve the knowledge and skills of COPASAH members to carryout community monitoring for accountability in health.
>
> (2) provide practitioners within the three regions, an opportunity to visit each other's work and learn from and also provide feedback to the practitioners using a common set of principles.
>
> (3) provide selected members, in-depth interaction and technical assistance through other more experienced practitioner(s) with the intention to improve their overall practice of community-based accountability or for specific problem solving.

IV. Thematic Domains for Capacity Building

The thematic content of the capacity building process was embedded in COPASAH's broad approach and understanding of social accountability practice. It included some of the following content:

1 - Conceptual understanding: of health as a human right, accountability as a core human rights dimension, the importance of active citizen ship in ensuring accountability, understanding of marginalization and social exclusion.

2 - Understanding of policy context: of health and related policies, the space for accountability in policy, primary care services, maternal health care services and so on, depending on the context of the trainees.

3 - Practice of accountability: including community monitoring and community ethnography for evidence generation, budget monitoring, PAR and use of ICT in

evidence generation. In each of the regions, different dominant methods of 'doing' social accountability practice have been focussed upon. The predominant methods that have been taken up for capacity building are as follows:

(i) Community Based Monitoring and Planning: a form of social audit of public health services, which facilitates active participation of citizens to provide regular and systematic assessment of the status of entitlement fulfilment (often through use of tools such as report cards), identification of gaps and deficiencies and their negotiation with health officials, and participate actively in planning process.

(ii) Community Ethnography: involves empowerment of communities to carryout vigilance of local health facilities, and also collect audiovisual evidence of rights to health violations that are later presented to authorities. Practitioners use a variety of evidence gathering tools including interviews, observations, photography and audiovisual tools.

(iii) Participation, Reflection and Action (PAR): is a methodology that involves building capacity of community members and health providers/authorities to explore and document the health challenges faced by a community in a participatory manner. This is then used to demand accountability from the relevant duty bearers in the formulation and delivery of health services, and to strengthen community/stakeholder engagement for the provision of people-centred services.

4 - In some cases specific issues were taken up during capacity building, especially relating to maternal health and health issues of marginalized and socially excluded communities.

The content of capacity building activities varied based considerably on the context. In Latin America, the practice of community ethnography to give voice to marginalized indigenous populations was a major focus of capacity building. In Eastern and Southern Africa, budget monitoring support was provided as this was an important issue identified by organizations in that region. In the Indian context, capacity building on the practice of community-based monitoring was undertaken extensively as there is a policy framework as well as long standing experience of having used this practice.

5. Employing technology for accountability practice: Information Communication Technologies have emerged as one of the key tools in evidence generation in demanding accountability. In the practice of community monitoring, the employing of ICT was taken up seriously by COPASAH in many locations, especially in South Asia. Practitioners were trained in the accountability practice and in the use of creatively employing ICT in evidence generation.

V. Methodologies Adopted to Build Capacity of the Community of Practitioners

Over the past three years, COPASAH's membership has grown, which indicates a growing interest in the specific perspective with which COPASAH approaches capacity building. At the same time, there has been a lot of cross-pollination in methodologies and strategies between members, which has been facilitated through its capacity building activities. The following broad approaches/strategies of capacity building have been employed:

1. Conceptual and thematic workshops:

The purpose of these workshops has been to consolidate knowledge in the field of social accountability. Consequently, the participants are senior practitioners and experts. During the course of the workshop, participants reflect on important questions related to the practice of social accountability, such as the purpose of social accountability, whether it is intended to transform the system or make it function as per existing standards, the role of social accountability in deepening democracy and the advantages and pitfalls of existing approaches. These workshops have also provided the opportunity to examine the role of community monitoring in varying political and economic contexts both within and between countries.

2. Skill-Building workshops:

These workshops have invited younger practitioners, seeking to learn the practical aspects of implementing social accountability practice. In both Latin America and South Asia, there has been a strong emphasis on building skills of practitioners (both young as well as more experienced ones), in using information and communication technology to generate evidence for social accountability practice. These workshops have typically been conducted over several phases, to ensure that there is continuity and support for practitioners in implementation of their learnings. Tailoring inputs to the needs of specific participants was required intermittently. Reflective sessions provided feedback to organizers in this regard, and helped to make the workshop content more relevant to participants in both regions. It has led to the formation of a cadre of practitioners who have been able to use the learnings to enhance their own practice and also share it with others.

3. Targeted Technical Assistance:

Several grass roots organisations face problems due to non-availability of "experts" during the course of their work. COPASAH addressed this by building a methodology of

learning which is akin to mentoring called 'Targeted Technical Assistance' (TTA), whereby COPASAH think-tank and experts in social accountability and practice offer physically handholding other members and member organisations to set up or make modifications to their practice. This calls for practitioners to take responsibility and mobilise other organisations for learning the approaches, perspectives and skills of accountability practice as framed by COPASAH.

In South Asia and Eastern and Southern Africa, in-depth targeted inputs have been provided to organizations seeking technical support. The nature of this support has varied. A case-study also emerged during this process. In some instances, localised workshops for both organizations as well as networks have been held, with the aim of providing in-depth training for interested new practitioners of social accountability. Such workshops have been held in Gujarat and Uttar Pradesh in India, Nepal and Bangladesh. Typically participants have been grassroots organizations or networks who want to learn more about social accountability practice and implement it. Another model that has been adopted is of providing sustained hand-holding for one organization, for a particular project. For instance, in the ESA region, technical and capacity building support was provided to the organization to develop a tool for public expenditure tracking. Similarly in South Asia, Dr. Abhijit Das went to Bangladesh and spent time with Naripokko to assist them in their work with hospital management committees. TTAs have the advantage of tailoring inputs to the specific needs and context of the host organization. They have been particularly useful in taking an 'interest' in social accountability to the stage of practice and implementation, and in filling a critical gap of the absence of 'experts' at the grassroots.

4. Facilitated Learning Exchange

'Showing' is a critical part of capacity building, and this was done best through facilitated learning exchange (FLE) visits between partners. Facilitate learning exchange is modeled on the peer learning theory and is in-built in the learning processes of COPASAH. It provides mutual learning opportunities to other peers to further learning. This results in solidarity among practitioners and also learning from each other. Such peer learning processes have taken place in ESA and South Asia regions. Three such FLE visits were organized in the South Asia region in the past 3 years. The pedagogy of FLEs included understanding the issue and context that the host organization was working on, followed by a field visit where participants 'see' the practice in action. They speak to the key actors in the practice and learn from the methodologies employed by the organization. Following this, participants reflect on what they have seen, and what they can incorporate in their own practice. The FLE's were useful in getting practitioners to actively learn from one another's practices,

especially in the case of new practitioners. Along with this, it was also a useful exercise to build solidarity.

5. Certificate course on 'Health System Accountability' for grassroots practitioners:

Capacity building of grass roots practitioners as 'certified accountability practitioners' has been initiated in Maharashtra, India. This has been done through a certificate course in collaboration with a social work college. The methodology consists of both contact sessions as well as distance learning at regular intervals. The contact sessions will build a conceptual understanding on various themes including right to health care, accountability and community based monitoring and planning, determinants/constituents of democracy and participatory planning of health services, importance of regulating the private sector and advocacy. There will also be a practical exercise involving organising participatory monitoring of one grassroots health related institution by student practitioners, along with regular mentoring in the field exercise. The first contact session of the course has just been completed.

6. Technology based learning:

In order to expand the reach of COPASAH's perspective and methodologies, and make it available to practitioners who may not be able to attend in-person workshops, an e-learning module on Community Monitoring has been created (eLearnCBM). The module is hosted on the COPASAH website. It is an interactive platform with a range of resources on community monitoring, exercises, case studies, lectures and learning modules. The module can be used by individual practitioners, or in the methodology of an online course.

VI. Reflections and Learnings

The various capacity building processes engaged in by COPASAH have fostered a common understanding of what COPASAH stands for and how members can participate and benefit from the different COPASAH initiatives. The process provides us several insights related to training of grassroots practitioners.

Learning and Capacity Building is an organic process: It has been quite apparent from our experience that learning is an organic process rather than a set of specified events, and this requires that trainers and 'experts' be flexible and engage in a constant process of iteration. It is essential that sessions of inputs be alternated with periods of reflections on part of both trainer and practitioner. This process is naturally more time and resource intensive as it requires a longer engagement with

participants. In all three regions, the engagement with trainees has been ongoing, with handholding in the periods in between.

Participatory learning methodologies are relevant for practitioners: COPASAH espouses a philosophy of capacity building that differs from the typical cascading model, which is often used in large scale capacity building programs. Instead of training certain 'key trainers' who then transmit information to those lower down in the hierarchy, COPASAH's approach focuses on providing input directly to the grassroots practitioner, thereby preventing dilution of inputs to the ultimate user of information. This requires that training methodologies be made more participatory and the pace of learning be adjusted to that of practitioners.

Flexibility and adaptability to the needs of the practitioners: The training needs may also change as the activities proceed and new issues may be identified that practitioners see as important. Moreover, capacity building needs to be demand driven, with expectations and pace being set by practitioners rather than experts. This means that different regions will have different agendas for capacity building, which is dependent on the needs of practitioners in that context. Sometimes this may mean providing a different intensity of input to some practitioners vis a vis others.

Innovations: Strengthening capacity of grassroots practitioners also means innovating in terms of methodology. Peer learning has emerged as an important and powerful tool for capacity building in COPASAH's experience as it allows practitioners to support each other in the process of learning and build solidarity at the same time. Situating capacity building activities in the field, within a background of community mobilization is key to the learning process. The processes also provide an opportunity for cross learning and building solidarity. Key member organisations have expertise in working with indigenous and marginalised populations identifying and highlighting vitally important contextual issues, and they have been a source of learning for others. For instance, in Latin America, capacity building processes have helped connect indigenous groups from across Mesoamerican regions. In India, member practitioners learnt about specific issues of manual scavengers through a facilitated learning exchange.

However, needless to say that such participatory and innovative methodologies requires more time, have to keep in mind the pace of the practitioners and need more resources. This is a great challenge to fit in such vibrant methodologies within resource constraints.

VII. Concluding remarks

COPASAH's capacity building activities over the past three years have laid a firm foundation for continued work in strengthening the way communities and health systems interact with each other in supporting community and primary care levels of the health system. The practitioners who participated in the capacity building workshops and FLEs have appreciated the potential of such initiatives for improving their community monitoring practice by facilitating sharing of approaches, methodologies and tools from other regions. It is hoped that in the coming years, these approaches to capacity building will be intensified and be able to empower practitioners in demanding greater accountability for the rights of the communities.

Annexures

Annexure A: Report on Capacity Building Activities Undertaken by COPASAH-South Asia

Annexure B: Learnings from COPASAH's approach to Capacity Building – ESA region

Annexure C: Capacity building process in Guatemala, Latin America – A community team for editing and disseminating audiovisual evidence gathered through communty monitoring

Annexure A: Report on Capacity Building Activities Undertaken by COPASAH-South Asia

REPORT ON CAPACITY BUILDING ACTIVITIES UNDERTAKEN BY COPASAH-SOUTH ASIA

A. BACKGROUND

Community of Practitioners on Accountability and Social Action in Health (COPASAH) is a global network of practitioners with a common interest and passion for the field of community monitoring for accountability in health. They interact regularly and exchange experiences and lessons; sharing resources, capacities and methods; in the production and dissemination of conceptual, methodological and practical outputs towards strengthening the field; and in networking and capacity building among member organizations.

COPASAH adopts various approaches including documentation of innovative practices, sharing experiences and reflections among practitioners through newsletters and a listserv, disseminating/making visible this perspective in the global accountability space through participation in conferences and dissemination of materials, as well as various capacity building initiatives. COPASAH's capacity building approaches aim to (1) expand and improve the knowledge and skills of COPASAH members to carryout community monitoring for accountability in health. (2) provide practitioners within the three regions, an opportunity to visit each other's work and learn from and also provide feedback to the practitioners using a common set of principles. (3) provide selected members, in-depth interaction and technical assistance through other more experienced practitioner(s) with the intention to improve their overall practice of community-based accountability or for specific problem solving.

This report will discuss COPASAH's approaches towards capacity building in the South Asian region, between 2013 and 2015 along with some reflections and learnings from the same.

B. APPROACHES TO CAPACITY BUILDING:

Keeping in mind the varied needs of practitioners and the richness of experiences in South Asia, COPASAH-South Asia has adopted various approaches towards capacity building in this region. These have ranged from conceptual workshops and capacity building trainings, to facilitated learning exchanges, to targeted technical assistance and so on. These various methods have been described in the sections below.

I. Conceptual and Skill-Building Workshops:

In a region as culturally, politically and economically diverse as South Asia, the practice of people-centred social accountability and community-based monitoring in India has taken different forms, achieved varying outcomes, and faced myriad challenges. Documentation of these has been lacking and this has been an important focus for COPASAH. As part of its learning strategy, COPASAH carried out two major workshops to map practices, build a common understanding and enhance synergies between experienced practitioners.

The first such workshop was held in Mumbai in February 2013, which was attended by practitioners from three countries (India, Bangladesh and Nepal), and within India from nine different states. This provided a range of experiences from varying contexts even within the countries. It was attended by senior practitioners and researchers and was focussed on answering more conceptual issues related to the practice of social accountability in the Indian context.

The second workshop, held in New Delhi in September 2013 built on the first one, helping practitioners to contextualize their own practice of accountability within the social accountability framework promoted and facilitated through COPASAH. It helped practitioners to clarify concepts and also present and discuss the various methods being used in social accountability practices. The second workshop was attended by grassroots practitioners from various campaigns, and social movements such as – women's rights groups, Adivasi (indigenous people) Movements, Dalit (the community discriminated on the basis of caste) community, strong people's organisations/movements and community based organisations. The thematic fields of children-adolescents and youth, community entitlement/ rights movement, dignity and identity (Dalits), sexual minority rights, women's rights, maternal health rights and the community development and health rights issues represented by participants made the workshop and the discussion on accountability quite enriching.

The third set of workshops was conducted at various points in 2015 and it focussed on building practitioners' skills on using Information and Communication Technology (Photovoice and other methods) in generating evidence and using it for negotiation of health rights. Recognizing the significance of Information Communication Technologies in citizen engagement for monitoring, social accountability monitoring tools, evidence gathering, gap analysis and advocacy in health service delivery, measuring change in empowerment process of communities in demanding quality health care and attempt to bridge the digital divide, COPASAH has experimented with the use of ICTs in social accountability. COPASAH thus facilitated the initiative of promoting practice and process documentation by supporting COPASAH members in developing skills and use of available technology to produce audio-visual documentation (photography, video-clips etc.) of CBM and use them for advocacy and negotiation of health rights.

Objectives:

While the specific objectives of each workshop were varied, the overall objectives of this method of capacity building can be summarized as follows:

1. To build a common understanding of the purpose of Community Based Monitoring and its role in empowering people to negotiate improved services with greater accountability

2. Build skills of practitioners on 'doing' social accountability, bringing about conceptual clarity and providing skills for using new technologies.

3. Present and discuss the range of community monitoring among practitioners of community monitoring/accountability and encourage practitioners to undertake documentation to look at processes of change through community monitoring/ accountability initiatives.

4. Encourage grassroots practitioners to innovate community accountability practice, to explore new issues and practice with the effective use of technology at the community level and to strengthen the solidarity among practitioners with collective learning and shared practice.

5. Enhance synergies and strengthen solidarity between practitioners through collective learning and shared practice

Pedagogy:

All workshops followed participatory principles and used methods of adult learning. Through various group exercises in the workshop, participants discussed and deliberated upon how they "do" social accountability.

- Group discussions focused on increasing the understanding of the participants on the role of evidence in community driven accountability approaches; identifying the different ways of collecting and presenting evidences by partners, as well as identify advantages and challenges in community participation in generating, collating and presenting evidence.

- Panel discussions were organized which provided insight on different social accountability practices on a range of issues, and in varying contexts. At the panels, practitioners doing social accountability both within and outside the NRHM framework, and from different countries and states, presented their models of practice along with key challenges in that particular context.

- Resource Mela/Accountability Haat: In the first workshop, a resource mela (exhibition) was organized which consisted of stalls where groups presented, explained and demonstrated to other participants the methods they had adopted for community monitoring on a particular

theme/issue. In the second workshop, a show and tell session named 'Accountability Haat' (haat, in local language means a people's market) gave opportunity to various practitioners to talk about their practices. Both these exercises gave participants an opportunity to present their own practice on a range of themes (such as marginalised communities, health services, women & dignity and children-adolescent-youth issues) and also using different methods such as report cards, use of Interactive Voice Recording System (IVRS) for tracking maternal death and working with hospital management committees to bring about transparency and accountability, using accountability approach and strategies in organizing manual scavengers etc provided rich practices in accountability and so on.

- Hands-on exercises: The ICT workshops were carried out in three parts, which consisted of skill building followed by field testing and then sharing of experiences. The workshops were very hands-on and practitioners were taught both concepts as well as provided an opportunity to implement them during the course of the workshop. During the sessions participants engaged with audio visual tools and technology such as photography, video cameras, video clippings from cell phones and other media tools such as SMS, website, blogs, facebook etc. Further, the practitioners were provided an opportunity to implement what they had learnt between two sessions of training, so that they had products that they could work with during the second round of training. Proposals were invited from different states as to the specific areas that they would like to look at while implementing the ICT learnings. Various such issues were worked upon such as health rights of manual scavengers, sanitation, maternal health, and so on.

- Reflection/experience sharing: The ICT workshops alternated skill building sessions with reflective sessions, which allowed practitioners to share their experiences of using ICT in their practice. This was extremely important as it resulted in an understanding of both the advantages as well as the pit-falls of using ICT. For instance, some of the partners shared the concern of communities with using photos during public hearings, as it would make them easily identifiable to the authorities. This cautioned other practitioners to take steps to ensure consent from the community.

Outcomes/Results:

1. The workshops helped to understand and map a range of existing social accountability practices and learning's of community monitoring processes in the region and within countries. A range of social accountability experiences were presented both within National Rural Health Mission framework (such as experiences of CBM from the states of Maharashtra, Tamil Nadu, Jharkhand, Odisha) and outside of NRHM framework (experiences from Gujarat, Uttar Pradesh and Madhya Pradesh where CBM through NRHM is not yet being implemented). Further, practices were monitoring a range of issues such as NRHM guaranteed services and entitlements, Maternal health entitlements, Integrated Child Development Services

entitlements, youth entitlements, determinants of health – Public Distribution System (PDS), Mahatma Gandhi National Rural Employment Generation Act, Water and Sanitation. Practitioners were using a variety of tools and methods in their social accountability practice such as facility Surveys, Exit Interviews/Polls, Social Autopsies, pictorial tools and report cards, telephone (IVRS, SMS) and Web Based Platforms. This richness was discussed, shared and an opportunity was provided to take an inventory of practices as well as to learn from each other.

2. The workshop discussions also amply demonstrated that there were gaps in knowledge and skills and it provided an opportunity to share the challenges faced; and develop skills for effective practice and use of community monitoring for accountability in health. While a lot of issues were flagged in the first workshop, the second workshop focused more on skill building of practitioners.

3. The workshops helped facilitate and strengthening our understanding of the purpose why we use community monitoring approaches, and provided a broad framework under which social accountability is practiced by COPASAH partners. In the first workshop, several areas were identified which require knowledge creation in order to document and project COPASAH's philosophy of undertaking social accountability.

4. Through the ICT training initiative, COPASAH was, to some extent successful in beginning a process to address the digital divide which is a major barrier for community level practitioners in using evidence effectively to influence change for the benefit of the marginalized. Photostories, photos with captions, audio –visual recordings turned out to be major tools to help organise people, in community building effective advocacy- community mobilization and creating awareness in the rural community. It also provided an opportunity to document the advantages as well as cautions that need to be exercised while using ICT in social accountability practices. This was done through reflections in between skill building sessions, and also written up in a discussion paper. The findings indicated that audio- visual documentation drew the attention of the authorities prompting them to problem solving action. Visual report cards were effective in generating awareness in the community with low literacy. The community strategically used evidence to communicate with providers at various levels of health system. It led to building greater visibility of issues related to maternal and child health through social media/ press releases and women and marginalized community members demanding quality health care services.

4. The workshop left behind a deepened sense of community among practitioners, and also brought more practitioners under the COPASAH fold. During the course of the workshop, the need and possibility for an independent youth practitioners' forum was discussed.

5. The accountability haat and resource mela provided participants with the opportunity to share their experiences as well as learn from others, and was a creative learning space.

Some feedback and responses of participants were as follows:

“What I liked most was the opportunity to share and rebuild our strategies which I can incorporate in the monitoring process in my states. It also gave me an opportunity to interact with practitioners from other states.” (Participant from Mumbai Workshop, February 2013)

“I have never been to a workshop on CBM, and CBM formally has not been following a process in which community have played a role, so it is a big challenge to work in Chhattisgarh, now I feel as if I am a part of large family and this family is going to support me in rolling out CBM in Chhattisgarh.” (Participant from Mumbai Workshop, February 2013)

"In Uttar Pradesh the officials stigmatise community and act as if something is wrong with us, we do feel disheartened, but this workshop gave us back our energy and our strength to go back and again fight." (Participant from Delhi Workshop, September 2013)

"The visit was instrumental in helping the participants to learn from the practical applicability of the principles and values of community based monitoring. It helped them in observing that increased collaborations between the government of Uttar Pradesh, grassroots community groups and civil society, would make it possible for women to realize their entitlements, utilize free, life-saving maternal health services and accelerate the reduction of maternal mortality in rural areas of the state through the implementation of community based monitoring to promote social accountability for health in the state." (Report of Uttar Pradesh FLE, December 2013)

II. Facilitated Learning Exchanges:

Subsequent to these workshops in February and September 2013, quite a lot of conversations had begun among participants, and as a continuation to these COPASAH planned to organise three facilitated learning exchange (FLE) visits in different parts of India. These visits were envisaged to facilitate peer learning and to enable strengthening of the practitioners’ forum.

The first of these visits was conducted at Naugarh, Chandauli district, Uttar Pradesh from December 17-19, 2013 with Gramya Sansthan (host organisation). The theme of learning **Community Monitoring of Maternal Health Rights** through the work of the ‘Mahila Swasthya Adhikar Manch’(MSAM). The participants group comprised of 13 participants from Delhi, Madhya Pradesh and Uttar Pradesh

The second FLE visit was conducted from January 22-24, 2014 in Tumkur (60 kms from Bangalore). THAMATE, a Dalit CBO working with Dalit communities and manual scavengers was

the host organisation for this visit. The theme of learning was **Dalit Communities and Challenges of Accountability Practice**. The participants group comprised of 18 participants from Andhra Pradesh, Delhi, Karnataka, Madhya Pradesh, Maharashtra and Uttar Pradesh.

The third FLE visit was conducted between September 18-20 2014 in Nagpur district of Maharashtra with Support for Training and Advocacy to Health Initiatives (SATHI) as the host organisation. The theme was learning about **Community Based Monitoring and Action processes in Maharashtra**. 49 Participants from CSOs working in states of Bihar, Uttar Pradesh, Jharkhand, Odisha, Madhya Pradesh, Karnataka, Tamil Nadu, Rajasthan and Gujarat attended this FLE.

Objective:

To provide practitioners within the region, an opportunity to visit a COPASAH member organisation's work and learn from their social accountability practice using a common set of principles.

Pedagogy

The design is based on peer and adult learning principles and the focus is on learning from the processes (and not evaluation of organisation's work) in the context of larger socio-political context and perspectives of the organisation. Understanding the socio-political context of accountability practice, learning from the community and critical reflection are the three pedagogical themes that guide the FLEs. Typically, the format followed by the FLE was as follows:

- The first day focusses on the theoretical understanding of accountability, community monitoring framework with an introduction to emerging accountability principles. The context of the organisation's work and background is then linked to the accountability work.

- The second is designed for learning from the field where the essential component is meeting with the community and if possible interaction with the local public service/health systems. In the UP FLE, participants also visited an area where the intervention was not active to compare the situation in the two locations.

- Third day is debriefing, sharing and analysis of the learning experiences and discussion on the accountability principles.

Outcomes/results

1. The FLE provided an opportunity for COPASAH members to observe and learn from advocacy undertaken at local, state and national level.

2. It provided exposure for participants at two levels – 1) to a range of issues such as sustainable livelihoods, and building cadres for supporting Dalits, maternal health, urban health and so on and 2) to a range of accountability practices both within and outside the NRHM framework.

3. Participants were able to reflect on the work being done by the organisation based on the social accountability principles that COPASAH espouses. They also were able to think about how these practices can help their own practice, and what can be applied in their context.

III. Accountability Lab

The first two workshops organized by COPASAH in February and September 2013 gave momentum and provided solidarity among the member practitioners of social accountability. Energised by these and other informal processes, a number of young practitioners who are directly involved with the accountability processes of the community continued email and skype exchanges among themselves as a practitioners' youth platform. Some of them also wrote articles for the COPASAH blog and listserv.

The need for continued support to sustain this group with inputs and opportunities for exchanges among themselves and their growth had been expressed several times. Hence a seminar was organised to provide inputs on certain areas of accountability in health to practitioners and also for facilitating discussion among themselves on exploring ways and means to strengthen COPASAH. This effort to promote reflection and learning would then continue on skype, over emails or whenever possible in physically organised sessions. **Accountability lab** connotes this learning space and process.

With this in view a one day meeting of COPASAH members who participated in the Mumbai and Delhi COPASAH workshops was organised at Centre for Health and Social Justice (CHSJ), Delhi on April 22, 2014. Thirteen participants from six states of India (Bihar, Delhi, Karnataka, Madhya Pradesh, Odisha and Rajasthan) participated in this meeting.

Objectives:

1. To facilitate discussions on some of the critical perspectives among COPASAH members

2. To discuss pathways to strengthen COPASAH and to increase the contribution as well as participation of members

The first accountability lab focussed on the theme of 'Critical Accountability Issues for Practitioners of Accountability in Health'. The objective was to facilitate clarity among practitioners on the various perspectives on accountability such as promoted by World Bank, international donor agencies and so on, vis-a-vis that promoted by COPASAH.

Pedagogy:

The accountability lab used conceptual lectures interspersed with discussions as the pedagogy. The first accountability lab had two lectures – the first which laid out theoretical issues and perspectives, and the second which demonstrated the practitioner and citizen centric perspectives as seen in a process around maternal health rights.

Outcomes:

- Practitioners developed a more clear understanding of concepts and application of said concepts, especially as they differ from other social accountability practices being promoted internationally.

- Strengthening of COPASAH as a network and greater interaction between members.

IV. Targetted Technical Assistance:

While the workshops provided an important learning and skill building opportunity for COPASAH partners, some partners requested more targeted assistance in their respective regions/countries. Such requests were received from four regions – Gujarat, Uttar Pradesh, Bangladesh and Nepal. The expectations from the targeted technical assistance (TTA) in each case were broadly similar – to introduce the concept of social accountability to organization/s members. However the number of days and format of the visit varied depending on each host organization's requirements. Three TTAs were conducted physically by one or more experienced COPASAH members, and one (with Nepal) was conducted over skype. In Bangaldesh a two day workshop was organized for key members of Naripokkhho, a women's rights organisation in Bangladesh. The workshop was held under the Women's Health Rights Advocacy Programme (WHRAP) on February 17-18, 2014. In Gujarat, the purpose was to conduct a state level training on social accountability in health, for participants from various organizations and networks. Therefore a 4-day training was organized from March 25 - 28, 2014 in Vadodara, Gujarat. The workshop was attended by 35 participants from 13 organisations. These organisations are working on a range of issues from child rights, right to food, natural resource management, adolescent health, adolescent rights, maternal and child health, women's rights and so on. Besides, the participating organisations are part of various active networks and campaigns like the Jan Swasthya Abhiyan (Public Health Campaign), Anna Suraksha Abhiyan (Food Security Campaign), Buniyadi Adhikar Andolan (Rights Based Movements) etc. In UP, a session was organized by the organization PANI for their members on CBM within the framework of NRHM. In Nepal, Beyond Beijing Committee organized a half day session for community based organisations from three different districts of Nepal along with some NGOs based in Kathmandu. There were altogether 19 participants as CBO and NGO representatives.

Objectives

1. To increase awareness among participants on health, health rights, entitlements and social political determinants of health.

2. To inform participants about concepts of social accountability and community action on health including community based monitoring

3. To build skills of participants on various methods and tools for evidence-based community action

Pedagogy

The TTA in-person workshops followed similar methods consisting of group discussions, case studies, panel presentations and hands-on exercises. Typically, the workshop was organized as follows:

1. Began with an introduction to concepts: Social Determinants of Health; Human Rights and Right to Health; and Power, Intersectionalities, Equity and Equality. Participants explored social determinants through case stories and questions around those.

2. This was followed by sessions introducing the concept of accountability, social accountability and community based monitoring along with examples of how they had been applied in different contexts.

3. Next, the tools and methodologies for social accountability, specifically community based monitoring were discussed and practiced.

4. Finally, in the last session, participants reflected on their learnings and planned a way ahead for how they were going to utilize the learnings from the workshop.

Outcomes/Results

- Strengthened capacity of host organization/organizations/networks and campaigns (child rights, adolescent rights, right to food and so on) in understanding the concept and conducting social accountability in Health.

- Generating an interest in social accountability practice among organizations and networks who may not have been implementing it systematically. In Gujarat the training was a first step towards formation of an alliance or coalition of District level NGOs ready to work together for Social Accountability and Community Action in Health.

V. E-Learning

In order to widen the discourse on social accountability, a need was felt to reach out to a larger base of practitioners globally, through leveraging the internet. With this idea, an online e-learning module "eLearnCBM" was developed, which converts the existing resources and reading materials into an easily accessible, interactive platform. The objective of the module is to support accountability practitioners in health to adopt new methodologies or improve upon their existing pedagogy and methodologies of practice. It consists of a repository of readings, guidelines, exercises and examples which are meant to support civil society practitioners in development and health who engage human rights perspective and framework. More specifically it is intended to support citizen centric monitoring for accountability practitioners in health to adopt new methodologies or improve upon their existing pedagogy and methodologies of practice. It also envisages having live updates of current and ongoing practices and will be a potential first of its kind virtual learning lab in people oriented and human rights based accountability practice in health.

Objectives

- To enhance and expand the understanding of community monitoring among new constituencies

- To enable new practitioners, grassroots activists to build their capacities and skills on community based monitoring

Pedagogy

The eLearn-Health CBM resource provides step by step information on community monitoring and its related components. It explains the concept of community monitoring and details out what are health and health rights and how they are related to community monitoring. Besides this it focuses upon the process of CBM, and methods, tools of how data and information is collected and how advocacy is done. The platform is hosted on the COPASAH website and can be used by practitioners to self-learn CBM. It is also intended to be used as a base for conducting online courses for small groups of practitioners from various parts of the world.

The Resource endevaours to provide an inclusive view and advocacy from socially exclude users perspective, and examples of CBM and its related components from different countries like Peru, Guatemala, Macedonia, India, Tanzania and Zimbabwe etc. have been included in different sections, however it is not an exhaustive module.

The sections in the Resource are divided as learning Modules, wherein each Module begins with the learning objectives and is substantiated with relevant case stories, examples from

different regions. The end of each Module provides posers for practitioners to reflect upon what they have learnt so far. Each section also summarises the content to briefly recapitulate what has been learnt so far.

Module I- The conceptual framework- reflects upon the concept of community monitoring and its related components;

- Module II - Process –explains through step by step approach how to move ahead in the process of CBM and these steps have been called building blocks here. The steps on which community monitoring is based upon include the policy review for identifying health entitlements and gaps, steps for community mobilization; steps on health entitlement awareness can be carried out; how village/ neighbourhood health profiles can be developed; steps to develop relationships with health functionaries and public officials and for developing a skilled team for community monitoring in health.

- Module III- Practice- Evidence building details out how community enquiry is conducted and how evidence is using different tools and methods

- Module IV- Advocacy section deliberates how organized, systematic and strategic processes can be used increase the voice and access to quality health care services and towards changing existing power hierarchies. It also reflects upon the use of media in promoting health accountability.

Additional elements are provided to enhance knowledge and practice. The set of methodologies for enquiry or research has tools, activities and literature that focus on citizen centric processes. It provides for a structured learning for a practitioner through experience based concepts, practical examples- exercises, sample tools and more specific materials related to monitoring for accountability in health.

Outcomes/Results

The eLearnCBM module is the first of its kind tool available for learning the practice of citizen led social accountability practice. It is currently in the process of being piloted and translated so that it can be used to run online courses for groups of practitioners who may not be able to attend in-person trainings organized by COPASAH. It is hoped that this medium of learning will make the perspectives on social accountability espoused by COPASAH, available to a larger audience globally, thus strengthening the discourse on citizen led, human rights based accountability practices.

C. CONCLUSIONS

A review of the range of capacity building methods and approaches employed by COPASAH South Asia is emblematic of the richness and diversity of its constituencies, and consequently their specific learning needs. The capacity building activities have targeted a range of practitioners – both experienced and new – with the goals of capacity building being different for each constituency. Different methodologies have also been experimented with, including bridging national borders with the use of information technology. The pedagogical approach has been extremely participatory in all methods, and has used the principles of adult learning. Because the COPASAH members themselves share rich experiences, this has been leveraged in the form of facilitated learning exchanges which provide a 'show' rather than 'tell' approach to learning. What is also evident is the importance of maintaining continuity between capacity building activities. In some sense, the activities in the South Asia region have been iterative, with new methods being devised to respond to needs of participants. This has also been able to hold the attention of practitioners, and one finds that this has also been able to strengthen and build solidarity in the network. Collective learning and sharing provides a powerful sense of belonging in a field where disappointments are frequent and hence the need for solidarity and encouragement, greatest.

Annexure B: Learnings from COPASAH's approach to Capacity Building – ESA region

Learnings from COPASAH's approach to Capacity Building – ESA region

I. Context

Social accountability is a growing movement in various countries in the Eastern and Southern African (ESA) region with varying levels of progress registered. In Uganda, health budget advocates have consistently argued for a budget increase to meet the 15% Abuja commitment which has always been challenged by the executive on the fact that while the health budget has exponentially increased over the years, outputs have not increased commensurately to the expected levels ***"they need more results from the more money".*** In effect they raise the question of efficient spending of allocated resources. Both government and advocates agree on social accountability it terms of allocative efficiency and efficient spending. Additionally, there are concerns on low demand and a weak citizen voice and complacence. This generally obtains in the ESA region.

Given the need for better and responsive healthcare, that there is growing interest in Social accountability to improve health sector performance. The first social accountability tool to be applied in Uganda was a Public Expenditure Tracking Survey (PETS) in the mid-1990s to follow up funding of public schools. Its major conclusion then was that public services were failing the poor most by either public spending not reaching the service points or if at all services reached them, they were of inferior quantity and quality. A series of reforms were initiated to improve performance of the education sector. This inspired social accountability work in the country and helped the citizens to begin building confidence to challenge policy makers on service provision. In Kenya, when a new constitution was adopted, the right to health was explicitly defined; various measures were instituted including free maternal health care and a reimbursement to enhance equitable access to health services.

Various mechanisms have also emerged to enforce accountability; these include accountability platform, contracts monitoring groups, civil society budget monitoring group among others applying various social accountability tools.

Need for Capacity Building

A case of Uganda

Action Group for Health, Human Rights and HIV/AIDS Uganda (AGHA) is a health rights centred advocacy organization located in Uganda that has pioneered and adopted some of the available social accountability tools to make health services responsive to the needs of citizens through striving to ensure effective health planning and promotion of transparency and accountability in health service delivery. AGHA leads a coalition of CSOs in 10 districts that are engaged in health advocacy for better quality health services at the district, regional and national levels and has been instrumental in engaging health policy makers like parliamentarians and civil society on health financing, human resources for health, access to medicines and reproductive health rights.

While AGHA had successfully applied the community score card, it needed to adopt other tools particularly PETS to advance its budget advocacy and health financing campaigns. Through targeted capacity assistance, AGHA requested for specific technical assistance to develop a PETS tool and build capacity of its staff in its application to supplement the community and citizen score card currently being used for community monitoring.

II. Philosophy and perspective to the approach

This support was geared towards empowering AGHA to help communities to actively engage in social acoountability as a vehicle for transforming Uganda's health systems towards the realization of the right to health which is in line with the COPASAH vision. It followed the same principles for COPASAH capacity building; it aimed to enable AGHA effectively use PETS to improve health outcomes; it was client focused, approaching Targeted Technical Assistance (TTA) from the needs as defined by AGHA, it was participatory and followed experiential learning. It was adapted and integrated in the AGHA programing to fit with organisation's need.

Key Principles

- Capacity building is demand driven and conducted after careful internal capacity assessment and technical analysis of the need organisation. For AGHA a rapid scoping and mapping was carried out narrowing down on three components of Primary Health Care (PHC); Non-Wage, Wage and development; geographically one pilot district was selected to inform scale up. The need was a tool in which case PETS that could help the organisation track health expenditure and inform evidence based national budget advocacy.
- Participatory reflective learning is then conducted facilitated by an expert in a given area
- Follow up actions agreed upon at the end of the training with much focus put on testing the knowledge through practice

III. Approaches

- Targeted technical assistance was used facilitated by a partner from UNHCO. It involved meetings, field tests and adoption of the tool.

AGHA staff during one of the sessions in the ED's Office

Objectives

- Targeted technical assistance was conducted with the objective of developing the capacity of AGHA to adapt and apply PETS approach in its health budget advocacy work. This intended to supplement other tools which were already being used by AGHA such as community scorecards, citizen report cards and applied budget work through periodic budget analysis to enhance its health financing campaigns in Uganda. The specific objectives included;
    - To orient AGHA staff directly involved in social accountability and advocacy on PETS
    - To identify the relevant program areas and indicators in AGHA to which PETS is applicable
    - Develop a tool for application of PETS by AGHA in its programing.

What worked

- The approach of targeted technical assistance was tailor made based on the organisation's expressed need. The beneficiary determined the direction of support so that it adds value

to the process of achieving the organisation's mandate. For the case of AGHA, TTA helped them to implement PETS in one of its programs in its strategic plan to promote transparency and accountability in the health sector. It is emerging from the current review of the strategic plan that PETS will be embraced as a mechanism for building solid evidence for budget advocacy work.

Which approaches didn't work and what were the challenges

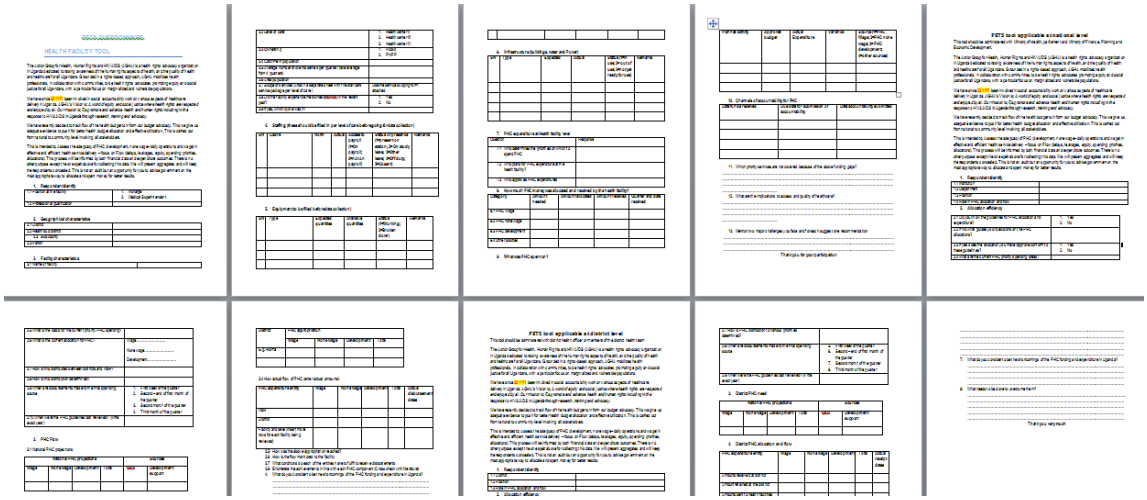
- The duration and funding of the TTA, was limited; the funding mechanism is not informed by the cost of the type of TTA needed. The support could not for example cover the piloting of the tool that was developed. The organisation however, has now integrated the tool in its social accountability programs and is rolling it out to inform its budget advocacy work.

What innovations were tried out and why

- The TTA supported the development of a tool (PETS) to enable AGHA track health expenditure of which is critical to the functioning of the health sector in Uganda. The nearest that is done in Uganda is national health counts which does not provide information of how much funds actually go into service delivery, this specifically looks at the flow of funds and identifies points at which leakages occur in the system.

IV. Results and Outcomes

- 5 staff were trained in the application of PETS. Staff are now able to monitor budget flow and spending using the PETS tool which was developed and providing quarterly budget briefs to the Ministry Of Finance Planning and Economic Development (MoFPED). This is in compliance with the requirement by MoFPED for CSOs to provide budget implementation briefs from districts of implementation with advice on budget effectiveness and efficiency.



Multi level PETS tool developed through TTA

- PETS is an empowering tool that enables citizens to link service delivery to spending. Using the results from PETS, citizens in the target areas can now question the allocations for the amounts received and demand for commensurate services.

- Improved budget analysis primary health care budget spending by local governments. The tool was applied to understand the challenges of huge utility bills for public health facilities. The finding was that budgeting was way below the actual consumption thus there were always arrears which accumulated overtime. When this information was presented to the parliamentary committee on health, the PHC non-wage which caters for utilities was increased in financial year of 2014/15

V. Challenges and Learnings

Challenges

- There was limited follow up mentoring and coaching after the training: The TTA should have provision for providing follow up grants where TTA facilitators can follow up and provide mentoring to the beneficiary organisation to be able to answer possible issues emerging from the support.

Learnings

- TTA is more effective when it is demand driven. The initiatives started are more likely to continue because they are based on the needs of the beneficiary organisation.
- TTA should support those initiatives which fit within the organisations ongoing work to ensure continuity and value addition.

Annexure C: Capacity building process in Guatemala, Latin America

Capacity building process – A community team for editing and disseminating audiovisual evidence gathered through communty monitoring

OBJECTIVES

BACKGROUND

At the beginning of the year, a team integrated by the heads of the research and the communication areas of CEGSS prepared a two-phase training program. The first consisted of ten two-day sessions each, to complete with a series of relevant content for editing and disseminating the evidences collected by the Council of Communities Guatemala for Health's (CCSG in Spanish). Such content would be taught in workshops by specialists in each field. Likewise, the program considered a second phase for implementation, practical and direct work of the trained members with leaders and delegates from various councils at the departmental and municipal levels.

Objectives

GENERAL OBJECTIVE:

To prepare community leaders for the editing of audiovisual resources for political incidence through technical training and community practice at the service of CCGS.

Specific Objectives:

1. To provide participants with Free Software, journalism, ethnography and audiovisual tools.
2. To develop their own audiovisual resources autonomously for CCGS' incidence process.
3. Contributing with the collection of evidence and the training of other leaders in the use of audiovisual tools and techniques for its gathering.
4. To know dissemination, monitoring and evaluation means of these products.

SELECTION OF THE EDITING TEAM'S MEMBERS:

The team was formed based on the profiles' evaluation from the participants of the project Advocates of the Right to Health 2014-2015. Through observation and final evaluation interviews, the potential members who were willing to, and who complied with a basic profile thought out the following way:

- Members must have completed the training phase 2014-2015, about basic audiovisual tools.
- Basic knowledge of technology
- To have interest and time availability to attend workshops for 2 or 3 days, throughout the first semester of 2015.

Linguistic and gender balance

Another important factor was the gender balance in the group. Searching for women who could participate was therefore prioritized, seeking alternatives for them to be able to participate in all activities, even if they didn't meet all the criteria. It was also prioritized to have one person per geographic or linguistic area.

Interest and availability

During the interviews or telephone communication held with each of them, their interest and availability became evident, except for Totonicapán's candidate -who had demonstrated abilities with the use of technology- but had to decline due to his work and family responsibilities. For this reason, Teresa Puac was the only chosen one for the department, and who is also the Departmental Delegate.

It's also worth mentioning that a common characteristic of the selected people is that they're all young adults. The group is very young, and they have shown closeness (in varying degrees) to technology, interest for their academic development and as community leaders. The group was made up as follows:

Number	Name	Municipality and department	Mother tongue	Academic level
1.	Rosa Sojven	San Pablo La Laguna, Sololá	Tz'utujil	High-school diploma
2.	Dagoberto Laínez	Ixtahuacán, Huehuetenango	Mam	Rural elementary school teacher, and started college this year
3.	Dulio Ramos	San José Ojetenam, San Marcos	Spanish	High-school diploma and three years of college education
4.	Teresa Puac	Totonicapán, Totonicapán	K´iche'	Currently studying High-school for adults
5.	Domingo Gómez	Cotzal, Quiché	Ixil	Rural elementary school teacher
6.	Otilia Soc	Queen Zone, Quiché	Q'eqchi'	High-school diploma with emphasis on computers
7.	Sebastián Cucul	Carchá, Alta Verapaz	Q'eqchi'	High-school studies
8.	Romelia Jalal	Tamahú, Alta Verapaz	Poqomchi´	High-school studies

To ensure participation and persistence in the program, CEGSS made a formal agreement in which fixed rates for travel expenses were established, allowing the participants to cover their transportation and accommodation expenses, and the corresponding payments to the facilitators of each workshop.

Methodology and activities

Shortly after starting work sessions, the Councils' activities changed priorities and workshops (which require enough time for their organization and execution) were postponed, so that the Communication and Research team could focus on preparing reports, and the tracking and monitoring of such local activities.

Halfway through the first phase, it was decided with CEGSS' direction that the methodology had to change due to the diversity of contexts and bases of each member. Using technology and autonomous work (in their communities) were the two pillars of the process. In addition, the scope of the topics –regarding which not everyone had previous knowledge, aptitudes, or particular interests– also limited the results of the first workshops.

It was then considered that a specialized accompaniment in the areas in which each member performed best would provide a better outcome. The process was then reorganized so that the methodology was mostly personalized. Each of the members was evaluated, and a meeting was held to discuss the progress and difficulties met in the first three months, after which the process was redefined individually for each member.

ACCOMPLISHMENTS

Produced materials

Throughout the process, several activities that made the learning evident took place. Thus a series of typical products of the process were created.

- **STORYTELLING**. Seven stories were prepared, which made evident the individual process that each of the members of the Editing Team had to be able to be a part of it. They can be seen at www.vigilanciaysalud.com

- **COLLECTION OF MATERIAL (EVIDENCES IN DIFFERENT MUNICIPALITIES)**. Monitoring visits in which the members of the team actively participated in the gathering of evidence were made. These evidences were then exhibited in departmental exhibitions, or at internal activities for each Council. In several municipalities, during June, the team members joined the facilitators to support in the orientation work regarding picture taking for new advocates. It's important to mention the activities that took place in the following places: Huehuetenango - San Juan Ixcoy, and Sololá, which was conducted by Dulio Ramos and Dagoberto Lainez. In Alta Verapaz, the activity was done by Romelia Jalal and Sebastian Bex. Lastly, Teresa Puac's constant activity in Totonicapán made the collection and editing of the evidences a much easier process in several municipalities of the department.

- **SOLOLÁ VIDEO EDITING**. After taking pictures and video, with the participation of Dulio Ramos and Domingo Gómez, a video was edited.

- **EXHIBITION AND PRESENTATION OF 2014'S PROCESS RESULTS**. Departmental exhibitions had oral and visual presentations of the Editing Team's work. In each department, the members of the team had roles of picture-taking, dissemination and presentation of evidences.

FACILITATING ASPECTS OF THE PROCESS

Technological equipment

Having new equipment made communication easier, as well has the preparation of evidence for dissemination. In 2014, cameras and recorders facilitated the process of collecting evidence; and in 2015, the computer assigned to each department (Isn't it assigned to specific people?) facilitated in different levels (depending on the departmental Council's dynamics) the possibility of improving the evidence for further dissemination.

During the 6 months that the training process and practices took place, all the members had access to tools that allowed them to communicate through the Internet. However, only 4 or them effectively used the computer to edit and divulge evidences: Dulio, Romelia, Teresa, and Dagoberto. In addition, Domingo, Sebastian and Otilia have had Internet access and electricity service problems, which limited their participation to the temporary possibilities of accessing such services.

Interest of the members

One of the main aspects that favored the development of the training process was the interest shown by the members. For most, this was the first opportunity they had to have access to computer software and technology, as well access to the Internet in an almost permanent way (although sometimes limited as mentioned in the previous section). Besides, they also had technical training about communication in general and audiovisual editing software.

Their interest was especially manifested regarding the use of computers and editing photographs. For such activities, the participation of facilitators from the Fotokids organization was important, since their experience in training young people about audiovisual media managed to generate interest and constant practices from the members of the editing team. To see the results of each member –from the facilitators point of view– see Fotokids' final report in the Annex section.

ACTIVITIES AND PROCEDURES THAT DIDN'T WORK

Lecturing and distance methodology

At the beginning of the process, methodology was prepared and discussed at CEGSS with the team members, which was based in directed learning, from intensive lecture sessions given by an expert on the subject, as well as practical activities to repeat with exercises at home. This methodology required commitment and constant practice from each member, as well as availability and ease to communicate doubts during the "distance" periods.

Nevertheless, most of the team members didn't have any previous experience with this methodology. Systematic reading and systematic practice of exercises was a heavy load to comply with. Some of them weren't able to complete certain exercises, while for others it was an easy task to do and send, and then to receive feedback.

The research team took over checking homework assignments one by one, and relevant corrections to indicate the needs to be reinforced, going from spelling issues, to substantive matters that required revision and deepening to ensure effective communication.

In most of the workshops, the experts noted that the comprehension level was very low, given the diversity of learning contexts and previous knowledge about the topics or techniques used. While the general methodology used by CEGSS is practical and actively involves people in decision-making; at the time of the training, their passive school practices background became noticeable, preventing a rapid acquisition of meaningful lessons. This made the process longer and with a lesser level of depth than expected. It was noticed less effectively in discussion activities about communication media, such as speaking, production of press releases, journalism and drafting; because the team members required basic knowledge in communication topics. Even though they received supporting material for those subjects, reading habits and comprehension were limited. Hence, it wasn't possible to ensure that they had the minimum conditions to receive the workshops.

This methodology was therefore not continued, preferring a more practical approach that didn't require reading nor discussion in depth.

CHALLENGES AND HOW THEY WERE OVERCOME

Integration of team members and the council

One of the challenges was to program parallel activities with the editing team and the council, so that the team members were integrated not only as part of the Council, but also as editors and communicators. It was a challenge because even though the training process' time period was extended, the abilities acquired and ready to be performed varied greatly from one member to another.

Some advocates members of the team were able to integrate seamlessly, working with collecting, organizing and editing the own material, or that of their peers in other municipalities. However, not everyone was able to incorporate, either because they didn't have well-developed skills or lacked the time. Those who did incorporate into the team without problems were Teresa Puac from Totonicapán, Dulio Ramos in Huehuetenango, and Romelia Jalal in Alta Verapaz and Domingo Gomez in Quiche at a lesser extent.

It was then decided that as of June, the members of the team would also comply with activities regarding collecting evidence, supporting their fellow advocates in their municipalities or others, and the editing of the material. In this way it was possible to also incorporate Dagoberto Lainez and Dulio Ramos for Sololá as well.

Using technology for editing

It is worth to consider that even if everyone had at some point worked with computer equipment, not everyone had had experience using open source software nor audiovisual editing software. Even writing in Spanish in a typewriter was complicated for most at the beginning. Using Linux wasn't easy for most of the team members nor for the Fotokids facilitators, who supported the training in audiovisual techniques.

It was therefore decided during the first months to assign tasks for the constant use of the computer and the Internet, facilitating to a large extent their work as team members. A reinforcement session was for the use of technology was added, and it was delivered by the facilitator that started the training in this aspect. They worked in periods of one to three day sessions to solve doubts and do basic exercises such as Google searches, writing in the "writer" software, as well as using an image editing software to prepare brochures in a quick and simple way.

Additionally, it was decided that as the collecting of evidences moved forward, an additional workshop would be provided to complete their first material. In the aforementioned session the software would be changed to Windows. For the time being, Dulio Ramos is the only one to have completed such process; the rest of the team members are still in the collecting evidence process in their municipalities.

Comprehensive training: Theory and practice

Practical training was resolved in the last months, especially during May and June, training team members in photography, video, and editing techniques. Despite the conceptual training they had about the whys, what for, how and for whom to communicate, it is still a challenge yet to be delivered to all the team members. This training started since work session one, but required too much time and for the rest of CEGSS' team to be physically present, e.g. field facilitators, who could make communication simpler, as well as producing ideas according to the work done in recent years.

For the time being, a first integration exercise was done with the interested parties for the editing of Sololá's video, in which local leaders with wide experience, the field facilitator of the department, a member of the team, and the facilitator and expert in audiovisual communication from Fotokids participated. The result was the first script written by a team that reflects both the Council's and the technical managers' ideas, whom are the team and Fotokids.

7.Monitoring and evaluation

Since its planning, this strategy was considered as part of a broader process of research and participative action, which required to have organized and constantly evaluated information, by CEGSS' organizers and by the leaders involved in the Team. In this way, monitoring instruments were prepared to allow keeping a record of different activities and their corresponding results.

In some cases, the evaluation was conducted in together, with organizers-leaders in group interviews or discussion sessions, both to articulate ideas and to consolidate the lines of work. The latter was the case of the meeting held during the second workshop, in which the different roles of the various bodies involved were clearly established: CEGSS, Council, and the Editing team. Extended dialogues about public health and the role of advocates and communicators of CCGS also took place.

After each session or practical workshop, individual or collective interviews were done, which were recorded and systematized. In addition to this work, a process of learning assessment was conducted, to measure the outreach for each of the members and identify strategies to supplant those that were not working. Reflecting about the individual process, as a team and as Councils, with the learning assessment process (as much as process, as well as self-assessment) was integrated into an intermediate evaluative report. This allowed a break from workshops to carefully observe the individual performance, methodological strategy and coordination of Councils. The result, as mentioned before, was the change

of strategy from theoretical-practical training to intensive practice to prepare the advocates at a technical level.

This strategy also allowed that the members of the committee integrated into the local level Councils' activities, both to give support to their peer advocates, as well as to collect and eventually edit evidences. This process is directly done with the field facilitators and the leaders of the different communities where they work.

COPASAH Global Secretariat and South Asia Region Node
Centre for Health and Social Justice
Basement of Young Women's Hostel No. 2
Avenue 21, G Block, Saket,
New Delhi-110017