Community Monitoring and Social Accountability of Health Services

South Asian Practitioners Workshop

20-22 February 2013

Sarvodaya, St. Pius Complex, Goregaon East, Mumbai

A Report

Organised by

Community of Practitioners for Accountability and Social Action in Health (COPASAH)

Regional Secretariat

Centre for Health and Social Justice, New Delhi

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Introduction

The Community of Practitioners on Accountability and Social Action in Health (COPASAH) is a network of practitioners with a common interest in community monitoring for accountability in health. It brought together practitioners, experts in the field of accountability from around India and other South Asian Countries for a three days dialogue from 20-22 February 2013. The primary objectives of the workshop were:

1. To build a common understanding of the purpose of Community Based Monitoring and its role in empowering people to negotiate improved services with greater accountability
2. Present and discuss the range of community monitoring approaches and share experiences among practitioners of community monitoring/accountability on sustaining these initiatives
3. Enhance synergies between practitioners by inviting new members to join COPASAH and undertake documentation to look at processes of change through community monitoring/ accountability initiatives;
4. Identify and review methods and modules and how it can support community driven initiatives to improve accountability and quality of services.

The key expected outcomes were:

1. To take an inventory of existing practices and learning's of community monitoring processes around the world;
2. Identify gaps in knowledge, skills; share the challenges faced; and develop skills for effective practice and use of community monitoring for accountability in health.
3. Facilitate in strengthening our understanding of the purpose why we use community monitoring approaches.

Throughout the workshop there was a consensus that the current environment does make it a crucial time to engage in community monitoring. Evidence of the increasing importance of approaches that encourage citizens to become more involved in scrutinising and expressing demand for public services, as well as exacting accountability from local service providers and including the institutionalisation of community monitoring in health can be seen at the local, regional, national and global level. The practitioners debated on the increasing use to improve the quality and accountability of health services and has also enable the community to play a larger role in not only evaluating the services provided but also hold health care providers accountable; and is grounded in good governance and supports in strengthening government accountability which is a perquisite to improving health services.

The four facilitators who planned the workshop and facilitated different sessions to ensure participation of all participants were Dr. Abhay Shukla, SATHI; Dr. Abhijit Das, CHSJ, Renu Khanna, Sahaj and Jashodhara Dasgupta from Sahayog. A total of 30 participants from two South Asian countries (Bangladesh and Nepal) and 9 states in India (Bihar, Chhattisgarh, Jharkhand, Gujarat, Maharashtra, Odisha, Madhya Pradesh, Uttar Pradesh and Tamil Nadu) participated in the three days workshop. To achieve the workshop objectives and outcomes, presentations by key speakers, panel discussions, talk shows, small group discussions/exercises were undertaken. Taking the extensive and rich outcome of this workshop the report has tried to capture the participants' views and highlight good practices, approaches and challenges faced by the practitioners. This report has been prepared by Sarita Barpanda from CHSJ.

DAY I

Jashodhara briefly welcomed the participants and requested the participants to briefly introduce themselves and share their expectations for the three days workshop. To make it easier for the workshop to cover these expectations, these were clubbed into the following four main themes:

Challenges, learnings and experience	Challenges at the operational level
Political scenario Privatisation Convergence of departments Experiences of trying to institutionalise into the system Expansion Sustainability	Individual difficulties Challenges/practical difficulties Current status Lessons, learning Advocacy
How?	**How do we continue beyond this workshop**
Approaches Methods, techniques How voices of marginalisation (esp women) can be heard Training Awareness raising, How to ensure peoples ownership Evidence based advocacy	Solidarity Partnerships Collectivize Make friends Cross learnings How to document work

Plenary Session I: Rights and Accountability

Renu Khanna from Sahaj, Baroda the moderator of the first session welcomed the experts: Abhijit Das, Director Centre for Health and Social Justice, Ravi Duggal, Program Officer, International Budget Partnership and Dr. Abhay Shukla, Coordinator, SATHI-Cehat a Pune based organisation and shared the need to recognise and activate the 'demand side' of service delivery, by establishing key process where communities exercise their rights and hold the state and service providers accountable for its obligations.

Abhijit Das: Citizenship and Accountability-Adding Value to Rights Based Approaches

In the plenary, Dr. Das provided a brief background on citizenship, citizens' rights and the need to include community monitoring in the framework of citizenship and accountability. Some of the key questions and concerns that need to be answered within the CBM context and the interest that CBM has emanated are:

a. The huge amount of money that has been put into development projects;

b. Is the money that is being channelled into development projects reaching the people who need it the most;
a. How do we strengthen the democratic process and distribute resources among the most marginalized section of the society so that they could raise their voices?

The 1950s colonialism started declining and democracy started to emerge. India achieved independence in 1947 and people belonging to higher class, got an opportunity to enter politics. People started questioning democracy in the 70s. In that period, in many countries, military rule was established. In India, although military rule did not happen, emergency was declared in that period and there was a massive crackdown on civil liberties and political opposition. In the 90s, socialism started to decline and the world entered globalisation, this new emerging market economy started to grow worldwide and during that period, citizenship and human rights issues came to the fore.

Relationship between citizenship rights and the state needs to develop. There must be accountability for the relation between state and citizen to get stronger. Citizenship in many ways brings accountability and participation together. **Without accountability the human rights approach makes no sense.** State will have all the power to control everything. In Singapore everything is structured and people do get services without any problem however the citizen of Singapore cannot raise any question or verify it. Homosexual, sex-workers have no place in their health system, and they are not provided with any services by the government.

Participation of people is essential in any democratic process though the concept has different context and time. Active participation of people always helps to establish a strong accountability system. When we use the term beneficiaries instead of citizens, it becomes difficult to raise questions or voice any concerns about the services that they receive. Citizens are not always consumers and they can formulate a framework of benefits from government. By conceptual definition government belongs to citizen so the parameters of service provisions should be framed by the citizens themselves and citizens should have all the right to choose.

There is a need to strengthen both horizontal and vertical systems of accountability and move from passive to active citizenship. In participatory democracy citizens raise voices to influence. Hitherto government did not have experiences of having to engage in direct dialogue with the people or listen to public voices. Raising voices or asking questions should continue so that the government keeps in mind that there are scopes of questioning each and every work that is meant to cater to the needs and benefit of the people.

Dr. Das concluded that the CBM system is not a revolution but a system for strengthening the democratic process in any country.

Ravi Duggal: Budget Work for Accountability and Impact

Ravi Duggal spoke about using budget as a tool for accountability and gave a brief overview of why it is important to understand budget formulation and participation of citizens in the formulation process.

Ravi shared an example from Nagaland which through social audit we can ask questioned the accountability decision-makers and also demanded to know about the outcome of any work.

In the Public Hearing system people can make inquiries on accountability in any budget allocation. Mr. Duggal said he happened to be present in a public hearing meeting in Nagaland where the Village Development Council (VDC) had all the power to decide what kind of development work would be taken up at village level. During that public hearing meeting, the VDC of that particular village had decided to buy a bus for public transport. As per decision, a bus was bought and the details of the expenditure were presented to the VDC. One member at the meeting noted a discrepancy in the details and questioned why Rs. 14 lakhs were spent when the real price of the bus was Rs. 12 lakh. He sought the particulars about the extra Rs. 2 lakh spent in the purchase of the bus. The concerned agency/ contractor and the concerned government officials had to show to the VDC where the sum of 2 lakh was spent. Ravi Duggal highlighted how budget influences people's lives and the need for active citizenship to promote accountability

Budget process is not a one-time activity. There are different phases of budget process (***Planning, Enacting, Implementation*** and ***audit*** are the four processes) and people can demand accountability in each phase. For example the health budget should emanate from the ground, ***e.g***. PHCs do know the load of patient and the needs of the community and they should be the ones to place the budget as per the needs, however in actual sense this is based on a format that is controlled by district/state level officials. In India, there is a Constitutional provision for effecting changes in the budget even after it is tabled. In practice, however, no changes have ever been made once the budget is tabled and presented in the Parliament for debate. Debates on prospective changes have been allowed at times, but pertaining only to tax issues.

Once a budget is tabled and it is voted into a law, the money gets transferred to different departments, then from the departments to the respective states. Each department delivers it services during one budget period. During this period, timely reports are to be made on expenditure by each agency that is given the responsibilities. The final stage is the audit stage. In this stage, the auditor audits only the financial part of expenditure. The CAG comments on the audit reports. Sometimes performance audit also takes place, but not on a yearly basis. Another kind of audit is social audit, which is not done by the CAG. A social audit deals with other aspects of the budget and it is usually done by civil society organisations. The CAG is in talks with CSOs to undertake social audits through collaboration. Civil society organisations could help to look at

service delivery, which is essential for equal distribution of resources. For example, if the government has mentioned reducing MMR in its budgetary goals but has made no monetary allocation for that end in budget, civil society organizations can intervene at this point and influence the budget. The Parliament is supposed to deliberate on these social audit reports and the Public Account Committee prepares a report on actions to be taken.

A single strategy aimed at influencing the budget making process does not work sometimes. There is a need to combine different strategies to influence the process. Civil society organisations can play a major role to engage in budget accountability. Some of the key processes that can be used to promote and institutionalise budget accountability an

- Local and global initiative
- Forming coalition with different organisations
- Citizen mobilization
- Engaging with the implementers
- Litigations
- Lobbying

Abhay Shukla: Community monitoring of health services in India in context of National Rural Health Mission

Dr. Abhay Shukla started his session with the following words,

"**When those with power lack motivation, then those with motivation must become empowered".** Dr. Shukla shared the history and evolution of community monitoring in India and stated that community monitoring as a process has taken many years to unfold and involved a lot of work by different organisation. Community monitoring is an institutionalised thing of what was done as part of the campaign on right to healthcare. On paper the health system is supposed to be responsive to people or belong to people. But on ground it is neither responsive nor it is controlled by the people. Historically, in the health sector there is an approach of charity but through community monitoring there is a complete shift and change in approach, where charity is replaced by social justice. This is how health is brought within the rights framework. There are tremendous inequities in society and these inequities are bad for both rich and poor. Inequities have grown in the last 50 years and need to be addressed through the approach of health rights. JSA is the Indian arm of People's Health Movements. People's health movement is a global process which is going on in 60 countries of the world. The condition of public health system was very bad

Dr. Shukla gave a brief overview of the community based monitoring process in India and highlighted the phases of community monitoring process in India. The pilot phase of CBM was launched in 2007-09 across nine states in India and covered around 36 districts and 1600 villages. Different committees were established at the block, district and state level to take forward the CBM in these nine states

Dr. Shukla shared the key processes of CBM and highlighted the positive impact of the CBM pilot phase as follows:

- Improvements in health services were seen in several states like Karnataka, Rajasthan and Maharashtra
- There were positive changes started to emerge in several states with evidence of improved accountability, responsiveness of public health system
- 'Jan samvads' (public dialogue) and 'Jan sunwais' (public hearing) proved to be effective forums for accountability
- Many innovations and alternative methods were developed for different local situations

Though there were improvements in the health system but some of the key challenges were:

- In many states, health department wasn't comfortable with the term monitoring;
- CBM was accepted by officials at the state level; however at the district and lower down there was limited acceptance;
- Instances of adversarial positions emerging between local health department officials and NGOs.
- There have been instances when health department and officials took offence after Jan Samvad (public dialogue);
- There has been a huge gap in building relations with panchayati raj institutions and it has been relatively weak in most of the states;
- Community monitoring tool perceived to be complex, there is a need to simplify and adapt it to make it user friendly;
- Fund release from Government of India has been sporadic and late this has had an impact on rolling out the process;
- There is a need for more human resources who can put in adequate time;

The impact of community monitoring was different in each of the nine states.

- For example in Tamil Nadu the pilot phase of community monitoring started in 5 districts, 14 blocks and 450 gram panchayats. Innovative and highly visual tools were developed, however the process was discontinued after jan sunwais/jan samvads;
- In Jharkhand, during the phase (2011-12) 96 blocks in 24 districts (50 villages each) were taken. Village Health Committee Sahiyya Resource Centres were established and unlike in other states in Jharkhand instead of NGOs a block training team was established and were involved in training. Folk cultural programmes like *kala jathas* (traditional folk artistes who performed through dance and music) were organised on wide scale for community mobilisation and awareness;
- In the State of Odisha, the term 'Community **monitoring'** was changed to **'Community Action'.**
- In Maharashtra, CBMP representatives participated in Rogi Kalyan Samitis (Patient Welfare Committee) meetings to suggest community health priorities for facility based planning. It was one of the positive things happened in Maharashtra.

Some of the key challenges faced post pilot phase was:

- CBM accountability processes have met substantial resistance from State health departments in nearly all states. The control by State health departments over financial and administrative mechanisms has been major basis for delays in the CBM processes; there has been reports of delayed fund flow, tedious reporting requirement resulting in interruption in rolling out of the community monitoring process;
- The role of NGOs have been diluted, and many a times the selection process for NGOs has been questioned;
- Grievance redressal mechanisms have not been established;
- Community based monitoring activities have been maximally effective regarding *local health services* whereas *actions and decisions need to be taken at higher levels.* Systemic problems have persisted such as staff vacancies, shortage of medicines due to procurement and distribution system;
- Empowerment of actual community members and involvement of PRI members has been slower than expected, requires substantial efforts
- There has been a tendency to convert the community monitoring into *'Karyakarta based' or 'Committee based monitoring'*
- There have also been transfer of key senior officials who did support the process, resulting in lack of enthusiasm and support after the pilot phase by the Ministry of Health and Family Welfare;
- Planning commission proposed to roll out community monitoring in LWE (Left Wing Extremism) districts, displaying problematic approach
- Since mid-2012, some revival of expression of support to CBM by the Ministry; however AGCA proposal for system of 'support units for community action' yet to be responded to in effective manner

Several key lessons emerged from Dr. Shukla's experience and learnings which needed to be recommended for further strengthening of the community monitoring process. At the national level there is a need to involve the Advisory Group for Community Action (AGCA) to push for stronger mechanism to support community monitoring. There is also a need to back community monitoring to look at nationally defined entitlements and grievance mechanisms, financial guidelines; however wider, coordinated civil society activism is required even to raise profile of community monitoring at national level and push for a national network to promote social accountability in health sector which will be synergistic with existing networks like Jan Swasthya Abhiyan. At the state level there is a need to continue and expand officially recognised spaces created by community monitoring; this would support in building pressure for guaranteed health services and effective action on issues raised at various level. There is also a need for better coordination with panchayat raj members, media and social sector networks in order to promote health rights actions even beyond community monitoring framework through a campaign mode.

Renu thanked all the participants and concluded that Community monitoring on public health issues assesses the quality and accessibility of health services from the perspective of the citizen is a valuable way to support demands for better policies and improve services and programmes which will take the needs of the poor and the marginalised into account.

Group Exercises/Workshops:

Group Exercise I: Collecting Evidence with Community Participation: Theory and Principles

The first group exercise focussed on discussing and debating on how do we do CBM? Does it actually help in deepening democracy? The participants were divided into four small groups and each of the group was given a key set of questions which they discussed and responded to as follows:

Group I:

Q.1. Is the purpose of accountability work to make the existing system work properly, or to challenge and change the nature of the system?

Response of Group I:

- We can initiate accountability related work and ensure that the existing systems respond to the citizens need as well as challenge and change the nature of the system;
- The key actor in the accountability process is the community; civil society organisations should play a supportive role and facilitate research, provide factual information, legal support and documentation of evidence as well as documenting the process of accountability;
- The focus should be to engage with existing system, occupy and utilise the space for making the system function; movements, agitation and protest should also be supported in order to
- In order to bring change in the system we have to take account of sociopolitical, socio-economical, cultural etc. factors and
- Need to work for making Health as political agenda for that we have to do mass awareness, mobilization and creating pressure groups at different levels.
- While engaging with existing system, we should take support from likeminded people within system which will help in smoothening the accountability work as well as it will reduce the threatening to the system.
- As to bring change in the system is a very long and tight rope walking process, we need to take care of frustration, loss of faith within community or civil society organizations.

Q.2. What role may accountability work have in shaping India in direction of a more democratic society? How do we understand 'deepening' or 'expanding' democracy, and how is this related with promoting accountability?

Response of Group II

- At present our democracy is system centric, not people centric; CBM has the potential to reverse it.
- Committees at level in CBM should be well represented by the voiceless sections.
- It should not be NGO driven but community driven/people's movement should be given weightage.
- The communities' ability and skill should be supported and build to question and challenge the system.
- Need for convergence/inclusion of social determinants.
- Rights holders asserting the rights and fight back the cases of denial.
- Create scope for planning, implementation and tracking the progress.
- Micro level issues are amplified.

Q.3. Should we consider accountability work to be 'non-political' or 'political' in nature? What are the implications if we consider accountability work to be 'political'?

Response of Group III

- There is a need to have a good understanding of the political structure, along with a clear strategy to influence policy decisions and processes.
- Community action should be led by the people, rather than NGOs being at the forefront
- Many women elected representatives are unable to play a proactive role in taking forward health issues due to patriarchal barriers. They need support from peer leaders and external support groups e.g. Mahila Swasthya Adhikar Manch.
- In the process of community action, issues moves from the non-political to the political arena over time
- Political engagement could be on developing broader consensus on the issue, and may not be restricted to engagement with a specific political party
- Communicate community voices, concerns with the political actors from block-district –state level e.g. issues like privatization of the public health system, non-availability of medicines
- Developing strategies on how to tackle larger issues around corruption
- Direct engagement of NGOs in the political process could run into risk e.g. mining operations in Odisha, Chhattisgarh etc.

Q.4. Do we visualise modes such as 'project oriented mode' and 'movement oriented mode' for doing accountability work (viewed along a spectrum)? What are key features, advantages and disadvantages of each?

Response of Group IV

- Majority of the projects have been initiated with intention of turning it into movements however these have ended in project mode;
- NGOs are bound to work in project mode when they are implementing government programmes as the focus of NGO work has been to generate awareness, and support in rolling out government schemes and programmes;
- The work is aligned to a preexisting framework/guidelines but there have been instances of spontaneous mass movement;

Some of the key advantages of working in a project mode are:

- Funds are available to roll out activities, and NGOs work with already developed frameworks/guidelines;

- Projects are relatively less threatening and pose less challenge, and are rolled out locally in limited area.

- However one of the major disadvantages of implementing through project is the fact that it has high bureaucratic control;

- Movement based initiative are controlled by people/mass and can continue without funds. A movement binds people/communities to a common cause and accountability is quite high. The major disadvantage of movements is the fact that people/NGOs are constantly questioned and most often there is police action, and many a times can be politically influenced;

The group work provided a space for reviewing the community monitoring process and identifying gaps and challenges and defining ideas for expansion of the effort.

Group Exercise II: Sharing Tools used by Various Groups; strengths and limitations

The second group exercise focused on increasing the understanding of the participants on the role of evidence in community driven accountability approaches; increase knowledge of different ways of collecting and presenting evidences as well as identify advantages and challenges in community participation in generating, collating and presenting evidences. The small group exercise undertaken by the four groups discussed and debated and responded to the following key queries **on Facility Survey, Public Hearings with presentation of testimonies, community score card and social audit.**

Each of the four groups discussed on one key method and attempted to respond to the following questions:

a. Facility Survey

Q. I. Definition

- Assessments of different types of health facilities using certain key tools and methods to improve health services; some of the key spheres that are assessed are:

- General infrastructure
- Human resources
- Basic services
- Emergency services
- Maternal health (BEmOC/CEmOC)
- Ayush
- Referrals

Q.2. What are the key methods used for facility survey?

The key methods used for facility survey are:
- Pictorial tools/ checklist taking Indian Public Health Standard(IPHS) into account
- Questionnaire
- Interview with Service Provider
- Client/citizen/patient survey
- Focus Group Discussions
- Interactive Voice Response System (IVRS), Mobile phones, SMS.

Q. II. How is data or evidence used in these methods? How is it analysed, collected and shared

Different states in India have used different methods to undertake facility survey. Some of the key methods that have been used in different states of India are as follows:

- **Uttar Pradesh**: MSAM leaders play a leading role, they collect information through pictorial tools checklist about facilities. They also lodge issues related to gaps and corruption through telephones/mobiles in IVRS. **In Uttar Pradesh the analysis is often carried out by NGOs themselves and then shared with the community members**

- **Chhattisgarh:** Interviews through structured questionnaires related to the facility are developed and NGOs interview service providers and community members on the facility provided and the key service provided and the quality of these services. The analysis is often carried out by NGOs and shared with the community members.

- **Tamil Nadu:** Facility survey is undertaken through IVRS, mobile phones, SMS. In Tamil Nadu. A private provider collates the information of the SMS and provides it in excel sheet which collected through IVRS/mobile phones and shared with the community to advocate for better services with support from the PRI; at the district and state level. NGOs share the result with health officials at the district and state level;

- **Maharashtra:** In Amravati community led NGO supported surveys are undertaken to assess on why facilities are poorly used. This is used to advocate for better services and community involvement in improving services.

Q. III. What is the role of the community in collecting, analysing and reporting the information?

The community plays an important role in collecting data, in reporting the data and taking the process forward for advocacy. Analysis of data specifically quantitative information is quite difficult; however social analysis and case studies are strongly presented by community members during advocacy.

Q. IV. What are the advantages and disadvantages of the data management process in this method?

The advantages and disadvantages of facility survey are as follows:

Advantages	Disadvantages
Facility survey helps in creating awareness about entitlements at all levels e.g. sometimes service providers are unaware of what services should be provided. Facility survey data is available to all when technology is used	Still do not have a strong system in place to do analysis and utilise the data It is sporadic and irregular Sometimes system is helpless and is not prepared to take into account the survey for .e.g. even if we complain that there is no doctor, the system cannot do anything as they are understaffed. Ownership of the data is still with the NGO, not with the community or the government.

b. Public Hearing with Presentation of Testimonies

Q.I. Definition

Public hearings are conducted to obtain public testimony or comment from citizens who are affected by particular issues can give their views, or share personal stories on how it has affected them

Q.II. How is data or evidence used in these methods?

Data and evidence is used to generate interest amongst citizens group to address issues, these can be disseminated as

- Case studies
- Brief Reports
- Written appeal/petition submitted to authority

Q. III. How is it collected, analysed and shared?

The data is collected through

- Through Village meetings
- Through continuous monitoring
- Through micro study of issues
- Appealing of community people to share their problems in the community

Q. IV. What is the role of the community in collecting, analysing and reporting the information?

Community is involved in

- collecting data and issues concerning citizens and the community;
- Holding of meetings and generating evidences to be shared with authorities as testimonial;

- Monitoring of services, schemes and programmes and whether these reach the poorest of the poor
- The community also plays a role in analysis and reporting, however in order for the community to do this, the communities capacity needs to be build.

Q. V. What are the advantages and disadvantages of the data management process in this method?

Advantages	Disadvantages
The community gets empowered with data collections skills The data from testimony will be evidence based	The community will not be able to analyse the data The community may not have proper data storage system, so that the data might get lost The individual for presenting testimony may not appear or give wrong information Community or some CSOs may not be capable of planning and analysing data

c. Community Score Card

Q.I. Definition

Community scorecard method is a method which empowers community to provide feedback to the service providers on the services that they provide. Some of the key characteristic of the method are:

- it represents the views, opinions or perceptions of the service beneficiaries/consumers/ the community at large (inclusive)
- Based on the communities perception/opinion of health services/ health indicators are rated;
- Since the rating colour coding of the services are in general, it opens space for debate and dialogues at various levels.

Q. II. How is data/evidence used in this method?

The data generated through this method are:

- Used for dissemination of the status of various services at various levels (from village to district level and from Health Sub Centre to district Hospital level);

- Used for planning in order to improve the services by addressing the gaps found during monitoring of services;

- Intervention based on the data happens at various levels i.e. from village to state and from Health Sub Centre to District Hospital.

Q. III. How is it collected, analysed and shared?

- It is primarily collected by the committee members (comprising of community members) supported by the NGOs;

- Data is collected through various methods like questionnaire, interviews, focus group discussions, exit polling and direct observation;
- Shared at various levels (village to state) Health Sub Centre to District Hospital;
- Shared at various forums (SHGs, Block, PHC, federations formed for this purpose).
- It is shared with the health system staffs and authorities and also with the legislative members

Q. IV. What is the role of the community?

- Since it is community centric, their participation in the process strengthens the validity of the data collected;
- Community gets into action/intervene the problems identified;
- By this constant engagement in the process their awareness increases;

d. Social Audit

Q.I. Definition

Social Audit is a process used to identify gaps between what should happen and what is actually happening through. This is undertaken through:

- Group Discussion
- Questionnaire
- Testimonials
- Right to Information

Q. II. How is data collected?

The data is collected through

- Monthly progress report
- Allotments
- Expenditure
- Bills and vouchers
- Listing of beneficiaries

And verified later in the field through oral, field and document verification

Q. III. What is the role of the community?

- Community is supposed to validate/question the information provided by the service providers and tae interest in provides the correct information and identify the gaps.

Q. IV. What are the advantages and disadvantages of this method?

Advantages	Disadvantages
- A lot of awareness generation and raises hope of change for community - As the verification is done on the basis of official	- Not easy to get updated and proper information - Reluctance from the service providers for providing information as that is legal documents

data the outright rejections do not happen - It makes gap analysis proper and methodical - Since facilitation is done by CSOs the data analysis is proper - It makes system accountable and pressure is built for change	can be used as proof against them - Data analysis is dependent on experts and CSOs - The process seems to point mainly on implementation issues and not on policy issues - Normally this becomes a fault finding exercise and relationship between community and service providers become tense - The action is usually taken on local levels and junior level functionaries are targeted

The participants recognised the strength and the limitation of each method and also the need to learn more about these methods as each of these methods were important and played a role in strengthening monitoring and involving citizens in the monitoring process.

The group exercise demonstrated that it is important to acknowledge the differences between each of the method, it also is important to recognise the strength of these methods being community driven instead of NGO driven.

DAY II:

Day II started with a moderated formatted discussion designed like a talk show and the focus was on understanding accountability process in India, Bangladesh and Nepal and the situation and conditions that supports the process, and the changes that are visible at the community level. The participants in the moderated plenary session were:

1. Shahidul Hoque, Bangladesh:
2. Rakshya Paudyal, Nepal
3. J S Santosh form Chennai, India
4. Kajal Jain From Maharashtra, India
5. Sandhya Mishra from Uttar Pradesh, India

Jashodhara Dasgupta facilitated the talk show and some of the key questions raised in this session by her and the participants' response to those are as follows:

Q I. Brief about the place where each of the participant come from and the work that is undertaken by them

Shahidol Hoque: Bangladesh is one of the smaller countries which have shown tremendous gains through success in health and population programme. However there have been many challenges despite various initiatives; some of these challenges are malnutrition, maternal mortality, low utilisation of public health facilities etc. **ICDDR, B** has been working in Chakaria, the southernmost district of Bangladesh. The focus of work has been working with community to identify problems, plans and participate in implementing primary health care activities.

Rakshya Paudyal: Beyond Beijing Committee (BBC) has been working for the issues of safe motherhood, safe abortion, uterine prolapse and nutrition anaemia and has been involved in community based

monitoring since the past one and half years. Its working in three districts – Morang (Terai region), Lalitpur (hilly) and Makawanpur (between hilly and Terai). In Lalitpur, youths are mobilized, in Makawanpur, youths and women's group is mobilized and in Morang, mother's group is mobilized.

J. S. Santosh: Sochara has been working in the state of Chennai, in the southern most part of India. This is a state which is considered to be one of the fairly developed states in India. Currently Sochara along with 27 NGO partners has been working in six districts and has rolled out the community monitoring process in these six districts.

Kajal Jain: Masum has been working in the western part of Maharashtra in Pune, and has been involved in rolling out community monitoring in three districts of Pune.

Sandhya Mishra: MSAM is a forum of poor rural women most of whom also belong to the more backward castes. It was formed at the end of an intensive campaign on women's rights to maternal health across Uttar Pradesh (U.P.) in early 2006. MSAM works in 11 districts. Sandhya has been working in the district of Mirzapur.

Q.2. is there a framework based on which you take community monitoring

Shahidol Hoque: Yes in the Chakaria Community Health Project initiated by ICDDR, B our goal was self help for health through community participation. The community members identified problems, and plan. They also participate in smooth management and implementation of the primary health care activities. The approach was bottoms up and the community involvement and participation was the key strategy to improve health services. In Bangladesh though the mandate of the government is health for all and community well being is often stressed; however there are evidences of compromised services in public sector largely due to lack of resources and lack of community engagement in health services.

Rakshya Paudyal: The community groups that have been formed in each village and these are known as Surveillance groups which comprise of 9-11 members. These surveillance groups (SG) do the facility survey as well as monitor the cases that takes place outside the health centres like maternal deaths that takes place in the community during home delivery. Some surveillance group focal person also monitors the CAC (comprehensive abortion care) centres. The SGs do facility survey on the basis of the standards provided by the government. Such as on the availability of equipments, staffs, medicines and infrastructures. They also monitor on whether the incentives given under maternal heath scheme such as transportation incentives on institutional delivery, incentives after 4 ANC checkups has been given to the service receivers.

J.S. Santosh: We have a National Rural Health mission rolled out by government of India and we see whether the schemes, programmes and entitlements provided through NRHM are being rolled out as per the promises spelt out. Our focus is especially on maternal health otherwise known as Mutthu Laxmi Reddy maternity benefits schemes. The community monitoring is as rolled out in the pilot phase through AGCA support. However we have tried to roll out community monitoring not only to monitor the health schemes and services but also the Integrated Child Development Services initiative of the Women and Child Department, we are thinking of including Public Distribution System.

Sandhya Mishra: We have been Anganwadi within the ICDS programme, nutritional status of the primary schools; these are some of the component of health which we are covering under our community monitoring. Our framework is as per Indian Public Health standards a standard guideline of government of India. We have 12 thematic issues, within health. Out of 12 issues we have build the capacity of our women leaders who roll out the monitoring and the results are shared with authorities. Five other issues: Nutrition, food security, social security, violence against women when they are not happy they do a demonstration the standards that are taken from the respective departments. Beyond health they are also looking at other standard guidelines set by other government departments and set up monitoring mechanism for each of these programmes.

Q.3. Can you tell us about the level of openness (is the government open and ready to hear about the feedbacks of the community) and is there a formal space to share systematically?

Shahidol Hoque: Government in Bangladesh has opened up and does take community into consideration, the problem is created by the people at the lower level, and there is a resistance at that level. Nowadays we do have district level sharing every quarter and the national government sees these meeting as a platform to hear us out and take our suggestions.

Rakshya Paudyal: We do share our findings with the district level government officials, but then nobody is sure whether the commitments made in these meetings will be kept or not. At the national level there is no space or scope to share. The political scenario in Nepal is fluid and currently there is no government or parliament and this limits bureaucratic decision making process.

J.S. Santosh: We call this as an invited space and this space for dialogue is available at all levels. At the village level space has been created so that village health and sanitation committee comprising of members from the community, service providers, and local government come together and discuss issues related to health status and condition in the village; now even volunteers and peer leaders can stand up and share their opinion with government service providers and officials; however this space is recent, four years back it would be impossible to even talk with the medical officer.

Kajal Jain: We have got spaces in Maharashtra: committees from top to bottom; regular meetings are held by government authorities (Taluka, village, district level, monitoring and mentoring committee) earlier we only had mentoring committee, monitoring committee is recent and was established last year. And these have been regularly meeting. Somehow local level needs are coming and local level issues are being solved, systemic issues are still the same: for example if there are no staff in health services then this remains unsolved, political will in the state is weak. Local issues addressed but bigger issues like human resources are not solved. No health professionals are willing to go to rural areas to work and political people also intervene and interfere in recruitment and posting. There is nobody to take responsibilities.

Sandhya Mishra: In Uttar Pradesh our space is at the district, state and block level, our committee leaders take their problems first to the block if it does not work out then it is taken to the district. These spaces are both formal as well as informal. Formally we do have Jan Sunvai (peoples hearing) in which government participates but informally we do agitate and demonstrate in front of government officials, and this is also quite effective. The authorities do listen but then they are also bitter that we criticise. But as there are large number of women in the group and these women have evidences of gaps so they are forced to take action. It is a challenge, however collectively we have been able to create these spaces.

Q.4. Does govt have resources to respond to the concerns raised? How much of the sector is private and how much is public and CM does it work with Private sector

Shahidol Hoque: We mobilise SHGs train them to take the process of community monitoring forward; it is easier to undertake community with government and its services; however in Bangladesh we do have a lot o political problems. Private sector has grown and till date we have not been able to introduce community monitoring in the private sector.

Rakshya Paudyal: It is very difficult to convince the government that budget and resources are not adequate in improving quality in health services; many a times during meeting government does not feel that lack of service is a problem. In Nepal due to lack of services private sector has grown and people are also quite dependent on these services.

J.S. Santosh: In Tamil Nadu, there is always a problem with resources; however this has not stopped us for advocating for better services for the people. In the district programme implementation plans of the government we have included plans to roll out community monitoring and have included resources needed to roll it out. However gaps still exist for e.g. treatment for snake bite is still a challenge. There is a need to include private health sector and roll out community monitoring in these services. .

Kajal Jain: In Maharashtra government is yet to focus on the supply side or take the communities into account. However people have started to demand for better services and when that is unavailable in government health services people opt out and avail services in the private sector. Ours is a market driven system, so if good services is not available in government services then people look for alternatives. However one thing that needs to be clarified is health is not a priority, neither for the government nor for the people.

Sandhya Mishra: There is no lack of financial resources but there is a lack of interest amongst community, citizens and even government to change, there is no will power or political commitment to change and improve health services. Inadequate services push community members to opt and seek private providers. I work in an area where the geographical terrain is very difficult and there is a lack of connectivity, and this has pushed people to opt for informal providers/quacks. In these poverty stricken areas you do not have health facilities and people are pushed to take services from quacks and informal service providers.

One of the key concerns raised was community monitoring in fragile/conflict zone. The participants discussed the challenges of rolling out community monitoring in these areas as follows:

- Many a times when people raise their voices in these areas they are branded as naxal and persecuted;
- In Tamil Nadu the community monitoring is budget driven and undertaken through a project mode not to deepen democracy.
- There is a difference between how community monitoring is perceived at different levels; as practitioners we see it as a way to deepen democracy; however government sees it as a feedback (consumer client mode). Government is paternalistic and limits the liberty or autonomy of the community. As a practitioner we talk about accountability and citizens' voice and with a paternalistic government it becomes very difficult to activate this voice. So unless and until the system changes and accepts the fact that maybe the system has failed to provide what community wants, you cannot do anything, so along with community monitoring there is a need to enable the environment;

- 85% of the people in rural Bihar depend on private providers, as service providers are reluctant to take up services in rural area/ naxal affected areas; so one needs to be realistic and see how useful community monitoring is in these kinds of situation.

  Community monitoring can be done effectively only in certain situations, only if government has promised services, if it has not been spelt out or promised then you need a different strategy to ensure that government includes it in the policy/programme document. Similarly it has to come out with guidelines, standards, which could be taken as a yardstick and services could be monitored by the community.

- There is a need to see whether the current community monitoring processes is community driven or committee driven. There is also a need to see who collects the date, who validates the data and where this data is placed in order to make the health systems more effective and the most important who listens and responds to the data. This is not evident in most parts of India

Jashodhara summarised and ended the session and put forward the concern raised by Abhay Shukla and shared the story of Uttar Pradesh where despite no space being provided by the state government space has been created through MSAMs efforts.

Exhibition – Marketplace of resource materials

In the post lunch session on Day II exhibition of posters, booklets, reports etc was held. Participants also shared their learnings through poster presentation, short movie about the community monitoring process carried out in their respective areas and the key learnings and challenges faced while taking this process forward.

Sandhya and Neetu from the MSAM team from Lucknow shared innovative visually explicit cards and posters which could easily be used by illiterate women from the villages to assess health centres and which were being used by the MSAM leaders to question and improve health service delivery.

Nitin from SATHI effectively showed a five minute movie on a public hearing in which citizens questioned the health care provider on services and the quality of these services.

Sudarshan from Odisha made a brief presentation on how the community monitoring process was being planned for roll- out over the entire state.

Smita Maniar from Gujarat shared the experiences of her organisation in conducting Community Monitoring. She also shared her frustration on the state's lack of interest in this process.

Santosh from Sochara, Tamil Nadu through innovative posters explained the community monitoring process and communities' participation in strengthening health service delivery.

Rakshya Paudyal in a brief presentation spoke about the community monitoring process and the apathy of the government in Nepal in recognising citizens need and the need to improve the quality of services.

Shahidol in an elaborate presentation shared the Bangladesh government's support in promoting community monitoring.

When the floor was opened for discussion following were some of the key issues shared by the participants:

Gurjeet Singh, Jharkhand: In Jharkhand we have block to state hearings. In state policy discussion are held and government comes up with the reports; there is space but there is also a backlash, people who share gaps are persecuted and victimised and incidences have happened . Since the past four years Jharkhand has had four state hearings.

Jay Verma, Bihar: Individual complaint mechanism has been established however village level community monitoring data has been shared at the village level and at the panchayat level data has been compiled, though a space has been created it is still recent and yet to be institutionalised at all levels.

Sudarshan Das, Odisha: Community monitoring in the pilot phase was successful, however currently we have established community advisory group, state planning and monitoring committee (review) and soon we are going to roll it out. But the interest in community monitoring is quite high and the Department of Education, Rural Development, Panchayat Raj, Women and Child and SC&ST have evinced interest in the community monitoring process.

Smita Maniar, Gujarat: In Gujarat there has been convergence between water and sanitation and health however the interest in community monitoring is limited till the block and we do have Jan Sunvai. At the state level there is no space for dialogue or discussions for community monitoring. There is no political commitment or interest in the state on what is happening at the local or district level. There is more focus on urban health development rather than rural health development.

Ajay Shrivastava, Chhattisgarh: It has been 13 years since separation from MP, there is space for the community voice as the state is small and the district level every Monday meetings are undertaken at the collectorate and the district collector and key officials ensure that the community voices are heard. However though we do have a community monitoring forum at the village level through the gram sabha, we are yet to establish a community monitoring process

Ajay Vishwakarma, Madhya Pradesh: In Madhya Pradesh there is a space for communities to speak, however government officials do what they want to do, so the voices are not heard and this makes it very difficult for any change to occur.

DAY III

Abhay Shukla and Renu Khanna briefly summed up the key discussion points of two days and what the participants had shared during discussions, debates, talk shows:

While there were a number of issues raised on accountability, governance, transparency and community monitoring, some of the issues that were consistently discussed and shared during each sessions by the participants were:

1. The range of social accountability experiences

- Within National Rural Health Mission (NRHM, the flagship programme of Government of India) framework (experiences of CBM from the states of Maharashtra, Tamil Nadu, Jharkhand, Odisha)
- Outside of NRHM framework (experiences from Gujarat, Uttar Pradesh and Madhya Pradesh where CBM through NRHM is yet to take forward)

2. Range of monitoring issues
- NRHM guaranteed services and entitlements
- Maternal health entitlements
- Integrated Child Development Services entitlements
- Youth entitlements
- Determinants of health – Public Distribution System (PDS), Mahatma Gandhi National Rural Employment Generation Act,
- Water and Sanitation

3. Range of methods and tools
- Facility Surveys, Exit Interviews/Polls, Social Autopsies
- Different pictorial tools and report cards
- SMS and Web Based Platforms

Participants identified many challenges and opportunities throughout the workshop. These can be summarised into the following key areas:

Challenges at the Community Level:

- The community often does not have much faith in the system, resulting in disinterest in people towards community monitoring processes
- High level of privatisation of health services leads to higher expectation from public health services, that remain unfulfilled
- Huge gap between demand and supply, the supply is inadequate so community monitoring raises a lot of questions, many of which remain unanswered
- If we do not take demands to their end solution, communities are disappointed and may lose interest; persistent unresolved issues are damaging for CBM;
- Making health a priority for community members and motivating them to take out time regularly for meetings, monitoring activities is a major challenge
- CBM is very process intensive and to reach the most marginalised in remote areas may be difficult
- There is also threat involved in some areas (e.g. naxal dominated areas, even in some other areas pressure from dominant sections not to carry on)

- Working in project mode inhibits voluntarism in the community. So making CBM sustainable is difficult and requires special kind of efforts
- Caste discrimination and gender bias does impact in formation of community groups/VHSCs
- Involving PRI members has been difficult to start with, however now with adoption of various strategies this has increased somewhat

Challenges at the Health Service Level

- **Major systemic deficiencies** in many states of India lead to 'CBM resistant' services which do not improve despite being repeatedly raised through CBM at various levels
- Community based monitoring activities have been maximally effective regarding *local health services* whereas ***actions and decisions at higher levels*** (esp. State) have often not been taken as required
- **Staff deficiencies** esp. of specialist and general doctors lead to 'structures without function'
- **Shortages of essential medicines** require change in medicine procurement and distribution systems (on lines of Tamil Nadu)
- **Entrenched corruption** at various levels becomes a major barrier to health service improvements

Challenges related to accountability mechanisms:

- Generally **lack of institutionalised and displayed service guarantees**, publicising entitlements and accountability mechanisms
- Most states lack effective **grievance redressal mechanisms**
- **Rogi Kalyan Samitis (patient welfare committee)** meetings often not held regularly, tend to be dominated by officials with minimal space to civil society organisations and neglect of patient priorities
- **'Untied funds'** may be 'tied' by formal or informal orders from above
- **PIP preparation process** often done in very short time period with minimal broader participation or consultation, need for addressing issues emerging from CBMP process

Resistance to CBM processes from State health departments:

- CBMP accountability processes have met **significant resistance from State health departments** in many states
- **Various forms of backlash** from local to district levels in certain states have adversely affected activities; pressurising activists to not raise critical issues

- Reluctance to include **NGO representatives in RKS** and to incorporate **community based suggestions during planning process** esp. related to district PIP formulation

- **Diluting role of NGOs,** downgrading their status in committees (contrary to NRHM guidelines), questioning their selection, trying to marginalise role of nodal NGOs or asking for **untimely 'exit'** of facilitating organisations

- **Reluctance to implement CBMP in full fledged manner**; delay or avoidance of key provisions such as State monitoring committee

- **Control by State health departments over financial and administrative mechanisms** has been major basis for constriction of CBMP processes

- Has led to delayed fund flows, infrequent installments, tedious reporting requirements, overly demanding auditing procedures, raising technical objections, all leading to interruption of activities

- Reluctance to include adequate funds for CBMP in state PIPs, resistance to support progressive expansion of CBMP, non-transparent mode of finalising CBMP sections of PIPs

Some immediate steps that participants from India felt that needed to be taken are:

- Advisory Group for Community Action, members and state civil society representatives need to be involved in **review of CBMP sections of State PIPs** from 2013-14 onwards

- As soon as feasible, **MOHFW should organise a national review of CBMP in various states** with involvement of State health depts. and nodal CSOs; such reviews should be held on annual basis as a facilitating platform

- **Administrative and financial guidelines for CSOs** implementing accountability activities with support from state NRHM

- NRHM supported **plan with dedicated budget (as % of total NRHM budget)** for generalising CBMP in all states

Some Short Term Steps:

- Standard display and publicising of Guaranteed health services in all villages and Health facilities

- Grievance redressal cells (with PRI, civil society and health officials) to be set up and publicised in all villages with phone numbers

- Toll free help line for lodging complaints, seeking redressal to be made functional and widely publicised

- Developing generic model of Community monitoring which can be supported through capacity building, tools and space for dialogue and accountability

Key modifications needed in financial management:

- After pilot phase, major trust was placed by NRHM in State health departments that they would positively support and expand Community monitoring
- If this has often not proved to be justified, then while maintaining collaborative mode of implementation, should alternative funding channels (e.g. autonomous society for accountability of public services) be explored?
- Require ownership and active involvement of state health departments without constrictive financial control

The dilemma and hope of community monitoring processes:

- Given the broader context of increasing privatisation of health services, CBMP is a process of winning back people's confidence in the public health system, while making the system much more accountable and functional

- Hence public health officials should actively welcome and promote the process, however despite some level of often cautious support, often there are attempts to control and constrict, which may do major damage

- Growing empowerment of people and health becoming a genuinely political issue may be an outcome that carries forward this process, even if in a modified form.

Guest Keynote

One of the notable special invitees to speak to the participants during the workshop was Sowmya Kidambi, currently the Director of the Society for Social Audit, Accountability and Transparency (SSAAT) set-up by the Department of Rural Development, Government of Andhra Pradesh to carry out independent Social Audits of the Mahatma Gandhi Rural Employment Generation Scheme (MNREGS). In her key note address Sowmya focused on her work with SSAT in rolling out MNREGS in Andhra Pradesh as follows:

There is a close connection between NREGA and health; the National Rural Employment Generation Act focuses on livelihood whereas health talks about life. One of the cases which starkly showed the apathy of health care services and providers of health care services was in Rajasthan where a pregnant woman was refused services by the Medical Officer in the PHC; the husband had not been able to arrange Rs. 5000 as demanded by the Medical Officer. Somehow the husband managed to arrange some money and requested the doctor to take up the case with a promise that he would give rest of the money later. Soon after the Medical Officer kept harassing the poor family to pay up the rest of the money. The husband requested Sowmya's team for help. Eventually the Medical Officer was trapped with support from anti-corruption officials and suspended; however the consequence of this action was huge, as no health care providers were

willing to be posted in the PHC. Poor people are vulnerable and their vulnerability increases specifically where health care is concerned, there is a need to be strategic and constructive.

The Employment Guarantee Act is a step towards the right to work, as an aspect of the fundamental right to live with dignity. It is a recognition that the state cannot retreat from rural development and is responsible to ensure food and livelihood security for the masses. Andhra Pradesh has been a leader in ensuring transparency in the implementation of NREGA. In addition to publicly sharing data on participation, the state has also created an independent agency to promote and oversee social audits of NREGA.

In Andhra Pradesh an independent social audit society has been established and this has been handed over to civil society activists. The work initially started in one district where with the registers shared by the Block Development Officer (BDO) a team from the society visited each household in each of the village to verify and validate the records. These records reflected the names of the beneficiaries, however none of the beneficiaries had received any wages for 100 days work as stipulated by the Act; the villagers realised that they had been duped. The Sarpanch and the BDO came and met the team from the society and requested them not to share these in the village meetings, however the society members went ahead and shared it in the village meeting. During the village meeting the social audit team realised that the corruption was deep and the five contractors who were supposed to build the road through the NREGA which would have paid the villagers their wage had been invited to the meeting shared that the money from the contract which was around Rs. 300,000, was shared at all levels with the people who handed them the contract, and the profit of share of the contractors was Rs. 50,000. After this experience the state decided to take up social audit extensively and introduced it in other districts. Some of the key experiences from this process were:

- Two reasons why social audit in NREGA has been successful in Andhra Pradesh: ***a.*** It is an independent body; ***b.*** .5% of the budget is put aside for social audit.

- The need for a larger team to take up audit. Youths in the village were trained. Currently there are 1100 District Resource Persons and 100 State Resource Persons.

- Extensive training of these youths, there has been criticism that there is too much training, but these trainings have been helpful in building a core cadre of resource persons in the state.

- States commitment to the social audit process has been firm, till date we have through the audit process identified that a total of Rs. 450 crores has been embezzled and 23 Crores have been recovered so far.
- Once the social audit is completed within seven days of its report action is taken by the vigilance team. Currently through the social audit process 30,000 have been implicated and out of these 11000 people have been punished. 500 have been removed.

- Promulgation of Action against people who have been found guilty in social audit is by the court headed by a first class magistrate. A minimum of three years imprisonment with a fine of Rs. 45,000 is imposed on those who are found guilty

Sowmya concluded her session by stating the need for the National Rural Health Mission to push for, ***a.*** An independent society; ***b.*** 0.5% for monitoring and accountability; ***c.*** standardized format, as NREGA in Andhra Pradesh did struggle with different formats; and ***d.*** Reports should be disseminated state, national as well as Auditor General Office.

The following queries were raised by the participants

Q.1. How did you identify and train youth volunteers?

Youth is a huge investment and we have tapped into it. On an average 4-5 youths are identified from one Gram Panchayat. These youths are trained for three days on social audits and Right to Information Act. They are provided with practical experience on how formats, registers and records should be maintained and key gaps in these which needs to be identified. These resource persons are then placed to roll out the social audit process; however it is ensured that the trained youths are not placed in their own village, but visit other villages to roll out the process. These youths question some of the systemic faults and also ensure that community/villagers are aware of social audit and accountability process.

Q.2. Whether independent society can take action and key recommendations on how to strengthen community monitoring process?

Every state has its way of implementing programmes. In many state the processes are subverted. Some of the recommendations from our experience that would benefit community monitoring processes in other states are:

- Ensure that the prosecuting agency and the investigating agencies are separate.
- Ensure that the audit reports are uploaded in the website. And people can access it;
- Share the community monitoring reports with the accountant general's office.

Closing Plenary Session

In the final plenary session Dipesh Dave, RCH NGO Coordinator, Ministry of Health and Family Welfare, Gujarat, Dr. D. R. Paropkari, Assistant Director, NRHM, Maharashtra and Mr. Pradip Prabhu, Human Rights Activist shared their perspective on community accountability and deepening democracy in India. The discussion was moderated by Dr. Abhijit Das

Abhijit Das: Seven years of National Rural Health Mission (NRHM) has in many ways revitalised health in India. NRHM has expanded funds, created a vision, provided a space to state and the district to undertake local planning, they have pushed for decrease in maternal deaths and infant mortality. Why do you think the benefit of NRHM have not been felt and is so low?

Dr. D.R. Paropkari: Though a lot has been achieved there is a general feeling that not much has been achieved. People are not aware of the various entitlements and schemes available and hence do not avail or demand these. Many a time's patients have shared that they have had difficulties in reaching health institutions for delivery as they have to spend from their pocket and make these arrangements for hospital care which is a part of their entitlement. There is a need to disseminate and create awareness on the various schemes and entitlements amongst the community. Visibilities of programmes have been dismal, dissemination and creating awareness is important and this has not been taken up on a priority basis.

Dipesh Dave: In many places government services have not reached, we are largely focussing in areas where services are not available and we depend on private providers. It is a struggle to ensure that service providers are available, especially in tribal areas. There is a reluctance of skilled health care providers to travel to remote areas and work in these areas; even doctors from the tribal community who have studied through seats made available to them through the government quota are reluctant to visit or work in these areas. So the biggest challenge today is human resources. Government is aware that this seriously dilutes the achievements and strides made in provision of health care. This is a crucial area that needs to be looked into and worked out.

Pradip Prabhu: There is a need to see it through a different dimension, I will cite three example, the first example is before community monitoring was introduced in India and there was a practice of the ANM announcing her monthly programme to the community members, in one of the meetings that I attended the ANM became nervous and started to cry, she cried because she suddenly realised that the people knew what her work was and what she was supposed to do, so in this case her trauma was because she was accountable for the work that she was supposed to do. The second example is from the district of Sundargarh where the Block Supervisors were asked to do one activity and one effort on their own time. One Bock Supervisor 'Chabi Mohanty' within six months brought down the IMR (which was high in the area) to 0. Chabi Mohanty did this by building a network of service providers at the community level and asked each of the service provider to take responsibility of following up in one village and ensure that each women were provided with institutional delivery services. When the Chief Secretary of the state asked her why she did it, Chabi responded and shared that for the first time she felt that she was a citizen. In the third incident evaluators who visited a PHC asked the Medical Officer present there as to where the Lady Medical Officer of the PHC was, the Medical Officer responded and said that he had asked her to go home and he could take care of the evaluation.

These three incidents reflect the true essence of how democracy is working in India. Schemes and programmes are being rolled out, but nothing has been done to change the mind set or attitudinal

changes. We have not done any work to deepen democracy. Mahatma Gandhi promoted gram sabha or village self rule, while Nehru promotes bourgeoisie parliamentary democracy. Eventually Gandhiji lost and in the process we have created inefficiency an instrumentality that does not allow a discourse of citizens.

Abhijit Das: Accredited Social Health Activists (ASHAs) and Village Health Sanitation Committees (VHSCs) have been established in every village to support in strengthening and making health services more accountable. Are they dealing with their responsibility and deepening democracy by creating accountability and transparency?

Dr. D. R. Paropkari: Through community monitoring NRHM is trying to strengthen democracy. However unless there is a demand from the community and the people, and community keeps a close watch on how the system works it will be very difficult for us to strengthen not only our but also our services. Though I have recently joined, I see community monitoring as an asset. Through community monitoring we are looking at gaps and also providing answers to address these gaps. Critical analysis is important to improve the programme. Simultaneously there is also a need to educate people on services and entitlements.

Dipesh Dave: Both ASHAs and VHSCs are functioning, however in the state of Gujarat it has been a struggle as there is duplication of many of the activities of ASHAs and ANMs. We are also overburdening the ANMs by asking her to fill too many reporting formats, the old ones are not phased out and new formats are being introduced. VHSC are supposed to make plans, but this has not been happening, it has been challenging as Government of India asks for village plan within twenty days of sharing the format with us, it is challenging as institutionally the VHSCs are still new and requires support in developing a plan. Secondly everybody talks about decentralised planning, money is released late and if we are unable to spend it then the budget for next year is decreased. We also have to respond to a thousand queries if we undertake any activities and develop any state specific issues. So most importantly there is a need to be sensitive about the needs of the respective states and there is a need to change the mindset of the people at the centre.

Pradip Prabhu: I will cite another example here Tamil Nadu is considered to be one of the progressive states; and one of the District Welfare Officer shared that when data is requested/demanded by the Head Office at the state then the data that is shared depends on what is asked for not necessarily the data that has been collected or collated. The whole problem is how right has been constructed. Rights in India has been constructed in the property context, it is as if I enjoy rights against the whole world. The rights holder and the duty bearers in health look at each other as adversaries. So there is a need to address the basic fundamental rights. The mistake is of combining ASHAs who are duty bearers and VHSCs who are the rights holders, the ASHAs will align herself with the system and this will result in them looking at VHSCs as adversaries rather than allies. Hegemonic process of how the state is operating and community monitoring is a counter hegemony approach. Rights can never be implemented, rights are always enforced, and so where health is concerned, rights will be enforced against the state. Right has to address its

eroding authority. Majority of the ASHAs come from affluence and she represents the elite. Now rights are people centered and are within the framework of property. Rights holder is constantly fighting against duty bearers. ASHAs are a theoretical mistake as she is a duty bearer. In theory it is difficult for ASHAs and VHSCs to work together. Community monitoring is a good attempt to bring the marginalised into mainstream.

In Nagaland the Chief Secretary strongly felt that communitisation was the answer to peace accord signed and he promoted it. This has resulted in drastic improvement in service delivery. The salary of service providers at the community level goes through the Village Health and Sanitation Committee. It is not only health but also education which has been handed over to the village committees. Two things happened with community involvement one government run school became popular and second private schools slowly closed down. So the answer to bad government is not 'no government' but 'more people and community involvement'.

Abhijit Das: Today in India can we ask questions on performance, has a space been created to ask questions?

Dr. D. R. Paropkari: Before a state programme implementation plan was top down and the budget lines were inflexible and we had to work within that right framework, now we do ask at the village level to work out their own needs and plan how they are going to spend it. Local level issues are being addressed and the focus is on participatory planning. Today we also can question and hold the government responsible and accountable.

Dipesh Dave: Some of the key reforms that are being undertaken at the state level are:

1. Planning for infrastructure construction of new health care services through GIS mapping;
2. Reforms and revision of transfer policy
3. Updating and regularly keeping in touch with our service providers through teleconferencing and satellite programmes.

Pradip Prabhu: In the mind of bureaucrat accountability and transparency are disempowering they do not see accountability and transparency as a process to stimulate community participation. The discourse of power can happen only if a voice is given this is where JAN SUNVAI (peoples hearing) has a place. In a remote PHC water in Sundargarh was a problem the Medical Officer did not have funds so he placed this issue in the Gram Sabha, and Gram Sabha took a decision and helped the PHC in accessing water by placing 2 kilometre pipe from the water source to the PCH. Sometimes government forgets citizenship from the point of view of citizens' accountability, as citizens we need to address views too.

Abhijit Das: Release of funds by the government has been a huge issue; there is intermittent fund release which has led to gaps in rolling out a strong intervention. It is said that it is a two way but then ownership of the state is quite weak it has become a NGO process?

Pradip Prabhu: You cannot have transparency in a market place, NGOs in India are creation of government, as ASHA is a creation of government and is majority of the time from the elite class unless the NGO thinks that I will stick and work even without funds then it becomes a community based organisation. Maturing of a democratic process is a question that is continuously posing. Democracy does not mean less power to the people better democracy means rights of the people increases.

The session was extremely enlightening and some of the feedback on this session from the participants was as follows:

Gurjeet Singh Jharkhand: I do not agree with Mr. Dave when he states that tribal people who have been supported by the state for medical education should go back to the tribal areas and work as doctors there. However service providers in the health sector are not available and this is a huge issue that needs to be discussed, debated and addressed so that primary health care is available for the poor.

Kajal Jain: The government representatives spoke about a two ways process; however funding is a huge issue especially towards the community monitoring process, and the state ownership towards the community monitoring is quite weak, how one can address these issues.

The plenary session ended with Abhijit thanking the speakers for coming forward to emphasize on the importance of citizenship to deepen democracy.

Future plans and follow-up for a stronger network

Some of the key suggestions given by the participants on the final day to take forward the accountability work were as follows:

1. National level newsletter that can reflect our work and experience of the state can be reflected (communications e-newsletter, websites, blogs etc);
2. Training workshop on community monitoring to learn more about tools, methods and mechanisms;
3. A collective advocacy initiative at the regional level as well as at the state level
4. Study visits and capacity building on budget accountability
5. Impact documentation
6. Expand into related sectors, alliance building
7. Cross learning visits

Taking the participants response into account Abhijit shared what has been planned and key activities to be undertaken through the COPASAH are:

- Highlighting state, community level experiences of practititioners through the internet platform i.e. e-newsletter, blog, facebook, website, lisserve (www.copasah.net)
- Case stories two from India and one from Bangladesh will be soon shared with the public.
- A set of conceptual papers to be developed and uploaded into the website
- One round of exchange visit to be undertaken this year;
- Training, technical support to partners and practitioners in the states.
- Documentation of best practices.

The steering committee members clarified and stated that COPASAH has not been seen as an advocacy forum but the focus of COPASAH will be to increase the practice of accountability, community space, mechanism and feedback. COPASAH and AGCA are complementary and do not duplicate each other; and two members of the COPASAH are members of AGCA. AGCA members are chosen by the government to support the ministry; whereas COPASAH is a community practitioner's forum. This broader process of COPASAH should be shared with AGCA members. One of the key suggestions was to have a dialogue with Ministry of Health and Family Welfare by a core team comprising of Abhay Shukla, Sunita Singh, Bijit Roy, Abhijit Das and Suresh who would draft the note and share it with the E-Group and subsequently can be shared with the ministry.

Participant Reflections

In the final session participants had the opportunity to share what they felt about the three days workshop:

Gurjeet Singh, Jharkhand: What I liked most was the opportunity to share and rebuild our strategies which I can incorporate in the monitoring process in my states. It also gave me an opportunity to interact with practitioners from other states.

Santosh, Tamil Nadu: The Group work was very good, session was planned very well, and the sessions were very planned, thanks to COPASAH for this opportunity to attend, we rarely get an opportunity to share what we have done in our states.

Sandhya Mishra, Uttar Pradesh: I learnt a lot from different states and different regions. The materials in the exhibition were also good and it gave us a lot of idea to take forward community monitoring in my state, it was also interesting to hear about different stories and different learnings

Abhay Vishwakarma, Madhya Pradesh: I loved the fact that I could speak and hear others but I had brought a lot of IEC materials in the form of flex and I could not use it as the space for display was limited.

Rakshya Paudyal, Nepal: It was a good opportunity for me to learn about so many tools and hear so many diverse case studies, I liked it.

Dr. Chandra, Tamil Nadu: My friends tell me there is corruption and nothing good is happening in India, I tell my friends come and work with my young friends on community monitoring and accountability this will inspire you. This workshop was inspiring

Suresh, Tamil Nadu: Now I know I am not alone I am full of energy (*Josh*) as I have learnt a lot and have met a force which will help me in my work. Thanks for this opportunity

Smita Maniar, Gujarat: This forum gave us an impetus that we are not alone I have heard many innovative ideas and I am taking this back to my state.

Shahidul Hoque: I learnt a lot because Indian government has adopted monitoring tools, though we are working in the community for a long time, I learnt a lot especially from social audit as it is a new concept for me. I will definitely use this in my project system and then budget monitoring was also very interesting.

Chedi Prasad, Bihar: A frog when it comes out of the well realises how big the world is and I will not call myself a frog but learning about CBM, CBMP or whatever name you call it was exciting and good learning.

Francis Xavier: I liked it as I learnt a lot and it was very good exposure for us as so many ideas were put forth.

Ajay Shrivastava, Chhattisgarh: I have never been to a workshop on CBM, and CBM formally has not been following a process in which community have played a role, so it is a big challenge to work in Chhattisgarh, now I feel as if I am a part of large family and this family is going to support me in rolling out CBM in Chhattisgarh.

Neetu Singh: on behalf of UP team I really thank you and appreciate the fact that I have been given an opportunity to speak and learn I do not have my return ticket and do not know whether I will get ticket to return, but this workshop was so helpful and so rich in learning and understanding that I do not care.

Bandhu Sane: My situation is the same and I did not have ticket and thought of returning back home, but then I appreciate coming here, I am taking this learning with me and I will share these with my team.

Sunita Singh, Madhya Pradesh: I liked catching up with my old friends; I felt good sharing the dais with my friends. I take the learning from Uttar Pradesh adolescent monitoring with me. I remember the challenges that I faced in Uttar Pradesh when the Secretary, Health roughly pushed aside my paper without even looking at it. In that kind of situation what the Uttar Pradesh team have been doing is amazing.

Sandhya Mishra, Uttar Pradesh: In Uttar Pradesh the officials stigmatise community and act as if something is wrong with us, we do feel disheartened, but this workshop gave us back our energy and our strength to go back and again fight.

Kajal Jain, Maharashtra: I liked the fact that our perspective on accountability, democracy, rights was good we regularly need these kinds of workshops ad forums, the only thing missing was the fact that it was a bit less lively but then it could be probably be because we should have brought more energizers and exercises.

Gouranga Mahapatra, Odisha: I called up our Mission Director and was sharing with him about this workshop and he said come here and we will talk so the experience was good and I enjoyed the learning, and I will definitely share with others in my state.

Jay Verma, Bihar: it was a learning experience and the food was good, the participant was good and I enjoyed it.

Bijit Roy, Delhi: This was so good, we wanted to do it through AGCA however could not do it, learnt a lot of tools and approaches especially from Tamil Nadu and Maharashtra. Now we need to look into our capacity and where does our strength lie and how best can we work collectively.

Santosh, Tamil Nadu: I have just started working and one thing I have learnt that government will promote health services but not rights so our responsibility is to promote health rights.

Jashodhara Dasgupta, Steering Committee Member, Uttar Pradesh: I am very happy that we could come here and be a part of this group, because CBM is yet to be rolled out in Uttar Pradesh so the lessons will help us in rolling out the CBM.

Abhay Shukla, Steering Committee Member, Maharashtra: I was pleasantly surprised: in the first group exercise on approaches I had put critical questions I was not sure, what the outcome of the discussion would be; but I was really fascinated to see how rich the group discussion was. Uttar Pradesh has not been a part of the NRHM community monitoring process but has still efficiently managed to undertake accountability. What I missed was the Karnataka participation they have been doing amazing work. I enjoyed listening and learning. We have started to synergize and hopefully we will be taking it forward.

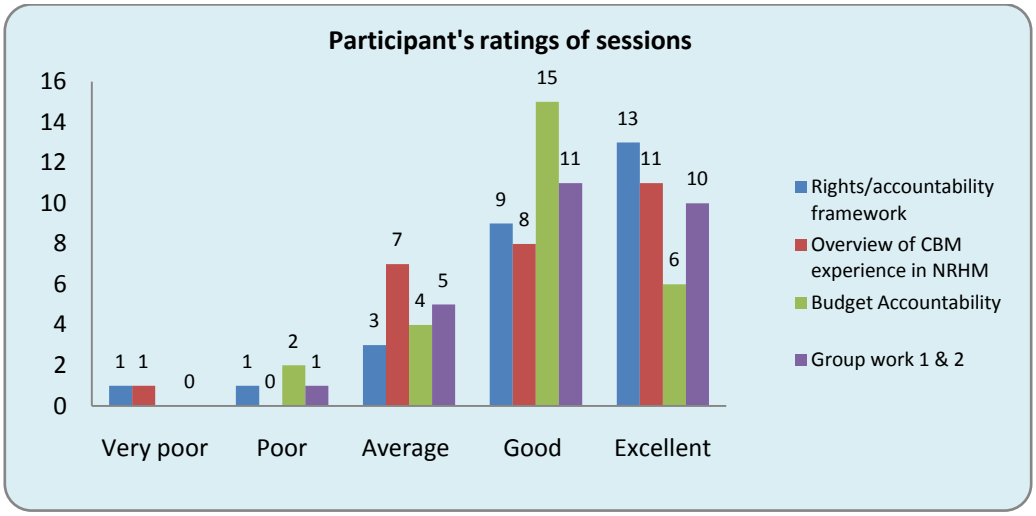
Abhijit Das, Steering Committee Member, New Delhi: Organisers anxiety is now gone as this was a huge success and we were worried about how many people will turn up, but then we have managed to delineate responsibilities. My request is to please write down your thoughts and work and share with us; we will support you in bringing it to the notice of others. We are prepared to provide you with support and we will turn this into a people state.

Renu Khanna, Steering Committee Member, Gujarat: Thank you very much I did not feel we were doing work as there was a lot of collaborations. The discussions were rich and each person contributed to the learning process.

Evaluation:

27 participants filled out evaluation forms. Overall the participants were happy with the content and the resource persons, and all the participants felt that the learnings provided through the

workshop was useful and provided them with answers on accountability. Only 1 participant felt that the plenary sessions was very poor, 2 of the participant felt that budget accountability was not useful and was not related to their work. Around 12 of the participants felt that the sessions were good and helped them in learning from other states; 12 participants strongly felt that the sessions and learnings were rich and enriched their understanding, were well planned and were content with the sessions and the facilitation by the resource persons.



South Asian Practitioners Workshop

"Community Monitoring and Social Accountability of Health Programmes"

20th – 22nd February 2013, Mumbai

Overview of Draft Schedule

Date	First session 9.30-11		Second session 11.30-1pm		Third session 2-3.30 pm		Fourth Session 4-5.30pm	Eve. prog. 7.30- 8.30
20 Feb	Registration, Welcome, inaugural songs, introduction etc (May have late start)	Tea- 11-11.30	**Plenary I–** 1. Budget as an accountability tool (Ravi Duggal) 2. Rights/ accountability frameworks (Abhijit Das) 3. Overview of CBM experience in NRHM- (Abhay Shukla)	Lunch 1-2 pm	Group work/**workshop I** - Sharing Approaches: how do we do CBM? do we actually deepen democracy? – (Abhay Shukla)	Tea 3.30 - 4pm	Group work /**workshop II** – Collecting evidence with community participation: theory and principles (Abhijit Das)	Welcome social/ dinner
21 Feb	**Plenary II** – South Asian panel – What is an Enabling Context for CM and SA in health (Jashodhara Dasgupta)		Presentations by the groups		Exhibition – marketplace of materials to share. Case studies, stories from the field to be shared by the participants		Exhibition – marketplace of materials to share. Case studies, stories from the field to be shared by the participants	Dinner
22 Feb	**(late start) Plenary IV** – Presentations before policy actors (Abhijit & Abhay)		**Plenary IV** – Moderated discussion with a panel of policy actors		**Plenary V** - Future plans and follow-up for a stronger network, contd exchanges and documentation (Abhijit)		**Plenary V** (Contd) - Workshop evaluation, wrap-up and goodbye (Renu)	Departures

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