COPASAH SOUTH ASIA FACILITATED LEARNING EXCHANGE VISIT -3

SEPTEMBER 18-20, 2014

Venue – Nagpur, Maharashtra

India

Community of Practitioners on Accountability and Social Action in Health

HEALTH CENTRE

COPASAH

CENTRE FOR HEALTH AND SOCIAL JUSTICE

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Abbreviations:

AAAS -Amhi Amachya Arogya Sathi

ANM- Auxiliary Nurse Midwife

AWW -Anganwadi worker

CBO-Community Based Organisations

CMO- Chief Medical Officer

COPASAH - Community of Practitioners on Accountability and Social Action in Health

CSO -Civil Society Organisation

FLEV- Facilitated Learning Exchange Visit

ICDS -Integrated Child Development Scheme

JSY -Janani Suraksha Yojna

MPW- Multi Purpose Worker

MSAM -Mahila Swasthya Adhikar Manch

PDS -Public Distribution System

PFI -Population Foundation of India

PHC- Primary Health Centre

PRA- Participatory Rural Appraisal

PRI -Panchayati Raj Institution

RKS- Rogi Kalyan Samiti

SHC- Sub Health Centre

SHGs- Self Help Groups

SPAD- Society for People's Action for Development

VHND- Village Health and Nutrition Day

VHSC- Village Health and Sanitation Committee

Background and Objectives

Community of Practitioners on Accountability and Social Action in Health (COPASAH) is a global network of practitioners that places a strong emphasis on the role of civil society to promote access to equitable and quality health services besides ensuring accountability for health services. COPASAH was set up by a group of practitioners who came together to share their experiences at Johannesburg in July 2011 and currently has a steering committee of eight members from Asia, Africa and Latin America. (*Visit www.copasah.net for more details)*
South Asia region workshops were conducted in Mumbai in February, 2013 and in Delhi in September, 2013 to promote the perspective of sharing experiences in community action.

Following these workshops COPASAH had 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. These learning exchange visits aim to provide practitioners an opportunity to visit a relevant organisation's work and learn from their social accountability practice using a common set of principles. The visits are an extension of the principles and concepts discussed during the South Asian region COPASAH workshop in September, 2013.

Amongst the FLE visits the first one was conducted at Naugarh, in Chandauli district of Uttar Pradesh from December 17-19, 2013 with Gramya Sansthan as the host organisation. The participants visited three villages including Karwaniya, Majhgai and Dumariya and got an exposure to learn about the functioning of the Mahila Swasthya Adhikar Manch (MSAM). They learnt from the women's struggle for community monitoring of maternal health rights. According to the participants the learning visit was an enriching experience and they got an opportunity to observe the various principles of community monitoring and accountability in practice. The group also visited a village (Nainvat) where MSAM is not active and could see the differences. The group comprised of 13 participants from Delhi, Madhya Pradesh and Uttar Pradesh.

The second FLE visit by social accountability practitioners of COPASAH in India was conducted from January 22-24, 2014 in Tumkur; Karnatka. THAMATE, a community based organisation (CBO) working with Dalit community and manual scavengers was the host

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

Advancing from the experiences of the former two FLE's the third facilitated learning exchange visit under COPASAH in India was organised from September 18-20, 2014 at Nagpur in the state of Maharashtra, with SATHI as the host organisation.

The three days exposure visit focused upon learning about Community Based Monitoring and Action processes in Maharashtra and from experiences of other participant CSOs working in states of Bihar, Uttar Pradesh, Jharkhand, Odisha, Madhya Pradesh, Karnataka, Tamil Nadu, Rajasthan and Gujarat. The group comprised of 25 participants in the third FLE however was later joined in by more than twenty members of the Jan Swasthya Abhiyan (JSA).

Day 1- September 18, 2014: FLEV 3- Nagpur

Setting the Context:

The first day started with setting the context for the FLE visit.CHSJ representative, Bharti Prabhakar set the context for the three day FLE and outlined the overview and aim of the FLE. She said that the learning visits were premised upon the peer learning methodology where participants would learn from experiences of community monitoring as being carried out in other states. The aim was to provide facilitated learning opportunity to practitioners within the region through visit to a COPASAH member organisation and learn from their social accountability practice and learn about a variety of accountability initiatives being undertaken by civil society organisations across other states of India. This was followed by a round of self introduction by the participants.

Background of Maharashtra: In the Context of Socio-Economical and Political Scenario; Present Status of Health Care System

Following the introductory round, Nitin Jadhav from SATHI deliberated upon the socio-economic and political context of Maharashtra to provide a brief background about the state and the health system. He briefed that Maharashtra was an economically well developed state and contributed nearly 15% of the tax in the country. It is the second largest populated state in India and migration from rural to urban areas in search of employment is a major issue in the state.

There are differentials in the literacy levels between rural and urban areas as it stands 70% for rural areas and 85% for urban areas and the literacy levels are relatively low for the Dalits and Adivasis (tribals). Similarly the differentials in poverty and wealth are starkly wide as gamut of extreme rich and poor are visible in the state. The tribal population is largely concentrated in 12 districts of the state. Amravati, Thane, Gadchiroli, Nandurbar have tribal dominated hamlets and Amravati, Gadchiroli are considered to be Naxalism affected areas. Historically, Maharashtra has had a vibrant social progressive and rights based movements' culture, which has led to formation of strong network culture in the state.

He added that the health service utilisation pattern is varied in the state as the usage is estimated to nearly 70 percent in the private sector and 30 percent of the population is estimatedly using

the public health services. The spending upon health in the state is nearly 0.5 percent of the GDP. He added that there is 1 doctor for a population of 500 in the state but still there is a lack of doctors in the public health system. Though the state of Maharashtra was producing surplus MBBS doctors and had large concentration of medical colleges and schools, however most of doctors are working in the private health sector. He noted that studies in Vidarbha region which is infamous for farmers' suicide suggest that the inability to pay loans and debts taken by farmers to pay the medical treatment bills have pushed nearly 30 lakh farmers below poverty line in the region. He highlighted that the state of Maharashtra was manufacturing 20 percent of medicines still medicines are imported from outside the state due to the commissions and involvement of middlemen.

Introduction to Community based Monitoring and Action process in Nutrition

Following the sharing of the context of Maharashtra, Hemraj Patil from SATHI, briefed the participants about the plan for the field visit. The field visit was planned for two Anganwadis[1] in the urban area of Nagpur city. The field visit was planned for two Anganwadis in Tajbagh and Bhandewari areas of Nagpur city and the participants were divided into two groups accordingly. The participants were oriented about the field visit and told that they will be visiting the Anganwadi Centers (AWCs) and meet the members of the mothers' committee there. The discussions will be around the Integrated Child Development Scheme (ICDS)[2] services available in the slums.

Archana Urlende, from Amhi Aamchya Arogya Sathi (AAAS) briefed the participants about the community monitoring and action process being carried out in provisioning of Supplementary Nutrition Programme of the ICDS scheme in the Nagpur city. She said that Nagpur city has 981 Anganwadi Centers and 22 Anganwadis of Bastis (urban slums) in six places have been selected for the monitoring process which started nearly 1.5 year ago. She informed that SATHI was the

[1] An anganwadi is the focal point for the delivery services to children and mother's in their communities under ICDS programme. An Aganwadi normally covers a population of 1000 in both rural & urban areas and 700 in tribal area. The Anganwadi worker, a local woman selected from within the community is an honorary worker and receives an honorarium. She is assisted by a helper who is also a local woman and is paid a small honorarium.

[2] The ICDS Programme is a centrally sponsored scheme of Government of India aims to deliver on integrated package of basic services to children under six years of age, to pregnant women and to nursing mothers right in their own villages or locations. Services such as supplementary nutrition, immunisation, health-checkups, referral services, nutrition and health education, non formal pre- school education are provided to children and pregnant and nursing mothers in the ICDS programme.

state nodal agency for the community action project of ICDS and AAAS was implementing it in Nagpur city. Mothers committees or groups and adolescent girls monitoring groups have been formed in the Bastis. Briefing about the fields Archana said, Tajbagh area is a Muslim community dominated area and the Bandewari area located near garbage dumping yard is dominated largely by Dalit communities and comprised of nearly a population of 12,000 -13,000 persons. Tajbagh has 7 (AWC) and Bandewari has 2 AWCs, where there should have been 12.

After the visit to the Anganwadis the participants of the groups shared the observations, learning and understanding that fostered from the visit.

Group 1- Tajbagh: Anganwadi No: 148

Tajbagh AWC

- The Angawadi is located in a Muslim dominant area and the entire locality is owned by a religious trust.
- The Angwandi worker is from non Muslim community and has built a good rapport with the Muslim community women. She is carrying out her work with the support from the Muslim community women since past 10 years
- The AWC is running in a rented accommodation (₹.750 per month) in a tinned structure with no proper ventilation, water and toilet facilities and no proper drainage system.
- The AWC is utilised for four hours in a day. Due to lack of toilet in the small room of AWC, children defecate in the drain outside the AWC
- Records are maintained for children, meetings of mother committees and adolescent girl groups
- The children are provided three types of packed nutrition supplements
- Records at the Anganwadi centre reflected prevalence of malnutrition and underweight amongst children
- Discussions with members of the mothers committee highlighted that the men counterpart were engaged in hawking and vending jobs or casual labour and most of them were addicted to alcohol and women did jobs like sewing to add some income to the household.
- Women are married early and were largely anemic

- Anganwadi worker and Arogya Sakhi (health workers)are equipped with adequate ICDS knowledge and basic ANC-PNC care
- The mother's committee has provided a platform for women to come together and monitor the services at the AWC
- Women in the mothers committee have started recognising their entitlements and have raised voice about worm infested nutrition supplements available at the AWC
- As a follow up of the voice raised by women's group, the Anganwadi worker raised the issue of worm infested nutrition material but the department did not support her
- An Arogya federation has been formed with the women committee and members can take loan at 2 percent interest for any emergency or ill health.
- It discerned in talks with the health workers that in a survey conducted on the family planning services, contrary to the conventional thought that the people of Muslim community bear more children, in Tajbagh the average number of children was relatively less and the highest number of family planning (sterlisation) operations after two girl child were availed in Tajbagh by the Muslim community people.
- The Anganwadi workers in Tajbagh raised an issue that the IEC material for children is published in local language (Marathi), and the community which they work in speaks Hindi. The language barrier issue is not being taken notice of by the concerned department.

Group 2-Anganwadi No 112: Tardi, Bandewari

Bandewari AWC

The AWC is being run in a rented small room and is attended by 25 children in the age group of 3-6 years. The place is very small and the children barely fit into the space. There is no separate toilet to be used by the children. The place is used for only 4 hours every day. The children get packed food as there is no separate place for cooking. With regard to other services, children in the Anganwadi Center are provided pre-school education and immunisation services. However, the mother's committee members said that there is no fix date for the Auxiliary Nurse Midwife (ANM) to visit the center and she comes as per her convenience. The AWW then call the children who are to be immunized.The mother's

committee meetings are held in the last week of every month, but are flexible as per other engagements. The discussions are around how to best use the packed food being given at the AWC, other supplementary homemade food that can be given and information on growth monitoring of children.

Group- 2 participants interacting with Anganwadi workers and mother's committee members

The meetings with the adolescent girls, however, take place as scheduled on the second Saturday of every month. The population covered is nearly 1100 and comprises of Scheduled Caste, Scheduled Tribe, and Other Backward Classes (OBC[3]) mostly migratory. The men (and a few women) work as daily wage workers- in companies or at construction sites.

Meeting at ICDS office Bandewari Anganwadi

Participants of Group- 2 interacting with CDPO at ICDS office in Bandewari

The meeting was attended by Jyoti Kadu- ICDS incharge at Bandewari and Aparna Pulle- CDPO

The population in the area generally comprises of people who have migrated from UP, Bihar, MP, and Chhattisgarh.

The CDPO said that people are not responsive to the services/ initiatives

[3] The Scheduled Castes (SC) and Scheduled Tribes (ST) are two groups of historically disadvantaged people recognised in the Constitution of India. The Scheduled Castes are sometimes referred to as Dalits and tribals referred to as Adivasis. Other Backward Class (OBC) I is collective term used by the Government of India to classify castes which are educationally and socially disadvantaged. (http://en.wikipedia.org/wiki/Scheduled_Castes_and_Scheduled_Tribes)

being provided. They don't even attend the immunisation rounds that are done periodically

The issue of finding adequate space is one of the key challenges in the context of urban areas, especially slums. Moreover, the government guidelines are also not clear enough. There are 981 AWCs in Nagpur- urban, all of which are being run in rented spaces.

They cited some challenges faced by service providers:

- Not given space/ building despite multiple requests
- Have to pay money even for holding trainings
- Lack of cooperation from the community

Participants' Observations:

- Socio-economic status: The people reside in Pukka houses, but the drainage facility is poor. The sewage lines are uncovered and the roads are not built. The participants' observed that the area is a potential breeding ground for mosquitoes and insects due to poor hygiene and sanitation. Despite being a declared slum, there is absence of drainage system as well as no supply of clean water.

Scenario outside the Bandewari Anganwadi

- In any community monitoring effort it is important for the community to come together
- The place for the AWC is very small. It was difficult for the participants to hold discussions with the people gathered due to space constraint. Keeping this in view, it would be challenging for the service providers to hold the various activities also
- Monitoring system employed by the community and its participation was not very clear
- The report card on display in the AWC was not updated and immunisation had not been taking place since April, 2014
- The two AWCs in the area were in close proximity
- There was lack of orientation before going for the field visit
- There seemed to be a lack of political will as well as limited government funds

- Good liasoning with the government service providers
- The space rented for the AWC was in gross violation of the Supreme Court guidelines. It also violated children's rights as the place was too congested and lacked ventilation and other required facilities for 25 children to even sit properly

It was highlighted that in any community monitoring effort, it is important to have an understanding on the level of the community as well recognise up to which level it can contribute/ participate. All the people from the community cannot participate at all levels. There has to be representation/ leadership from a few people to ensure smooth functioning of the process. Besides the NGO providing technical support should be in the role of a facilitator and not a leader. This is important for sustainability of the process.

Debriefing, Learnings and Reflections from the field visit:

Subsequent to the field visits the participants enriched by the experience shared their observations, learnings and understandings from the two Anganwadis. The issues of space constraint in urban areas, lack of infrastructure, hygiene and sanitary issues, lack of drainage system were highlighted by the participants after the visits to the Anganwadis.

- In both the groups it was the first experience for many participants to learn about community monitoring and action process in an urban set up and they compared the village and urban level dynamics
- The hygiene and sanitary issues, besides lack of drainage system were highlighted by the participants and it discerned that during rainy season lack of drainage might be leading to water logging and could be a breeding ground for many communicable diseases.
- The participants in group 2 which visited the Anganwadi in Bhandewari delineated that liasioning of the workers with the department was a learning for them
- The regular holding of ANC meetings of the mothers committee were learning for the participants of Group 1 in Tajbagh. It discerned that the members of the mother's committee were given regular information and counseling about ANC services in the meetings.
- A common concern highlighted by the participants in both the groups was the overcrowding in the Anganwadis and lack of proper sitting space, toilets, infrastructure,

light and ventilation, potable water, storage space for nutrition supplements. The participants highlighted that the government has set standards of 40 pupils in an Anganwadi but the Anganwadis were catering to nearly 70 pupils on a regular basis and 130 were registered.

- While sharing experiences of ICDS in state of Tamil Nadu, P. Rajan from Tamil Nadu Voluntary Health Association said that in Tamil Nadu record for each child is maintained individually in the AWC and there are some AWCs which are being run by the private sector.

Substantiating the concerns shared by the participants from the field visit the members of SATHI and AAAS too expressed the concern that the AWC's are being run in the rented accommodation in Nagpur city.

Experiences of Implementation of the Community Monitoring and Action Process in the ICDS Project in Nagpur city

Following the debriefing session by the participants about the field experiences, Archana from AAAS elaborated the experiences related to implementation of the community monitoring and action process in the ICDS project in Nagpur city. She elaborated that the initiating process had been difficult as the establishment of community monitoring committees took nearly a year. Initially discussions were held with the Child Development Program Officers (CDPOs) to kick start the community monitoring process and support was not very forth coming. SATHI is the nodal agency for implementing the National Rural Health Mission (NRHM) monitoring project in the state of Maharashtra. SATHI organised a workshop in Pune, Maharashtra where an interface with the CDPOs was organised. Besides this there were discussions on the action plan and strategies for effective functioning of the NGOs with the government. AAAS as a partner NGO took the responsibility of implementing it in the Nagpur city. She added, though the intervention area for the organisation was not new as work on health was going on and Arogya Sakhis (health workers) were from the same community where the organisation had been working, but there had been no interference with the work of AWW. Committees had not been formed in the Anganwadis and mothers committees existed only in records on paper and there was lack of supervisor visits in the Anganwadis. When the intervention of AAA started two

years ago in ICDS, the Anganwadi workers were reluctant to share information and data. An interface was thus established between the AWW and the Arogya Sakhis.

She added that the monitoring process has led to some changes on the ground level. Though the Anganwadi supervisors are required to visit the centers twice in a month, however it was being done twice in a year before the monitoring process began and most of the CDPOs were not aware about the number of AWCs falling under their jurisdiction. Following the monitoring process the frequency of visits of Anganwadi supervisors has increased, Anganwadi Worker (AWW) absenteeism has declined, the centres have started measuring the weight and height of children, pregnant women. Malnourished children are identified and monitored regularly and severely malnourished children are recommended to Nutrition Research Centre (NRC). She added, the maximum impact in the monitoring process was affected through Jansunwais (public hearings).A public hearing was held on March 5, 2014 in Nagpur in which different officials of the ICDS department, CDPOs, dieticians, ex-officials of ICDS were present. The data and evidence generated from monitoring processes was presented before the officials and media also provided support in highlighting the issues of AWW absenteeism and discrepancies in the functioning of the Anganwadi centers.

Besides the public hearing, news broadcast and follow-up by the electronic media which highlighted reports on data for malnourished children after survey done by the organisations too effected changes. Archana added, the government data showed that only 1300 children were malnourished in Nagpur, however the data collated from 22 Anganwadis the intervention area of AAAS in Nagpur was collated and the ratio was derived for 981 Anganwadis existing in Nagpur, which reflected a count of nearly 5,000 malnourished children. Outlining an example on alternative way of monitoring she said, *Bal Haq Gath* (Child Rights group) have been formed where children(boys and girls in the age group 12-15 visit the Anganwadi for an hour and monitor the services of Anganwadi

Archana from AAAS sharing experiences of ICDS monitoring in Nagpur

workers. The monitoring by the children's group and observations by them led to bringing issues such as AWW absenteeism to surface and reporting of other malfunctions in the Anganwadis.

Corroborating Archana's stance, Nitin Jadhav from SATHI, briefed that SATHI has an experience of more than 7-8 years in carrying out community monitoring in Maharashtra and community action process in ICDS as a pilot has been initiated by it since past two years. He outlined that the experiences illustrate that linkages have to be established between Anganwadis starting from the block, district up to the state level and accountability should be at the state level to generate maximum effect.

Day 2: September 19, 2014

Sharing the Experiences and Present Status of Accountability Related Work in Various States of India

The second day sessions commenced with a brief recapitulation of the proceedings of the first day and the field visits. Further the sessions were marked by group discussions and presentations and the participants were oriented to a variety of accountability initiatives being undertaken by CSOs as representatives from organisations across different states presented their experiences. The aim of the sessions on the second day was to observe and learn from advocacy undertaken at local and state levels for issue-based activities such as right to health, education, ICDS, comprehensive health and building cadres for supporting excluded communities and women.

The representatives shared their varied work experiences of accountability, rights and equity in the context of empowering women in claiming health rights in Uttar Pradesh (UP) and Gujarat, ensuring accountability of men towards maternal health rights in Madhya Pradesh, human dignity and health-human rights of the excluded, Dalit communities in Tamil Nadu, Bihar; and manual scavengers in Karnataka, and varied accountability challenges, ensuring accountability from government for free medicines to all in Rajasthan, for basic health structures in Bihar, community based monitoring of the health system and ICDS in Maharashtra and Odisha respectively.

Experiences from Melghat and Gadchiroli, Maharashtra

Someshwar Chandurkar, shared experiences of community monitoring and action intervention of Apeksha in Melghat district in Maharashtra. He outlined that the area is infamous for malnutrition and 400 infant deaths were reported on average, and many women were severely anemic with hemoglobin ranging between 3-4 gm, when the organisation Apeksha started its intervention in 2007 in 3 Primary Health Centres (PHCs) in the area. The biggest challenge was that public health services were not being utilised by the community. The remote location of the area amidst dense forests and inaccessibility besides lack of transportation posed another challenge for workers of the organisation. The organisation began its intervention by holding regular meetings and with counseling of community people; however the intervention could not yield much results in the first attempt.

The workers reinitiated the attempts and collated the proactive key persons; members of Panchayat who were quite active and held regular meetings with the community members. This time some transformation was visible about and resultantly a change spiraled in 2008. Community people were involved in collecting data and evidence was generated upon non-functioning of Rogi Kalyan Samiti (RKS), shortage of essential medicines and other denials in health care. Arogya Mahasangh was formed with the support of organisation which carried out monitoring of health services. Presently, the ownership of the health federation rests with the community itself. The federation started with 20 members and the number of members has grown now to more than 100, and the community monitoring has spread to 30 villages now.

Someshwar sharing experiences of CBM intervention in Melghat

Vijaylaxmi from AAAS also shared the experience of community based monitoring in Gadchiroli district, which is Naxalite affected area. She noted that the foundation for community monitoring in the work area began with a simple idea of 'whether the public health system is our own'. The monitoring and action process were carried out by federation of women and Dekh Rekh Samitis at block and Taluka levels and included PRI members and persons with disability and they were able to effect a change in ANM and MPW absenteeism by utilising Right to Information (RTI) and generate a calendar for visits of ANM. The Dekh Rekh Samiti has also been able to generate disabled friendly structures in some health facilities.

The sharing of experiences by Vijaylaxmi and Someshwar generated a debate among participants on how Naxalites view the work of community monitoring being carried out by the organisations. Bindu Singh from Gramya Sansthan noted that the organisation Gramya too has been working in Naxalism affected areas in UP and till now they have not faced any problem as the proposition laid by Naxalites is also that they are working towards community reclaiming their rights which is in alignment with the work of the CSOs as they work for the community and in ensuring accountability. It discerned from the debate that CBM work has been a difficult proposition in the tribal and remote areas, however CSOs have strived to carry it.

Sharing the experiences and present status of accountability related work in various states of India

Other representatives also shared their varied work experiences of accountability in health and other fields including education, ICDS and PDS. Bindu Singh from Gramya Sansthan highlighted the example of monitoring carried out by women under Mahila Swasthya Adhikar Manch (MSAM), which has forced health service providers to be responsive and provide quality health services and carry out maternal health audits in Uttar Pradesh (UP). Briefing about MSAM, she said that the platform was formed in 2006 and is working across 11 districts of UP and 12,000 women are members of it. MSAM is a platform to talk about different issues of women. Women identify the issues themselves and carry out monitoring. The women have been empowered to demand better health services and hold dialogue with the health officials backed by strong data and evidence.

***Representative of MSAM Bindu Singh, sharing experiences of accountability in health for women* in**

The tools developed for monitoring are women friendly. Considering the low literacy levels of women pictorial tools are used which women can relate to and use easily. Data is collected on maternal deaths and state level lobbying is done by women themselves. Monitoring committees have been formed at three levels - village, block and state level. A helpline has been initiated- Mera Swasthya Mera Adhikar and contact details of Chief Medical Officers (CMOs) and other health officials have been distributed at every level.

Pradeepa, representing Anandi in Gujarat, shared the collective experience of four organisations Anandi, KSS, KNBS and SAHAJ on community monitoring in health in Gujarat. She said the organisations have been working with excluded been the major units of intervention. Pictorial maternal health tool called *Bawli Madi* (maternal health tool in the local language) were used to collect data for women for pregnant women on few indicators. The health department refused to accept the evidence initially and cross checked the data with the community. Public hearings

were held where the evidence was shared with the authorities. The Jan Sunwais led to some significant changes:

(i) Female gynecologist was not available in the Baria block since past 15 years, the hearing created an impact and the gynecologist was appointed there. (ii) Recordings were done on the issues of informal demand of money and placed in the hearing. She added that the organisations have been able to make a beginning and enable communities to monitor accessibility and quality of maternal healthcare through use of 'safe delivery' indicators; and to equip communities with skills of identifying and reporting maternal deaths. And based on these interventions hold dialogues with healthcare providers and district health officers to make the health system more responsive and accountable.

K B Obalesha, representative of THAMATE sharing accountability experiences for manual scavenging communities in Karnataka

K B Obalesha, representative of THAMATE from Karnataka shared the accountability experiences for manual scavenging communities. Providing a brief background about the inhuman practice he said, it continues across India but is worst in states of Karnataka, Tamil Nadu, Gujarat, UP. There has been no proper count of persons engaged in practice, the census of 2011 enumerated more than 16 lakh persons engaged in this practice. The practice has been restricted to certain communities like Valmikis, Musahar and Bhangis in North India and Madiga, Malas in South India and had been largely carried out from generation to generation. Manual scavenging as an occupation is entrenched in caste discrimination. He said, THAMATE has carried out the CBM process taking some key strategies into consideration which are in tune with The Employment of Manual Scavenging and Construction of Dry Latrines (Prohibition) Act 1993 and Prevention of Atrocities Act (Scheduled Castes and Scheduled Tribes). The strategies involved working on four different aspects including (i) Prevention (mass awareness, information on acts, rules and regulations), (ii) Eradication (ensuring accountability of government, fact finding on health issues related to the practice, filing cases) (iii) Rehabilitation (demanding social security for aged

persons, alternative employment/skill training for youth) and education for children (iv) Affirmative action for the marginalised community of manual scavengers. The key strategies involve taking children, youth and old age persons of these communities into consideration and form different Vigilance Committees to establish linkages with national forums to ensure accountability for the marginalised community.

Jay Verma from Population Foundation of India (PFI) shared experiences of community monitoring in Bihar. He said the biggest challenge had been the absence of structures at the grassroots level. Sub -Centers were not functional and not existing in many places of the work area and PHC was the first point of reference catering to a population of 2 lakh. The process started with awareness on NRHM entitlements, formation of CBPM committees at village, block and district levels (300 villages, 10 blocks in 5 districts), capacity building and coordination for collective action (with PRIs, PHED, SHG, ICDS. Meetings of the CBPM committees Community enquiry and facility surveys were facilitated.

Representative of PFI, Bihar sharing experiences of CBM in health

Following this sharing of report card was done; village health action plan was prepared and shared for integration into the Block Health Action Plan. Jan Samwads (public hearings) were also organised at block level. He added that this led to some changes such as emergence of strong CBPM committees and led to increased role of Panchayati Raj Institutions (PRIs) and accountability of the health services providers has been sought. RKS meetings have been regularised at many places and community has been motivated to access health services from health centers. New Health Sub Centers have been started in many places and the efforts led to opening of a PHC which had been constructed 25 years back. RKS funds are being used for purchasing essential drugs and equipments in many places. There has been increased use of untied fund at the sub-centre and at VHSC level also besides increase in supplies of medicine to sub centers. Health services were accessed for the first time in some of the locations. The CBM

process has led to changes like there have been reduction in demand of informal charges in many places. The process led to establishment of coordination between service providers and community and committee members as earlier community people were not aware when ASHA was coming to the villages and the services she was providing.

Experiences of improving access to public health services for Dalit and Muslim women in Bangalore, in 27 slums urban slums in the three areas (7 city wards) of southeast Bangalore were shared by Ayesha Sultana, Society for People's Action for Development (SPAD). She said that the solidarity groups and Self Help Groups (SHGs) were formed and CBM process was initiated with spreading awareness on health. A study was also conducted in Vani Vilas hospital (under Bangalore Medical College). Six Monitoring Committees were formed and weekly hospital visits were conducted apart from case documentation and follow-up of negligence and corruption besides other cases and schemes. Interface meetings were held every 2-3 months and follow-up was done with senior health officials. Meetings were also held with local leaders, Corporators and MLA on hospital issues. The CBM process led to some changes in ensuring accountability like a Medical Officer (MO) was placed in a maternity home which did not have a MO earlier, ANC days were increased and facilities such as that of drinking water and other infrastructure has been ensured. Free family planning services in an Urban Family Welfare Centre (UFWC) have resumed after the CBM process. She added that though the process led to some changes, the organisation faced some challenges like backlash from the staff, denials of entry in hospitals, intimidation by local goons and moreover system-level changes still remain elusive.

Kshitiz Sisodia representative of Prayas shared the experience of CBM in health in Rajasthan. He said that the Jan Swasthya Abhiyan (JSA) network, of which Prayas is a part, took the initiative to strongly oppose the action of downsizing the Rajasthan state Free Medicine Scheme. JSA has been actively working (Alwar, Baran, Pali, Dholpur and Jaipur) in Rajasthan. Under the monitoring process, besides Rajasthan VHND strengthening was also carried out in 16 districts of the state of Madhya Pradesh, besides Rajasthan. The network carried out advocacy for various health issues and universal coverage of health in the state, school development plan, mid-day meal, school Health Programs and carried out strengthening of School Management Committee besides monitoring of Public Distribution System (PDS).

Representatives of Prayas in Rajasthan sharing accountability experiences in health and PDS

Besides strengthening Community Based Organisations (CBOs) the CBM process focused upon monitoring and sensitising service providers PRI strengthening and advocacy at district and state level. Networking with other allies was forged including the JSA, Advisor Group for Community Action (AGCA), Right to Food Campaign, National Education Assembly and All India People Science Network. The monitoring process led to the rejection of announcement for downsizing the Free Medicine Scheme. Political parties also aligned their election manifesto as per the demands of by JSA in Rajasthan during election. Moreover, the Government was previously planning to demolish many schools, but has stopped the demolition due to regular advocacy.

Gurjeet Singh from JSA, Jharkhand shared the experiences of CBM and how it has led to awareness in community and developed ownership. Health functionaries became responsible for their duties and the interface has led to smooth communication and behavioral changes in both the service providers and community. The PRI members' involvement for health issues has increased and the process has facilitated convergences with other line departments such as ICDS and Public Health department.

Gouranga Ch. Mohapatra from Odisha shared the Community engagement in ICDS through mother committee and Jaanch committee (vigilance committee). He said the mother committees are being formed for each Anganwadi Centre (AWC) under ICDS since 2006, with the objective to ensure effective management and functioning of different program under ICDS and emergency food programs across districts.

Representative of JSA Odisha, Gouranga sharing experiences of community engagement in ICDS in Odisha

The role of the mothers' committees involved in identifying and caring for malnourished children, motivate parents to send 3 to 6 year child to AWC, ensure regular and timely functioning of AWC, presence of Anganwadi workers, ensure MAMATA Divas (mother's day), identify malnourished children besides monitoring other health services. The Jaanch committees were initiated from April 2011 across rural revenue villages and in urban centres across the AWCs. The President of the Jaanch committee prepares a monthly list of monitoring schedule among the Janch committee member and one member each frequently visits the AWC and rest of the members monitor the AWC on rotation basis.

Representative of SOCHARA, sharing experiences of Community Action in Health in Tamil Nadu

Ameer Khan representing SOCHARA shared the experience of Community Action for Health from Tamil Nadu. He said that the community action intervention in the state has been carried out at the policy level and the government level. A negotiation approach was adopted relative to the confrontation approach in the community action process as emphasis was laid upon community ownership. Close ties were established with the doctors association, ANM unions and discussions were held with political leadership to include health issues in their agenda. Emphasis was also laid upon strengthening of the public health system.The community action process thus was more of a tripartite agreement between the community, government and NGOs in Tamil Nadu and the NGOs were facilitators of the

process. The overall impact of the community action process was that it led to democratization of the monitoring committees at the field level. The community got engaged in water tank cleaning and monitored ICDS services. Khan added that with the community action process, though much changes could not be affected at the system level, but changes were visible at the village level, community people have started running the committees themselves through government funding. At the program level with the help of the social equity tool monitoring was done not only of higher castes but all castes and it involved taking both rights and responsibilities into consideration. The overall impact of the monitoring process led to the democratisation of the monitoring committees at least at the field level.

SATHI representatives from Maharashtra shared the experiences of Community Based Monitoring and Planning (CBMP) though the medium of a short film. The short film showcased the experiences of community engagement of SATHI since 2007. It delineated that initially SATHI covered 5 districts and 225 villages under CBMP in 2007. In 2011, the community monitoring process had expanded to 13 districts, 140 PHCs and 780 villages including the former 5 districts in the state of Maharashtra. The process has brought in some changes as the community has started recognising their health rights and initiated a move to claim them. The community monitoring and planning is done through the Gram Arogya Samitis (health committees) starting from the village level to state level. Monitoring and planning is carried on by the community through the committees and progress reports are prepared for health centers and data collated along with testimonials is shared with health officials and other stakeholders at the public hearings. More than 500 public hearings have been organized by SATHI and the process of CBMP has led to some significant changes. The Anganwadi workers have started taking height and weight measurements at the Anganwadi centres as they are aware that the monitoring and planning committees monitor and check the records. The community has started questioning the health service providers about immunisation services, when and where is VHND held etc. The film showcased experiences of community as to how informal demands by health service providers have reduced and a donation box for informal demand of money set up in health center has been converted into a complaint box. It also highlighted testimonials of how cheques of Janani Surakhsa Yojna (JSY) were encashed within five days of being highlighted at a public hearing.

Experiences of Men's accountability and intervention for maternal health in Madhya Pradesh (MP), an intervention of collaborative efforts of CHSJ, Gram Sudhar Samiti and Dharti were shared by Ragini Mishra from Gram Sudhar Samiti. She said the accountability work is being carried out on various issues in MP; but the men's accountability process is being carried out in 30 villages of Sidhi and Morena districts which are infamous for their deep rooted patriarchal hegemony. Young men between the age of 20 and 35 years are being sensitized since 2011 on responsible gender relationships and their duty to demand maternal health entitlements. Taking responsibility for change in personal behaviours, they also collectively negotiated with the local health service providers for improved maternal health services.

The strategy and tools of community based monitoring (CBM) were used to negotiate with the providers for change and to ensure accountability of health system. Through the medium of participatory rural appraisal (PRA) the needs of health care from a community perspective were understood and it aimed to involve community in demanding health services, to look at social determinants of women's health with the participation of the community; and to build understanding on social accountability in the community. On the basis of the PRA exercises, two charters i.e. Public health charter (10 points) and Social services charter (8 points) were evolved and placed in public places. Capacity building of the men's group was done and they did survey on VHND, Arogya Kendra's, facility surveys (PHC sub-centers) and report cards were prepared on the basis of the survey. Monitoring process has also led to bringing to surface the dysfunctional health services like that in Karavahi PHC which is catering to 22 villages (including 14 villages under intervention). The PHC does not have electricity connection and lanterns/ petromax lamps are used during the night for deliveries. Public hearings are held every Tuesday now and issues of denial of health rights are sorted there. Nearly 1750 post cards were

Representative of Gram Sudhar Samiti, Ragini sharing experiences of gendered accountability in health in MP

sent by the active community members to health officials from nearly 150 villages, to apprise the health providers about the denial of health services.

The visual (through power point presentations and film) and oral presentations on the accountability work experiences led to further discussions on the challenges faced in the community action processes and to devise strategies to take community monitoring further for ensuring accountability at all levels. Following this session the participants were divided into three groups on the basis of the states: Group 1 comprised of Bihar, UP, Jharkhand and Odisha; Group 2- Karnataka, Tamil Nadu and Maharashtra and Group 3 comprised of participants from MP, Rajasthan and Gujarat. The groups were given a task to collate the challenges in CBM from their experiences and chart out strategies to overcome the challenges which were discussed on the third day of the facilitated learning exchange visit (FLEV).

Day3: September 20, 2014

Discussion on strategies for collective advocacy for CBMP

Progressing from the sessions about the community monitoring and community action processes across different states delving into community empowerment and impact of CBM, the third day aimed to discuss upon strategies for collective advocacy for CBMP, at national level, including processes by which campaigns like Jan Swasthya Abhiyan (JSA) could take up such advocacy and addressed questions such as how to take the action plan forward on the national front.

Participants divided into different groups discussing on challenges in CBM and developing strategies to overcome the challenges

The third day began with presentations on challenges in community based monitoring processes and possible strategies for collective advocacy for CBMP by the respective groups. The representatives of the states were divided into groups where each group presented the challenges and strategies as follows:

Group 1: Jharkhand, Bihar and Uttar Pradesh

Challenges	Strategies proposed
- Variations in the state in CBM process -In Odisha the process of CBM is in continuum since the pilot of NRHM, in	- The mandate of CBM should build on documents of Planning Commission and Panchayati Raj, not

Jharkhand the process is at a standstill and the states of Bihar and UP are non starters in CBM process - There is no clear mandate of the system - CSO groups also do not have clear mandate on CBM process though sporadic efforts are being carried out, the process and priorities are not listed out. - Resources are limited and not channelised - CSOs are not inclined to work with government funds - Screening process of CSOs is not transparent, and there are questions on integrity - Political and administrative will is not forthcoming - Non negotiable processes cannot be defined as CBM - Role of media needs to be inbuilt - The mandate of CBM has not been linked to planning though termed CBPM - The ICDS, PDS (social security schemes) have not been included in the ambit of CBM - There is a need of periodic and concurrent, which need to be linked with community capacity building - State and national level advocacy needs regularity - Need of convergence of CSOs - Need to integrate with Panchayati Raj	on NRHM - Clear-cut timelines, protocols are required from the centre on funds - CBM rules need to be notified by different departments such as Women and Child Development, Public Health etc. There should be Service providers rules - Unit cost for innovation of states - CSO led process should be monitored and campaigned by pressure group - Setting up of Directorate of resources at state level and funds to be directed to the CSOs through a director appointed for social audit - Action Group on Community Action needs to be more active (support of mass movement) - Other accountability processes need to merged and departments need to be inter-linked

Institutions (PRIs).Different committees are running parallel to the committees under CBM. CBM should strengthen and integrate PRIs	

The second group comprising of Karnataka, Tamil Nadu and Maharashtra presented the challenges and strategies for CBM separately for each state as:

<u>Karnataka</u>

Challenges	**Strategies**
- Secondary and tertiary care services are going to be privatised - Out of pocket payment expenditures - Maximise the work in CBM - Outsourcing of staff - Privatisation in the public health system and private health care system - Free medicines are only for common ailments - Inadequate staff/manpower - Delay in fund distribution - Night services have to be strengthened - Schemes are present but are not implemented and do not reach across at all levels - There is no policy at state level - Government is taking monitoring into its hands - NRHM has a mandate but state does not put any pressure	- Work on both sectors (public and private) - Clinical establishment act needs to be re-looked at - CBM needs to be carefully approached - Fight at the policy level - Networking is another strategy - Effective functioning and autonomy to community members through state levels too - It has to be done through a third party for monitoring - NGOs need to be pressurised and use RTI on state for effective functioning of NRHM mandate - Converging of committees need to be present - Networking from people's movement need to be there - Right to health movement needs to look

- Community participation needs to be present at all levels - Support from other organisations (networks) is not present, people's movement is not there from grass root levels - Health movement or network are not including people to organize mass programs - Food prices (Right to food) and should be taken up	at a larger level (an example from Karnataka)

Tamil Nadu

Challenges	**Strategies**
- Planning before implementation - State government utilises all the budget at the higher level - There is no equity in schemes - Deviation of purpose in schemes (used somewhere else) - Health seeking behaviour is poor in rural areas and people do not come out for any implementation - Health care service have been decentralised - Networking, planning and programmes do not involve partners who are needed for networking organizations - Line department convergence to all health and other issued is not there	- Find out total needs based allocation of budgets through all the NGOs - Public health system has to work in all sectors, to make it a people's movement - Government has to take initiative of networking and should allocate funds for accountability purposes - NREGA social audit –is separate and should not be within department and has to release funds but a contradiction

- Protests are compromised to small issues - Government is doing a divide and rule policy - Networking has some development, financial support is there but limited in some sectors	

Maharashtra

Challenges	**Strategies**
- Need to relook at the way organisations are looked at (media and publications) - Budget is not shared across all the levels - If there is no change in policy level there won't be any change - Private practitioners have been told to cancel their registrations but no action has been taken place - Acts could prove wrong for both sides - Voluntary organisations helped set up a CBM model but it needs to be taken at all levels - Execution of Gram Sabhas at all levels needs to be modified - Computerisation of services - The rules outline that NGOs should be included in the mandate but NGOs are not present during the PIP or any mandate stage, not present	- Newsletter to be prepared through various organisations - Budgets need to be shared and tracked at all levels - Private practice needs to be controlled - Collaborative efforts across all the states - Right to health should be legalised and made functional (all the other health rights, etc.) - Gram Sabhas, should be held with participation of people and needs to be a mandate

- Policy needs to look at government run hospitals (doctors who are trained and should be working in those hospitals for some years) - Disabled people are not being looked at in all schemes - Community is not involved in any government mandate (during planning or implementation) - Detachment exists within NGOs also	

Group 3: Madhya Pradesh, Rajasthan and Gujarat

Challenges	**Strategies**
- No intervention at policy level and departmental levels - Data is no available from village level to district level - CBM ignored at all levels by the health system - Transfer of officials hamper the process - Lack of regularity in fund flow - Lack of accountability on behalf of staff - CBM process not carried out according to guidelines - Nation Urban Health Mission (NUHM) has not begun in Gujarat - Budget not utilized fully and gets lapsed - No provision of monitoring after	- Need for capacity building - Tools should be upgraded - The process of CBM should be carried from bottom (grassroots to upwards) - Strengthen CBM at village level - Strengthen and activate Jan Swasthya Abhiyan (JSA) and other networks like Maternal Health Rights Campaign (MHRC) - Decentralisation of plans : Plans should be made at the grassroots level as the plans do not get integrated in PIPs

capacity building - Lack of funds in RKS - JSA not strengthened in the state and the network is relatively inactive - Lack of political will on health- Politicians not sensitive about health issues - Lack of community involvement in PIPs	

WAY FORWARD: Towards building solidarity of practitioners of community action in Health

It discerned from the presentations of the groups that sporadic efforts of CBM have been carried out across states by organisations and these initiatives have been with support from government in many places and some have been carried out autonomously. To overcome the challenges at the state level a consensus emerged amongst the participants that a national level collective campaign needs to be initiated and an independent body is required to take it forward.

E. Premdas from CHSJ facilitating way upon CBM

E. Premdas from Centre for Health and Social Justice (CHSJ) said, "As a community level practitioner it will be beneficial if we can make a dent at the national level and we require a forum and a voice for the same. It has to be devised that how the accountability voice can be brought together. We need to look at what can be possible in the next 6-8 months to start with. We need to explore if there a possibility of a collective and how to take it further. It should not be a burden; we need to look what is possible from our experiences."

Abhay Shukla from SATHI said, "If we look back at the context of India nearly two decades back, the terms like community accountability, community monitoring and social audit were not part of the common discourse. The scenario is changing today and community accountability is coming on the agenda and there are some resistances to it by the system. It is a struggle which can be termed as a strategic one, as it is not a white and black struggle." He added that different allies and spaces exist which need to utilised strategically overcome the resistance of the system.

He added that there are systems where community accountability has been accepted to some extent however it has been resisted in many contexts, and the degree of resistance varies across states, he said. The process of community monitoring is being constrained in some form or the other such as there is no provisioning of funds at places, and there is no timely release of funds.

The community monitoring process needs to be community centric and needs to be institutionalised, bring together CSOs, community and political representatives. There is a need to upscale the process right from the grassroot level the national level. And there is need to take the struggle forward inspite of the constraints of funds and mandate.

We need to deliberate upon what can be done at the national level collectively, he said. In order to clarify confusions about the role of AGCA and COPASAH, he specified that AGCA is not a community monitoring body and it is a committee chosen by the government. Whereas COPASAH is a global level technical support structure and a platform which promotes capacity building, knowledge generation and facilitates bringing of community monitoring practitioners together though peer learning methodology. He also highlighted that we need to make a clear distinction between '**FORCES'** and '**SPACES'.** VHNSC and AGCA are spaces and bodies like JSA, MSAM, MHRC and others are forces. Though the spaces are not requisite, but we need to utilise and expand them and strengthen the forces. If the forces are organised, then the problems right from the village level to up, can be shared with the Ministry of Health and AGCA and these spaces should be utilised fully.

Abhay Shukla from SATHI deliberating upon CBM and future framework

With technical inputs from E. Premdas from CHSJ and Abhay Shukla from SATHI: It was also agreed that all the present CSOs would generate state wise status report on CBM process which would encompass components such as the scope and scale of funds, institutional mechanism, and role of CSOs, accountability mass events (public hearings), impact and change supported by case studies, resistance and challenges. The status report content framework was developed in accordance with the condition that CBM has been carried out in accord with official support, partial official support or in an autonomous manner.

Key action points for way forward:

Some key action points emerged from the deliberations and discussions held on charting out the way forward towards building solidarity of community accountability practitioners in Health which include

1. ***Network and solidarity of community action practitioners:*** It discerned that an inclusive network of practitioners and grassroots activists who are involved in community based accountability processes in the health sector be formed. The network would work on two basic principles that of 'INCLUSION' and 'CONSOLIDATION' Though the network would focus on community accountability initiatives of the member organizations however it would be a part of the wider health movement and associate with movements and networks. This process would be inclusive as it would bring together diverse coalitions and activists, existing networks apart from the health sector working in the different states on community accountability processes, with a right based approach. (MNREGA, social services sector, education etc.) As the process of collation proceeds, simultaneously some activities would be conducted collectively over the next six months and regular feedback and meets would chart the course of the process further.
2. ***Status report on community action:*** State wise status reports on Community action and accountability processes in the health sector would be prepared by the participant organizations representing different states in the FLEV-3 and the reports would focus on elements including scale of community accountability activities, institutional mechanisms (whether supported by NRHM or not), role of CSOs, key accountability processes (such as public hearings), impact based on case studies, different forms of resistance and challenges faced from the health system. The status report will be compiled by mid-December, 2014 and subsequently will be shared with various decision makers as well as civil society networks to promote accountability of health systems, service providers and to ensure Health Rights. (The details of the framework of status report are tabulated in Table1)

Table 1: Status report Framework

Framework for status report		
Focus- CBM in health services		**Timeline-** December 15, 2014
Post –Pilot framework Where CBM has happened with official support	**Modified Post Pilot CBM – Some official support**	**Autonomous CBM- Gujarat and Uttar Pradesh**
• Scope and scale of funds (Villages, PIP)		• Process of CBM-scope, issues, tools used, network
Framework • Involvement of CSOs at various points, marginalization of role of CSOs • Institutional mechanisms-involvement of multi stake holders • Accountability mass events (public hearings)	Modified framework of CBM	• Response by the state (confrontation with state, rallies, protest (dharna), interface with state
Impact – supported by case studies , stories of change		Impact and lessons learnt
Resistance and challenges	Resistance and Challenges	

3. ***Policy brief on community action and core demands on community action:*** Premised upon the status report and experiences of practices of community action a policy brief envisaging accountability for Health Rights will be developed. A team of activists from various states will work towards formulating the policy brief and share the core demands with various key decision makers. (*The core demands are tabulated in Table 2)*

Table 2: Core demands

Develop Organisation framework to ensure autonomy
Develop Legal and operational guidelines besides developing • Grievance redressal • Non negotiable components • Role of CSOs • Role of service providers
Autonomous body to be developed for scale and mechanism for management of funds
Establish relations with existing governance mechanisms (such as with Panchayati Raj Institutions (PRIs), Gram Sabhas)
Framework for Community based Planning (Rogi Kalyan Samitis, PIPs)
Comprehensive framework for all social services sectors, food, water etc.

4. ***Formation of E-communication group:*** It was decided to form an e-communication group of practitioners in social accountability in health (community monitoring and social action). The communication group was to be facilitated by CHSJ. The participants also were asked to provide the contacts of other people and networks who could not be a part of the meeting.
5. ***Further action:*** It was proposed that all community activists on health would meet after a period of six months. The status reports collated from the states would be finalised and prepared for release. An interim meeting with some key persons will be explored to work on the reports.

The outcome of the discussions on the status report was outlined in terms of roles and responsibilities to carry on the coordination of the report further (Refer Table 3, 4 and 5 for reference).

Table 3: Responsibilities for Coordination of Status Report from the State

State	Responsibility
Uttar Pradesh	Bindu Singh, Gramya Sansthan
Bihar	Jay Verma, PFI
Jharkhand	Gurjeet Singh, JSA

Madhya Pradesh	Ajay Lal, CHSJ
Odisha	Gaurang Ch. Mohapatra
Rajasthan	Kshitij, Prayas
Gujarat	Mahima, SAHAJ
Maharashtra	Bhausaheb Aher, SATHI
Karnataka	Obalesh, THAMATE
Tamil Nadu	Ameer Khan, SOCHARA

Table 4: Overall Responsibility for State Groups

Person responsible	**States**
Ameer Khan	Tamil Nadu, Maharashtra, Karnataka
Ajay Lal	Madhya Pradesh, Rajasthan, Gujarat
Haldar	UP, Bihar, Jharkhand, Odisha

Table 5: Task group which will put forth the core demands

Name	**Organisation**
Gurjeet Singh	JSA, Jharkhand
Obalesh	THAMATE, Karnataka
Bindu Singh	Gramya Sansthan, UP
Ameer Khan	SOCHARA, Tamil Nadu
Nitin Jadhav	SATHI, Maharashtra
Renu Singh	CHSJ, New- Delhi

Conclusion

According to the participants the learning visit was an enriching experience and they got an opportunity to learn about the various principles of community monitoring and accountability as being practiced across different states apart from the field of health on a single platform of (FLEV), through COPASAH. Participants from about 10 states of India unanimously said it was an enriching experience to learn about the CBM process being implemented in ICDS services in an urban area. Most of them indicated that it was their first experience of learning about community monitoring in an urban area, and according to them ICDS services in urban set up seemed to be more critical as compared to the rural areas and malnutrition was severely prevalent amongst children in the urban areas relative to the rural areas.

The participants' outlined that state wise status reports on CBM which were proposed at the FLEV-3 in Nagpur, would be helpful to place before the decision makers and policy makers the actual reality of the health systems substantiated with evidence and data collated right from the grassroots level to the state level. According to them the status report would be helpful to gauge the situation of denial of health rights across different states.

The three day learning exchange visit ended by thanking SATHI, CHSJ and AAAS for giving an occasion to COPASAH members to learn about community monitoring in an urban set up.

ANNEXURE

Annexure 1- Schedule

Third facilitated learning exchange visit under COPASAH

Venue- CNI-CHPD, Nagpur, Maharashtra

18th – 20th September, 2014

Day one- 18th September 2014

Sr.	Subject	Time	Theme	Facilitation of session
1)	Registration	9.00 to 10.00		SATHI Representative
2)	Welcome and Introduction	10.00 to 11.00	2 minutes to each person	CHSJ Representative
3)	Background of Maharashtra in the context of socio-economical and political scenario; present status of Health care system	11.00 to 11.15		Nitin Jadhav, *SATHI*
4)	Preparations for field visits- - Introduction to Community based Monitoring and Action process in Nutrition	11.15 to 12.00 (Tea during Session)	PPT	Shubhada Deshmukh, *Amhi Aamchya Arogyasathi, Maharashtra*
5)	Field Visit	12.00 to 2.30	• Field visit includes visit to Aganwadi, meeting with mother's committee, providers	Field Coordinator – Archana, *Ahmi Amachya Arogysathi* Participants will be divided in two

Sr.	Subject	Time	Theme	Facilitation of session
			and community. • Field visit will be organized in urban area of Nagpur city.	groups.
Lunch 2.30 to 3.30				
6)	Sharing of experiences of field visits	3.30 to 5.00		CHSJ Representative and Hemraj Patil, *SATHI*
CBMP of Health Services				
7)	Sharing experiences, learning and Challenges in CBMP process in Maharashtra	5.00 to 5.30 (Tea during Session)	**Panel discussion on** Challenges and strategies to deal with - - Community - PRI members - Health providers - Health officials	- Vijayalaxmi, *Ahmi Amachya Arogysathi* - Ravi Waghmare, *MASUM* - Someshwar Chandurkar, *Apeksha Homeo Society* and - Javed Shaikh, *Halo Medical Foundation*
8)	Open discussion	5.30 to 6.30	- Question and answers	CHSJ, Rep. and All presenters
9)	Short film on CBMP process of Maharashtra followed by clarifications	6.30 to 7.00	-	Bhausaheb Aher, *SATHI*

Learning exchange and advocacy for strengthening Community based monitoring and planning in various states of India

Day Two-19th September 2014

Sr.	Subject	Time	Theme	Facilitation of session
1)	Welcome and introduction	11.00 to 11.30		Bhausaheb Aher, *SATHI*
2)	Review of previous day	11.30 to 11.45		Hemraj Patil, *SATHI*
3)	Objective and background of this workshop	11.45 to 12.00		Nitin Jadhav, *SATHI*

			Theme	Facilitation of session	
4)	Sharing the experiences and present status of accountability related work in various states of India	12.00 to 2.00 (Tea during Session)	10 mins. For each state followed by 20 mins. for discussion ***(*points for presentation has given below)***	1.Bihar- PFI representative and other participants 2. Karnataka- Obalesh and other participants 3. Madhya Pradesh- Ajay and Ragini 4. Orissa- Gaurang Mohapatra 5.Uttar Pradesh- Neetu Singh and Bindu	6.Rajsthan- Kshitiz Sisodia 7.Gujarat- Pradeepa 8. Maharashtra- Ninad 9. Jharkhand- Gurjeet Singh 10. Tamilnadu- Ameer Khan

Lunch- 2.00 to 3.00				
5)	Key constraints and obstacles in accountability related processes	3.00 to 4.00	Group work followed by presentation	Bhausaheb Aher , *SATHI*
6)	Possible modalities of further developing Community accountability processes, both with and without support from the Public health system	4.00 to 5.00	Group work	Nitin Jadhav, *SATHI*

7)	Administrative formalities like travel reimbursement, bill settlement etc.	5.00 to 6.00		Jessy , *SATHI* and *CHSJ* representative

Day three- 20th September 2014

1)	Review of previous day	10.00 to 10.30		Hemraj Patil, *SATHI*
2)	Presentations of previous day's group work	10.30 to 12.30 (Tea during Session)	10 mins. for each group	Nitin & Bhausaheb, *SATHI*
3)	Discussion strategies for collective advocacy for CBMP-type process at national level, including processes by which JSA could take up such advocacy	12.30 to 1.30	Open discussion	Abhay Shukla, *SATHI* and Premdas, *CHSJ*
Lunch- 1.30 to 2.30				
4)	Next action plan	2.30 to 4.00		Premdas, *CHSJ* & Abhay Shukla, *SATHI*
5)	Vote of thanks	4.00 to 4.30		Bhausaheb Aher, SATHI

points for state wise presentation on present status of accountability related work -

- Sector in which accountability related work is going on such as Health, education, PDS etc.
- Geographical area and overall structure of work
- Key processes (not activities)
- Association in any state level/national level network
- Impact of accountability related work

Annexure 2:

Third FLE- Nagpur visit, September 18-20, 2014: Participants List

Name	**Organisation Name**	**Email id**	**Contact Number**
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Annexure 3- CBM in Uttar Pradesh – MSAM experience

महिला स्वास्थ्य अधिकार मंच, उत्तर प्रदेश

महिला स्वास्थ्य अधिकार मंच क्या है?

- महिला स्वास्थ्य अधिकार मंच उत्तर प्रदेश में ग्रामीण गरीब, दलित, मुश्लिम व आदिवासी महिलाओं का संगठन है।
- 2006 से यह मंच समय–समय पर विभिन्न अभियानों एवं संवादों के माध्यम से बेहतर स्वास्थ्य सेवाओं की मांग करता आ रहा है।
- यह संगठन उत्तर प्रदेश के 11 जिलों में कार्य कर रहा हैं इसमें 12 हजार महिलाएं वर्तमान में सदस्य है।

महिला स्वास्थ्य अधिकार मंच क्यों बना?

भारत के उत्तर प्रदेश राज्य में सबसे अधिक मातृ मृत्यु होती है। इसके कई कारण हैं–

- कही ग्रामीण व गरीब इलाके में उचित स्वास्थ्य सुविधा न होना।
- कही पर मातृ स्वास्थ्य सुविधाओं तक गरीब व ग्रामीण महिलाओं की पहुँच नहीं हो पाती।
- जनकारी का अभाव।

इसी कारण एक राज्य स्तरीय अभियान पूरी नागरिक पूरा अभियान 2006 में चलाया गया जिसमें कई जिलों की नेतृत्वकारी महिलाओं ने प्रदेश में मातृ स्वास्थ्य सेवाओं की यथा–स्थिति, सबूतों के आधार पर सरकार व सेवा प्रदाताओं को बताने काप्रयास किया। इस प्रयास को लम्बे समय तक जारी रखने के लिए मातृ मृत्यु के मृद्दे पर लगातार अभियान चलाने के लिए 26 मई 2006 को इन नेतृत्वकारी महिलाओं ने महिला स्वास्थ्य अधिकार मंच उत्तर प्रदेश का गठन किया।

महिला स्वास्थ्य अधिकार मंच के 5 मुद्दे

- मातृत्व स्वास्थ्य का अधिकार।
- खाद्य सुरक्षा और पोषण का अधिकार।
- रोजगार का अधिकार।
- सामाजिक सुरक्षा का अधिकार।
- महिला हिंसा से सुरक्षा का अधिकार।

महिला स्वास्थ्य अधिकार मंच की पहचान

मंच का पहचान कार्ड (बिल्ला)– मंच की महिलाओं को मंच का सदस्य बनने के लिए एक बिल्ला दिया जाता हैं जिसपर उनका नाम, सदस्यता न0, गाँव, ब्लाक व जिला का नाम लिखा होता है।

महिला स्वास्थ्य अधिकार मंच की पहचान

- कमेटी–

गाँव स्तर, ब्लाक स्तर, जिला स्तरव राज्य स्तर पर एक कमे होती हैं। कमेटी के सदस्यों का चुनाव मंच के सदस्यों द्वारा किया जाता है।

- प्रशिक्षण– मंच की हर स्तर की कमेटी की सदस्यों को उनके मुद्दों पर समय–समय पर प्रशिक्षण दिया जाता है।
- निगरानी– मुद्दों पर कमेटी की महिलाओं का प्रशिक्षण होने के बाद कमेटी की महिलायें उस पर निगरानी का कार्य करती है। जैसे क्या गरीब महिलाओं को उनका हक मिल रहा है या नहीं। निगरानी के आँकडे एकत्रित करके रिपोर्ट तैयार किये जाते हैं।

महिला स्वास्थ्य अधिकार मंच की पहचान

पैरोकारी–

मंच की महिलायें निगरानी के बाद निकले आँकड़ों को लेकर, मुद्दे से सम्बन्धित अधिकारियों के पास पैरोकारी के लिये जाती है जैसे– जन सुनवाई, सी0एम0ओ0 से मिलना, जिला व राज्य स्तर पर पैरोकारी के लिए टीम बनाकर उच्चाधिकारियों व स्वास्थ्य मंत्री से मिलना।

मंच से जुड़ने के फायदे?

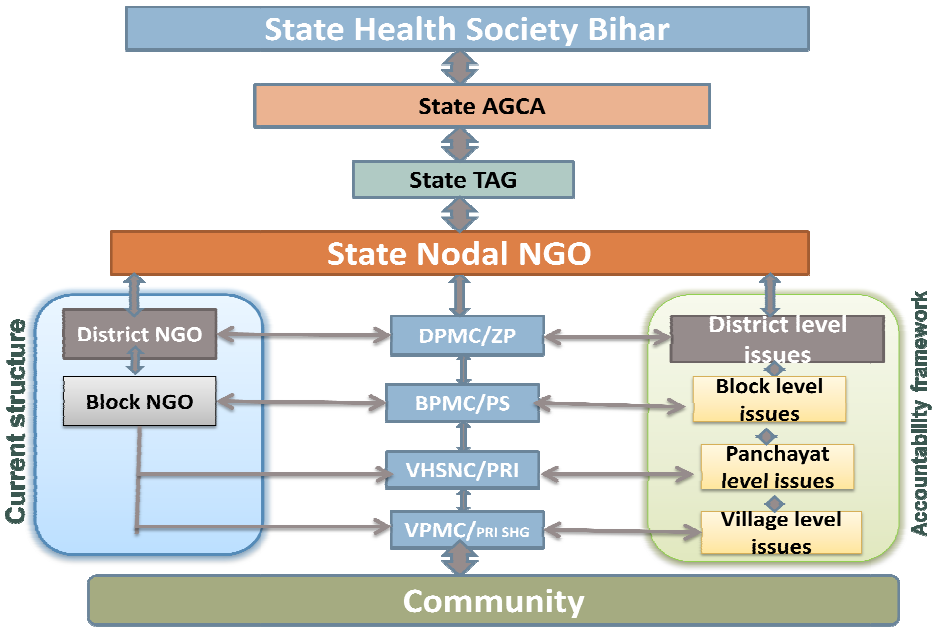
- महिलायें अपने स्वास्थ्य अधिकारों के बारे में जान पायेंगी व उसके लिए खुद से पहल करेंगी।
- सरकार द्वारा चलाई जा रही योजनाओं की जानकारी होगी तथा उन योजनाओं तक उनकी पहुँच बढ़ेगी।
- मंच की अपनी एक पहचान है, जब महिलायें मंच से जुड़ती हैं व बिल्ला पहन कर जाती हैं तो उनको सम्मान मिलता हैं और अधिकारी एवं सेवा प्रदाता उनको पहचानते हैं।
- वंचित व हाशियें पर रहने वाली महिलाओं की आवाज हर स्तर पर पहुँच पायेगी।
- मंच से जुड़ने के बाद महिलायें अपने स्वास्थ्य व पोषण के मुद्दों पर पैरोकारी कर पायेंगी।
- महिलाओं का पंचायत में अपना स्थान सुनिश्चित होगा तथा वे दूसरों की भी मदद कर पायेंगी।

महिला स्वास्थ्य अधिकार मंच का ढाँचा	महिला स्वास्थ्य अधिकार मंच की कमेटी
गाँव स्तर की कमेटी	गाँव स्तरीय बैठकें •मासिक पंचायत स्तरीय बैठकें •मासिक
ब्लाक स्तर कमेटी	ब्लाक स्तरीय बैठकें •हर दो माह में
जिला स्तर कमेटी	जिला स्तरीय बैठकें •हर तीन माह में
राज्य स्तर कमेटी	राज्य स्तरीय बैठकें •हर छः माह में

Annexure 4 – Community Based Planning and Monitoring Programme Bihar

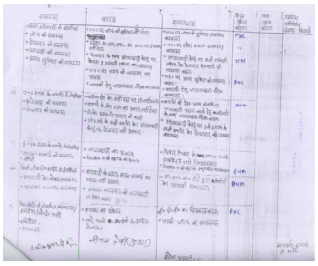
COMMUNITY BASED PLANNING AND MONITORING PROGRAMME BIHAR

19th – 20th September, 2014



Key Processes

ACMO VARIFYING TESTIMONY



VHAP

- Community enquiry and facility surveys
- Sharing of community and facility level report card
- Village Health Action Plan prepared and shared for integration into the Block Health Action Plan
- Jan Samwads organized at block level

CBPM project - Impact

TESTIMONY PRESENTING CASE

CROSS CHECK OF EVIDENCE OF TESTIMONY

- Emergence of strong CBPM committees- increased role of PRI and seeking accountability of the health services providers, regularization of RKS meeting in Fatehpur, Imamganj , and Rajauli (now MOIC has dissolved RKS), and motivating community to access health services from health centre
  - Starting of Health Sub centre of Malhari and Nagma- repairing of door, window, whitewash using untied fund of HSC and also contribution of labour and materials by community
  - Opening of Additional PHC in Gamhari - (constructed 25 years back) and in Bahadurpur, Gram Panchayat alloted Panchayat Bhawan to start APHC last year
  - Constitution of RKS in Bahadupur APCH- 12 members, but account has to be opened, land for construction of APHC already has been indentified and approved
  - RKS fund used for purchasing essentials drugs and equipments in Rajauli, Imamganj, Fatehpur and Bahadurpur
  - Increased use of untied fund (HSC and VHSC level)-purchase of B.P. instrument, HB, Bleaching powder, Dari, use for sanitation purpose, repair of handpump, almirah for HSC
  - Modification of list of beneficiaries and inclusion of more beneficiaries in THR list – Khaira village

CBPM- Impact

DEFUNCTI ADDITIONAL PHC GAMHARI EARLIER

FUNCTIONAL ADDITIONAL PHC GAMHARI NOW

- Denial of paying un official charges- but in Darbhanga and Bhagalpur health service providers demanding
- Established coordination between service providers and community and committee members - earlier community does not know when she come in the villages and what are the services she is providing
- Support to ASHA in mobilizing community- earlier community does not accept her advise but now due to collective effort community are motivated to access health services
- Increased supplies of medicine to HSC (Baijani in Jagdishpur block and Vishrampur, Guriapakari, Kuibhar, Nagma, Bansi in Imamganj block) and Additional PHC – Habibpur and deputation of Doctor

Lessons

➢Involving elected representatives in the CBPM programme. is a way of fostering democratic institutions and promoting communitization.

➢In the long term, ownership of the CBPM programme by elected representatives could be a critical strategy for long term sustainability of the programme- (Co-opting representatives from the Health Committee of the Panchayat Samiti and Zilla Panchayat as members in the BPMC and DPMC)

➢Experience shows that community involvement has lead to finding local solutions for local problems.

➢Communities can take measures to reduce inequity

➢Awareness on health entitlements helps communities contribute to health system strengthening

Lessons

➢Civil society and the government must commit to provide support to the community for systemic changes.

➢it s not enough for communities to understand only their entitlements, but also be a part of the solution to problems.

➢Communities are willing and able to contribute actively to finding and participating in solutions.

➢The CBPM programme needs to be upscaled.

➢Communities and individuals are threatened while raising concerns.

Annexure 5- Improving access to public health services for Dalit and Muslim women in Bangalore urban slums, SPAD

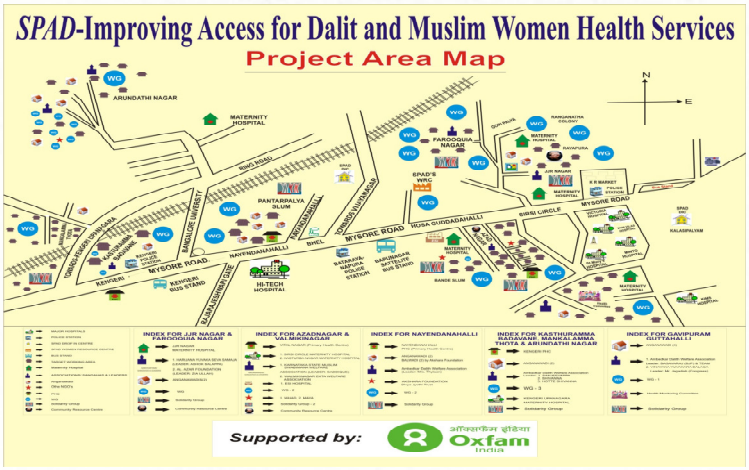
SPAD
Society for People's Action for Development

ACCESS TO HEALTH PROJECT

Improving access to public health services for Dalit and Muslim women in Bangalore urban slums

Processes, impact and learnings

Project map



Access to Health Project, SPAD

Project outreach

- 27 slums in 3 areas (7 city wards) of southeast Bangalore
  - Solidarity groups and SHGs
  - Awareness on health
- BBMP: 2 Referral Hospitals, 4 Maternity Homes and 1 Urban Health Centre
- Study initiated in Vani Vilas hospital (under Bangalore Medical College)

Access to Health Project, SPAD

Community monitoring of maternal health services

- 6 Monitoring Committees formed
  - Weekly hospital visits
  - Case documentation and follow-up
    - Negligence, corruption etc.
    - Schemes
  - Interface meetings every 2-3 months
  - Follow-up with senior BBMP health officials
- Meetings with local leaders, Corporators and MLA on hospital issues

Access to Health Project, SPAD

Community monitoring of maternal health services (contd.)

- Monitoring of anganwadis
  - Facilities, Take Home Rations, Bhagyalakshmi scheme etc.
  - Participation in and monitoring of health camps
  - Follow-up with CDPO on anganwadi problems
- Referrals
  - Awareness in community, case collection
  - Study of referrals at Vani Vilas hospital and initial discussion with staff

Access to Health Project, SPAD

Key Achievements

- One Maternity Home without Medical Officer now has one
- Better facilities
  - ANC days increased
  - Drinking water, hot water, chairs etc.
  - Cleanliness
- Resumption of free Family Planning services in an Urban Family Welfare Centre (UFWC)

Access to Health Project, SPAD

Key Achievements (contd.)

- Cases detected which resulted in changes in procedures
  - Tampon case
  - Referrals

Access to Health Project, SPAD

Challenges

- Backlash from staff
  - Complaints to corporators etc.
  - Refusal to allow inside hospitals
  - Intimidation by local 'goondas'
- System-level changes still elusive
- BBMP misgovernance & scandals
- Delay in NUHM

Access to Health Project, SPAD

Network-level activities

- Member of Janaarogya Andolana Karnataka (JAAK) and its Bangalore Urban chapter
  - Provided inputs for and conducted awareness on NUHM
  - Advocacy with BBMP on staffing, medicines, diagnostic services, referrals etc.
  - Participated in campaign for free medicines, agains privatisation etc.
- Member of Right to Food Campaign, Pension Parishad, Forum to end Malnutrition etc.

Access to Health Project, SPAD

Other strategies

- Formation of Federation of women's groups (Koogu Mahila Okkuta)
  - Water and sanitation, pensions, employment etc.
  - Awareness and advocacy on ward and sub-ward committees (74th amendment issues)
- Private sector and patient rights
  - Patients charters
  - KA Private Medical Establishment (KPME) Act, Clinical Establishments (CE) Act etc.

Access to Health Project, SPAD

Annexure -6: Accountability Related work Health Rajasthan

Accountability Related Work Health

- Rajasthan Free Medicine Scheme was planned to be downsized, JSA Rajasthan took the initiative and strongly opposed the action.
- VHND Strengthening in 16 Districts of Madhya Pradesh.
- Advocacy for various health issues and universal coverage of health in the state.

Accountability Related Work Education and PDS

- School Development Plan
- Mid-day meal/ School Health Program
- School Management Committee Strengthening
- Monitoring of PDS

Key Processes

- Community Based Organization Strengthening.
- Monitoring and behavior change of service providers
- PRI strengthening
- Advocacy at district and state level.

Association in any State level/Network Level

- Jan Swasthya Abhiyan
- Advisory Group for Community Actions
- Right to Food Campaign
- National Education Assembly
- All India People Science Network

Impact of accountability work

- Renunciation of announcement for downsizing the Free Medicine Scheme.
- Parties adopted a few points from election manifesto as demanded by JSA, Rajasthan during elections
- Govt. was previously planning to demolish many schools and had stopped demolishing the schools due to regular advocacy.

Annexure –7: CBM in Jharkhand

Community Based Monitoring and accountability process.

Jharkhand

Initiation 0f CBM:NRHM

- Pilot conducted in3 Blocks in 3 district (40 villages each) through AGCA/PFI/CINI and other CSOs -2008-09
- OXFAM/CINI intervention in 70 villages in two district from 12-13 onwards

Objective

- To raise awareness level of the community on the available Government health services.
- To encourage participation of the community in the monitoring of Government health services.
- To ensure accountability among the Service Providers to provide stipulated quality service.
- To identify the basic gaps in the delivery of quality Health services.

VSRC Intitatives:Reach out

- FY 10-11.. 5,80,000.
  (24Blocks @20,000per block=480000,and Rs/- 1 lakh for State CBM).
- FY 11-12 ..21,40,000.

(48Blocks @-30,000per block=14.4,Dist@25,000 = 6.0,State @ 1,00,000/-)

- FY 12-13.. 29,45,000.

(96 Block@15,000 per block=14.4,Dist@25,000=6.0,State@1.5,lakh

- Capacity building of Health Official@7.55,lakh)

VSRC Intitatives:Reach out

- 2013-14 -5 Blocks per district
  - 20000/ block
  - 30000/district
  - 150000 at state level
- 2014-15 5 blocks per district
  - 20000/ block
  - 30000/district
  - 150000 at state level

Process

- Identification of Block and Villages.
- ToT of Block Training Team
- Formation of CBM teams at Village level.
- Training of CBM teams
- Community Assessment of Services
- Scoring and compilation of
- Score Sheets.
- Mobilizing Health functionaries
- community for Public Hearing
- Jan Samwad-Public Hearing.
- District and State Samwad.

CBM PROCESS INDICATORS

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efgykl eqk; dsl kFk ppkZ				
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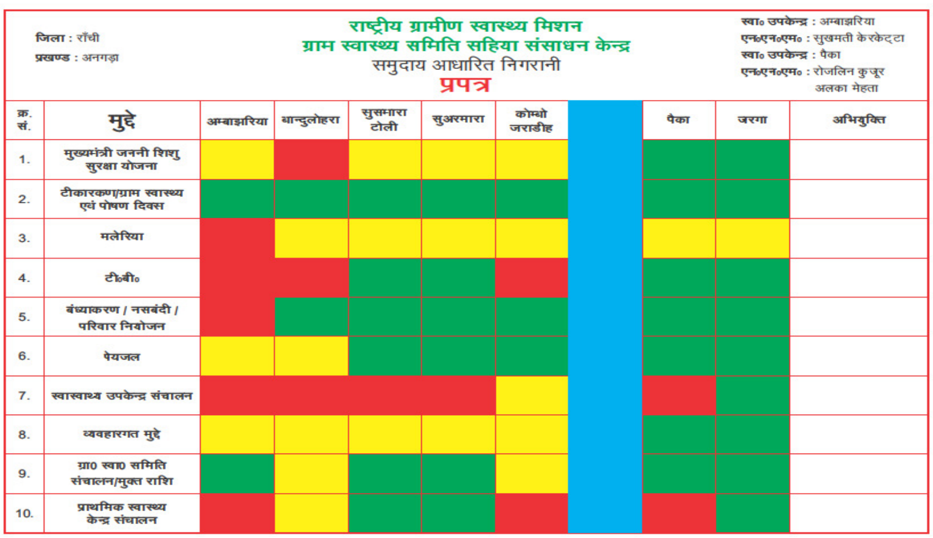
Sub Centre format



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प्रखण्ड : अनगड़ा

राष्ट्रीय ग्रामीण स्वास्थ्य मिशन
ग्राम स्वास्थ्य समिति सहिया संसाधन केन्द्र
समुदाय आधारित निगरानी
प्रपत्र

स्वा० उपकेन्द्र : अम्बाझरिया
एन०एन०एम० : सुखमती केरकेट्टा
स्वा० उपकेन्द्र : पैका
एन०एन०एम० : रोजलिन कुजूर
अलका मेहता

क्र. सं.	मुद्दे	अम्बाझरिया	बान्दुलोहरा	सुसमारा टोली	सुअरमारा	कोम्बो जराडीह		पैका	जरगा	अभियुक्ति
1.	मुख्यमंत्री जननी शिशु सुरक्षा योजना									
2.	टीकारकण/ग्राम स्वास्थ्य एवं पोषण दिवस									
3.	मलेरिया									
4.	टी०बी०									
5.	बंध्याकरण / नसबंदी / परिवार नियोजन									
6.	पेयजल									
7.	स्वास्वाथ्य उपकेन्द्र संचालन									
8.	व्यवहारगत मुद्दे									
9.	ग्रा0 स्वा0 समिति संचालन/मुक्त राशि									
10.	प्राथमिक स्वास्थ्य केन्द्र संचालन									

Changes ..seen...

- Awareness and ownership developed in community.
- Health Functionaries became responsible for their duties.
- Smooth Communication and Behavioral changes in both side.
- PRI members involvement for health issues.
- Convergences with other line departments, ICDS, PHED.

Glimpses of the Activities...

State level training of block coordinators and community mobilizes of Oxfam CBM Project

Glimpses .....

CBM Process in Rampur village, Chainpur

CBM Process in Barwenagar Health sub centre , Chainpur

Challenges

- No CSO presence in the process now
- Target of 12-13 not achieved due to lack of will and public pressure
- EOI for VSRC support planned in 2012-13
- EOI finalized in 2013-14
- MOU still due

Other CBM process

- 1500 schools social audited by Gram Sabha : Right to education entitlements with active involvement of SCPCR through Jharkhand RTE forum
- ICDS and NSAP report card through SHG : PRADAN, RTF in one distt, PDS audits in three distt with supreme court commissioner office
- 1000 ICDS centers monitored through Report cards methodologies :JASHN initiatives
- Social audit directorate getting set up for MGNREGA : Jharkhand MNREGA Watch:5block pilots planned
- VHSNC pilot social audit on,Social audit of RSBY Planned by PACS partners

Impacts – Spin off from CBM: Koderma SHG federation Hearing ;9th Sept

कल्याणकारी योजनाएं बिचौलियों-अफसरों की साठगांठ से चलाई जा रही हैं : बलराम

भोजन का अधिकार अभियान पर जागरूकता कार्यक्रम का हुआ आयोजन

कार्यक्रम में गीत प्रस्तुत करतीं महिलाएं।

लोगों के बीच वक्ता को सुनते ज्यां द्रेज।

भास्कर न्यूज | दूसरी तिलैया

एपीएल बीपीएल खत्म करो,सबको राशन पेंशन दो, रोजीरोटी अधिकार अभियान, भूख से मुक्त हर इंसान, गोदामों में सड़े अनाज, फिर भी बच्चे भूखे आज जैसे नारों के साथ मंगलवार को दामोदर महिला मंडल, की हजारों महिलाओं ने ब्लॉक मैदान में आयोजित भोजन का अधिकार अभियान जागरूकता कार्यक्रम में शामिल हुई। मौके पर सुखा रूप से सुप्रीम कोर्ट की ओर से गठित आयोग के राज्य सलाहकार बलराम व सामाजिक कार्यकर्ता ज्यां द्रेज भोजन के अधिकार अभियान के विकास व अंकिता मौजूद थी। अभियान की शुरुआत बलराम व ज्यां द्रेज ने संयुक्त रूप से की। कार्यक्रम का संचालन पिंकी देवी व आभार प्रकट मीना देवी ने की। मौके पर प्रदान के अभिजीत, वलीन पांडेय, अमित, वंदना, प्रणव, विमल, दीपक, खिरत, राजेश, गोविंद, गणेश, पूनम सिंह, वंदना, पिंकी, अनिता, रिंकी समेत कई लोग मौजूद थे।

सुप्रीम कोर्ट की ओर से गठित आयोग के राज्य सलाहकार बलराम ने कहा कि कोडरमा जिला में योजनाओं की जो स्थिति है वह शर्म की बात है। जिले में योजनाओं की हालत बद से बदतर है। यहां की अधिकांश जन कल्याणकारी योजनाएं बिचौलिए व अफसर की साठगांठ से संचालित हो रही है। मनरेगा पेंशन आंगनबाड़ी जैसे जन कल्याणकारी योजनाओं का शत प्रतिशत लाभ लोगों को उपलब्ध नहीं हो पा रहा है।

इन योजनाओं का समुचित लाभ जरूरत मंदों तक नहीं पहुंच पा रही है। बलराम ने कार्यक्रम में जिले के अधिकारी, मंत्री व जनप्रतिनिधियों के नहीं आने पर अफसोस व्यक्त करते हुए कहा कि ऐसे कार्यक्रमों के माध्यम से जमीनी हकीकत से रू-ब-रू होने का अवसर मिलता है। उन्होंने रसोइया को नियमित मानदेय नहीं मिलने पर हैरानी जताते हुए कहा कि पूरी व्यवस्था ही पंगु हो गई है। बलराम ने कहा कि जिले में राशन व पेंशन की योजनाओं पर बिचौलियों का कब्जा है।

नाटक के जरिए आंगनबाड़ी की बदहाली दर्शायी

कार्यक्रम में नाटक के जरिए आंगनबाड़ी की बदहाल स्थिति पर कटाक्ष की गई। वहीं उन वितरण प्रणाली को दुरुस्त व मनरेगा के हालात को नाटक के जरिए मंचन करते हुए लोगों को इसकी कमियों व ऑफिसर-दलालों की लालफीता शाही को बखिया गया। जिसे लोगों ने काफी सराहा। वहीं दामोदर महिला मंडल संघ की ओर से समेकित बाल विकास परियोजना पर आधारित नागरिक रिपोर्ट कार्डकेर महिला मंडल की सुधा दीदी ने प्रस्तुत करते हुए आंगनबाड़ी की स्थिति के सुधार पर कई सुझाव दिए गए। नाटक मंडली में कविता देवी, शिवु देवी, सुधा देवी, संजू देवी, पूजा देवी, मीना देवी, तुकलेश्वरी देवी व पूनम देवी थीं। वहीं कार्यक्रम में काफी संख्या में महिलाएं पहुंची थीं।

कार्यक्रम में मौजूद महिलाएं।

भूखा रहकर इंसान न तो शिक्षा प्राप्त कर सकता है और न अपना विकास : द्रेज

वहीं सामाजिक कार्यकर्ता ज्यां द्रेज ने अपना संबोधन जोहार कहकर कर शुरू किया। उन्होंने कहा कि देश में भोजन का अधिकार लागू करना बहुत जरूरी है। चूंकि को पक्के मकान बनाने वाले मजदूर खुद कच्चे मकान में रहते हैं, उन्हें आधे से कम मजदूरी मिलती है। उन्होंने कहा कि भूखा रहकर इंसान न तो शिक्षा प्राप्त कर सकता है और न अपना विकास। द्रेज ने कहा कि आंगन क्षेत्रों में स्वास्थ्य, शिक्षा की मुकम्मल व्यवस्था सुनिश्चित करने की आवश्यकता है।

We must become the change we want to see – Mahatma Gandhi.

Annexure 8- CBM experience Odisha

CBM under Health System

The Phase- I of Community Monitoring in Odisha was called as **Community Action** as it was felt that Communitization of health care can not be possible if we do not carry along with the health providers. It was thought the use of word 'monitoring' may mislead the providers-as finding fault in their service delivery. To ensure the co-operation of the health providers in the programme Community Action instead of Community Monitoring was introduced in **July 2007**

Activities undertaken in Phase-I

- Collection of data from the village level
- Compilation of the village score card
- Cumulative report card at SC, PHC, CHC, District and State
- Facilitation of village level and facility level monitoring exercise
- Preparation of village and facility level report cards
- Sharing of report cards and experiences through GKS, RKS meetings and **Public Hearings (Jan Samwad/ Jan Sunwai)**
- Planning for improvement

Achievements in Phase-I of Community Based Action (CBA)

- Government orders have been issued at each level for cooperating in community action activities.
- The GKSs in formed under the community monitoring activities received Rs.10000/- each for undertaking different activities on a priority basis.
- Awareness on different health entitlement has been increased which has also resulted in enhanced demand for services at community level.
- To make it easier to understand, materials were developed at regional and local level.
- Participation of media was very active.
- Health plan was initiated in some GKS
- Delay in JSY money has been minimized.
- Minimize gape in service delivery

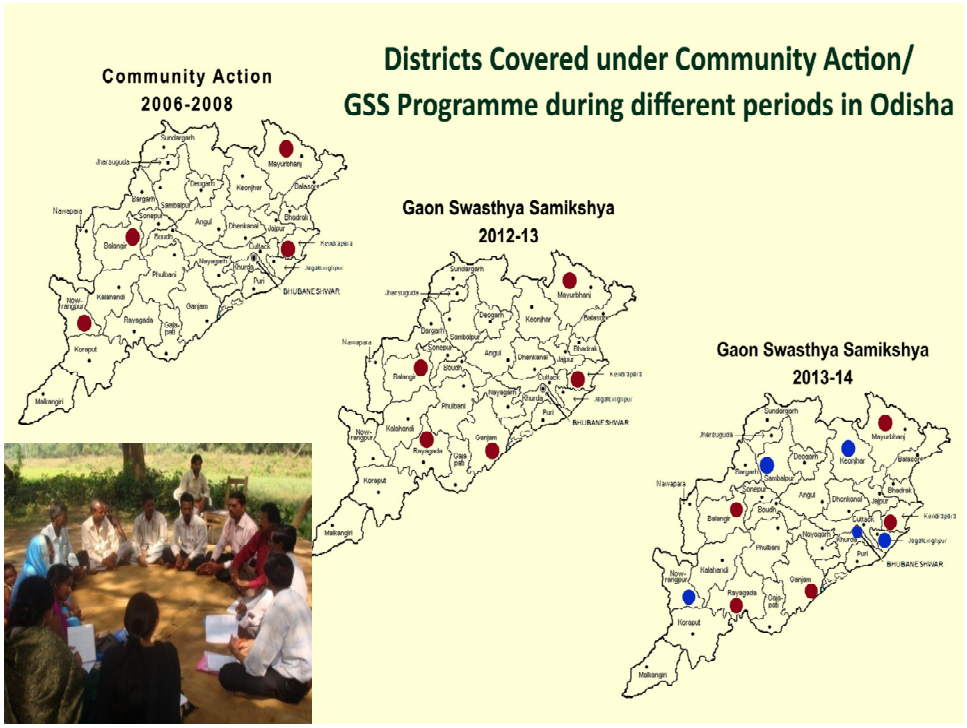
After 2008

- The community action process got a setback beyond phase one with the change of leadership at Mission Directorate level despite the wholehearted efforts of members of SAGCA.
- The initial enthusiasm during the phase one among the key stakeholders and the SAGCA lost as it was felt that the process may not be sustainable without Government ownership and support.
- However with the change of leadership at the Mission Directorate level in the year 2010 the efforts of SAGCA regained momentum.
- It was again proposed to undertake the community monitoring in the name of ***Gaon Swasthya Samikshya***

Current Phase (2012-13 onwards)

- Reinitiated after a gap of 3 years
- Renamed of ***Gaon Swasthya Samikshya***
- Giving a local flavour
- Adaption to local condition
- Wider involvement of the departments other than health

  (H&FW, W& CD, RD, PR, School & Mass Education & SC & ST)


Districts Covered under Community Action/
GSS Programme during different periods in Odisha
Community Action
2006-2008
Gaon Swasthya Samikshya
2012-13
Gaon Swasthya Samikshya
2013-14

Coverage of Current Phase of CBA

2012-13

- Implemented in 5 districts
  - **Kendrapara, Mayurbhanj, Rayagada, Ganjam and**
  - **Balangir**
- 82 blocks, 1543 Grampanchayats and 11796 GKS

2013-14

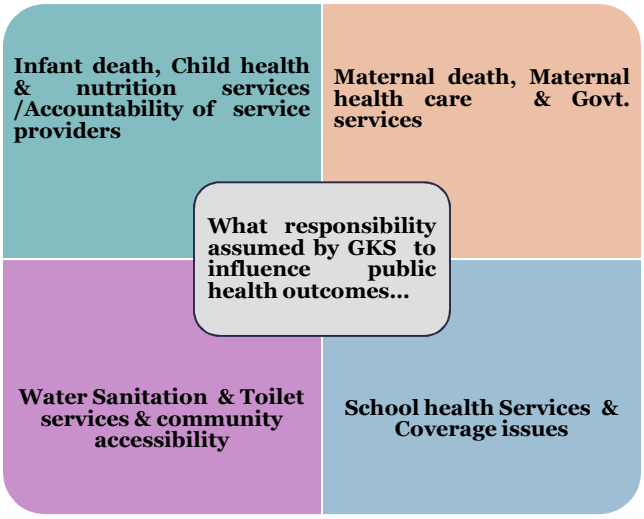
- Expanded to 10 districts including five districts coved in year 2013-14
  - **Kendrapara, Mayurbhanj, Rayagada, Ganjam and Balangir**
  - **Jagatsinghpur, Keonjhar, Khurda, Sambalpur and Nabarangpur**
- 132 (82+50) blocks, 2508 (1543+965) GPs and 18380 (11796+6584) GKS

- But the expansion of 5 district was not approved by the ministry and the old 5 district will continue in this year.

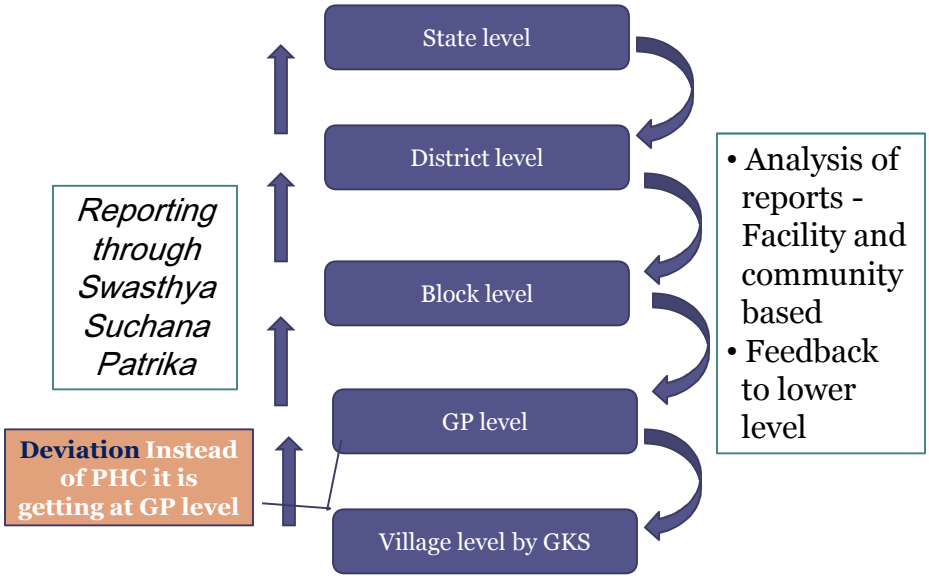
Objectives of GSS Programme:

- To Promote ***community level dialogue on birth and death***, causes, action required
- To work as a mentoring team to build partnership with health system-health providers and community to ensure Quality and accountability in the delivery of health services.
- Taking care of the needs of the poor and vulnerable sections of the society and their empowerment.
- Convergence for effectiveness and efficiency. Linking health with health determinants.
- Responsive health system meeting people's health needs.

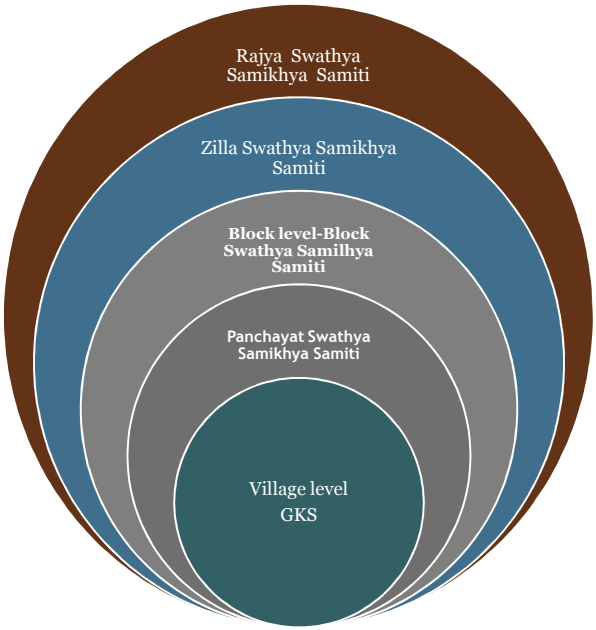
Themes/ Sectors we analyze through Suchana Patrika



Structural framework



Gaon Swathya Samikhya - Functional Base at Various level



State level

State Swasthya Samikshya Committee

- Minister, Health and Family Welfare - Chairman
- Secretary, Health and FW – Co-chairperson
- Co-Chairperson of AGCA- Co-chairperson
- Secretaries of RD, PR, W&CD, Education & SC&ST
- MD, NRHM – Convener
- Nodal Officer-AGCA- Nodal Officer
- Director, Special projects
- Director, Social Welfare
- Chief Engineer, SWSM
- DFW, DHS
- All AGCA Members
- At least 3 members from each District Swasthya Samikhya Samiti

GP level - Monthly

Panchayat Swasthya Samikshya Samiti

- Sarpanch – Chairman
- ANM – Convener
- Facilitator (NGO/CBO person)

Members

- Panchayat Samiti member
- CRC/MCH Coordinator SSA
- All Ward Members
- GPEO
- President and Secretary of the GP SHG federation
- ICDS Supervisor of the area
- All Conveners, GKS (AWW)

Village level -Monthly

- ***Activity undertaken by GKS***
- ***Each of the birth and death is discussed*** in the monthly GKS meeting.
- ***Data collection, validation, analysis and interpretation*** pertaining to health & determinants of health (nutrition, drinking water & sanitation etc.)
- ***Analysis*** of the different aspects of death including services provided, what more could have been done, how to prevent further such deaths etc.
- ***Swasthya Suchana Patrika*** prepared and sent to the GP
- Action points relating to death which could be taken up at the GKS level included in the action plan of GKS.

Output of the GP level

- ***Fixed day monthly meeting*** headed by GP Sarpanch
- ***Analysis*** of GKS Swasthya Suchana Patrika analysis
- **Discussion points** - Causes of death, community efforts, actions required to prevent death, supports at the GKS and GP level
- ***More visioning*** – analysis of the maternal death reports, verbal autopsy report, Matru Surakshya Jojna (Mamata, JSY, JSSK, VHND, Immunization, Nutrition, School health, GKS functioning) and schemes of other department(Drinking Water, Sanitation, school health) etc.
- Action points – what GP and GKS would do further
- Gram Panchayat Swasthya Suchana Patrika prepared and reported to the block level

Block level – Bi-monthly

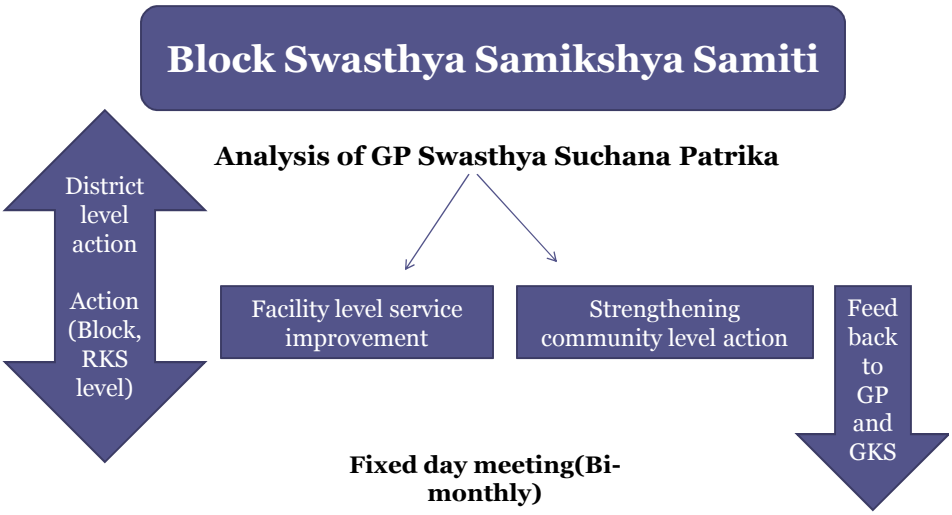
Block Swasthya Samikshya Samiti

- Block Panchayat Samiti Chairman – Chairman
- Block Medical Officer – Executive Chairman cum Convener
- NGO member – Facilitator

Members

- BDO
- All members of Zilla parisad
- DI /BRCC of Schools
- CDPO,
- JE, RWSS
- PHEO
- Medical Officers PHC(N)
- WEO
- BPM
- President and Secretary, Block SHG federation

Output at the block level



District level

District Swasthya Samikshya Samiti

- President, Zilla Parisad – Chairman
- Collector – Co-Chairman
- CDMO – Convener
- NGO member – Facilitator

Members

- PD, DRDA
- ADMO(FW)/PH/DPHEO
- PA, ITDA
- DSWO
- DPC, DPEP/SSA
- Exe. Engineer, RWSS
- DPM
- Dist. ASHA/GKS Coordinator(Asst. Manager)
- Block Chairman
- Block MOs
- BDOs
- President, Secretary of SHG District SHG federation

Output at the District level

- ***Quarterly meeting*** on a fixed day
- Analysis of Block Swasthya Suchana Patrika
- Discussion on the overall health situation on the Blocks/District
- ***Action points*** at the district level
- Issue of necessary directions to the block
- Addressing the issue of ***inter sectoral convergence***
- Reporting in "District Swasthya Suchana Patrika"

Output at the State Level

- Meeting on ***six monthly*** basis
- Analysis of reports from the districts
- Analysis of the ***overall output of the interventions***
- ***Issue strategic directions*** to resolve the issues at the district level
- ***Resolve issues*** related to health service delivery, resource mobilization, inter sectoral convergence, human resources management etc.
- Decide on the mid course corrections and replication of the initiative to other places.

Progress made so far

- State Swasthya Samikshya Samiti has been formed and one meeting organised and the meeting Presided by Hon'ble Minister, H&FW)
- Launching of GSS Programme by Hon'ble Chief Minister of Odisha (3rd March 2013)
- State Nodal Agency has been selected
- Development of common understanding among line departments
- Renaming the Community monitoring i.e. Gaon Swasthya Samikshya
- Resource materials for Gaon Swasthya Samikshya were developed
- Reconstitution of expended State AGCA notified by Mission Director, NHM,
- The MoU signing with the 51 NGO partners for Block level & 5 NGOs for District level facilitation of GSS Programme was completed on 28th February, 2014 in five old districts. First phase fund has been disbursed.
- The tools of GSS Programme i.e. Village Report Card, Score Card, GP Compilation Data Sheet & Swsathya Suchana Patrika for GP, Block, District & State level was finalized and printed.

Challenges

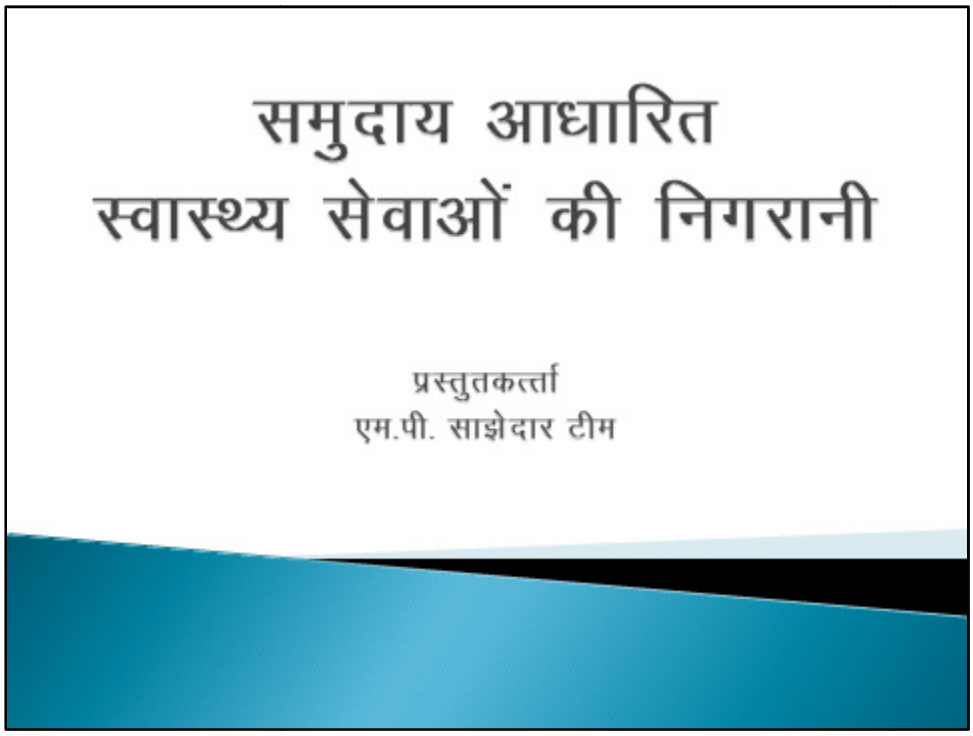
- Delay in decision making
- Lack of Pro-activeness
- Timely release of funds by the district health administration to district & block facilitating NGO partners
- Resource provision is inadequate
- Convergence of the line departments at all level was dificult

Lesson Learnt:

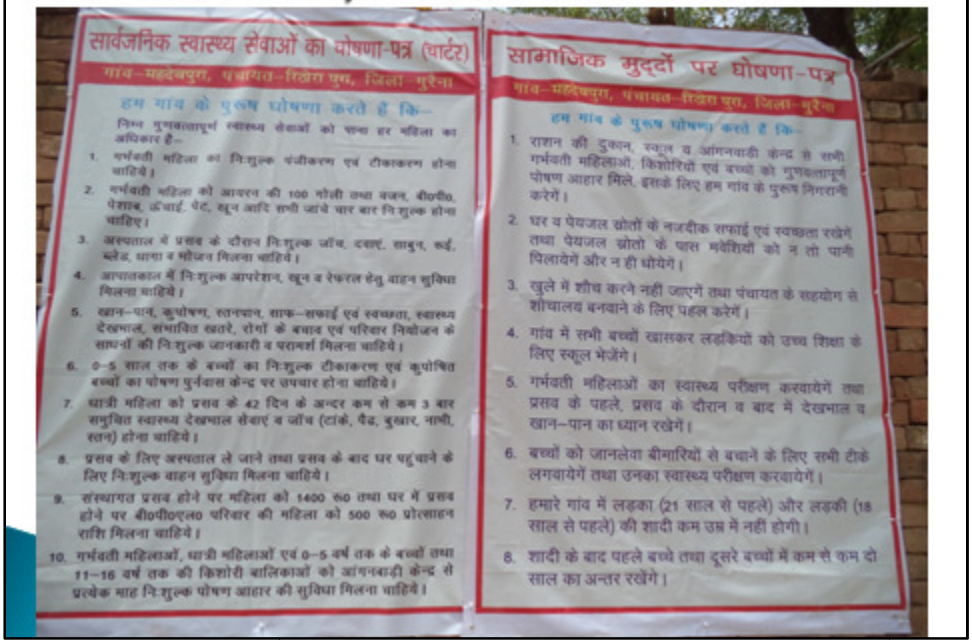
- Involvement of community in public health care is a critical task as it needs to inter link convergence and involve key stakeholders from all related field of health.
- Given the scale and the scope of the programme, it is extremely significant that there is a pro-active role of civil society in this process and space is created for the community ownership building, interpersonal relationship building with service providers at grass shoots level
- Convergence at village and GP level with line departments is a challenge for impact level change.
- Identification of credible Block level NGOs for implementation of GSS Programme
- Involvement of PRIs
- Social & Political activism is needed to carry forward

Community empowerment is a process for
building collective decision making & ownership
with accountability on health services,
deliverables & its social determinants.

Annexure 9: Community Based Monitoring of Health Services- MP Sajhedar Team



सामाजिक एवं सार्वजनिक घोषणा पत्र



समुदाय के साथ घोषणा पत्र पर चर्चा व चस्पा

सर्वे प्रपत्र पर क्षमता वर्धन

ग्राम स्तर पर मिलनेवाली स्वास्थ्य सेवा का अवलोकन एवं साक्षात्कार

रिपोर्ट कार्ड बनाना

गतिविधियां

- पोस्ट कार्ड अभियान – 750
- जनसुनवाई हेतु ज्ञापन तैयार
- 15 गांवों से पंचायत प्रस्ताव
- जन सुनवाई में ज्ञापन देना
- 15 गांवों में कुल 1047 हस्ताक्षर
- फालोअप
- मिडिया
- एनआरएचएम टीम का दौरा 20 सितम्बर को

सांधी पत्रिका

sidhi patrika

दावों की पोल | टिमटिमाहट में आंख खोलते हैं नवजात, पहले भवन नहीं था, अब बिजली का रोना

लालटेन की रोशनी में प्रसव

कहां जा रही राशि

बजट का रोना