Issue No.- 8 July-September 2014

COPASAH Communiqué

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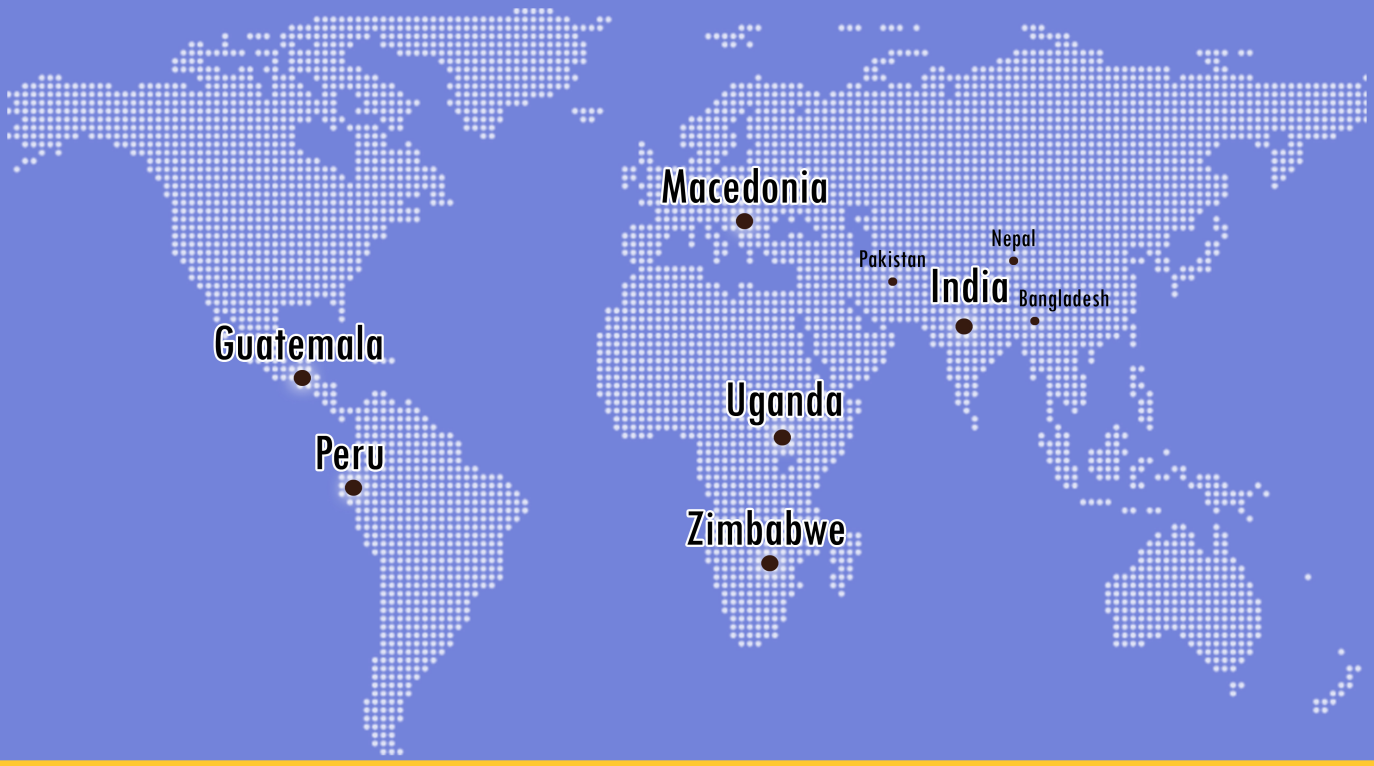

SPECIAL EDITION

Published on the occasion of Global Symposium on Health Systems Research, Cape Town, South Africa, Sept 29 – Oct 3, 2014

Active Citizenship through Bottom up Knowledge Generation and Peer Learning

Dr. ABHIJIT DAS

Content

Health systems, and indeed many public systems are in crisis today with the increasing pressure of privatisation. At the same time there are calls for implementing rights based approaches which focus of strengthening the state apparatus and state investments for service delivery. In such conditions poor and marginalised communities in poor and poorly governed states are faced with the challenge of escalating costs, apathetic and unresponsive services of uncertain quality. Global targets often translate into coercion at the local level. In this entire scenario there is little space for communities or the ultimate beneficiaries for negotiating appropriate services, asking for improved quality and for articulating grievances.

Community based accountability mechanisms, often called social accountability mechanisms are emerging as an important imperative for increasing people's participation including demand for public services, improving program efficiency as well as promoting public program accountability. These methods have emerged from a deep frustration of marginalized people to hold public systems accountable at the local level, even as their 'states' kept making tall and sometimes empty promises through ineffective and inefficient policies. Experiments in diverse contexts of Latin America, South Asia and Africa have shown that citizen and civil society are able to compel 'states' to honour their promises using various methods of generating and collating evidence and arguing through these. In the last three years COPASAH has been able to further strengthen such practices in the field of health by building capacity among a large number of practitioners in different regions of the world and also by developing a series of knowledge products which have distilled lessons from practice. Today COPASAH members are at the vanguard of social accountability practices in many countries and there is considerable interest in taking the process forward.

There is also an emerging interest among donors in expanding the practice of social accountability for ensuring greater effectiveness of development aid. At least two global collectives[1] have been formed where donors, international technical organisations and governments are the principal actors. Researchers in Universities and research organisations are also

[1] TA Learn (http://www.transparency-initiative.org/) and Global Partnership for Social Accountability ((http://gpsaknowledge.org/)

interested in understanding the overall value of bottom up accountability measures in improving the effectiveness and quality of health services, and in health outcomes of the people. COPASAH is their conceptual ally but also somewhat different since its principal stakeholders are field practitioners and implementers, and its principal interest lies in broadening and deepening the processes of active citizenship through bottom up knowledge generation and peer to peer learning. COPASAH represents a unique practitioners' collective which derives theory from practice and also strengthens practice through innovation, learning and capacity building.

In this young and evolving field our members include individuals and organisation with a strong track record of existing work as well those who have just started working. In its short existence of a little over two years, COPASAH, has created a global presence with acknowledgement from various practitioners, academicians and donor communities. The knowledge products and the processes of learning from practice have received encouragement and appreciation. The membership of COPASAH has risen to nearly 200 and the listserv has over 600 members. We hope that this work will continue and will be able to provide a platform to the key actors in the field of social accountability in health through sharing knowledge and resources generated from field practice and interpreted by the practitioner.

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About the Author:

Dr. Abhijit Das, Director - Centre for Health and Social Justice (CHSJ), Delhi, India is one of the founding members of COPASAH. Currently he is the member of global steering committee and will function as the global coordinator of COPASAH from 2015. CHSJ, is one of the pioneering organisations in the field of social accountability in health and community monitoring in India (www.chsj.org)

COPASAH at Global Symposium on Health Systems Research
Cape Town 29th Sept - 4th Oct 2014

Satellite Session – (30th September, 2014, 12.00 -14.00 hrs, **Venue:** Room No. 1.41)

Note that this satellite session is already full

- **Title:** New resources and opportunities for participatory research in health systems: Areas of focus for Health Systems Global
- This session will present and discuss with participants the issues, resources and capacities for participatory research and how these could be developed and supported through the SHaPeS Thematic Working Group in Health Systems Global. It will review work done and launch key resources on participatory action research, social accountability and innovations in social media in health systems research from networks such as EQUINET and COPASAH. We will identify with participants areas of future work for the participatory cluster of the SHaPeS TWG and invite participation in the cluster. The session will also feed into a follow-up SHaPeS presentation in the Symposium.
- **Organisers:** Regional Network for Equity in Health in east and southern Africa (EQUINET), COPASAH and Rotterdam Global Health Initiative Erasmus University ,for the participatory cluster in the SHaPeS TWG for Health Systems Global
- **Speakers from COPASAH:** Walter Flores & Abhijit Das (representing COPASAH) and Rene Loewenson, EQUINET, East and Southern Africa (COPASAH global steering committee members)

Promoting Accountability for Maternal Health through Report Card

Experiences from two blocks of Dahod district, Gujarat, India

Experiences from two blocks of Dahod district, Gujarat, India delineate how Social Accountability mechanisms on quality of maternal health such as maternal health monitoring tools and Village Health and Nutrition Day monitoring check lists can increase the awareness of community women on maternal health and health entitlements.

SUNANDA GANJU, RENU KHANNA, MAHIMA TAPARIA (SAHAJ) AND NEETA HARDIKAR (ANANDI)

Introduction

SAHAJ and ANANDI have initiated a collaborative project 'Enabling Community Action for increasing Accountability for Maternal Health' since 2012 in four Primary Health Centres of two backward and inaccessible blocks of Devgarh Baria, in Dahod district and Gogambha block in Panchmahal district respectively, covering 25 villages each.

The project has two objectives: To 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.

This article lays out in detail the results of the community monitoring process on the quality of maternal health in one of the two project districts.

Awareness meeting with Sangathan women and Panchayat members about village health and nutrition day

The Context

Dahod is one of the most backward districts in the developed state of Gujarat. It is dominated by tribal population. Majority of people have small land holdings and migrate to urban areas in search of employment and work either as farm labourers or at construction sites. The tribal population is huge - 72.3 percent relative to state average of 31.5 percent [1]. According to DLHS 3, only 42.7 percent of pregnant women in Dahod were registered in the first trimester of pregnancy compared to the state average of 52.3 percent and only 46.5 percent had at least three antenatal checkups relative to the state average of 54.8 percent.[2]

The Accountability Process

Situational Analysis

The situational analysis was conducted by the ANANDI team in both the blocks. The analysis

[1] Census 2011

[2] Indian Institute of Population Science, District Level Household Survey, Initiated in 1997 (I: 98-99, II: 2002-04 and III: 2007-08)

revealed that Village Health and Nutrition Day (VHND) called Mamta Divas in Gujarat, was either not being held and wherever held was irregular. Majority of women were not aware that certain checkups were required to be done; blood pressure, abdominal checkups and haemoglobin tests were not conducted regularly. Information on maternal health entitlements was not provided uniformly to all. Benefits under the Janani Suraksha Yojana (JSY)[3] or Kasturbha Poshan Sahai[4] schemes, could not accrue to women as they did not have bank accounts and cheques could not get deposited. The Primary Health Centres (PHCs) and sub-centres were ill-equipped and short staffed.

Women's Perceptions of 'Safe Delivery'

Women's perceptions of 'safe delivery' were captured through group discussions and participatory exercises. Women valued a clean and fully equipped hospital having skilled staff which treated them with respect. Women wanted the village *Dai* to accompany them to the hospital during delivery.

Development of a Monitoring Tool for Maternal Healthcare

'A Maternal Healthcare' monitoring tool based on the concept of 'Safe Deliveries' combining both the technical and women's perspective and quality of ante-post natal care based on the NRHM standards was developed by the teams of SAHAJ and ANANDI. The tool was finalised based on the inputs given by *Dais* and members of the local women's organisation, who were involved in filling it. The monitoring tool was filled twice for each pregnant woman by trained local volunteers, once in the eighth month of pregnancy and then within 20 days post delivery. Quality checks were done on 10 per cent of the filled forms.

Report Cards on Quality of Maternal Health Services

A Report Card was compiled based on the data gathered from discussions with 117 women. The findings were shared with the respondents and the *Sangathan* women during community meetings to corroborate the information. Based on the analysis of the feedback that emerged from community meetings, a report card was prepared and colour codes were used to communicate the status of performance indicators - red indicated poor, yellow represented average and green indicated good.

Three report cards have been produced so far: December 2012-May 2013, June 2013-December 2013 and January 2014-June 2014.

Dialogue with Health Officials, Sangathan Women and Panchayat Members

The report cards were used as a base for dialogues with different stakeholders such as the *Sangathan* members, the health system representatives, local elected representatives and other leaders. The dialogues led to formation of collective plans with specified responsibilities.

Visible Changes

Improved Responsiveness of the Health System

Series of changes spiralled after the report card findings were shared with the health authorities. After seeing the Block report card, Block Health Officers and the PHC Medical Officers sought a separate report card for each PHC, to assess the situation of PHCs in their respective blocks. Enthused by the report card, one Medical Officer said that he wanted to change the 'reds to yellows'. On the basis of the field observations and the report card, ANANDI team highlighted that Mamta Divas was not covering all concerned women for ante-post natal care. A request was made to the Medical Officer, in a meeting, to hold weekly antenatal(ANC) clinics in the PHC, following which the Block Health Officer began to monitor the Mamta Divas himself.

Weekly ANC Clinics at PHCs

Within a month of the first meeting, weekly ANC clinics started at the PHCs and the ANANDI team organised checkups for pregnant and lactating women including

[3] Janani Suraksha Yojna (JSY) is a conditional cash transfer for institutional deliveries under the National Rural Health Mission in India

[4] Nutrition scheme for pregnant BPL women in the state of Gujarat, in India

those who were high risk. It was the first time for many pregnant women that all their checkups were done and they were also provided iron folic acid tablets in the clinic. Such weekly clinics at PHCs are now being held regularly since August 2013.

Improvement in Mamta Divas (Village Health and Nutrition Day)

Following the first report card sharing meet, there has been improvement in regularity and quality of services and turnout on the Mamta Divas. *Sangathan* members are involved in mobilising women to attend the Mamta Divas and avail the services. Community leaders along with the team of ANANDI are now involved in the systematic monitoring of the Mamta Divas and it is done through a special monitoring tool. Issues such as irregular conduct of Mamta Divas, lack of instruments and irregularity in supply of nutritional supplements by Anganwadi have been identified. Women who are unable to attend Mamta Divas call health workers on their mobile phones for administering TT and immunisation to their children.

Improvement in Quality of Maternal Healthcare

A comparison of the data in Report Card 1 and Report Card 3 shows improvements in many indicators:

- Registration within three months of pregnancy increased from 31.4 per cent to 54.3 percent in Dhabva and 17 percent to 41.8 percent in Sevaniya.
- Within ANC checkups, weight measurements increased from 2.1 percent to 18.6 percent in Sevaniya and 2.8 to 6.5 percent in Dhabva
- Tetanus Toxoid coverage in Sevaniya increased from 70.2 percent to 79.0 per cent.
- Distribution of Iron Folic Acid tablets increased from 6.3 percent to 13.9 percent in Sevaniya.
- Awareness on High Risk Symptoms increased from 22.8 per cent women to 32.6 per cent in Dhabva and in Sevaniya it has doubled from 14.8 percent to nearly 29 percent.
- Awareness on schemes/ entitlements increased from 5.7 percent to 15.2 per cent in Dhabva and 4.2 percent to 37.2 percent in Sevaniya.
- Institutional deliveries increased from 45 per cent to 66.6 percent in Sevaniya and from 57.1 percent to 84.6 per cent in Dhabva.
- Home deliveries conducted by trained *dais* increased from 23.8 percent in Dhabva to 60.6 per cent and from 7.6 percent to 20 percent in Sevaniya.
- Promptness of treatment within 30 minutes of arrival at a facility increased in Sevaniya from 33.3 percent to 90 percent and from 50 percent to 72.7 per cent in Dhabva.
- Service guarantees that of free transportation (to and fro) increased from 33.3 percent in Sevaniya to 40 per cent and expenses incurred in government hospital have reduced from 55.5 percent to 25 percent in Sevaniya.

Continued on page 33

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Strengthening Community Focused, Primary Healthcare-Oriented Approaches to Social Accountability and Action

Experiences from Tanzania and Zimbabwe show that access to resources and uptake of services at PHC level need both an informed and organised community, as well as a willing authority to cooperate, engage and act upon community health concerns.

BARBARA KAIM, GREYSMO MUTASHOBYA, JITIHADA BARAKA, CALVIN FAMBIRAI, TATENDA CHIWARE, MEVICE MAKANDWA AND MASIMBA NYAMUCHETA

Community participation and social empowerment are considered important in ensuring health systems remain accountable to the populations they serve. However, unless health systems are oriented towards comprehensive primary healthcare, and are people-centred and publicly led, social differentials in access to healthcare interventions will remain high irrespective of the level of community involvement. People from poorer households and marginalised communitieswill be unable to afford or access healthcare, with little or no social power to direct resources or improve services at the community level.

A view of Cassa Banana, the informal settlement

This calls for more explicit attention to how communities can organise themselves to defend their right to health. It calls for a more active citizenry who understand and can assert their own needs and interests, and who have the space, skills and authority to articulate how their health systems are organised, financed and reached by communities. Community and health worker meetings, and resources need to be in place to provide for dialogue with sections of the health system to ensure that these rights are met.

In this context, communities have an important role to play in monitoring the progress and enhancing accountability in the interests of improved health and greater equity and social justice for health.

Taking this into consideration, the Training and Research Support Centre (TARSC) Zimbabwe, in cooperation with the east and southern Africa region of COPASAH and the Regional Network for Equity in Health in east and southern Africa (EQUINET) undertook a programme to explore ways to strengthen social voice, agency and demand for improved resourcing and functioning of the primary healthcare system (PHC) in the region. This programme showed over 10 years of work involving 20 studies in nine countries in the pra4equity network within EQUINET and on other areas of social power and organisation of PHC in EQUINET (see www.equinetafrica.org), and the more recent learning in COPASAH on issues of social accountability.

The EQUINET studies have shown that using participatory reflection and action (PRA) processes can increase awareness within communities to support early detection of and response to problems and uptake of services. It can also activate joint mechanisms that increase

cooperation and trust between communities and health systems. And the 2012 EQUINET Regional Equity Watch showed that bringing resources to the primary levels of the health system is important to close the gaps in service access and coverage. The question that the COPASAH/ EQUINET programme wanted to address was whether a structured, participatory approach towards the organisation of community and frontline health worker's evidence and experience could lead to increased attention and allocation of resources forcomprehensive primary care and community health services, and for the functioning and uptake of those services. The following two case studies, funded by COPASAH, with technical input from TARSC in EQUINET, set out to explore this question.

PRA Approaches towards Social Accountability and Action: Case studies from Tanzania and Zimbabwe

Tanzania: Health Promotion Tanzania (HDT) and Ifakara Health Institute, Tanzania (IHI) are working on a community based distribution (CBD) programme in Bukirira Village in north west Tanzania, a part of the country that records high fertility rates, low contraceptive use, and a high proportion of teenage pregnancies. Despite many problems in initiating the programme, CBD is recognised as an effective strategy for strengthening PHCprovision of family planning services using community structures that include home visits bytrained agents with the aim of promoting the use of safe contraceptive methods.

The aim of this programme was to use PRA to assist in revitalising the work of the CBDs in Bukiriro Village, while also identifying strategies for improved dialogue, action and accountability between community representatives, CBDs and health workers.This involved identifying and prioritisingfamily planning health needs in Bukiriro, and the skills, resources, and actions needed to reinstate the CBD programme. With support from the nearest health facility and other key stakeholders, the Bukiriro Health Committee organised atraining programme for the CBDs, successfully negotiated with local authorities for CBDs to receive a small monthly stipend, and arranged for the District Health Management Team to assign two additional full time health workers at Bukiriro Health Centre in order to ease the workload there. Progress measured against a set of progress markers developed by the community at the start of the programme, and review of health facility records, showed significant improvements in the delivery and uptake of family planning services.

Zimbabwe: The programme in Zimbabwe, coordinated by the Zimbabwe Association of Doctors for Human Rights (ZADHR), Zimbabwe National Network of People Living with HIV (ZNNP+) and TARSC, is based in Cassa Banana. It is a marginalised informal settlement of 300 families situated approximately 40 km north of Harare, the capital of Zimbabwe. Local authorities have failed to provide basic health and social services in Cassa Banana,which adds to the myriad of problems residents of the settlement are facing. Residents have limited access to clean water and ablution facilities, and the closest public health centre is 20 km away.

The programme began in February 2014, with the community using PRA approaches to identify major health problems of diarrhoea, gastro-intestinal parasites and HIV. A Community Health Committee (CHC) was formed to organise community actions to address priority health problems and the underlying environmental health concerns. The CHC members invited representatives of related councils to attend the community meetings anddiscuss the roles and responsibilities of the public representatives. As of July 2014, no local authority had responded to the invitation sent out by the CHC. The CHC developed a detailed Action Plan for improving the water and sanitation situation, strengthening HIV prevention and support services, and building alliances with local government, to ensure that their basic health rights are met.

Critical reflections

The programme attempts to gauge whether improved community engagement through PRA processes can lead to better social accountability, increased access to resources at the PHC level and improved uptake of services.

The Tanzanian case study is easier to assess. Since the beginning of the programme, health authorities were willing and interested in engaging with the community to improve access to services. Health facility staff also had a vested interest in reinstating the CBD programme since it was likely to minimise the work load at the facility. This resulted in a series of constructive dialogues between community.

representatives, CBDs and health workers, leading to improved access to quality health services, greater trust inthe health system at community level, and greater accountability on the part of the health workers.

Furthermore, authorities at district level committed to providingfunds in the form of monthly stipends for the CBDs, as well as increase the number of staff at the PHC facility. The more organised voice of community representatives in demanding the revitalisation of the CBD programme played an important role in catalysing these successes.

The programme in Cassa Banana, Zimbabwe has also seen some positive developments, even though it has tillnow failed to engage with the duty bearers to clarify roles and responsibilities. The programme has helped to increase levels of awareness and advocacy on the rights of the Cassa Banana community. It has also led to a much greater level of community organisation and planning, and a renewed energy to find solutions to their problems. Community strategies have been both practical and strategic: for example, to buildmore toilets and fix the water pipes, while also approaching both public and private stakeholders to gain their recognition and support. It is too early to assess whether these actions will lead to a positive engagement with local authorities. Considering the lack of overall accountability in the Zimbabwean socio-economic and political arena, the leaders in Cassa Banana are under no illusion that this is likely to be a long process.

More generally, these case studies have shown to date that:

- Increased access to resources and improved uptake of services at PHC level needs both an informed and organised community, as well as a willingness on the part of those who have the power and decision-making authority to cooperate, engage and act upon community health concerns.
- The Bukiriro case study strengthens the view that if health personnel at PHC level are capacitated, supported and provided with more resources to deliver on plans that have been mutually agreed with community representatives, then they are more likely to feel satisfied with their work and to be more responsive to community needs.
- As highlighted in Cassa Banana, even when duty bearers are not fulfilling their obligations, participatory approaches can strengthen the voice and agency of communities, moving people to look critically at their situation and to act together. These are important influences in creating a demand for recognition of their rights, and the need for social change and transformation.

Over the next few months, the organisations involved in this programme both in Cassa Banana, Zimbabwe and Bukiriro Village,Tanzania, will continue to track progress and documentlearning about longer-term influences on resourcing and functioning of primary care systems. □

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Calvin Fambirai (Director) and **Tatenda Chiware** (Programme Officer) are at the Zimbabwe Association of Doctors for Human Rights (ZADHR). **MasimbaNyamucheta** is from the Zimbabwe National Network of People Living with HIV (ZNNP+). See www.zadhr.org and www.znnp.org.zw

Generating Evidence for Accountability and Social Mobilisation through Community Ethnographers

CEGSS has initiated a participatory-action research exercise in 37 rural municipalities of Guatemala to develop capacities of marginalised citizens to use audio-visual tools for the monitoring of public health policies and healthcare services.

WALTER FLORES, SILVIA SÁNCHEZ AND JULIA DELGADO

The Centro de Estudiospara la Equidad y Gobernanza en los Sistemas de Salud-CEGSS (Centre for the Study of Equity and Governance in Health Systems), a civil society organisation based in Guatemala, is currently working in 37 rural municipalities of Guatemala. CEGSS is implementing systematic and participatory approaches to generateknowledge, develop tools and build the capacity of key social actors and particularly the marginalised citizens for monitoring of public health policies and healthcare services.

Of the 37 municipalities where CEGSS works in, 35 have a majority of indigenous population. In these municipalities, the Citizens Councils for Health (CCH) implements a community monitoring approach that includes: data collection and analysis, presenting written reports of findings to the authorities and engaging in advocacy actions and social mobilisation. When the monitoring reports received from several CCHs during 2013 were presented before the concerned authorities, they were often told by the officials that in order to take action, reports needed to be substantiated with strong evidences such as photographs, videos or complaints voiced by the persons affected. Written reports or summaries given through CCH leaders were not sufficient.

Exploring the new camera

The CEGSS research team carried out field visits in municipalities across different regions of the country to assess the expectations and motivations of CCH members in engaging with audio-visual tools to support their community monitoring work. Community leaders who are a part of CCH opined that use of audio-visual tools to document the failure of healthcare services and other problems such as corruption was significant to advance their work. Audio-visuals would also be useful to record the assurances given by the authorities concerned to solve the problems identified through community monitoring and recordings of what the authorities committed would help ensure that they fulfilled the promises.

Designing the Intervention

While analysing the data gathered from field visits, it discerned that the demand to use audio-visuals grew from the communities own work. A participatory-action research process was thus designed after deliberations at CEGSS as a substitute to the traditional vertical interventions and with an intention that communities could keep control on their own process. CEGSS and a group of community leaders from the different CCHs discussed the skills that community representatives were to acquire during the training. It was also agreed that the particular interest of each CCH representative, preferences for using video,

photography or radio were to be taken into account. CEGSS thus designed a flexible training programme in which the research team facilitated the process and took responsibility of tailoring mentorship sessions based on the interests, base knowledge and time availability of trainees.

Skills to be Developed and Audio-Visual Equipment

Taking into account the expectations of CCH members, CEGSS developed a simplified list of different tools that would be useful to obtain information and help the media to convey the messages.

Tools to gather information:

- Survey
- In-depth interviews
- Group interviews
- Life stories

Mediums to convey messages:

- Visual (photos)
- Audio (radio spots)
- Audio-visual (videos)
- Written and visual (Newsletters with text and images)

The CCH representatives chose the appropriate tools to gather information according to their interest and selected the media to communicate the messages they wanted to convey according to their suitability. Each CCH was provided with a small digital camera with capacity for both still images and video recording, two 32 GB memory cards, one small digital voice recorder and a small tripod. Each CCH signed an agreement with CEGSS, which included the responsibility to take care of the equipment and provide support to the people elected from their community for training. After the training process gets completed, each community leader is entitled "community ethnographer" for the intervention.

Implementation Process

The idea of intervention was taken up with each CCH and based upon their interests, they were asked to select two-four people who would participate in the training. By July 2014, CEGSS visited 27 municipalities out of 37. A total of 82 people are currently being trained out of which 33 percentare females.

In the first workshop, participants were asked to list out the issues they wanted to document focusing on the issues affecting access to healthcare in their communities. Different issues were highlighted by the participants including lack of medicines in healthcare facilities, demand of informal charges by healthcare providers, facilities not being open for business, abuse and maltreatment of service users by healthcare providers. The CEGSS facilitators presented examples of the tools that could be used to seek information on the problems faced by communities and the different media that could be used to convey the information gathered. Majority of the participants chose video as a medium and it emerged a second favourite medium while few selected radio spots.

During the second workshop, participants learned to use the digital voice recorder and the camera. An action plan was also developed in the workshop which included: a synopsis of the audio-visual product to be developed via video, photo feature, radio spot; a work plan to gather information using in-depth interviews, a survey, group interviews, etc. Based on the work plan, a schedule was set for individual training and mentorship process along with work on audio-visual products.

Information obtained till August, 2014 reveals that the participants are producing the audio-visual material and CEGSS is facilitating individual and group mentorship.

CEGSS has also produced a manual to support skill development, which contains simple descriptions and guidelines for the tools and on the types of media. It also includes summary of the Right to Information law which is an essential piece of legislation backing up the work carried out by CCH.

Monitoring and Learning

As the intervention is a participatory-action research exercise, CEGSS has been reviewing the process through monthly reflection meetings to obtain feedback and suggestions on the functioning of the process, motivation levels of participants along with the problems encountered during implementation.

In addition, CEGSS is carrying out detailed documentation and systematisation of the learning processes. It is being carried both by the community participants and the CEGSS team through different means:

- Digital dairies that will be the basis to produce short stories of the learning experience following digital storytelling approaches.

- Short documentaries of key aspects emerging out of these interventions, for instance, how communities are engaging with technology; what is the level of engagement of young people in this process; life stories of some community participants portraying exceptional engagement and resilience to overcome the challenges of using new tools and technology.

- A documentary that will narrate the proceedings of the entire process beginning from January 2014 to the completion of the first phase in December 2014.

Challenges and Lessons Learned

- One of the main challenges from the commencement of the initiative has been the "language barrier." Majority of CCH representatives are indigenous people, whose native language is not Spanish. In one of the regions, CEGSS opted carry out all the activities in the local indigenous language after the participants pointed out that they were not able to understand much of the insights in the training. A second major challenge for some participants has been difficulties in learning the use of the camera and digital voice recorder. After the initial training session, several participants opted out from the training process due to difficulty in handling the equipment. The earlier participants who opted out have been replacedby some new members.

- Despite the challenges, CEGSS has strived ahead with the motivation and drive of community participants. Many were initially cautious about the use of the camera and voice recorders but after a few mentoring sessions, they gained the confidence and the skill to handle the equipment and started recording data from different sources.

- The demand for mentorship is rapidly growing. CEGSS started with a group of five facilitators and till August 2014, three additional members have been added to the media team to support the mentorship prcess for production of videos, radio spots and newsletters.

Forthcoming Steps

After completing the audio-visual products, the participants will communicate the material through local cable, community radio and community assemblies. The material will also be available at the website (www.vigilanciaysalud.com) and will be shared with authorities at provincial and national level. The first phase will conclude with a national workshop which will be attended by all the participants and facilitators to reflect upon CEGSS' collective learning and the plans for a second phase will be rolled out in January 2015.

CEGSS hopes to report about the result of their initiatives early next year through the COPASAH communiqué. In the meantime, if you would like to know more about this intervention, feel free to contact Walter Flores at wflores@cegss.org.gt or waltergflores@gmail.com

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About the Authors:

Walter Flores is the executive director at CEGSS and the global coordinator for COPASAH. He holds both a Master and a PhD from the Liverpool School of Tropical Medicine, UK.

Silvia Sanchez is an Anthropologist and is currently a post-graduate student in cultural anthropology in the USA. While at CEGSS, Silvia was a research assistant and research coordinator for the period December 2012-July 2014.

Julia Delgado is a Historian with a postgraduate degree in Cultural Studies. She is coordinating the project on community ethnographers at CEGSS

Monitoring and Accountability Work to Enhance the Immunisation Coverage and Preventive Health Care Services for Roma Ethnic Minority in Macedonia*[1]

Dr. BROJAN PAVLOVSKI

Introduction

Roma minority represents the marginalised group of population in Macedonia. Their socio-economic situation and lack of education, employment, housing and social security hinders the access to quality health care services. The community often faces hidden discrimination and violation of health rights. These circumstances have led to major health disparities among Roma people, marked by higher prevalence of chronic diseases and shorter life expectancy as compared to the rest of the population in Macedonia.

Prompted by weak health situation of Roma minority, a group of civil society organisations (CSOs) led by Association for Emancipation, Solidarity and Equality of women (ESE) in Macedonia, conducted a situation analysis in 2009-10, and developed an advocacy strategy based on the approach of applied budget work. Immunisation coverage rate for children in Macedonia at national level was reported to be above 95%, however the research conducted by CSOs in 2010 showed that the immunisation coverage rate among children from the Roma ethnic minority varied between 35% - 85% for different vaccines. Despite immunisation and preventive services being guaranteed free of charge for every child, several outbreaks of vaccine preventable diseases occurred in the Roma communities during 2010-11.

The gaps in immunization and health services suggested a need for continuous monitoring to make the Government accountable for the implementation of measures for increased immunisation coverage of Roma children. Consequently, the community monitoring work was introduced in 2011, to monitor the implementation of the activities aimed specifically for Roma minority within the Programme for active health care of mothers and children. The subsequent advocacy process led to adoption of specific measures for increased immunisation coverage of Roma children in the Programme, which includes the preventive health programme adopted by the Government and implemented by the Ministry of Health. The community monitoring process in the Roma communities was conducted by four organisations including the Center for democratic development and initiatives (CDRIM), Association of educationists and for protection of the rights of women and children (LIL), Roma association for multicultural affirmation (Roma SOS), and KHAM from 2011 – 2012, while ESE continued with the budget monitoring process at the national and local levels.

Community Monitoring Process

The Roma CSOs initiated the community monitoring process in eight municipalities in Macedonia. The process started with capacity building of the staff through two workshops. The participants were acquainted with the basics of community monitoring and the different methods and tools used in the monitoring process. After the initial capacity building, the organisations implemented the community monitoring process starting with community mobilisation which led to community inquiry conducted by utilising the tools. The feedback from the community inquiry formed the basis for advocacy at the local and national level.

Community Mobilisation

The process for community mobilisation aimed to mobilise Roma people so that they could proactively seek their rights to health. In the initial phase of mobilisation each of the organisations identified individuals from the communities where they were working. This process started with “mapping the village” exercise and this process

[1]* The article has been summarised and reproduced from COPASAH Communiqué- Issue: 2

helped the organisations to identify different settlements within the Roma communities and the key persons from each settlement. These individuals were either the recognised informal leaders, or those who had the potential to influence the community.

These groups were trained on the following issues:

- Rights for preventive health care services related to immunisation
- Specific measures aimed for Roma people in the Program
- Different aspects related to the process of immunisation

The informal bodies from the community helped the CSOs to prepare for and implement the process of strengthening the knowledge of the entire community. Health staff from the primary health care centers was invited in the workshops and during public discussions in the communities, which helped in strengthening the interface between the Roma community and health professionals regarding the rights and process of immunisation.

Community Inquiry

The objectives of community inquiry were:

- To assess the level of coverage of Roma people in the preventive health care services including immunisation coverage, visits by community (outreach) nurse, educational workshops for children's health and immunisation, distribution of health promotional materials regarding immunisation and child's health.
- To assess the satisfaction level of Roma people with these services
- To assess the barriers that Roma people face in accessing immunisation services and other preventive health care services
- To assess the possible obstacles that prevent primary health care centers from fulfilling their duties in preventive health care services

The inquiry was conducted through interviews, focus group discussions and exit interviews with parents of children aged 0 – 6 years, in sixteen settlements covering a total of 820 Roma people and a community score card was prepared for each settlement based on the inquiry. Fifteen health care workers from the primary health care centers in the same municipalities were also included in the inquiry.

After community score cards were prepared, the organisations conducted a process of validation of the results by presenting the findings to a broader group of members of the community. Overall, results showed that the community (outreach) nurse did not visit Roma settlements, there was lack of educational workshops and educational material was not distributed among Roma people. One of the key problems identified was that people in the settlements were not receiving invitations for immunisation and wherever received it was an irregular process as the invitations were sent through post. The categories assessed through the score card are shown in Table 1 (representative of three Roma settlements).

TABLE 1

Category	Roma Settlements		
	Settlement Dame Gruev/ Municipality Gjorce Petrov	Settlement Svinjarnik/ Municipality Saraj	Settlement Zlokukjan/ Municipality Karposh
Coverage with health care services related to vaccination	50%	30%	42%
Outreach activities in the Roma communities, implemented by the Primary health care centers (educational workshops and distribution of educational materials)	19.8%	21%	21.8%
Knowledge of Roma people regarding the vaccines and the vaccination as a process	55.66%	41%	49.6%
Access to the health care services for vaccination	70.4%	43%	45.4%
Delivery of invitations for vaccination	9%	2.5%	25.6%
Quality of health care services related to vaccination	83.9%	54.3%	66.5%
Communication of health care staff with the Roma population	79.3%	37.83%	55.3%
Identification of non-immunized Roma children	87.2%	56.66%	94.4%
Payments of the Roma people related to access to immunization services	67%	37.48%	22.5%
Services delivered from the outreach (community) nurse	59.7%	36.16%	51.6%
Level of coordination between the different departments related to immunization process	87.5%	87.5%	87.5%
Implementation of the activities from the Program for active health care of mothers and children and services delivered by the Institute for health care of mothers and children (from the perspective of the Primary health care center)	60%	60%	60%

Budget Monitoring

Parallel to the community monitoring work, ESE conducted a national level monitoring of the implementation of the Programme for active health care of mothers and children using the applied budget work approach. The data was collected through requests submitted to the Ministry of health according to the provisions under the Law for freedom of information. Analysis showed that during 2011, with amendments in the Programme, the activities which aimed specifically at Roma people were reduced in means of scope and budget, and were merged with the activities which aimed at other vulnerable groups (rural population and poor people). Moreover, the activities intended for Roma were not fully implemented and part of the funds marked for these activities remained unspent. The main challenge during budget monitoring was the release of poor quality data from the Ministry of health, which was often incomplete, confusing or inconsistent.

The findings from both monitoring processes showed that the budget cuts and the lack of commitment for implementation of the measures on national level got reflected on local level. The consequent negative impact on Roma communities, due to lack of coverage with preventive health care services and insufficient immunisation coverage of Roma children, led to the continuation of health disparities among Roma as compared to other ethnic groups in Macedonia.

Advocacy

The partner organisations jointly prepared a national level advocacy strategy based on the findings that emerged from community monitoring and national level budget monitoring of the Programme. The following national level advocacy goals were set:

- Adoption and implementation of measures for additional community (outreach) nurse visits in Roma families.
- Adoption and implementation of health education workshops in Roma communities.
- Translation of health educational material in Romani language and distribution of the material among Roma communities.
- Proper delivery of invitations for vaccination in Roma communities through employment of couriers.
- Implementation of activities marked for active screening of the Roma communities in order to identify and immunise non-immunised Roma children

In 2012 end the national level advocacy process was conducted. Member of Cabinet from Ministry of health incharge of implementation of Roma related health policies within the Ministry, Minister without portfolio responsible for the implementation of activities from the Decade for Roma Inclusion in Macedonia were identified as the relevant target stakeholders in the process. Findings from the monitoring process were shared with these stakeholders in the direct meetings and the need for adoption and implementation of specific measures was emphasised. Based on the findings of the monitoring processes a policy brief and recommendations for improvement of the situation were listed and these were submitted to the Ministry of health and the Government.

In addition, the local organisations carried out local level advocacy within respective municipalities based on the specific problems and needs identified in these.

Outcome

After the national level advocacy, the Ministry of health and the Government adopted measures for increased coverage with preventive services of Roma people in the Programme for active health care of mothers and children. In the Programme for regular medical checkups of school children and students, the Ministry of health and Government adopted measures for field identification of non-immunised school age Roma children who had dropped out of schools.

To foster the monitoring and accountability work, Macedonioan organisations are planning to further build their capacities in the field of social audit. It is believed that the implementation of this methodology will contribute to the efforts of the CSOs to enhance transparency and accountability of the Government and its institutions and to improve the service delivery on the field.

Conclusion

The organisations learned that it is essential to strengthen and mobilise the community in order to empower them for demanding the health care services rights. It is significant because only an aware and mobilised community can successfully advocate for their own rights. The community needs to be involved in all of the stages of inquiry, from its preparation to conduction and in collation of final results. Significantly, the final results need to be shown in a manner that easily understood by the community to enable them to identify problems and monitor the future progress on their own. □

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Community Action in Health Service Delivery in Khyber Pakhtunkhwa (KP), Pakistan

A pilot project initiated in the year 1999 in the Punjab, Pakistan, showed the way for the formation of Primary Care Management Committee with community volunteers as well as healthcare providers as its members. Informal community engagement in the health sector was thus formalised. This article brings out in detail how community participation has brought in transparency and accountability in effective health service delivery.

GULBAZ KHAN

In 1999, a pilot programme was initiated in three Basic Health Units (BHUs) in Lodhran district of Punjab province in Pakistan, wherein civil society organisations were given a leading role to play and the management of the BHUs was contracted out to Punjab Rural Support Program (PRSP). The pilot programme was later expanded to the Rahim Yar Khan district in 2003. The perceived success of the expansion resulted in extension of the innovation to all four provinces of Pakistan under the President's Primary Healthcare Initiative. In *Khyber Pakhtunkhwa (*KP), reforms in the health sector introduced healthcare standards[1] under which informal community engagement has been formalised and the Primary Care Management Committee (PCMC) has been notified as first of its standard. In continuation to these reforms, PCMC were then notified in 2010.

Citizen Engagement for Social Service Delivery (CESSD)[2] is a five-year DFAT (formerly AUSAID) funded capacity development initiative aiming to enhance capacities of both social service committees and government officials at the district and provincial level. It works with the Department of Health at the district level and local areas, to facilitate and oversee the improvement of the delivery of basic health services, using selected standards, by forming and strengthening the Primary Care Management Committees (PCMCs) and it also supports the concerned provincial departments to incorporate community managed social service delivery approaches in their operational policies.

Primary Care Management Committee

- Primary Care Management Committee (PCMC) is a formation of a group of community volunteers along with healthcare providers, who work for the improvement of health services in the primary health facility through implementation of quality health standards of Health Department. The General Body is formed by the 100-150 representatives selected by their respective villages, executive body is formed by 8-10 volunteers from the community as well as the facility staff and chairperson of the union council. Women's representation is a challenge but is given priority wherever it is possible. The Chairperson is mandatorily elected from the community, while the doctor-in-charge of the health facility is the default secretary of the PCMC.

Broad responsibilities of the PCMC include implementation of social accountability tools; developing, reviewing, managing and monitoring the FDP; enhancing coordination with the health department and others; record keeping; ensuring financial transparency; and regular monitoring and oversight.

PCMC Capacity Development Process

The process of identifying and selecting the PCMCs is inclusive and is made in close consultation with the district health officials.

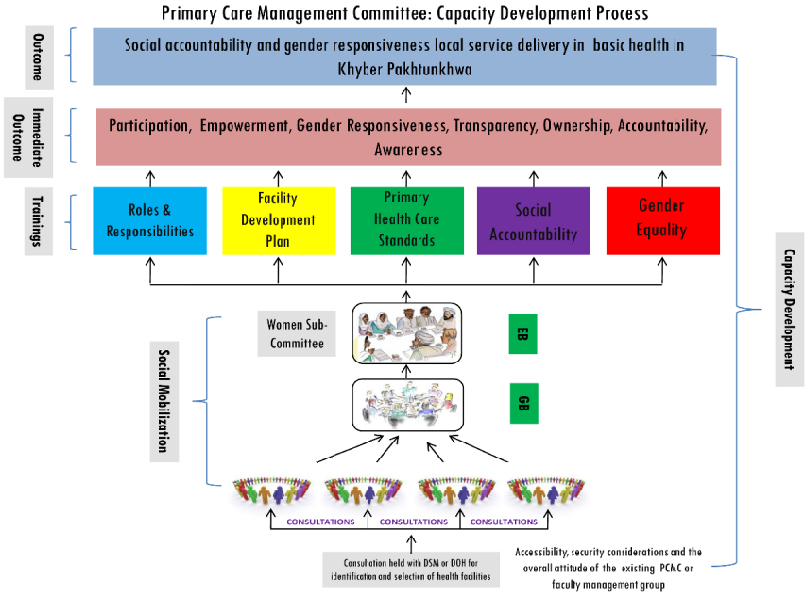
[1] The Primary Care Health standards were developed by Health Regulation Authority (RHA) in close collaboration with GIZ. Initial draft was shared in 2006 with health practitioners.

[2] CESSD is working in three core areas, primary education, basic health and rural water supply schemes. CESSD initiated its activities in health sector in April 2001 and is currently working in 11 districts of the province including Abbotabad, Charsadda, Chitral, Haripur, Kohat, Kohistan, Mansehra, Mardan, Nowshera, Peshawar and Swabi.

Key functions of PCMCs

Facility Development: All the executive members of the PCMC are trained on developing Facility Development Plan (FDP) which enables local aspirations to be fulfilled while bringing in concrete results for improved health service delivery. To make FDP's gender responsive, women and girl child issues are also included in it directly or indirectly. The Women Sub Committee conducts its own meetings and transmits the issues to the male counterpart. Through the participatory process, a set of issues have been identified and included in the facility development plans which include the following:

- Construction of boundary walls
- Provision of electric water cooler for safe and cool drinking water (MDG-7)
- Increasing the quota of medicines (MDG 4-5)
- Beautification of the facility including plantation and white wash
- Construction and rehabilitation of toilet facility specifically for women users
- Appointment of facility staff including doctors (MDG 4-5) at key positions
- Staff discipline including absenteeism (MDG 4-5)
- Installation of Public Information Boards (Open Government Agenda)
- Installation of chairs in waiting area



- Procurement and placement of garbage bins (MDG 4-5-7)

Creating Awareness: The PCMCs key objective is to create awareness among health services users. In the General, executive members conduct health and hygiene sessions to help the community understand the provision of basic services at BHU level. The executive members also arrange for self sessions in mosques, hujras, schools and social gatherings, through which PCMC reaches out to maximum number of users and creates awareness on health rights and entitlements. A strong fact has emerged from the field that "community awareness helps increase the number of patients in the BHU OPDs".

Gender Inclusiveness: It is binding to include women as executive members, However where culture does not permit, a Women Sub Committee (WSC) is constituted to represent women specific needs and priorities in the mainstream development process. When the PCMC meets regularly, a representative of WSC presents or gives in writing its decisions during the sub-committee meetings, which then becomes an integral part of the PCMC agenda. The PCMC transmit all the decisions to the WSC and make sure that all the objectives are taken well by all the members, deliberated upon and decisions are taken for necessary actions. Similarly, women also provide constructive input towards development of facility plans.

PCMC's Role in Social Accountability

Ensuring Transparency: PCMCs do not have financial flow from the government, but they have clear standard financial procedures which are practiced for resource generation and expenditures incurred. All the financial transactions are recorded properly and presented in the monthly meetings accordingly. All the PCMCs are also bound to provide reports to district health officials.

PCMCs also engage in implementing social accountability tools like Public Information Board (PIB). PIB contains critical information on

examination fee, OPD timings, number of staff, list of available tests and information on handling of complaints. It is installed at an appropriate place within the BHU, so that health service users can benefit from the information displayed on it and track staff absenteeism, corruption including overcharging, non-availability of medicines and test facilities besides other things.

Use of PIB has led to some positive developments and helped identify gaps in health services delivery. Health service users and active PCMCs members used PIB information to enforce primary healthcare standards at BHU Pakha Ghulam, Peshawar. Observations from the field also highlight that PIB intervention has led community people to identify issues of staff absenteeism, corruption, overcharging, and demand of informal payments for free services.

Complain Management System (CMS): A comprehensive Complain Management System (CMS) has been introduced at the facility and district levels to address the grievances of the health service users for effective service delivery and it also includes the PIB component. Experiences from the field have shown positive results over the last few years since institutionalisation of CMS and notification by health department. Several complaints have been registered by the community members before the district officials on staff absenteeism, corruption, medicine and non-availability of facilities for tests. The district officials take note of these complaints and apply sanctions on the facility staff. There have been cases where changes were visible wherein a doctor was removed and the facility staff was fined for overcharging, thus putting corruption practices to end. All the requisite tests are being conducted free of charge as a result of CMS.

The facility administration also helps resolve issues on daily basis on the advice of health officials. Problems of community are transmitted to PCMC members for resolution. PCMC members either solve the issue at the facility level in consultation with the doctor-in-charge or forward it to the district health officials for immediate resolution. If the case cannot be handled at the facility level, it is presented before the higher officials. This process breeds a sense of ownership amongst community members and accountability on the part of the facility administration.

Improving Participation: It is mandatory for PCMC to hold monthly meetings which has to be attended by all the executive members. In absence of women in the executive committee, Women Sub Committee representatives must attend the meeting and the sub committees agenda points should be part of the regular PCMC meeting. Two General Body gatherings are also held in order to reach out to maximum users of health services in the catchment area. It has now become evident that wherever participation of the general and executive members improves, it results in improved health service delivery.

Recommendations: The recommendations for better service delivery include, among others, giving more visibility and representation to PCMCs , district-level coordination platform for better confidence and rapport building with the community, lobbying with the provincial government to consider PCMC for resource utilization, production of information materials and a comprehensive approach towards improving basic services.

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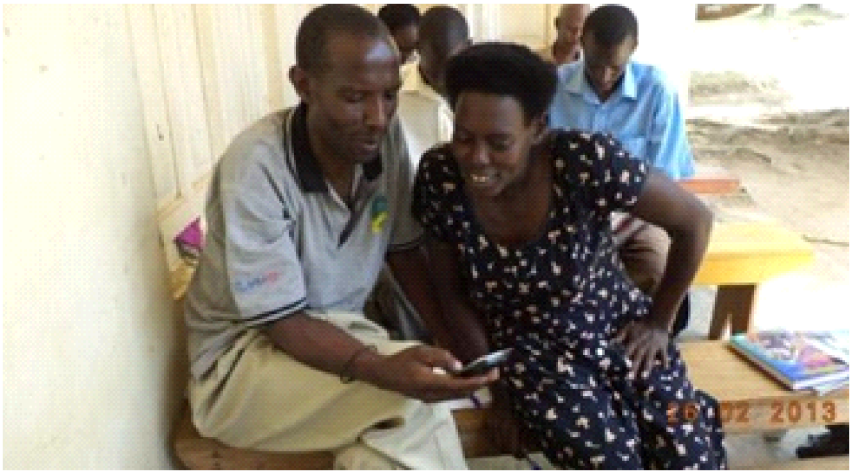
Information Communication Technology for Improving Maternal Health in Local Communities

SMS-based platforms complemented with suggestion boxes, community radios and community advocates structure have now emerged as popular social accountability monitoring tools in developing countries.

ROBINAH KAITIRITIMBA

Information Communication Technology (ICT)-based social accountability monitoring tools have become increasingly popular in developing countries. With the increasing popularity, accessibility and coverage (70.7 percent) of mobile technology, more and more people are using it to raise their concerns. Most ICT solutions are based on simple messages through mobile SMS (poll questions, results and useful information) service designed to strengthen community-led development and citizen engagement. The tool allows citizens to engage more actively in civil society issues by monitoring service delivery and helping keep governments accountable. In essence, they facilitate social accountability - a single SMS leads to a bigger discussion involving all citizens registered on the SMS platform.



Community advocates with a UNHCO staff learning how to use mobile phones to monitor health service delivery

Uganda National Health Consumers' Organisation (UNHCO) is among the pioneers in using SMS-based social accountability platforms in Uganda. UNHCO with support from Catholic Organisation For Relief and Development Aid (CORDAID) is implementing a project in three districts namely: Luweero, Kamuli and Lyantonde. The project aims at "reducing maternal mortality using the rights based approach through increased communication and information sharing". The project is using the text messaging approach to raise awareness on maternal health and also to solicit feedback from the community. Both men and women are registered to receive maternal health information through text messages. Once registered, community members are able to send feedback to the platform on the status of service delivery and hence demand accountability.

It is interesting that community members have found this platform very useful and secure to raise their concerns and currently there are more than 2,168 beneficiaries who receive and send feedback. UNHCO has been able to handle the emerging issues with the help of Village Health Teams, district and local governments and the "Text to Change" tool. Aggregated data from the project districts is shared quarterly with the Ministry of Health through its Quality Improvement Taskforce and the Maternal Health Cluster where UNHCO represents other civil society organisations. The Ministry then mandates its various implementation arms to address issues during the subsequent quarters.

The ICT platform is complimented by suggestion boxes, community radios and community advocates structure to improve health services. A case in point is Kalagala health centre IV in Luweero district of central Uganda where the suggestion box is managed by the Health Unit management committee chairman who organises community dialogue meetings. Issues from the suggestion box and radio talk shows are presented and discussed for improved healthcare. In

one of the meetings at Kalagala health centre IV on an issue pointed out through the suggestion box, the community informed about the lack of a resident doctor. The issue was discussed and the message was forwarded to the district administration. Resultantly, a resident doctor was appointed at the health centre.

The community is using the SMS service to report situations such as cleanliness, availability of medicines and health worker absenteeism at health facilities. These issues are compiled and recorded in a register, which is then reviewed by the Health Unit Management Committee (HUMC). The community is then informed through SMSs, radio broadcast and community dialogue meetings. In Lyantonde district of Kaliiro Sub County, the community held its leaders as well as the health officers accountable through a community dialogue where they brought to light the behaviour of the officer-in-charge of Kaliiro HCIII. The officer-in-charge used to abuse patients and force them to pay for mama kits that is supposed to be given free of cost to pregnant women. The authorities responded to the community's complaint, transferred the health worker and brought in new workers. Since then the community has not faced any problem with regard to accessing health services. Tumusiime, a boda bode cyclist says, "Thank you for helping us. I had stopped coming to this health centre as the health workers were never present. Once when I was not well and came here at midday, I found the facility closed. But since the time they have brought in new health workers, I easily get the services I need whenever I come here." □

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Innovative Strategies for Community-Based Monitoring of Health Services

Insights from experiences in Maharashtra, India

NITIN JADHAV AND ABHAY SHUKLA, SATHI[1]

Community-Based Monitoring (CBM) is a powerful approach for ensuring accountability and people-oriented governance of public service delivery systems. Since 2007, Community-Based Monitoring and Planning (CBMP) of health services is being implemented in several states of India, including Maharashtra (the second largest state of the country) where this process now covers over 800 villages and has demonstrated significant positive impact. In this context, we are sharing here certain key innovative strategies that have been utilised and the findings from our experiences. The lessons would be of use to civil society organisations working in other countries, while implementing the community accountability methodologies.

Glimpse of Health providers who are trying to understanding the present status of village level services which were rated by community and displayed in the form of score card.

Public Hearing (*Jan Sunwai*): A tool for ensuring health rights through mass dialogues

Public hearings or *Jan Sunwais* are among the most crucial CBMP processes in Maharashtra, which help empower ordinary villagers to "speak truth to power". Public hearings can act as a powerful mechanism to promote responsive, accountable and transparent local governance. In the public hearing, findings from the CBM processes and case studies of denial of healthcare are presented before an expert panel, which is followed by responses from health officials, thus providing an opportunity for people to demand corrective action by health functionaries. Till date around 450 *Jan Sunwais* (public hearings) have been organised at various levels as part of the CBMP process in Maharashtra. The key elements of an effective public hearing include:

- **Mobilisation of people from various communities:** Local organisations mobilise people and active citizen's groups in the area. Their presence at the public hearings ensures that critical issues be raised and pressure created to fulfill popular demands. Usually disempowered groups, including women, members of oppressed caste groups and the poor, are actively encouraged to speak, which helps to build a momentum and ensure active participation.
- **Involving local elected (Panchayat) representatives:** Panchayati Raj is a system of governance in rural India based on elected local bodies. The presence of elected Panchayat members during the *jan sunwais*

[1] SATHI (Support for Advocacy and Training to Health Initiatives), Pune, India is the State nodal organisation for Community based monitoring and planning in Maharashtra.

builds political pressure for resolution of issues, and helps to ensure inter-departmental coordination among officials who are often resistant to work together.

- **Inviting relevant public health officials:** Generally, officials who are at least one rank higher to the officials/staff against whom the complaints are being made are invited for the hearings. The rank of the officials invited and the issues presented in the hearing should be closely correlated, to ensure that the officials assigned the job are asked to take action on issues that come under their jurisdiction.

- **Constituting an appropriate panel of judges:** Prominent experts from various fields like teachers, lawyers, doctors, journalists, etc. are invited to participate as panelists in the jan sunwais. They mediate the dialogue and give an autonomous opinion or 'judgment', thus contributing to responses by government officials and taking key decisions.

- **Seeking media attention for the event:** Media plays a vital role in disseminating the findings. Hence it is important to contact the media in advance and ensure coverage of the decisions and the processes during the hearing.

- **Persistent follow-up to ensure action:** A follow-up meeting to improve specific health services is usually planned with public officials soon after the hearing, where activists discuss the detailed recommendations and plan of action that emerged from the hearing. This ensures implementation of the key recommendations.

The *Jan Sunwai* process is an illustration of how popular actions from outside the system (external accountability) can activate senior officials to take action regarding subordinates (internal accountability).

Key Insights on Public Hearings

- These are "popular forums for prompt justice", which are more direct and accessible than the current formal justice system. Public hearings "tilt the traditional power balance in favour of people", as ordinary people get an opportunity to ask questions, while those in power are required to respond.

- Public hearings can provide a "mediation mechanism between programmatic designs and local level implementation". For example, the posts of health workers are vacant in many places, and in such a situation, the demand is not just for proper work by the existing staff, but also for the appointment of additional staff in keeping with the growing requirements.

- The public hearing ensures that diverse stakeholders with somewhat differing interests- community members, public health officials, civil society organisations, local elected representatives, media persons- come together and form a temporary alliance for a common goal, "the improvement of public health services".

- Public hearings act as relatively equitable platforms for dialogue between users and providers to solve the problem, which has reduced the gap between the administration and local people, leading to redressal of many genuine grievances. *Jan Sunwai* (public hearing) has evolved into *Jan Samvad* (public dialogue) in many areas of Maharashtra, moving the discourse towards affirmative action beyond fault finding.

Use of mobile phone for text messages (SMS) to conduct CBM surveys

To conduct surveys on issues related to large number of health facilities across the state in a rapid manner, a simple technique is being used to analyse community based feedback- SMS (text messages) sent from ordinary mobile phones. These SMSs sent by CBMP activists from across the state are analysed using a simple software, which helps to bring out reports of large state-level surveys within a couple of days. It was observed that while data collection and analysis is important, such surveys based on filling and compiling written questionnaires are time consuming and require substantial resources. Hence the idea of SMS-based surveys originated, and this tool is now being used on a regular basis.

Process of data collection through SMS-based surveys

- **Capacity building of activists to be involved**: The activists involved in the process are oriented through actual demonstrations regarding data coding, use of mobile phones for sending data in a standard format, correction of possible mistakes while typing messages, and solutions to common problems.

- **Identification of issue and preparation of short checklist for data collection**: In each round, health service issues are identified which are important for ordinary people, easy to quantify, and where it is feasible to collect objective data without major training. Based on each issue, a short checklist is developed at the state level, which is disseminated to CBM implementing civil society organisations.

- **Time bound data collection during defined period**: The time period (specific dates) for data collection is communicated to the activists involved in data collection. Each activist collects the information based on the checklist, codes the responses and sends one or two coded messages to a given mobile number. Most of the answers are in the form of fixed choices (like yes/no) or numerical values.

- **Data collation, analysis and preparation of report**: All messages are analysed with the help of software which converts the entire information into spreadsheets. This analysis is often complemented with telephonic interviews of community-based activists and providers to get some qualitative insights, following which the report is prepared and widely disseminated to civil society organisations, members of CBMP multi-stakeholder committees, media and concerned health officials. "Standard voice messages" are being used to disseminate key findings to different stakeholders involved in the CBMP process.

Based on the SMS survey system, four surveys have been conducted so far in Maharashtra on the following issues:

- Checking "availability of ten essential medicines" in 36 PHCs across 12 districts of Maharashtra.
- Patient feedback on quality of services available at rural hospitals by interviewing patients in 24 rural hospitals/sub-district hospitals in 13 districts.
- Confirming actual round the clock availability of doctors and nurses in 24x7 PHCs in 25 PHCs across 12 districts.
- Assessing the status of laboratory services in 123 PHCs across 13 districts of Maharashtra.

Overall this is a simple and rapid method of data collection, which is easy to generalise and can be managed with modest resources. However basic orientation of each activist involved in the data collection, along with computer software and analytical skills at state level are necessary. Such surveys can provide evidence for advocacy and the media can be informed about the key findings on a regular basis.

However basic orientation of each activist involved in the data collection, along with computer software and analytical skills at state level are necessary. Such surveys can provide evidence for advocacy and the media can be informed about the key findings on a regular basis.

Continued on page 33

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Putting Principles into Practice in Peru

A vivid demonstration of the local and global challenges faced towards ensuring social accountability processes and reclaiming right to health

ARIEL FRISANCHO

As the global health community is progressively embracing "universal health coverage" (UHC), it is important to analyse the contribution of Rights-based approaches (RBAs) to health, for realisation of this objective. While setting specific standards to be achieved by the health system[1], RBAs also extend the concept of 'what' should be addressed by UHC and 'how' it should be addressed[2]? Amongst the most important contributions of RBAs to the UHC debate, are the principles of citizen participation i.e. citizen monitoring and accountability.

Indigenous leaders discussing/sharing practice of citizen monitoring

Building on the vibrant and inspiring-though non-articulated-citizen monitoring initiatives and experiences gained by diverse organisations at the national and sub-national level in Peru; the coalition of Open Society Foundations, Foro Salud, CARE Peru and Salud Sin Limites (Peruvian NGO) brought together more than 100 nation-wide civil society leaders and activists in June 2013. The meet was organised to share the initiatives and lessons learned through practice of citizen monitoring, focusing significantly on indigenous leaders and representatives[3]. The wide range of experiences shared in the workshop revolved around citizen monitoring of public policies, public budget allocation, sexual and reproductive rights, quality of the health services and health rights. [4]

Holistic view of Citizen Monitoring from the field

Many significant conclusions were drawn from the workshop held in June. It includes advances identified for improved knowledge on rights, development of the empowerment processes for diverse participants involved in citizen monitoring, improved negotiation capacities, increased transparency on budget management, the national recognition of the role of citizen monitoring committees and improvement of healthcare quality, recognition of rights and responsiveness of health providers to people's needs and demands[5].

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[1]Backman, G., Hunt, P., (2008) *Health Systems and the right to health: an assessment of 194 countries*, www.thelancet.com Vol 372, December 13, 2008.

[2]Which includes the right to live under specific social determinants of health, though this issue would be part of another article for COPASAH Commmuniqué

[3]CEGSS – Centro de Estudios para la Equidad y Gobernanza en los Sistemas de Salud (Guatemala) was a special participant, bringing their experience on citizen monitoring of public policies and health services.

[4] As one result of the workshop, ForoSalud and CARE committed themselves to organize a specific workshop for indigenous organizations to build capacities on citizen monitoring. This workshop was implemented under COPASAH's Regional Project on October 2013, with the participation of nearly 30 leaders of indigenous organizations from different Peruvian regions. 29 individuals (24 women and 5 men) , 25 coming from eight Peruvian regions' grass-roots, indigenous organisations: FEMUCARINAP (San Martín, Loreto, Puno), Red de salud de Collique (Lima), Comité de Vigilancia de Huancavelica, LAS NAUTINAS (Loreto), AIDESEP (Madre de Dios), ADEMUC (Puno), ACOMUC (Puno), OJIRU (Ucayali), Asociación de Promotoras de Salud de Luricocha (Huanta- Ayacucho),FECONACA (Satipo – Junín), ORDEMI (Ucayali).

[5]ForoSalud (2014) Report to Open Society Foundations on the Citizen Monitoring Workshop*"De los principios a la práctica: El enfoque de derechos humanos en la Vigilancia ciudadana de políticas públicas en salud"*. Lima, 18 y 19 de Junio del 2013.

Significant changes in policy are a result of the political advocacy built on Puno's citizen monitoring model. The initiative became a reference point in the national context for the issue of citizen monitoring, quality healthcare services and right to health thus contributing to the design and launch of National Policy Guidelines for the Promotion of Citizen Health Monitoring[6].

Lessons learned from different experiences:

- Strategic alliances, such as those established with public actors like Ombudsman and Integral Health Insurance in Puno and civil society actors like ForoSalud, Movimiento Manuela Ramos are significant to strengthen the capacity of rural women's agency and to address unequal power relations.
- Implementation of accountability approach based on dialogue and promotion of good governance, building mutual understanding, increasing trust and credibility between healthcare providers and citizen representatives is significant.
- Use of the principles of International Human Rights framework at the local level in an effort to strengthen the quality of care provided in healthcare services is significant in the context of the United Nations Human Rights Committee (June 2009) resolution which positions maternal mortality as a human rights concern[7].
- The citizen monitoring initiative provides lessons that can be utilised in monitoring of the implementation of Universal Health Insurance, the actual benefits of conditional cash transfers, the implementation of participatory budgeting and the monitoring of outputs-oriented budgets

A long and winding road: Challenges faced by citizen monitoring and health rights realisation within health services

The major challenges faced while supporting a rights-based, democratic and responsive health system are:

- Lack of support from the current national government for community/citizen monitoring as compared to the previous government is a major challenge. The Ministry of Health in Peru is focusing more on financial changes than on quality or rights-respect mechanisms.
- Amidst limited governance or accountability mechanism scenario a renewed joint effort of the coalition of Ministry of Health, regional and local governments and the civil society is required to ensure implementation of citizen participation mechanisms and citizen monitoring.
- The major 'systemic' barriers like low quality of decentralised health management (lack of leadership and skills to manage and monitor the enforcement of national/regional policies) and the lack of definition of performance indicators are another challenge. Certain aspects of Human Resource policy are a challenge as concentration of officials and public authorities at the sub-national level; poor salaries and working conditions and lack of public career path, affect the sustainability of commitments
- Improvisations in economic conditions have made more public resources available relative to earlier times. As a result most of the "traditional" civil society leaders have become public servants or are involved in public social programmes. Though it is a positive development, but it has limited the potential of civil society organisations for ensuring an informed, empowered citizenry to promote citizen monitoring.
- Over the last decade, a vibrant civil society in health has emerged in Peru, however the society at large remains ignorant of health rights and importance of citizen participation. It is a challenge to involve community for the realisation of health rights and social justice.

The Global Arena: Enabling Environment for Good Governance?

- The international health cooperation actors and global stakeholders are too focused on Millennium Development Goals (MDGs) metrics and stress on direct work with government bodies, with reduce the support and scope of social processes in promotion of governance and social accountability. Pressure from donors to define impact and results linked to the MDGs for

[6]Peruvian Government – Ministry of Health (2011) RM No. 040-2011 / MINSA, 14 January 2011.
[7]United Nations' Human Rights Council (2009) Resolution on Preventable maternal mortality and morbidity and human rights, A/HRC/11/L. 16/Rev.1 / 16 June 2009.

complex, long-run processes with limited resources—is a major challenge for citizen monitoring work.

- The current trends of international cooperation towards Universal Health Coverage suggest that there is a risk of the "capture of the concepts", i.e., making Universal Health Coverage a synonym for Universal Health Insurance, which could be an important tool to realise UHC, but doesn't guarantee, universal access to good quality, rights-respectful healthcare[8], nor does it a clearly engage with other health determinants.

- The global interest rests more on addressing chronic diseases and conditions, and the internal inequalities get masked by the national averages of the MDGs, etc.). The resources and efforts utilised in addressing chronic diseases push other health priorities to a back seat.

Facilitating Citizen Monitoring and People-centeredness

The analysis of the previous challenges helped to prioritise the conditions to be in place to facilitate further community monitoring work and these include:

- Political will and political decision-making.

- Political engagement and commitment to promote health rights and rights-based approaches.

- Normative framework adapted to social context.

- "Appropriateness" and support to the citizen monitoring initiatives from national/sub-national authorities, implementing the necessary institutional arrangements for their adequate functioning, provisioning the resources that are needed and sensitising health personnel

- Capacity building of the citizens who will implement the citizen monitoring and of authorities/ providers who are supposed to promote and facilitate its implementation and listen to its findings.

- Establishment of representative, genuine participatory policy dialogue spaces between public authorities and civil society/ people representatives to debate/ negotiate changes.

- Citizens are aware and adequately informed about the rights and entitlements, with organisational capacities.

- Communication strategies.

- A better inter- sectoral articulation with other civil society coalitions at both national and international levels.

- To adequately disaggregate the concept of "Universal Health Coverage", to achieve a clear understanding of all the components included in it e.g. quality, rights-respect, governance and accountability mechanisms, demanding commitment from governments.

- Capacity building of the civil society: increasing mechanisms for sharing knowledge; creation of permanent leaderships; active engagement of young people; and proactive learning from practice.

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[8]Richard Horton, at The Lancet Global (May Edition) alerts on how the quality dimension of health care has been somehow left aside by all the MDGs processes within the countries.

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Integrating Health Rights and Social Inclusion Perspective in Community Based Monitoring

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The context of CBM and social exclusion in India:

In India, Community Based Monitoring (CBM) process in health has been used to enhance the ownership of the people over the public health system and for improving performance of the public health system. [1] Both from the practitioners as well as the policy perspective, community monitoring is increasingly being recognised as an evidence based approach and as a method for ensuring community awareness on their entitlements and strengthening their capacity to hold governments accountable to secure the entitlements. It has been employed as a potential medium to fill up the knowledge and power imbalance between the health care providers and the community, especially the rural and the semi-literate communities in various contexts. Such models have been adapted to varying contexts in other countries as well.

While the CBM approach strives for improving the conditions of health services through the participation of community, this approach has not so far looked at the structural barriers of social exclusion and discrimination that impact the health status of marginalised communities who get left out even otherwise in a fairly well functioning health care system. Such exclusion and the experiences do occur on account of factors such as gender, caste, religion, disability and ethnicity, among others, which are known as 'axes of discrimination'. The usual parameters in the citizen report card such as infrastructure, health human resource, equipment, availability of services and a citizen report card do not capture the factors of 'discrimination' experienced by the marginalised community in subtle or overt manner which has consequences to accessing health services even in an optimally functioning health centre. Such covert or overt manifestations of discrimination are ingrained in the attitude behavior and inter-relationship not only of the individuals seeking health care but also with the community which such person belongs to. Much of these issues belong to the social structures and socialisation processes of which the health care providers as well as the disadvantaged communities are part of. From the perspective of the health rights of the marginalised and socially excluded communities, it is critical to integrate such factors of discrimination in the CBM approach for effective use of CBM for the realization of health rights. Such an

Group Discussion with members of the muslim community on the perception of discrimination in Health Care in West Bengal, India

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[1] CBM is a form of a social accountability process which involves drawing in, activating and motivating community, capacity building and allowing the community and its representatives to directly give feedback about functioning of public health services. As an approach it facilitates community participation through exchange of information on the policies, programmes and entitlements in the schemes.

effort has been undertaken by Centre for Health and Social Justice, (India) and a few experiences of this process are shared in this article.

Social exclusion and impact on health

Social exclusion is a multi-dimensional and intersectional process driven by the dynamics of the unequal power relationships resulting in individuals and groups and being fully or partially excluded from full participation in the society. The intersectionality occurs due to the multiple 'axes of discrimination', factors which are embedded in the socio-cultural – political structures of society such as gender, caste, race, religion, ethnicity, disability and sexual orientation among others. For example, the discrimination experienced by a disabled Dalit[2] woman in India will be understood both in the context of patriarchal society and hierarchy of caste and the preferential value attached only to able bodied persons.

Social exclusion processes, which take various forms and expressions in health and health care, result in poor health outcomes of the person belonging to marginalised community. Discriminatory and exclusionary practices in health care can be in the form of negligence or denial in admission to medical treatment, inadequate or poor quality medical treatment, neglect by service providers, being uncounted[3] or not included in the processes of health programmes on account of social identity of the citizen (patient) seeking health care. These result in serious denial of health entitlements and violations of health rights and consequently poor health outcomes as compared to the privileged community.

Impact of such structural axes of discrimination results in gross disadvantages in relation to health rights and quantitative data of health outcomes can be only a least indicator and not the sole representative of such societal malaise. For example, National Family and Health Survey (NFHS) - III reflect the low health indicators of the socially excluded groups of Dalits and Adivasis[4] and is aggregated as schedule castes (SC) and scheduled tribes (ST) respectively. Terms like SC and ST themselves do not however represent the vast variation of groups and not at all the societal processes of marginalisation due to untouchability.

Integrating Social discrimination in CBM

Centre for Health and Social Justice (CHSJ), which is one of the pioneering organisations in CBM in India, has started an intense process of attempting to address issue of social exclusion through the tool of CBM. CHSJ in alliance with Poorest Areas Civil Society (PACS) and other Civil Society Organisations (CSOs) have initiated a process of CBM in the selected 100 blocks of seven states (Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Uttar Pradesh and West Bengal) with low health and development indicators as compared to the national average. The blocks have been identified and selected on account of weak health and development indicators along with the substantial presence of the major socially excluded groups in India, viz. Dalits, Adivasis and Muslims[5]. The aim was to attempt to look at the issues of social exclusion and discrimination, to identify them through a systematic process and address through the CBM approach.

The CBM process for *health rights and social exclusion* aims to capture the perceptions and experiences of the marginalized communities while accessing and availing health services. It attempts to delineate experiences of discrimination in the attitude and behaviour of the service providers and how they perceive social exclusion is happening in health services institutions such as Primary Health Centers and Sub-Centers. Maternal health services

[2] "*Dalit*" refers to one's caste in South Asia; it applies to members of those subordinated castes which have borne the stigma of "untouchability" based on birth. They are also traditionally forced into occupation such as tanning leather, manual scavenging and sweeping streets etc. which is considered "impure" or "polluting." Due to their caste identity Dalits regularly face discrimination and violence which prevent them from enjoying the basic human rights and dignity promised to all citizens of India. http://www.ncdhr.org.in/dalits-untouchability/

[3] In Oria language, the state language of Odisha (India) there are various terms to explain social discrimination or social exclusion, the closest of which is 'apariganana' which means not being counted or not being taken into consideration.

[4] '*Adivasis'* is the collective name used for the many indigenous people of India. Adivasis are not a homogeneous group; there are over 200 distinct peoples speaking more than 100 languages, and varying greatly in ethnicity and culture. However, there are similarities in their way of life and generally perceived oppressed position within Indian society. www.adivasi.ozg.in/about

[5] Sachar Committee report commissioned by the Government of India on the status of Muslims, has shown that the human development status of Muslims in India is very low and is only comparable to that of Dalits and Adivasis.

provided unique window to understand this, as every woman interacts with health providers and health care institutions in different times of her life cycle.

Process

The experiences shared followed a rigorous process for over eight months to understand the contexts and various actors which has led to the formation of a tool on discrimination perception.

- **Consultations with CSOs working with marginalized communities**: To facilitate an understanding of the experiences of social discrimination, at first level, state level consultations were held with the civil society organisations of all the seven states categorised in four clusters. The CSOs provided basic inputs on various types in the practices of discrimination with different communities and in varying socio-political contexts.

- **Field visits**: Two organisations in three states were selected for an in-depth understanding of the issues addressed by CSOs working with marginalised communities. The organisations and the field visits included those working with Muslim, Dalit and *Adivasi* communities. Hence a total of six in depth field studies were conducted following the methodology of in-depth interviews with key actors, group discussions with the communities of the marginalized followed by reviews of documents.

- **National level consultation**: To share and to develop a framework for understanding social discrimination and a CBM process integrating social inclusion perspective, a national consultation with experts was conducted. A rights based framework, with accountability and human rights perspectives was suggested for understanding social discrimination in health. It was also suggested that the CBM facilitators were to be provided the perspectives of health rights through a training module.

- **Preparation of Module**: A basic capacity building module integrating the perspectives, knowledge and skills of understanding social inclusion and health rights with a special focus on the Muslim, Dalit, Persons with disability and Adivasi communities was developed. This was delivered in two phases, the first on perspectives and knowledge on the framework and the second, for five days on CBM and social inclusion. About 150 persons from community were taken through this process, which would be the basic anchors of CBM process and community level investigators.

- **Preparation of Tools**: The field enquiry tools included survey formats focusing on (1) the maternal health services (2) facility surveys of Primary Health Centers (PHC) and (3) sub health centers. These tools covered the functioning of health care institutions at the community level and the delivery of services including maternal health services. The data was gathered by surveying facilities, observation and group discussion. (*See Box-1)*

The draft tools were devised after series of deliberations and standardization of tools was done to capture social exclusion in health care services and were translated to Hindi(used in five of the seven states), Bengali (one state) and Oriya (one state).

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Box -1

Tool on health services, quality of care and institutional discrimination

- The tool has set of questions organized in six sections - (1) human resource availability, (2) infrastructure (and allied facilities such as water, toilet, electricity), (3) equipments, (4) availability of services, (5) quality of services and (6) perception of discrimination by the community based on the behavior and attitude of the service providers linked to social exclusion in the health services (whether scolded, ignored, abused). The sections 4, 5 and 6 on availability, quality and social discrimination were filled up with in-depth discussions with the marginalized community availing services from the particular health centre because they belonged to stigmatized community of Dalits. For example questions included if they felt ignored or neglected in the case of delay in ante natal checkup or felt abused during delivery.
- Data was collated based on the responses (affirmative or negative) for each of the thematic category and a report card along with a narrative report was prepared.

Peru: ¿los principios en la práctica? Retos globales y locales que enfrentan el derecho a la salud y los procesos sociales que promueven la rendición de cuentas (Social Accountability Processes)

ARIEL FRISANCHO

A medida que crece el consenso hacia la Cobertura Universal en Salud (CUS) en la comunidad internacional, resulta importante analizar la contribución del Enfoque Basado en Derechos (EBDs) aplicado a la salud para el logro de dicho objetivo.A la vez que establece estándares a ser desarrollados y alcanzados por los sistemas de salud[1], el EBD aplicado a la salud amplía el concepto sobre ***qué*** debe garantizar la Cobertura Universal en Salud y sobre ***cómo*** debiera hacerlo[2]. Entre estos ***cómo***, algunas de las más importantes contribuciones del EBD a la visión y debate de la CUS son los principios de participación ciudadana (ej., vigilancia o monitoreo ciudadano) y promoción de la rendición de cuentas.

Construyendo sobre la base de las comprometidas e inspiradoras – aunque no articuladas – iniciativas de monitoreo ciudadano y la experiencia desarrollada por diversas organizaciones de base y de la sociedad civil en Perú, tanto en el nivel nacional como sub-nacional, Open SocietyFoundations, ForoSalud, CARE Perúy Salud Sin Limites (ONGPeruana)reunieron en Junio del 2013 más de 100 líderes de sociedad civil, activistas y organizaciones de base, con especial prioridad a líderes y representantes indígenas,para compartir sus iniciativas y lecciones aprendidas al implementar vigilancia / monitoreo ciudadano[3]. El espectro amplio de experiencias abordaron el monitoreo ciudadano de a) las políticas públicas, b) la asignación y ejecución presupuestal, c) los Derechos Sexuales y Reproductivos, d) la calidad y el respeto a los derechos en los servicios de salud[4].

Una vista panorámica del Monitoreo Ciudadano desde las voces del campo

Entre las principales conclusiones del referido taller, se identificaron avances comunes, como un mayor conocimiento de los derechos y la implementación de procesos que

[1]Backman, G., Hunt, P., (2008) *Health Systems and the right to health: an assessment of 194 countries*, www.thelancet.comVol 372, December 13, 2008.

[2] Lo que incluye el derecho a vivir en condiciones y contar con determinantes sociales que favorezcan la salud.

[3]CEGSS – Centro de Estudios para la Equidad y Gobernanza en los Sistemas de Salud (Guatemala) fue un invitado especial, compartiendo su experiencia en vigilancia ciudadana de las políticas públicas y de los servicios de salud.

[4] Como resultado del taller, ForoSalud and CARE se comprometieron a desarrollar un taller específico de construcción de capacidades y de planificación de iniciativas locales de monitoreo ciudadano para organizaciones indígenas. Este taller, que dio inicio formal a las actividades de COPASAH en el Perú, se realize en Octubre del 2013, con la participación de cerca de 30 líderes de organizaciones indígenas de 8 regiones del Perú, 24 mujeres 5 varones, además del coordinador regional del Proyecto CEGSS (CARE Perú) y l@sfacilitador@s del ForoSalud: FEMUCARINAP (San Martín, Loreto, Puno), Red de salud de Collique (Lima), Comité de Vigilancia de Huancavelica, LAS NAUTINAS (Loreto), AIDESEP (Madre de Dios), ADEMUC (Puno), ACOMUC (Puno), OJIRU (Ucayali), Asociación de Promotoras de Salud de Luricocha (Huanta- Ayacucho),FECONACA (Satipo – Junín), ORDEMI (Ucayali).

contribuyen al empoderamiento para las personas vinculadas al monitoreo ciudadano,mejores capacidades de negociación, mayor transparencia de la gestión presupuestal, el reconocimiento nacional al rol que cumplen los comités de vigilancia y las mejoras alcanzadas en temas como la calidad y el respeto a los derechos en los servicios de salud y una mayor capacidad de respuesta del personal de salud a las necesidades y expectativas de la gente.[5]Uno de los principales cambios en políticas fue resultado de la incidencia política realizada sobre la base de la experiencia de vigilancia ciudadana de Puno. Dicha iniciativa se constituyó en un punto de referencia nacional para el diseño de políticas públicas de promoción de la vigilancia ciudadana en salud (Lineamientos de Política para la Promoción de la Vigilancia Ciudadana en Salud)[6].

Algunas lecciones aprendidas desde las distintas iniciativas son:

- La importancia clave de las alianzas estratégicas, como las establecidas con actores públicos (como la Defensoría del Pueblo de Puno o la Dirección regional del Seguro Integral de Salud de Puno) y actores de sociedad civil(ForoSalud, Movimiento Manuela Ramos, etc) para fortalecer las capacidades de agencia de las mujeres rurales y para abordar relaciones desiguales de poder.
- La importancia de implementar un enfoque de rendición de cuentas basado en el diálogo y la promoción de gobernanza, más que en el enfoque de "nombrar y acusar": construyendo mutua comprensión, incrementando la confianza y credibilidad entre las autoridades de salud / personal de salud y los representantes ciudadanos.
- La manera en la que los principios del Marco Internacional de Derechos Humanos ha sido utilizado en el nivel nacional y local en un esfuerzo para fortalecer la calidad de atención en los establecimientos de salud.Esto es particularmente importante al dar cumplimiento a la Resolución de Junio del 2009 del Comité de Derechos Humanos de las NNUU que establece que la muerte materna evitable es un problema de derechos humanos[7].
- Las iniciativas de monitoreo ciudadano brinda lecciones que pueden ser transferidas al monitoreo de la implementación del Aseguramiento Universal en Salud (política pre-eminente del Gobierno Peruano), los beneficios reales de las transferencias condicionadas de dinero, la implementación del presupuesto participativoy el monitoreo de los presupuestos por resultados (PPRs).

Un largo y tortuoso camino: retos enfrentados por el monitoreo ciudadano y la realización del derecho a la salud en los servicios de salud

Sin embargo, existe todavía un largo camino por recorrer. Existen retos mayores para alcanzar un sistema de salud más democrático y con mayor capacidad de respuesta a sus necesidades y derechos:

- no es prioridad del actual gobierno facilitar condiciones para el monitoreo ciudadano.El Ministerio de Salud del Perú ha iniciado la implementación de un proceso de reforma del sector salud que prioriza el tema financiero (extensión del aseguramiento público y privado para registrar al mayor número posible de población) que mejoras en la calidad u otros mecanismos de protección y garantía de derechos.
- existen limitados mecanismos de gobernanza o rendición de cuentas, debido – en parte – a la persistencia de desiguales e injustas relaciones de poder, dentro de las cuales l@sciudadan@s y especialmente los que viven en mayor pobreza y ruralidad, todavía consideran a la salud como un "favor" concedido por el Estado (limitado entendimiento del derecho a la salud).Se requiere de un renovado

[5]ForoSalud (2014) Informe a Open SocietyFoundationssobre el Seminario taller internacional de Monitoreo Ciudadano*"De los principios a la práctica: El enfoque de derechos humanos en la Vigilancia ciudadana de políticas públicas en salud"*.Lima, 18 y 19 de Junio del 2013.
[6] Gobierno del Perú – Ministerio de Salud (2011) RM No. 040-2011 / MINSA, 14 de Enero del 2011.
[7]United Nations' Human Rights Council (2009) Resolution on Preventable maternal mortality and morbidity and human rights, A/HRC/11/L. 16/ Rev.1 / 16 June 2009.

esfuerzo en el que puedan converger el Ministerio de Salud, los gobiernos sub-nacionales y locales y las redes de sociedad civilpara asegurar la implementación de mecanismos de participación y monitoreo ciudadano.

- Existen todavía retos "sistémicos" clave: limitados estándares de calidad y desempeño; débil gestión regional y local de los servicios de salud; discriminación y sub-valoración de la participación ciudadana; alta rotación de funcionarios y prestadores, condiciones retadoras de trabajo y bajos salarios; ausencia de carrera sanitaria o incentivos y una muy limitada cultura de rendición de cuentas. Sin su abordaje, las mejoras buscadas por la vigilancia ciudadana no tendrán efectividad ni sostenibilidad.

- de otro lado, en la medida que ha mejorado la situación económica del país, diversos líderes "tradicionales" de la sociedad civil se convirtieron en servidores públicos, lo que, en ocasiones, ha limitado el potencial de la sociedad civil para realizar una labor totalmente independiente de vigilancia ciudadana.

- la sociedad peruana todavía no tiene una mayor comprensión del derecho a la salud o la importancia de la participación ciudadana.

La Agenda Global: un ambiente favorable para la gobernanza?

Otro reto se presenta analizando las tendencias actuales de los actores de la cooperación internacional y otros actores globales, muy enfocados en las mediciones de las metas de los ODM y el trabajo directo con los gobiernos, con márgenes muy reducidos para apoyar procesos sociales como la promoción de gobernanza y rendición de cuentas. La presión de los donantes por definir impacto y resultados vinculados a los ODM en procesos complejos y de largo aliento que no tienen – necesariamente – resultados previsibles como esel caso de los procesos sociales, plantea grandes retos al impulso de la vigilancia ciudadana y la promoción de la rendición de cuentas.

El análisis de las tendencias de los procesos hacia la Cobertura Universal en Salud, permite analizar dos riesgos adicionales: el primero, la "capturade los conceptos", como hacer de la CUS un sinónimo de "Aseguramiento Universal en Salud", el mismo que podría ser una herramienta importante en el camino a dicho objetivo, pero que no garantiza *per se,* acceso universal a servicios de calidad, respetuosos de los derechos[8], y tampoco una agenda clara en relación a los determinantes sociales de la salud. El segundo reto está asociado al interés global de abordar las enfermedades crónico degenerativas y otras condiciones crónicas y a las desigualdades internas enmascaradas por los promedios nacionales de los ODMs, los que pueden generar una percepción de "tarea cumplida" de lo que serían las "agendas tradicionales de salud" (mortalidad infantil, mortalidad neonatal, mortalidad materna, salud de l@s adolescentes).Siendo vital abordar las condiciones crónicas, no se puede hacer ello a expensas del descuido de otras prioridades de salud que todavía demandan el mayor de los esfuerzos – y recursos – para su atención.

Facilitando el monitoreo ciudadano y políticas centradas en las personas

El análisis de los retos anteriores permite identificar un primer conjunto de condiciones necesarias para ello:

- Voluntad y decisión política en favor de mecanismos de gobernanza (goodgovernance)

- Compromiso político de las autoridades hacia los derechos humanos y el EBD

- Marcos normativo,adaptado a los contextos y realidades locales

- "Apropiamiento" y apoyo a las iniciativas de monitoreo ciudadano por parte de las autoridades nacionales / sub-nacionales, e implementación de los arreglos institucionales necesarios para su adecuado funcionamiento, asignando los recursos necesarios y sensibilizando al personal de salud en este nuevo enfoque

- Fortalecimiento de capacidades, tanto para aquell@sciudadan@s que implementarán el monitoreo ciudadano y las autoridades / prestadores de salud que promoverían y facilitarían su

[8]Richard Horton, en TheLancet Global (MayEdition) alerta sobre cómo la dimensión de la calidad de la atención de salud fue, de alguna manera, dejada de lado por los procesos de alcance de las MDM al interior de los países.

desarrollo y atenderían sus hallazgos

- Existencia / construcción de espacios de diálogo de políticas, representativos y participativos, entre las autoridades públicas y l@s representantes de la sociedad civil y organizaciones de base, para discutir y negociar los cambios a realizar
- Ciudadan@s conscientes y adecuadamente informad@s sobre sus derechos y "entitlements",con adecuada capacidad organizacional
- Estrategias de comunicación social
- Una mayor articulación con otras coaliciones de sociedad civil (en salud e inter-sectoriales) tanto en el nivel nacional y en el internacional
- Desagregar adecuadamente el concepto de "Cobertura Universal en Salud", para lograr un entendimiento claro de la integridad de todos sus componentes (ej., calidad, respeto a los derechos, gobernabilidad y rendición de cuentas), y de la demanda por un mismo nivel de compromisos por parte de los gobiernos
- Inteligencia organizacional del lado de la sociedad civil: incrementando sus mecanismos para compartir conocimientos; la creación permanente de liderazgos; el activo involucramiento de jóvenes y el aprendizaje pro-activo desde la práctica.

Los mecanismos de vigilancia ciudadana deben ser procesos que contribuyan con un mejor desempeño del Sistema de salud en sus distintos niveles de gestión, gobernanza y prestación de servicios, teniendo a las necesidades y expectativas de la población como su principal prioridad. Los mecanismos de monitoreo ciudadano, ligados fuertemente a espacios participativos sobre la definición e implementación de las políticas, hacen posible que las expectativas, percepciones y demandas de las personas retro-alimenten y enriquezcan el desempeño de los equipos de salud y del Sistema en su conjunto.

El monitoreo ciudadano y la existencia de espacios legítimos de diálogo y de rendición de cuentas entre el Estado y la sociedad civil deben informar e influir en la implementación de políticas orientadas a los nuevos Objetivos de Desarrollo global (MDM). Desde esta perspectiva, el monitoreo ciudadano es un estímulo y un catalizador para una mejor capacidad de respuesta de los servicios de salud y contribuye decisivamente a la gobernanza del sistema, llevando a la práctica los principios del enfoque basado en derechos. □

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Peru

Continued from page 25

Putting Principles into Practice ...

Citizen monitoring mechanisms should develop into processes that contribute to the improved performance of the health system at different levels of management, delivery and governance of healthcare, while making people's health needs and expectations the central priority.

Citizen monitoring mechanisms linked to participatory dialogue spaces make it possible that people provide feedback on expectations, perceptions and demands and enrich the performance of healthcare teams and the overall health system.

Citizen monitoring and genuine dialogue and accountability spaces/ mechanisms between the State and civil society should inform the implementation of new policies oriented to the new MDGs. In this view, citizen monitoring is a stimulus and catalyst for healthcare services' responsiveness, contributing decisively to the health system's governance and taking rights-based approach and its principles into practice. □

Continued from page 5

Promoting Accountability for Maternal Health ...

- In Dhabva, not a single pregnant woman spent on child delivery compared to 62.5 percent of the women who had to incur expenses in Report Card 1.

Increase in information regarding High Risk Symptoms and Entitlements

One of the most significant changes that have been observed is the rise in awareness about high risk symptoms. As per Report Card 1, only 14.8 percent women in Sevaniya had information about high risk symptoms/danger signs during pregnancy which increased to nearly 28 percent in Report Card 3. Similarly, in Dhabva, it rose from 22.8 percent to 32.6 percent. Information about entitlements/ schemes of JSY, JSSK and Kasturbha Poshan Sahay was as low as 4.2 percent in Sevaniya which increased to 37.2 percent, and in Dhabva it increased from 5.7 per cent to 15.2 percent.

Quality of Care during Delivery

Institutional deliveries increased from 45 percent to 66.6 percent in Sevaniya, and in Dhabva the rise was from 57.1 percent to 84.6 percent. Promptness of treatment within 30 minutes of arrival at a facility increased in Sevaniya from 33.3 percent to 90 percent and from 50 percent to 72.7 percent in Dhabva.

Conclusion

Social accountability mechanisms like maternal health monitoring tools and VHND monitoring check lists have increased the awareness of community women and their families on the importance of antenatal checkups and their entitlements. The Report Card has given an opportunity for a dialogue with the health system representatives and the community stakeholders, and resultantly led to a more responsive health system. There has been a visible improvement in both availability and quality of services during VHND. The staff at PHCs has become active and women with complications are referred to appropriate health facilities by the health system staff.

□

Continued from page 22

Innovative Strategies for Community-Based Monitoring...

Implementation of 'low intensity CBM processes on voluntary basis': An approach for generalisation of community accountability processes

At present around 25 CSOs are involved in implementing CBMP in 13 districts of Maharashtra, working in an intensive project mode which has been important to demonstrate the feasibility of this process. However community accountability and participation is a core principle which now needs to be expanded in a somewhat less intensive manner, moving beyond the project mode, in many more areas. Based on such considerations, the following innovative processes have been carried out since January 2014:

- **State-wide public process for identifying new civil society organisations interested in implementing CBM:** An advertisement was published in a leading circulated across Maharashtra, inviting applications from organisations interested in taking up community-based monitoring on a voluntary basis. Despite a short deadline, 121 applications were received, which were screened based on defined criteria, especially experience of conducting accountability oriented activities. Thus 34 new organisations were shortlisted and four regional workshops were conducted to orient these organisations.
- **Capacity building process of civil society organisations for implementation CBM process on voluntary basis:** Five persons with experience of rights-based work in the health sector were selected from different geographical regions, to work as Regional Resource Persons (RRPs). They were involved in facilitating regional workshops and visited each of the identified CSOs in their respective areas, guiding them to take up CBMP activities in a voluntary manner. Various communication materials such as posters, presentations and tools for data collection were provided to these CSOs and each of them was enabled to develop CBM

processes in at least 15 villages and three PHCs in a block.

- **Implementation of CBM process on voluntary basis by newly involved CSOs:** Regional resource persons and the CBMP state nodal organisation interacted with these newly involved organisations, enabling them to conduct a range of community accountability processes within a short period and with modest resources, including:
- **Health rights awareness activities** such as campaigns to promote community based monitoring, publicising healthcare entitlements.
- **Community-based data collection** through group discussions in villages and interviews of health service users, using a concise tool made for this voluntary exercise, covering basic services in the PHC.
- **Organising accountability events such as public hearings.** These organisations have prepared community report cards which are displayed in the form of large coloured posters which are presented in public hearings organised at the block levels. During the last six months, 14 such public hearings have been organised in new areas spread across eight districts of the state, opening the way for wider generalisation of such accountability processes. □

In a recent public hearing, one of the panelists was a local newspaper reporter, who published a news item the next day with the headline: "The PHCs are dirty, and the cleaning staff does not heed orders by officials." The medical officer shared the published news with the staff responsible for the job, and thus the process of change was initiated. Without further ado, responsibilities were assigned and within three days both PHCs were thoroughly cleaned up; a change which has been sustained. Resultantly, within a few months, an organisation which was completely new to the accountability processes, worked voluntarily and received ample support from the community, leading to concrete change in health services.

This is another example which explains what it means when we say, '**people can reclaim public services**'.

India

Continued from page 28

Integrating Health Rights and Social Inclusion ...

- **Tool on the perception of Social Discrimination:** A tool on the perception of discrimination of the socially marginalized community was developed to capture perceptions of people on discrimination based on caste, religion, ethnic (tribes) and disability with gender as a cross cutting issue across the axes of discrimination. The format entails capturing the perception of the socially excluded groups through group discussions over the types of discrimination/ untouchability faced in the health services. This is being rolled out and leads to the next phase of CBM based on social exclusion. (See Box-2)
- **Pilot Testing:** During the second phase of the seven day module on health rights and social inclusion the participants were oriented to health rights, CBM approach and a pilot testing of the field enquiry tools was done across the seven states. The tool captured perspectives through interviews, group discussion and observations. The data was complied and analysed and on the basis of the results a follow up was taken as advocacy campaign. The feedback was given by all the participants on the language clarity, ability of the community to understand such questions. The tools also simultaneously were to be used as a medium for discussion on health rights violations in the communities.

Rolling Out of the tools on social discrimination:

About 150 participants from 45 Civil Society Organisations in 7 states have been trained in the perspectives of tools and the process of administering it. A plan of action has been drawn

Box 2

Community perception tool for the enquiry into the perception of Social Discrimination in Health

- The tool has a set of questions arranged thematically on the possible experiences social discrimination in ICDS (Anganwadi) centers, Village Health and Nutrition Day, experiencing discrimination in maternal health services and perception of discrimination in Primary Health Centers.

- The tool is filled through in-depth group discussions with socially excluded groups (Dalits, Muslim/ Adivasis/ disabled and other socially excluded groups). The responses of all the participants are recorded on the basis of affirmative or negative responses.

- Each section entails specific number of questions ranging from experiences of discrimination in terms of behaviour of the service provider towards the marginalised community people (The service provider does not visit Dalit/ Muslim hamlets for immunization etc., practices untouchability while examining patients, information is not provided about health schemes to socially excluded groups, health providers talk offensively, made to sit at a distance, the health service providers take money for free services, abused during delivery, asked to wash sheets after delivery etc.)

- The cumulative score is calculated on the basis of affirmatives and negatives responses to gauge community's perception on the prevalence of social discrimination in services as well as health centers.

- The report card is arrived at based on 'levels of tolerance' to discrimination that is set by the community and process facilitations e.g. of the 150 responses to 15 questions in a group discussion with 10 people, 25 responses (83 percent) can be negative indicating less prevalence of discrimination. However if the tolerance level to discrimination is pitched at 10 percent, since it falls below 90 percent, the community will interpret it saying discrimination is prevelent.

up to use CBM approach with the perspectives of social inclusion in 100 PHCs, equal number of sub-centers and the tool on discrimination as well as that on maternal health services would be rolled out in about 800 communities of the marginalized.

Learnings, Challenges and Limitations

- The societal and structural process of social exclusion and discrimination are very subtle and covert in many societies and hence require a strong perspective to capture these processes.

- The generalised tools are inadequate to capture the processes of discrimination

- In many communities the process of 'victimisation' and 'silencing' has been so strong that a denial emerges as a the first response

- Nature of discrimination experienced by Dalits, Muslim minorities and tribals are so diverse that community mobilisers and investigators have to be highly tuned to this and have to be perceptive

- The community perception tool with various levels of tolerance offers an indication towards the prevelance of discrimination. An articulate community and community leaders play a great role in breaking the silence.

- Presence of health providers from the excluded community even in a historically discriminatory health institution offers a unique challenge as the community denies any discrimination due to the similarity of identity, though the behaviour of the health care system as whole would not have changed a bit.

Conclusion

The tool on social discrimination in CBM is not meant for an academic purpose, but for catalysing effective action to make health system more equitable and accessible to the marginalised communities without discrimination. An advocacy campaign for this is being planned along with the CBM processes. The tool is a work in progress and is hoped that the CBM process, will help arrive at a better tested tool.

□

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References:

Acharya, S S (2013). 'Universal health care: Pathways from access to utilization among vulnerable populations' in *Indian Journal Public Health*, 57 (4), 242-47

Baru R, Acharya A, Acharya S, Kumar A K S & Nagraj K (2010). 'Inequities in Access to Health Services in India : Caste , Class and Region' in *Economic and Political Weekly*, XLV (38), 49-58

Centre for Health and Social Justice, Primary reports & Archives, Delhi, India available at http://www.chsj.org/reports.html accessed on August 20, 2014)

Kabeer N (2005). 'Social exclusion: concepts, findings, implications for the MDGs', available at www.gsdrc.org/docs/open/SE2.pdf accessed on August 20, 2014)

Kadun, P B and Gadkar, R D (2014). 'Social exclusion – Its types and impact on Dalits in India' in *IOSR Journal of Humanities and Social Sciences* (IOSR- JHSS), 19(4), 81 available at www. Iosrjournals.org

Shukla A, Scott, K and Kakde, D (2011). Community Monitoring of Health Services in Maharashtra in *Economic and Political Weekly* , XLVI (30), 78-85

Shukla A, Saha, S and Jhadav, N (2013). 'Community Based Monitoring and Planning in Maharashtra- India', Support for Advocacy and Training to Health Initiatives (SATHI) with Community of Practitioners and Social Action in Health (COPASAH), 1-18

WHO, 'Exclusion: Meaning, measurement, experience and links to health inequalities-A review of literature', social exclusion knowledge network background - I available at www.who.int last accessed on May 10, 2014)

COPASAH at Global Symposium on Health Systems Research, Cape Town

(01 October, 2014, **1630 to 1800 hrs,** Venue : Meeting Room 1.61-1.62)

- **Title:**Building people-centred health systems through the social empowerment of marginalized populations: Moving from theory to practice (Paper Number 565.00)
- **Presentation type:** Participatory session
- **Field-building dimension:**Original experience of learning communities and knowledge translation platforms engaged in strengthening health systems.
- **Contributors**: All the contributors above are members of the Community of Practice in Accountability and Social Action in Health (COPASAH) and also members of the participatory research cluster within the SHAPES group at Health Systems Global.

  - Chair: Edward Premdas Pinto
  - Contributor Africa: Geoffrey Oppio
  - Contributor Asia: RenucKhanna
  - Contributor Latin America: Walter Flores
  - Fish bowl moderator: Barbara Kaim

COPASAH at Global Symposium on Health Systems Research, Cape Town

Presentations by COPASAH members at GSHSR : A number of COPASAH members from various countries will be doing oral presentations as well as poster presentations. Please note that this list is not exhaustive. For more exhaustive list please see Copasah Communique, issue no. 6, p.17-18, available at ***http://www.copasah.net/uploads/1/2/6/4/12642634/copa_communique_-_6th_edition.pdf***

Note that this list is not exhaustive

Name & Presentation	Type
Abhijit Das, India (Oral)	Community based monitoring improves informed choice and quality of care of family planning services **October 2, 16:30-18:00**
Abhay Shukla, India (Oral)	Communities reclaim the Health system, making services People-centred: Lessons from community monitoring and planning of Health services in Maharashtra, India **October 2, 16:30-18:00**
Barbara Kaim, Zimbabwe (workshop)	Participatory Action Research for People-centred Health Systems: How do I do it? 3rd October 11.30 – 13.00 , Room2.41–2.43 Organised by TARSC/ EQUINET
Ariel Frisancho, Peru (Oral)	Inequities in health care for the indigenous and afro-descendant population in Latin America: Contributions of civil society organizations to assemble participatory governance in health care systems. 02October 2014, 1430 to 1600 hrs., Room 2.65-2.66
Ariel Frisancho, Peru (Oral)	HWAI Health Workforce Advocacy Initiative's Satellite Session "From HRH Research to Policy Change: the Role of Advocacy." 29 September 2014, 13:30 – 15:30 hrs
Geoffrey Opio, Kenya (Oral)	Contributor from Africa (member of the editorial board of COPASAH)
Walter Flores, Guatemala (Oral)	Exploring the governance of the Guatemalan health system: power relations affecting decision-making and its implications for equity
Jashodhara Dasgupta, India (Oral)	Informed, organized and empowered: poor rural women's negotiations for health and its social determinants in Uttar Pradesh, India
Edward Premdas Pinto, Abhijit Das, India (Poster)	Open Learning Spirals : Pedagogical innovations for peer learning to facilitate knowledge translation and capacity building towards people oriented health systems in South Asia
Renu Khana & Others, India - (Poster)	Strengthening quality of Maternal health Care through Social Accountability mechanisms - Experiences from selected districts of Gujarat, India. 3 October 2014. Session time: 13:50 – 14:20 hrs
Barbara Kaim, Zimbabwe Post-symposium workshop	Facilitator of One Day Post Global Symposium Workshop on "Participatory Action Research for People-centred Health Systems" (Hosted by TARSC and pra4equity-EQUINET and ALAMES, Fountains Hotel, Cape Town, 4 October 2014

Issue Papers

Developing an Approach towards Social Accountability of Private Healthcare Services

Anant Phadke, Abhijit More, Abhay Shukla, Arun Gadre

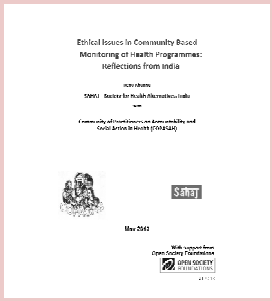
The issue paper discusses the rationale and perspective related to need for social accountability of private healthcare services. Propositions about likely steps and processes through which it can be developed have been supported by examples from practice in India.

http://www.copasah.net/uploads/1/2/6/4/12642634/developing_an_approach_towards_social_accountability_of_private_healthcare_services_-_sathi.pdf

Ethical Issues in Community Based Monitoring of Health Programmes: Reflections from India

Renu Khanna

The issue paper explores the different sets of power relationships and resultant ethical dilemmas that arise when developing community monitoring systems. The process of community based monitoring and planning (CBMP), how it is implemented, ethical principals in community action, various sets of relationships within the process of CBMP, and challenges within the existing power discourse have been discussed in detail.



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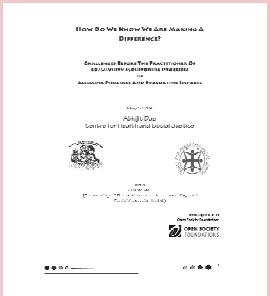
How Do We Know We Are Making A Difference? Challenges before the Practitioner of Community Monitoring Processes in Assessing Progress and Evaluating Impacts

Dr. Abhijit Das

The issue paper discusses the different conceptual dimensions of community based monitoring. It explores the difficulties of monitoring and assessing progress and results. A practical methodology for assessing progress, drawing lessons and for establishing robust evidence based results in the field of community based monitoring has been proposed and described.



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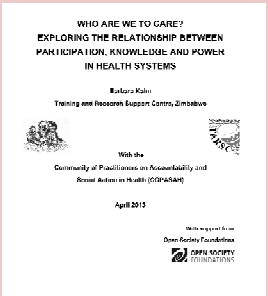
Who Are We To Care? Exploring the Relationship between Participation, Knowledge and Power in Health Systems

Barbara Kaim

The issue paper focuses on how the interaction between people's participation, knowledge and power affects the functioning of health systems. There is a blend of discussions on concepts and issues with descriptions of experiences and case studies from around the globe. It attempts to discuss alternatives and approaches that can be used to build a more just and equitable health system.



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Case Studies

Citizen Monitoring to Promote the Right to Health Care and Accountability

Ariel Frisancho and Maria Luisa Vasquez
The case-study is a demonstration of citizen engagement in building transparency and accountable systems, which are essential for good governance and democracy. It focuses on the key importance of strategic alliances with public and civil society actors to strengthen the capacity of rural women's agency and to address unequal power relations.
http://www.copasah.net/uploads/1/2/6/4/12642634/citizen_monitoring_to_promote_the_right_to_health_care_and_accountability_-_care.pdf

Women in the Lead: Monitoring Health Services in Bangladesh

Sarita Barpanda, Samia Afrin, Abhijit Das
This case study highlights the accountability component of the Women's Health and Rights Advocacy Partnership (WHRAP). It discusses the activities, outcomes and challenges faced in implementing the three pronged accountability approach of organising women from marginalised sections into *Nari Dal*, training them to conduct monitoring visits in hospitals and working with elected representatives to create a participatory and relevant review and planning mechanism.
http://www.copasah.net/uploads/1/2/6/4/12642634/women_in_the_lead_-_monitoring_health_services_in_bangladesh_-_sarita_barpanda_samia_afrin_abhijit_das.pdf

Community Based Monitoring and Planning in Maharashtra, India

Abhay Shukla, Shelley Saha, Nitin Jadhav
The case study analyses the diverse experiences of community action for accountability of health services that have emerged in Maharashtra after the National Rural Health Mission came into being in 2007. The focus is on drawing out lessons from organising several hundred Jan Sunwais (Public hearings) and dozens of 'stories of change' associated with this process. The strategies discussed will be of value for health and social activists working for accountability of public services in various contexts across the world.
http://www.copasah.net/uploads/1/2/6/4/12642634/community_based_monitoring_and_planning_in_maharashtra.pdf

Claiming Entitlements: The Story of Women Leaders' Struggle for the Right to Health in Uttar Pradesh, India

Abhijit Das and Jashodhara Dasgupta
This case study recounts how a group of women from the extremely marginalised sections of society have become empowered and are monitoring their entitlements around health services and other services associated with the social determinants of health. It describes the evolution of the Mahila Swasthya Adhikar Manch (Women's Health Rights Forum), its activities and some of the results of their advocacy action with a focus on their empowerment process.
http://www.copasah.net/uploads/1/2/6/4/12642634/claiming_entitlements.pdf

Accountability and Social Action in Health - A Case Study on Solid Waste Management in Three Local Authority Areas of Zimbabwe

Training and Research Support Centre (TARSC) with Civic Forum on Housing (CFH)
This case study shares the evidence and experience of participatory research to build capacity, strengthen accountability and facilitate sustainable options at the local level on solid waste management. It maps the feedback and review activities undertaken with communities, the private sector and service organisations in three local authority areas of Zimbabwe and the lessons learnt by TARSC and CFH.
http://www.copasah.net/uploads/1/2/6/4/12642634/accountability_and_social_action_in_health_zimbabwe.pdf

Steering Committee Members

The COPASAH Steering Committee (SC) includes representatives from each of the three geographical regions represented in the convening (Africa, India and Latin America) and a representative from Accountability and Monitoring in Health Initiative (AMHI). The SC is composed of the following members:

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COPASAH Membership Status

- Africa-41
- Europe-8
- Latin America-3
- South Asia-73
- Individual members-80

COPASAH Communication Channels

COPASAH VISION, MISSION AND VALUES

Vision

Communities are actively engaged in promoting accountability and transforming health systems towards the realization of social justice.

Mission

COPASAH'S mission is to nurture, strengthen and promote collective knowledge, skills and capacity of community-oriented organisations and health activists - primarily from Africa, Asia and Latin America - working in the field of accountability and social action in health, for promoting active citizenship to make health systems responsive, equitable and people-centred.

Values

COPASAH, as a global community of practice, believes that in order to make our vision a reality, community monitoring for accountability in health, is a strategic tool which needs to be guided by the following values within the overarching principles of endorsing community knowledge, bottom up and participatory processes in knowledge generation, challenging digital divide and upholding the relevance of contextual reality.

- A citizen led and community centric process promoting active citizenship
- A contextual, decentralised, bottom up and participatory process of knowledge generation, resource sharing and empowerment.
- Enables communities facing inequities to assert their rights and to participate in concrete actions to bring about changes in health services and equitable distribution of resources
- Gives voice to peoples' perspectives
- An empowering process where actors related to the health system are encouraged to address power imbalances that affect people's health
- Linked to action or advocacy which aims to influence or change health policies and programs in favour of the marginalized communities.

Strategies

- Nurturing a community of practitioners will be done through the cross pollination of ideas, experiences and resources
- Facilitate systematic exchange of knowledge, practice and resource sharing
- Facilitates bottom-up and participatory practice based knowledge generation
- Create opportunities for interaction between practitioners
- Collection, collation and production of appropriate conceptual and operational frameworks
- Inform and influence policy makers on health rights and dignity
- Building strategic alliances for citizen led – community centric accountability
- Global and local solidarity as well as collaborative action for health rights and dignity

COPASAH COMMUNICATION CHANNELS

Community of Practitioners on Social Action in Health

facebook

https://www.facebook.com/pages/Community-of-Practitioners-on-Accountability-and-Social-Action-in-Health/226700847451158

Community of Practitioners on Accountability and Social Action in Health

Platform for Sharing	Forum for Dissemination	Resource for Learning
COPASAH BLOG	COPASAH WEB	Community Monitoring Resource Pack
www.copasah.wordpress.com	www.copasah.net	www.copasah.org

Published by Centre for Health and Social Justice
Global Communication Hub for COPASAH
Basement of Young Women's Hostel No. 2, Near Bank of India, Avenue 21, G Block, Saket, New Delhi-110017, India
www.copasah.net