South Asia Region Workshop on Social Accountability and Community Monitoring in Health

21st - 25th September, 2013
USO House, New Delhi

ORGANISED BY: Community of Practitioners on Accountability and Social Action in Health

SOUTH ASIA REGIONAL SECRETARIAT: Centre for Health and Social Justice, Delhi, India
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List of Acronyms

CBM- Community based monitoring
CBMP- Community based monitoring process
CBO- Community based organisation
CBR- Crude birth rate
CHSJ- Centre for health and social justice
COPASAH- Community of practitioners on accountability and social action in health
HMC- Hospital management committees
ICT- Information communication technology
IMR- Infant mortality rate
MDR- Maternal death review
MLA- Member of legislative assembly
MMR- Maternal mortality rate
MP- Member of parliament
MSAM- Mahila swasthya adhikar manch
NGO- Non government organisation
NMR- Neonatal mortality rate
NRHM- National Rural Health Mission PDS
PHC- Primary health centre
PRI- Panchayati raj institutions
SATHI- Support for advocacy and training of health initiatives TFR
TFR- Total fertility rate
VHSC- Village health and sanitation committee
South Asia Region Workshop on
Social Accountability and Community Monitoring in Health

Background
Community of Practitioners on Accountability and Social Action in Health (COPASAH) organised a workshop on “Social Accountability & Community Monitoring in Health” for the south Asian region from September 21- 25, 2013. The main objectives of this workshop were:

1. To increase knowledge of social and political determinants of health, health rights, entitlements and accountability
2. To increase knowledge of various community monitoring/ social accountability methods which have been applied in the region, including the role for civil society organisations
3. To develop skills in applying social accountability methods

The workshop had been planned and facilitated by four facilitators- Dr Abhay Shukla, SATHI (Support for advocacy and training of health initiatives), Dr. Abhijit Das, CHSJ (Centre for health and social justice), Ms Renu Khanna, Sahaj and Ms Jashodhara Dasgupta from SAHAYOG. A total of 41 participants from two South Asian countries (Bangladesh and Nepal) and 11 states in India (Andhra Pradesh, Bihar, Gujarat, Karnataka, Maharashtra, Madhya Pradesh, Odisha, Rajasthan, Tamil Nadu, Uttar Pradesh and West Bengal) participated in the five days workshop. The focus of the workshop was learning through practice. Therefore, the session plan concentrated on providing practical learning along with discussions on conceptual issues. The report has tried to capture the key discussions that took place in each of the sessions.
Day 1: September 21, 2013
Key Focus: Foundational concepts on health and health rights

Welcome and Introduction
The first day commenced with welcome of the participants by Edward P. Pinto and Bharti Prabhakar, from Centre for Health and Social Justice. This was then taken forward by Jashodhara Dasgupta, coordinator, SAHAYOG, Lucknow and Renu Khanna, coordinator, SAHAJ, Baroda, facilitators in the workshop. Jashodhara gave a brief history of the felt need of coming together of community practitioners, and it became a reality with the official formation of COPASAH in July 2011. Currently, COPASAH is a global platform with members from south Asian, sub Saharan African and latin American countries.

This platform provides for coming together, sharing skills and knowledge, sharpening insights, contributing to others’ work and learning within communities engaged in accountability work. Renu said that social accountability can be seen from two perspectives- one is the funding organisation perspective like that of World Bank, and the second is from the point of view of the community wherein the strength and capacity of the community is recognised. COPASAH lies in the latter. Renu expressed that there is a need to exchange and discuss varied perspectives to enrich our experiences. Therefore, as an outcome of the workshop we should all be in the field trying to learn, be in touch with each other and share experiences.

This was followed by an ice breaker aimed at enabling the participants to get familiar with each other. Everyone was asked to make groups of three- mother in law, son, and daughter in law. When daughter in law is said all daughter in laws have to change the
group, but none can go to the group they have been to earlier. This way everyone can have a conversation and try to know each other. Following this exercise the participants were asked to express their expectations from the five day workshop, which are listed below:

- Methods and sustainability in communication
- Link between community monitoring and advocacy
- Community’s capacity building to ensure sustainability of the process and its incorporation into the system
- Documentation, evidence building
- Possible challenges and how to overcome them How can common issues be taken collectively while undertaking advocacy
- Advocacy methods and tools
- How to work towards policy changes
- Should be participatory and activity based
- Friendly and mutually respectful environment

Premdas gave an overview of the sessions across the five day workshop. He said that the following themes contributed to the development of the social accountability framework and will be covered over the next five days:

- Foundational concept on health and health rights
- Socio-political contexts of accountability in health
- Methods and processes of social accountability - learning from experiences
- Promoting evidence based accountability processes - generating community data
- Dissemination, advocacy for change and review of the process

He also introduced the formation of various committees from among the participants to ensure timely participation and smooth conduct of the workshop. These included coordination committee, cultural committee and a committee for recap of the previous day’s discussions.
Premdas ended the welcome note by saying that we all have assembled here to share our experiences with each other and thereby contribute to strengthening the community of practitioners.

**Socio-Political Determinants of Health**

*Facilitator- Jashodhara Dasgupta*

This session aimed at developing an understanding on social and political determinants that affect health and to help participants develop linkages of community monitoring and its application with the community monitoring of health. Participants were split into five groups, and each was given different incomplete stories. The groups were asked to identify:

- What is happening?
- What will happen later?
- Identify the health/ social/ political issues in the story
- What is the group’s understanding by the story?

After 45 minutes, each group made a presentation based on the given areas. This session provided a broadening of the perspectives in community monitoring. Practitioners usually limit their focus, but this session enabled participants to understand monitoring beyond National Rural Health Mission (NRHM). It clarified that monitoring did not mean getting behind health providers but to have a broad understanding of all factors that affect health. From the stories it was very clear that it was not only the clinical factors that affected the health of the characters but also other social and political factors like social security, caste, economic status, gender, use of pesticides and many more. It was recommended that there is a need for all practitioners to think out of the box, have a holistic approach by including all social, economic and political factors as determinants of health when monitoring health.

Efforts were made to increase involvement of participants. With this in mind, six experienced individuals from among the workshop participants were prepared as resource persons. They were briefed beforehand to co-facilitate group discussions and also contribute to other participants' understanding of concepts.
Health and Human Rights
Facilitator- Renu Khanna
This session was conducted through an interactive power point presentation and explained the various concepts regarding human rights and health rights. It covered the history and evolution of human rights. This session provided clarity on the concepts of rights, human rights and health rights. One of the main points of differentiation were that human rights are aspirational and universal where as rights are codified and legally accepted and are legal obligations of the state and vary from state to state. There are various rights of which health rights is one which covers Right to Health. The session also covered the following aspects of health services that would come as a part of health care:

- **Availability**- from the point of view of services, facilities, health supplies, essential drugs, determinants of health etc.
- **Accessibility**- in terms of availability of economic support and access to information
- **Acceptability**- of services from the purview of personal preferences, cultural acceptance, medical ethics etc.
- **Quality**- of medicines, skill set, safety etc.

It was also made clear that though health is not a right in India, there are certain entitlements under the NRHM for which the state is accountable towards the citizens. Knowledge of these rights, their sources and mobilisation for claiming them was emphasized. The necessity of making social accountability a right was also discussed, so that more practitioners become health rights advocates to ensure public disclosure of upwards and horizontal accountability.

Individual autonomy and marginalisation: Power, equality and equity
Facilitator- Abhijit Das
The session started with an exercise called “Power Walk”. The participants were asked to choose from a bowl of slips, describing different characters. The group was asked to be those characters for the next half hour and to make the character’s circumstances as their own reality. The rationale behind this exercise was that the human rights emphasize on the importance of empathy with others’ suffering and understanding the environment and circumstances that people belonging to different strata have to face. Everyone was asked to take a blank paper and write down their responses to the following scenarios in Yes/No:
1. I have passed high school
2. I read the newspaper everyday
3. There are utensils kept in the house for washing. I want to rest. Will I rest?
4. I’m hungry. Food is ready. Nobody in the house has eaten, still I can eat the food
5. I am in the mood for sex. But I’m not sure whether my partner is in the mood for sex, but we had sex
6. I don’t want a child. My partner wants a child. We use a contraceptive
7. I have a red, itchy spot in my genital area. I will go and meet the doctor
8. I can easily use open areas for urination
9. There is a child in my house with diarrhoea. I know what to do and can immediately arrange for treatment
10. My sister in law is pregnant and I have noticed she has dizziness and swelling in feet. I can convince her and take her to the hospital
11. I don’t hesitate to go the hospitals as the attitude doctors and nurses is sympathetic towards me
12. I know that when I go to the hospital I will have no problem in getting the medicines

After everyone had marked their responses, they were asked to score themselves as follows:

- For responses marked as “Yes”, they were required to give themselves +1 point
- For responses marked as “No”, they were asked to give themselves -1 point
- Next, they were asked to add up all the points and the characters were categorised based on their scores
  - Score between +8 to +12: policeman (+12); male widow (+10)
  - Those scoring -10 points: female sex worker; physically challenged; female vegetable seller; tribal (adivasi) woman
  - Those scoring -8 points: male pavement dweller; female beggar; illiterate woman

The audience was asked to identify the reasons for the above findings. Those getting negative scores were asked to reflect on how they felt being these characters, and how it felt writing ‘No’ repeatedly to some of basic rights and facilities they are entitled to. It
was highlighted that although everyone has equal rights, but the opportunities available to an individual differ due to different circumstances. Our condition in the society is an outcome of the intersection of different hierarchies and power dynamics. The people in power want to divide people on the basis of gender, caste, religion, economic condition, work, education and region. The identities which had negative marking shared that they felt disturbed, frustrated, lack of enabling space. This activity clearly showed that any person’s individual autonomy is determined by their social position and this social positioning is determined by factors such as gender, class, caste, sexuality, religion and this process is called intersection. It is the social position which adds an advantage or reduces it. The facilitator made it very clear that awareness does not change life situations; one needs to diagnose and understand the power dimensions and work towards increasing autonomy for the weakest/marginalised sections in the society.

**KEY LEARNING:** The lens of power and equity was used to discuss the perspectives of social accountability in health. Health itself was set within the larger framework of human right to health and health as socially and politically determined. The framework of social accountability was sharpened pitching it within the social, political, economic and cultural contexts of determining the marginalisation of communities.
Day 2: September 22, 2013
Key Focus: Foundation Concept - Social Accountability & Community Monitoring

Accountability Chain
Facilitator- Jashodhara Dasgupta

Day 2 started with the session on accountability chain and was facilitated by Jashodhara Dasgupta. The session was aimed at understanding how the chain of accountability looks like, the types of accountability, the relation of accountability with community based monitoring and the link between power and accountability. The facilitator mentioned that many among the participants are engaged in community monitoring under the framework of NRHM, some are engaged in food security while others are working on ICDS. It was important to understand this more deeply with a focus on health. The participants were divided into groups and to each group a small situation was given. Each group was asked to discuss the situation, list down the persons accountable in the given scenario, and make a chain of accountability to explain the factors/individuals responsible for the service provision. The participants were asked to discuss what happened, what is going to happen after this, how does this story move forward, why is it happening like this, and how do we understand this when we talk about the person affected. The following five scenarios were given:

- A woman, belonging to scheduled cast community, suffering from bleeding after child birth
- A girl of four years weighing only 10 kg
- A three years old child suffering from Measles
- Delivery of a 37 year old woman who was pregnant for the seventh time
- A 16 years old girl having infection after abortion

This participatory exercise helped the participants to understand the various people accountable in the given scenarios and the mutual relationships of each of these actors. It was pointed out that although lack of awareness can be one of the factors, it is not the only factor. The social context in which it happened and the lack of other providing factors are equally responsible. A person who is not getting the basic essentials required for living cannot be expected to think and act beyond these.
Using a power point presentation the facilitator discussed accountability in the context of community based monitoring. She started by explaining the difference between accountability and answerability. While accountability needs motivational factor and has some boundaries and protocol, answerability is moral and repeatedly seeks answers. However, accountability functions in the framework of hierarchy of power relations and can be used to enforce sanctions, while answerability cannot enforce. Accountability is of the following three types:

- **Horizontal Accountability**- involves the government’s internal system
- **Vertical Accountability**- citizens try to hold the government accountable and comprises of citizen associations/ individuals claiming their rights through public action, demonstration, public hearings, public tribunals etc.
- **Hybrid Accountability**- a joint function of citizens and state actors. In this type of accountability the state invites citizens to join in accountability and monitoring through joint review missions, community based monitoring, hospital management committees with citizen members, help-lines and other feedback mechanisms.

However, there are certain gaps associated with each of these types of accountability. Horizontal accountability depends on robust institutions, individuals of integrity and absence of collusion. Vertical accountability depends on the strength of citizen action, media collaboration, state-society relations and absence of repression. Hybrid accountability depends largely on the government intent- if it is being done only on paper with no real intention of involving citizens, then it will have no results. Human rights and accountability are interrelated because accountability is not just a managerial function. It must include a remedial action that guarantees non-repetition. For an effective accountability mechanism state-society interactions assume an important role.
Socio-political contexts and health systems: Health system context in our countries and states

Facilitator - Dr Abhay Shukla

The session was aimed at contextualising community monitoring with the perspective of marginalisation and power and to expand knowledge and insights into using community monitoring as a tool for the empowerment of the marginalised. The health systems function in two contexts - the health systems context and the socio-political context. To understand these contexts the participants were taken for a group exercise, wherein they were divided according to their state/ country and were asked to reflect on the context/ situation in which they are working.

Each of the groups was asked to think about the state of health services in their respective areas and grade their public health system on a scale of +5 (well functioning health system, providing services efficiently) to -5 (poor public health system). At the same time they had to grade the level of democracy on the scale of +5 (open/ democratic) to -5 (restrictive).

One person from the group was then asked to choose his/ her position from among the four quadrants and give reasons on why the position was justified.

+5 PUBLIC HEALTH SYSTEM

Quadrant II | Quadrant I
-5 ________________ +5 DEMOCRACY
Quadrant III | Quadrant IV
-5

The first quadrant included states where the public health system as well as democracy were in a good condition and comprised of Tamil Nadu and Maharashtra.

The second quadrant belonged to areas with a reasonably good health system, but lack of democratic processes. Bangladesh, Gujarat and West Bengal came under this category, due to the good state of infrastructure, but there was a lack of community involvement in the decision making process.

In the third quadrant were states where neither the health system infrastructure was good, nor the civil society organisations or the community was being given the space to participate in the democratic process. Uttar Pradesh came under this category.
The fourth quadrant comprised of states where the democratic processes were strong and involved the community in various decision making processes. However, there was a lack of basic health facilities, staff and infrastructure. Maharashtra and Odisha were included under this scenario.

The facilitator pointed out that when we are looking at the context of the health system from the viewpoint of accountability, both these processes have to be considered. Just because we have a say in electing a member of parliament (MP)/ member of legislative assembly (MLA) does not mean a democratic set-up. The interaction and relationship of this elected representative with the community is equally important. Political space is essential for a democratic functioning as it gives an opportunity to ask why services are being given and why they are not being given. However, to ensure people’s access to quality health services, changes in health system are required which need an understanding of the system.

A good knowledge of the health system also helps in organising the community accountability actions effectively. A health system is the sum total of all the organizations, institutions and resources whose primary purpose is to improve health. There are three major components of health systems- inputs (necessary for system to be organised), structure (to organise and deliver services) and outputs (result of service delivery). The knowledge of health systems can be used to build justification and arguments for framing demands, collect information and organise participatory surveys.

Accountability is linked with responsibility and therefore, need to know responsibility of providers / officials at various levels to make specific demands and also to follow up issues through various levels of the health system.

The COPASAH website was introduced and screened by Lavanya Mehra in the post lunch session. She introduced to the participants to the various resources available on the website, the listserv, membership etc.
However, there are certain features of the health systems that may hamper accountability, like, large numbers of contractual staff with limited skills and motivation, covert privatisation in the form of lab tests, medicines to be procured by payment outside the facility, overt privatisation of public facilities and narrowly targeted vertical programmes (e.g. Family planning and Pulse polio) which draw away major resources from people’s health needs and priorities. Therefore, it becomes imperative that community based accountability is combined with efforts for Health system change through community accountability processes that create ‘political will from below’ and generate social pressure for improved functioning of health system. However major policy constraints may limit significant improvement despite community pressure. Hence, there is a need to combine accountability with policy advocacy, social movements and action research towards pro-people health policy changes.

Introduction to Social Accountability
Facilitator- Dr Abhijit Das
The aim of the session was to provide a greater understanding of the framework, methodologies and processes of community monitoring and to understand the perspectives of social accountability and its linkage with community monitoring of health services.

The facilitator started with the discussion on the importance of social accountability and stated that it is primarily to improve programme effectiveness, efficiency of development investments and to reduce corruption. Social accountability is also to improve the social and economic development status of the poor and excluded by challenging the existing political relations and decision-making in favour of the disempowered and marginalised. According to the rights framework it is the responsibility of the state to respect, fulfill and protect the rights of the citizen and provide services that are accessible, acceptable and meet certain quality standards. But the lived reality differs from this framework. All persons do not enjoy equal human rights due to political marginalisation, all the necessary services are not accessible to all population groups due to the lack of necessary documentation, cost of care, distances etc. and quality of services is poor for marginalised communities - in some cases there may be denial of services or poor outcomes.

This reflects gaps at the rights acknowledgement level, policy level, programme design/management level and the operational level. Hence, social accountability mechanisms assume greater importance to map these and the various instruments adopted can be litigation, social movements, studies, reviews, policy briefs, budget review, community monitoring, expert review etc. The essential conditions for social accountability are:

- Acknowledgement of entitlements within a rights approach - ‘Compact’ and ‘standards’
• Appropriate Mechanisms - ‘Health System’ ‘Resources’
• Availability of information for review - ‘Transparency’
• Mobilised communities/ active citizens - ‘Participation’ and ‘Voice’
• ‘Space’ for presenting review
• Possibility of change - ‘Remedies’ and ‘Redress’

Accountability cannot happen without hard questions, and these questions most often bring about turmoil. Participatory democracy starts with participatory chaos. The operational elements for a social accountability approach include space for civil society/citizen action, presence of laws/standards of service delivery and transparency, community mobilisation against deficiencies of services, facilitation for community mobilisation, capacity building and evidence review, and space and opportunity for dialogue with providers/public authorities. Given these conditions it is important to transform individuals from subjects (praja) to citizens (naagrik), fully aware and conscious of their rights to ensure intensive community engagement in all steps.

KEY LEARNING: The discussion of social accountability chain in its vertical, horizontal and hybrid forms was applied to health situations of participants. It was reinforced that an understanding of the processes of social accountability in health was related to the situation of health systems which in turn gets shaped and leveraged by democratic spaces available within particular political contexts. Different participants mapped the south Asian democracies in the range of highly authoritarian and undemocratic states to slightly liberal states.
Day 3: September 23, 2013
Key Focus: Community Monitoring - Learning from Experiences

The day began with the recap of day two. The first session of the day discussed “Experiences of Social Accountability - Learning from NRHM” and Dr. Abhay Shukla started the discussion by describing a brief history of community monitoring process within the National Rural Health Mission (NRHM).

Recap for sessions conducted on second day

Community Based Monitoring in the Context of National Rural Health Mission
Facilitator- Dr Abhay Shukla

In the initial phase of NRHM, the Government only focussed on implementation of NRHM programme and was never concerned about whether the entitlements were reaching the community or not. Dr. Shukla then went on to describe how Community Based Monitoring (CBM) process has evolved, and emphasized that CBM has not come from government attempt but is a result of people’s efforts and health movement in the country. A National Pilot phase on CBM was launched in 2007-09 in 9 states across the country. These nine states include Assam, Chhattisgarh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Odisha, Rajasthan and Tamil Nadu. The CBM covered 36 districts and 1600 villages in these nine states. Different committees were formed under CBM in the nine states.

These committees were formed at state, district, block, primary health centre (PHC) and village level. The committees were constituted with members from diverse fields- state level officials and panchayati raj institution (PRI) members. This was the first time that multi-stakeholder committees were formed in India. Dr. Shukla then talked about the objectives and approaches of community based monitoring process (CBMP). He said that the all CBMP are based on the following core components:

1. All accountability requires countervailing power (an agency which can ask questions and is autonomous) and space for people to raise questions
2. Expanding democracy in the health system/ services through-
   a. Creating forum for direct democracy (e.g. gram sabha)
   b. Expanding representative roles
   c. Reactivate reclaiming representative democracy
d. Activating health system accountability

In our country there is a need to strengthen countervailing power and PRI members have to come forward and participate in CBM process to reclaim direct democracy. CBM process also requires active support from the state. The process of community monitoring needs to incorporate a bottom-up approach, and involves four key steps- (a) awareness generation at community level and is done through meetings and mobilization process; (b) formation and capacity building of village health and sanitation committees (VHSC) and monitoring committees; (c) data collection; (d) jan sunwai (public dialogue or public hearing).

To give a perspective to the above discussions case stories on awareness generation among community about their health rights from two states- Karnataka and Maharashtra were presented.

Karnataka: Presentation by KB Obalesha on community monitoring with dalit and manual scavenging community on community health services
In Karnataka, the community monitoring process was implemented in four districts and in 560 villages. Mass awareness campaign was held for two and half months. For this campaign a committee was formed for writing health rights community songs and script for street play. The school teachers, community leaders, panchayati raj institution (PRI) members participated actively in the campaign. In each of the villages involved in the campaign, discussions were held for understanding the health issues in the villages. Participatory rural appraisal was also done during the campaign and from this process, the actual issues regarding health entitlements were identified.

Learning: Awareness creation and mobilisation are necessary in accountability process

Maharashtra: Presentation by Shubhada Deshmukh
In Maharashtra awareness programme was done through village meetings, in which discussions on community based monitoring process were carried out. The people were told about the role of community in various processes of community monitoring.

Learning: Without awareness community based morning cannot be done

Group Exercise: Debate on the importance of committees in the community monitoring process
The participants were divided into two groups and each group was assigned a topic to debate on:

Group A - Community monitoring requires multi-stakeholders committees
Group B - Community monitoring should be done by communities themselves- Committees should not hijack the process

Group A gave the following points as reasons for involving committees in community based monitoring process:
- Multi-stakeholder views could be included, which can provide multiple perspectives
- Powerful community representation
- Community voice representation
- Information sharing for greater community involvement
- Community awareness will be increased
- Process will be easy and effective
- Capacity building of community representatives
- Reduced communication barrier
Group B gave the following points for not involving committees in community based monitoring process:

- Claimants rights will be heard directly
- No tokenism of community representation
- Non-dilution of issues
- Gaps and problems in community based programme can be identified and discussed directly
- Planning and implementation will be undertaken by the community directly
- Budget processes can be monitored by the community

From the discussion it came out that any monitoring process requires the participation of community members as well as a committee to organise and take forward the key decisions and objectives. At the same time it is imperative that decision making by the committee considers the opinion of its stakeholders, the stakeholders and community members are free to express their opinion even though they may be different from that of the leadership, the community leadership should be approachable and open to discussions and importantly function democratically. To ensure these components an internal verification system has to be in place.

**Other Methods of Community Monitoring**

**Facilitator- Jashodhara Dasgupta**

The session was moderated by Jashodhara Dasgupta and in the session four presentations were given on methods of community monitoring outside the National Rural Health Mission framework. There were four themes of community monitoring and accountability models on which presentations were made. For each of the presentations two volunteers were identified from among the participants, as follows:
<table>
<thead>
<tr>
<th>TOPIC</th>
<th>PANEL SPEAKER</th>
<th>DISCUSSANTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensuring Accountability of Health Services: Lessons learnt at the local level (Bangladesh)</td>
<td>Samia Afrin, Naripokkho</td>
<td>Ayesha Khatun, Brajeshwar Prasad Mishra</td>
</tr>
<tr>
<td>Mera Swasthya Meri Awaz (Uttar Pradesh)</td>
<td>Pravesh Kumar, Sahayog</td>
<td>Neeraj Juneja, Madhavi Kalbele</td>
</tr>
<tr>
<td>Making a difference in maternal health services: community monitoring (Gujarat)</td>
<td>Mahima Taparia, SAHAJ and ANANDI</td>
<td>Karuna Philip, Saurabh Raj</td>
</tr>
<tr>
<td>Manual Scavengers (Karnataka)</td>
<td>K B Obalesha, Thamate</td>
<td>Naresh Kumar, Sadiya Siddiqui</td>
</tr>
</tbody>
</table>

They were asked to give their comments on the presentations, keeping in mind the following:

- Identify the gap in policy, implementation and programme
- Conditions for social accountability
- Role of community in the process
- Identify the challenges

**Presentation 1: Ensuring Accountability of Health Services: Lessons learnt at the local level- A case study from Bangladesh - Samia Afrin**

The project was implemented in 2001 in Bangladesh by Naripokkho and its community based organisation (CBO) partners as a way to strengthen the existing accountability mechanism. The focus was to work towards re-activation of hospital management committees (HMCs) through identification of barriers to accountability. HMCs are formed by the Ministry of Health and Family Welfare to monitor the work of the upazila and district level hospitals. These are chaired by Member of Parliament (MP) and the Upazila chairman is the co-chair. The HMCs have an officially recognised fora where local people and administration can sit together and discuss problems, identify solutions and take local measures.

Samia Afrin presenting the community monitoring process undertaken by Naripokkho, Bangladesh
As part of this initiative, advocacy aimed at reactivation of HMCs was undertaken for regular meetings and actions for improvement. The CBO partners were trained for monitoring and collecting data from the health facilities. Building relationships with local government representatives and members of HMCs through regular follow up and data sharing was also carried out.

Key achievements have been formation of HMCs in 13 out of 14 hospitals where Naripokkho is working. Committee members are now more proactive in identifying problems and taking measures to solve them. There has been a reduction in the collection of informal fees from patients and improvement in the supply of x-ray machine, x-ray film, food, ambulance, medicine, lab reagents etc. Doctors are regularly reporting to duty and the patient flow (mainly women) has increased. Some of the challenges identified were that members of parliament (MP) don’t stay locally and don’t meet regularly for meetings. Besides political instability leading to change of government kept the committee inactive for some time. Conflict between the MP and Upazila Chairman is also a reason for inactivity of committees at many places. Most importantly, the HMC does not have any sanctioning authority nor any funds.

The important learning has been that providers’ accountability is essential for smooth programme implementation. HMC can play a critical role for ensuring accountability and solving problems locally. The local MP who chairs the HMC has influence both with the local authority and the central government. An active MP can improve services and initiate necessary reforms in the health sector. In the absence of “decentralisation”, the HMC can function as an intermediary mechanism for ensuring accountability and standards. Local CBOs and media can help improve services through regular monitoring and reporting.

**Presentation 2- Mera Swasthya Meri Awaz: A case study form Uttar Pradesh- Pravesh Kumar**

This was a pilot project implemented by SAHAYOG in Uttar Pradesh to monitor the informal payments for maternal health services. In order to systematize the monitoring efforts, in late 2011, SAHAYOG and its CBO partners launched a new strategy using information communication technology (ICT) to collect data on informal payments for maternal health services. This campaign, called the *Mera Swasthya Meri Aawaz* was launched in Azamgarh and Mirzapur districts of Uttar Pradesh. The system was adapted and integrated with an interactive voice response (IVR) system to make it simple for illiterate communities to use. This platform helped in mobilising women to fight for their rights and improvement of health services. Between January 2012 and May 2013 (15 months), a total of 867 reports of informal payments were made. It was also found that reporting was highest in areas that had active, grassroots community groups. This indicated that merely providing a toll-free reporting help-line will not ensure that users of health services will be motivated to report a grievance, especially since they will not recover the money paid out. It requires a level of ‘active citizen engagement’ to take the trouble to report informal payments. The data was shared with government officials at all levels, who found it extremely useful for their supervision of health facilities. It enabled them to take immediate action and led to improvement in situation at many places. Some of the key lessons learnt are:

- Evidence can be accurately generated about the extent, nature and amount of informal payments, which was a shift from the collection of sensational anecdotes to systematically recorded evidence of informal payments being demanded
• With assistance and training, poor rural women are able to use mobile phones to make confidential complaints about informal payments, thereby making them active agents not passive beneficiaries.

Pravesh Kumar, Sahayog (Uttar Pradesh) presenting the Mera Swasthya Meri Awaz case study

• Anonymity and untraceability of complaints reported gave women a sense of safety to return to the health facility in the future to seek services without retaliation.
• The ‘dual approach’ campaign, which combined information about entitlements with knowledge about a complaint mechanism were invaluable tools for the poor illiterate women in the project districts.
• Involving district-level government officials from the beginning led to a more positive engagement and instant response that resulted in lives saved.

Presentation 3- Making a difference in maternal health services: Community monitoring- A case study from Gujarat by SAHAJ and ANANDI - Mahima Taparia
The project focused on enabling community action for increased accountability for maternal health. Women and dais in the community were involved in developing tools for community monitoring. Data from the community enquiry was shared and validated with respondents, community groups like sangathan women/dairy members and health volunteers. The report cards thus prepared with intensive inputs from the community were shared with the health officials including Taluka head officer and Medical Officers in the chosen locations. The results of the process were immediately visible.
There was increased access and utilization of maternal health facilities in the locations covered, health system became more responsive, primary health centres (PHCs) started working efficiently with the result that more women were availing ante-natal services. The report card gave an opportunity to the women and the facilitators of the process to have a dialogue with the health system and the community stakeholders resulting in improved utilization of services and entitlements.

Presentation 4 - Manual Scavengers of Karnataka - K B Obalesha
The presentation focused on the living conditions of Karnataka’s manual scavengers. The occupation involves manual removal of excreta from “dry toilets”, and can be categorised as a form of slavery and forced labour as it is a caste-based occupation for Dalits in India. A National Act prohibiting the employment of manual scavengers as well as construction of dry toilets was passed in 1993. Despite the continuing practice, the State denied existence of manual scavengers, owing to the act. This led to lack of monitoring of this practice in the state as well as denial of health care services and entitlements to this group. As part of the advocacy efforts visual presentation of stories of denial of rights and deaths of manual scavengers was provided. Evidences from the ground pointed to threats by the police, non registration of FIRs and rejection of monitory compensations in cases of deaths of manual scavengers, by the state. Data on the population of manual scavengers and numbers of dry toilets in the state in both rural and urban areas as per the census registers was presented before the authorities.

Success through evidence based advocacy in terms of some recognition on this practice, discussion in the Parliament on their status and the Manual Scavenging Abolition and Rehabilitation of Scavengers Act 2013 have been achieved. However, mobilization of manual scavengers’ community is going on through organising them, linkage with unions, creating evidence- by photo documentation, fact finding and community level research on health of the
manual scavengers, affidavits by persons in manual scavenging are some of the strategies being undertaken.

It was noted by the facilitator that extreme and powerful methods have been used to convince the state health system. Developing a body of evidence by adopting these innovative approaches was a huge challenge. As discussed in the previous day’s session, accountability has various aspects. Legal and judicial accountability is also one of the methods of accountability and community monitoring is not the only one to be looked into.

The facilitator summarised the session by stating that till now the community monitoring practitioners in India have been mostly involved in CBM process within the enabling environment in NRHM. This structure of CBM within NRHM has a certain structure, guiding principles and standards. It provides a platform for dialogue and an enabling environment for improvement of services. CBM can never be successfully implemented through a fixed formula. Consequently, it is imperative to look beyond the NRHM framework and look at the accountability systems of PDS (public distribution system), manual scavenging issues, HMCs initiatives, methodology adopted to stop informal payments in hospitals in UP and work towards picking up the quality of maternal health and services given. However, it is equally important to consider the challenges faced by each of these and think of ways to overcome them. In Bangladesh HMCs have been set up, but they lack funds. In Uttar Pradesh also an interesting contextual factor can be found: the communities are better mobilised and reporting is higher in areas where there are women’s
Jashodhara Dasgupta summarised the key points from the panel discussion

organisations, compared to where women’s organisations are not present. The Karnataka study reveals the importance of grounded evidence to make the state accountable. Another important perspective was the Gujarat example where community’s actual thinking on the issue has been considered and not what the non-government organisation (NGO) has been thinking (challenging the context).

When we talk about community awareness, it goes a long way in creating community mobilisation and only then some accountability work can be done. CBM and improved accountability can happen when the local people are aware of their entitlements. In the previous session it was discussed that how the government wants to implement CBM in Madhya Pradesh, Jharkhand, Bihar but with no NGO involved. The role of mobilising groups is to be understood and acknowledged. One cannot look at the community alone for community monitoring. For accountability it is essential to work at various levels- people at the district, state and national level, and involve people who are willing to listen to the issues and push for them.

Given this, it is equally important that our media for extracting and sharing data should be acceptable to the community. Not only the data collection tool, but the data sharing tool needs to be discussed. Unless the community is not aware of the findings and related issues, there can be no accountability. Sustainability is equally important and it needs to be figured out as to what level we want it to be- at the community level only, solely with the government, or shared between the two. There are three types of community monitoring approach:

- **Horizontal** that is government system, which involves the political leaders and government departments
- **Vertical** that is people’s system- people seek accountability from leaders, elected representatives and departments
• Hybrid system where there is a role for both, a role for the elected representatives, official and providers, and a role for the CSOs. By far this seems to be the most effective method for ensuring sustainability. The case study of Bangladesh HMCs is an example of a hybrid platform. However, to make it work efficiently and effectively is a challenge.

Social Accountability Haat*
In the post tea session an 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. This was a group work involving the participants and aimed at presenting the work on social accountability and community monitoring. All the participants were divided into groups under four themes: (i) Marginalised communities, (ii) Women and dignity, (iii) Health services and accountability and (iv) Children, adolescent and advocacy.

*Haat in local language means “people’s market”
the participants had been informed in advance to bring posters, brochures, books, booklets, photographs on the primary issue/theme that they are working on in their organisation or the issue addressed by their organisation.

KEY LEARNING: The day focussed on learning from the practices of accountability from number of fields- community based monitoring and monitoring under the framework of National Rural Health Mission (NRHM), Maternal Health Report Card, use of Interactive Voice Recording System (IVRS) for tracking maternal death and working with hospital management committees to bring about transparency and accountability, using accountability approach and strategies in organizing manual scavengers etc provided rich practices in accountability. Along with this a show and tell session named ‘Accountability Haat’ (haat, in local language means a people’s market) gave opportunity to various practitioners to talk about their practices on the themes of marginalised communities, health services, women & dignity and children-adolescent-youth issues.
Day 4: September 24, 2013
Key Focus: Community Monitoring- Community Evidence (Community Data)

Generating community data- Principle and practice
Facilitator- Dr. Abhijit Das
The session started with a discussion on the difference between social accountability and research. Social accountability was seen as an exercise wherein the society / community put pressure on service providers on the basis of equality, equity and social justice. It seeks to question the system service providers and officials. The results and expected outcomes depend on the context of our goals and objectives. Social accountability is empowering and involves people directly.

Research, on the other hand is an expert based and elite subject. It is extractive and contributes the expert in gaining more knowledge. It is also one of the tools to showcase the communities’ realities, but its understanding requires some level of expertise. The community faces difficulties in understanding research terms, but it could influence the management level decisions. Accountability initiatives require strong evidence building, and therefore, research has a role to play. But at the same time it needs to be done in a way that it is not too sophisticated and takes the focus away from social accountability.

The various data collection techniques are enumerated below:

1. Participatory Rural Appraisal/Participatory Learning Methods/ Participatory Learning Appraisal

Facilitating Organisation + Community Group

Agenda Setting

- Mapping
- Sorting
- Classifying
- Listing

2. Testimonial/case study and fact findings: It helps in giving voice to the experiences of the people. It has been proved time and again that these case stories are reflections of ground realities and are more effective than all the data put together
3. Secondary data analysis (government document): This can be done through proactive disclosure, RTI, hospital records, hospital management information system etc. However, while extracting evidence/data through this method it is important that confidentiality is maintained, as the disclosure can bring harm to the complainant.

4. Facility monitoring/photo documentation): These are observation based methods

5. Questionnaire: This method helps in recording specific information

6. Media evidence: Substantiate evidence, we can also generate media evidence

7. Individual interview

8. Participatory data collection/Score card/Survey: It helps in getting the community involvement in deciding the issues

9. Legal affidavit

10. Media evidence

Provided these various methods of collecting data, it also becomes important that the issues are identified and there is complete clarity before undertaking advocacy.

Conducting a participatory group discussion

Facilitator- Jashodhara Dasgupta

A handout on “Working with Groups” that talked about the characteristics of a group, how they work and provided tips for developing and facilitating groups was shared with the participants. The participants were asked as to when we need to work with groups. Some of the responses given are enumerated below:

- Focus group to generate/take information
- Awareness generation
- Making an action plan
- Analysis and sharing of data collected
- Training and capacity building

Mock group discussion exercise with a group of ten people and remaining participants as observers

They were then asked to share the problems they faced while working with groups. The concerns highlighted were issues of participation, communication, acceptance (whether the group was
open to new ideas), handling a dominating sub-group within a group, leadership and decision making and over-dependency on the facilitator. The session proceeded through a group exercise for which a group of ten volunteers were identified and given five minutes to reflect on a common topic. This group of people were then asked to hold a focussed group discussion among themselves and the other participants were asked to observe the FGD on the basis of following points:

- What is the level of participation?
- How does the communication flowing?
- How does the group manage conflict/disagreement?
- Who is sharing leadership in the group and what kind of leadership?

The observations were discussed at length and a common set of characteristics that characterise the group dynamics were identified. These included:

- Not all members of a group participate equally. The reasons can range from language barrier, lack of expression, lack of opportunity to voice their views or lack of knowledge/awareness on the subject
- Some people were not able to participate as they could not make up their mind as to which side they were on
- Lack of leadership and focus and no encouragement to other people’s participation

The facilitator summarised the session by stating that effective and result oriented facilitation is imperative to any group discussion. It needs a leader to provide direction and focus and also encourage everyone’s involvement. At the same time it becomes important to handle those not in favour tactically, so as not to make them our adversary. Any group discussion should end with a summarisation of the key points arising out of the process.

Facilitation
- Improve everyone’s participation
- Encourage more listening

Observe the process

Diagnosis of the group processes

Conducting a fact finding

Facilitator- YK Sandhya
The session proceeded through a presentation on “Documenting Maternal Deaths: The process and things to keep in mind”. It discussed the necessity of a maternal death review (MDR) process and how could it be done.

Maternal death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy/after delivery, from any cause related to or aggravated by the pregnancy or its management, but not from accidental causes. In India, more than two-thirds of
all maternal deaths occur in a handful of states. Consequently, MDR becomes essential. The steps identified for any MDR are:

- Reporting of the death
- Verifying whether it is a maternal death
- Community based review of all maternal deaths
- Analysis
- Action

Maternal death surveillance is important as it provides an opportunity to assess quality of care, helps in identification and notification of maternal deaths, helps in reviewing circumstances and medical causes leading to the death, helps in identifying remedial factors and interventions that can save women’s lives, helps in recommending corrective action. A handout on the various tools used for community based maternal death review was shared and discussed with the participants. It included: (i) forms for reporting, (ii) verification, (iii) tools for community based review of maternal death.

It was highlighted that while reporting it was important to not just document the incident of maternal death, but get information on entitlement awareness, social status of the deceased woman, her pregnancy history, and a chronological documentation of events starting from when she first decided to seek care to the circumstances that led to her death. There can be certain challenges while documenting MDR, such as missing paper trail in most cases of deaths in rural areas (admission slip, prescriptions, receipts, death certificate, post-mortem etc.), reluctance on the part of health officials to share information, and victimisation of family giving details of circumstances leading to maternal deaths especially if it is a case of denial of services or medical negligence Informed consent. However, it is also essential to maintain confidentiality and working.
closely with the Ministry at the centre and with state and district level government officials as well as frontline providers. It is important to ensure that the learning is “fed back into the system” rather than adopting an adversarial outsider stance. The presentation was followed by a role play exercise, in which participants were divided into two groups. Each group was to create a scenario involving three roles- family of deceased, interviewer and service provider. They were asked to collect information for MDR documentation applying the principles discussed in the session.

**Reviewing secondary data**

**Facilitator- Abhijit Das**

The session was aimed at introducing the participants to the methods for extracting data from secondary sources. The definition of key health indicators- infant mortality rate (IMR), maternal mortality rate (MMR), crude birth rate (CBR), neonatal mortality rate (NMR), total fertility rate (TFR), etc. were discussed and concepts clarified. A brief exercise to provide an understanding on their calculation was also undertaken. It was explained that these measures were important to understand the overall health scenario. The points highlighting the importance of secondary data from the perspective of community monitoring are as follows:

- The community monitoring practitioners should able to understand and interpret the data which were available in our secondary sources about the overall health status of a particular area.
- Calculate and interpret the numbers to simplify the data and share with the community in a simple manner so that the community could also understand the data of their area
- Comparison with data at various levels, and comparison with NRHM goals and MDR goals can provide useful insights and judge the status of the health situation

**Conducting community monitoring**

The session was aimed at providing a practical sense of presenting reports to the policy makers and responsible authorities and to facilitate a discussion on the relevance and application of different methods of advocacy and dissemination. The participants were divided into six groups and asked to practically apply community monitoring methods on three topics. Each of the groups was asked to present a report choosing appropriate method of discussion- such as dialogue, public hearing, report card presentation etc.

**Cultural Evening**

The COPASAH workshop was a unique gathering of people from different states of India and Bangladesh. A cultural evening was organised with the purpose of providing the participants with an occasion and space for cultural expression. The cultural committee formed on the first day of the workshop coordinated for the same. This was followed by a special dinner. The participants enjoyed the evening to the fullest and this helped in overcoming all barriers and forging a stronger bond.
The topics given are given below:

- Public transport system in Delhi
- Training programme
- Food and stay arrangements of the training venue

The day’s learning sessions ended with the assigning of topics after which the groups went on to discuss their strategies for the next day’s presentation.

**KEY LEARNING:** Some important methods were discussed and worked upon in small groups on the theme of generating community based and community related evidence—using participatory group discussion, conducting a fact-finding study or recording a case-study, reviewing secondary data were the important methods discussed. This was followed by a practical session on participants collecting data using appropriate tools on the themes of training workshop, food & accommodation for the training and on the Delhi transport experiences.
Day 5: September 25, 2013
Key Focus: Community Monitoring - Advocacy and Evaluation

The fifth and final day of the workshop began with the recap of the previous day. After the recap, Dr. Bharti Prabhakar introduced an online learning resource which was specially prepared for community monitoring and social accountability practitioners. The overall purpose of the Resource Pack is to equip the practitioners of Community Monitoring with appropriate and relevant resources of good quality so that they may become effective in empowering communities to engage with public health systems for the fulfilment of health related rights. The Resource Pack pulls together existing materials and manuals on Community Monitoring and allied topics, as well as draws upon the existing practice of community monitoring in different parts of the world. The special focus of the Resource Pack is to enable new practitioners to build their own skills, through an approach that brings together a conceptual framework, instructions and practical examples. It also seeks to help practitioners of community monitoring use this information and the lessons learnt to improve practice.

Then the participants presented the community monitoring exercise findings they had done the previous day of the workshop. The participants divided into six groups the previous day gave presentation on their respective topics. The panel comprising of Jashodhara Das Gupta, Abhijit Das, and Edward P. Pinto identified certain gaps in the presentations made and provided insights on addressing these. The process of questionnaire development needs to be considered keenly, so that key issues of concern are not left out. They related that documentation can be further strengthened by collecting case studies.

Overall the efforts made by all the participants were lauded and it was pointed out that they had been able to provide some qualitative information. The participants had mostly used scoring or report card method to present their data but it would have been useful if the participant had used different methods rather than using only score card or report card methods. However, it was also highlighted that variation in the choice of enquiry method would have been helpful for a greater understanding, such as use of checklist for food and stay arrangements, group discussions for training workshop. The panel had commented that more in-depth information was needed and

Group presentation by participants on monitoring exercise for public transport system in Delhi, training programme, food and stay arrangements of the training venue
if the group had used group discussion as a methods so only numbers would not help in understanding this and some in-depth and qualitative information was required.

**Advocacy as a part of social accountability process**

**Facilitator - Dr Abhijit Das**

Collecting data and presenting findings is not an end in itself. It is important to work towards bringing about a change. Sharing the data, the evidences, the information that has been collected through community monitoring process and developing them into evidence is important for social accountability practitioners to bring about changes in the health system. The data can be shared with community, service providers, media, concerned government authorities etc. Constant follow-up and information sharing with the various actors is the fulcrum of the process and can effectively lead to public action and build shared spaces for negotiation. It was emphasised that NGOs should try to focus on building participatory democracy and build the process of evidence based advocacy, rather than becoming the face of the community and thereby making themselves vulnerable. Bringing about a change is as important as sustaining it. This can be effectively done by building a shared platform for negotiations and dialogue between the community, NGOs and officials, and through leadership building and community mobilisation.

**How do we know we are making a difference? Reviewing progress**

**Facilitator - Dr Abhijit Das**

The objectives of the session were to understand the process of impact of the community monitoring, besides learning the methods and skills in evaluating the process of community monitoring. Having developed clarity on concepts of community monitoring and social accountability, the participants needed to understand the programme theory of how the desired change will be achieved. For undertaking any new process it is imperative to have a complete understanding of what change we seek to make in our communities. This can be achieved through appropriate programme theory. Setting the programme theory and anticipating the trajectory of change is essential to the monitoring and evaluation process. This needs to be accompanied by vigorous documentation of the stories of change and should be done in a way that progress can be charted and ongoing learning from within the programme implementation process can be
incorporated. Apart from the stories of change, stories of resistance and positive outcomes are equally important to document the lessons learnt and challenges faced. It is, however, useful to remember that changes in power relationships can take considerable time to take place and initial changes can be difficult to sustain. The facilitators of community monitoring process are often too anxious in trying to see whether the project inputs are being delivered in time. In order to strengthen the learning component of our intervention, it is important to focus on strengthening community leadership, which is an important outcome of our efforts.

Follow-up plans and closing
The session was specially focused on future plan. COPASAH is a platform for collective learning. Edward P. Pinto thanked the entire CHSJ team for all the support and wonderful work they put in to make the COPASAH workshop successful. He called on everyone to start writing and share their experiences, case studies and practices with the larger group. He asked the participants to share how they felt being a part of the workshop. The practitioners shared that the entire workshop has been tremendously successful and everybody contributed their bit. Some of the participants expressed their willingness to share the advocacy work through the COPASAH platform and said that it was a good opportunity to learn from others' experiences.

It was also highlighted that as an outcome to the workshop it is understood that learning from the workshop will be disseminated to a larger group and a collective of community practitioners is created. This platform can be provided technical support with the focus on designing, content and knowledge sharing.

The Resource Persons selected for the workshop took forward the discussions that they had over the five day period with the participants. They asked for suggestions as to how all of the like-minded people that had collected for the workshop can come together in future and mutually learn and share. It was highlighted that COPASAH is in no way a platform to change the world; it is to help us grow. COPASAH is a learning collective than a network.
During the course of the workshop, the need and possibility for an independent youth / younger generation practitioners’ forum was greatly discussed by participants in their free time and it was discussed at a considerable length on the last day. Most of the practitioners agreed with the felt need for such a platform and about seven members (Hemraj Subhash Patil, Juned Kamal, Madhavi Kalbele, Mohona Chatterjee, Neeraj Juneja, Rakesh Sahu, Sadiya Siddiqui) volunteered to facilitate this process, take the conversation forward among them and have requested COPASAH to play a handholding role. If this takes shape it would be the first autonomous group of social accountability practitioners in India. This is apart from the plans that participants from particular states are making for themselves and taking forward as a resource team in their own jurisdictions.

The practitioners expressed the need to come together physically to share their experiences, continued sharing to strengthen their learning and the network, at least once a year. It was proposed to achieve this objective through:

- Using technology to connect more often and expand learning from each other
- Providing technical support on community monitoring
- Learning visit could be organised for the practitioners and financial support can be provided
- Learning about situation of marginalised communities and advocacy efforts
- The work should be done at two levels- local and national level, as follows-

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| • Bihar team has agreed to organise a state level workshop  
  • Self learning among the participants  
  • Community mobilisation and awareness in Madhya Pradesh | • Community monitoring tools sharing  
  • Pool of resource people to the platform  
  • Learning and sharing  
  • Ask questions on community monitoring |

The team suggested meeting on a regular basis through Google hangout and Skype. A great need is also felt in developing a few of these sessions and resource material in various Indian and other south Asian languages.

**KEY LEARNING:** The day began with the presentation of tools, methods and the report card on the three themes. Drawing on from the sessions the discussion and inputs continued on the advocacy for change and the evaluation processes to assess how we are making a difference.
Evaluation

31 participants filled out evaluation forms. Overall the participants were happy with the content of the workshop and interactions with the resource persons. All the participants felt that the learning provided through the workshop was useful and provided them with answers on accountability. More than fifty percent of the participants rated the sessions from satisfactory to excellent in each case. Participatory exercises were appreciated by majority of the participants.
Conclusion

The Community of Practitioners on Accountability and Social Action in Health (COPASAH) South Asia Region Workshop on Social Accountability and Community Monitoring in Health was a rich learning experience as it provided a platform to grass roots level practitioners of social accountability in various issues of human rights and dignity to meet and share their experiences and consolidate the social accountability framework promoted and facilitated through COPASAH. The five day training workshop was designed on adult and participatory learning principles. Richness of experiences, variety in issues of practice and similarity in the social accountability perspectives were the highlights of this workshop. The participants contributed richly to the workshop as many of them were experienced and represented some of the leading campaigns and social movements in the country such as- women’s rights groups, Adivasi (indigenous people) Movements, Dalit (the community discriminated on the basis of caste) community, strong people’s organisations/movements and community based organisations. The thematic fields of children-adolescents and youth, community entitlement/ rights movement, dignity and identity (Dalits), sexual minority rights, women’s rights, maternal health rights and the community development and health rights issues represented by participants made the workshop and the discussion on accountability quite enriching.

During the course of the workshop, the need and possibility for an independent youth / younger generation practitioners’ forum was greatly discussed by themselves in their free time and it was discussed at a considerable length on the last day. If this takes shape it would be the first autonomous group of social accountability practitioners in India. This is apart from the plans that participants from particular states making for themselves and taking it forward as a resource team in their own jurisdictions.

The workshop left behind a deepened sense of community among practitioners. The session plan and the methodology of holding sessions were greatly appreciated. This helped in overcoming the greatest language barrier that we had. Some of the participants from Bangladesh did not know Hindi (spoken by majority of the participants) and some of the participants from south India too did not know Hindi. Without having formal translations the challenge was met by bi-lingual and sometimes even tri-lingual (Hindi, English and Bangla) facilitation by the facilitators. A cultural evening show-cased diverse cultural richness from participants and helped in forging a great bonding between all the practitioners. It was filled with different language and cultural songs, short performances and fun.
# AGENDA

**Workshop on Social Accountability and Community Monitoring in Health, Sept. 21-25, 2013 Delhi (India)**

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<td><strong>Theme</strong></td>
<td><strong>Theory: Foundation Concept - Power, Marginalisation and Health</strong></td>
<td><strong>Theory: Foundation Concept - Social Accountability &amp; Community Monitoring</strong></td>
<td><strong>Practice: CM - Learning from Experiences</strong></td>
<td><strong>Practice: CM - Community Evidence (community Data)</strong></td>
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<tr>
<td><strong>Day 1 (21 Sept)</strong></td>
<td><strong>Day 2 (Sept 22)</strong></td>
<td><strong>Day 3 (Sept 23)</strong></td>
<td><strong>Day 4 (Sept 24)</strong></td>
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<td><strong>9.00-9.30</strong></td>
<td><strong>Registration Introduction to the workshop</strong></td>
<td><strong>Recap</strong></td>
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<td>9.30 -10.30</td>
<td>Welcome and Introduction to the Workshop (JD and RK)</td>
<td><strong>Accountability Chain (JD)</strong></td>
<td><strong>Experiences of Social Accountability - Learning from NRHM (AS, EP &amp; RP)</strong></td>
<td><strong>Generating community data - principles and practice (AD)</strong></td>
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<td><strong>10.30-10.45</strong></td>
<td><strong>Tea</strong></td>
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<td><strong>10.45-11.45</strong></td>
<td><strong>Social-Political Determinants of Health (JD)</strong></td>
<td><strong>Accountability Chain</strong></td>
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<td><strong>Advocacy as part of Social Accountability processes (JD &amp; RK)</strong></td>
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<td>11.45-13.00</td>
<td><strong>Socio-political contexts and Health systems (AS and EP)</strong></td>
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<td><strong>(10.45 - 12.15) : Conducting a participatory group discussion (JD)</strong></td>
<td><strong>How do we know we are making a difference? Reviewing progress - Evaluation (AD)</strong></td>
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<td><strong>13.00 -14.00</strong></td>
<td><strong>Lunch</strong></td>
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<td><strong>13.00-13.45 : Lunch</strong></td>
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<td><strong>15.30-16.00</strong></td>
<td><strong>Tea</strong></td>
<td><strong>Tea</strong></td>
<td><strong>14.30 - 15.45 : Reviewing Secondary Data (AD)</strong></td>
<td><strong>Evaluation, Follow-up plans and Closing (RK)</strong></td>
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<td><strong>16.00 - 17.30</strong></td>
<td><strong>Individual autonomy and marginalisation: Power, equality and equity (AD)</strong></td>
<td><strong>Introduction to Social Monitoring Café / Show &amp; Tell (EP, RP &amp; PNT)</strong></td>
<td><strong>Conducting community monitoring on (1) Food and Stay arrangements (2) Public Transport (3) Training Programme (AD &amp; RK)</strong></td>
<td><strong>Conducting community Monitoring Café / Show &amp; Tell (EP, RP &amp; PNT)</strong></td>
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**AD - Abhijit Das**  **JD - Jashodhara Dasgupta**  **AS - Abhay Shukla**  **RK - Renu Khanna**  **EP - E. Premdas**

**CM - Community Monitoring**  **RP - Resource Persons**  **PNT - Participant/s**  **SS - Y. K. Sandhya**
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