Demanding Accountability of the Non-State and Private-for-Profit Actors in Health
## Editorial

### Ebola, Zika, MDGs and SDGs...

*Shifting Polices and a Clarion Call for the Accountability of Non-State Actors in Health Policies*

E. PREMDAS PINTO

‘Shifting sands’...

This term could best describe the ever shifting global health policies and priorities in recent years. Within a short span of time the buzzwords in health and health care have changed several times - health as a human right, comprehensive health care, selective health care, universal health coverage, financial protection, Millennium Development Goals (MDGs) - and the current buzzword is ‘Sustainable Development Goals’ (SDGs)! The euphoria of MDGs and SDGs, paradoxically however, is also marked by the alarm caused by Ebola and Zika viruses, in addition to the continued deaths of millions due to entirely preventable communicable diseases such as diarrhea, tuberculosis and malaria, maternal deaths, and ethnic conflicts and refugee crises. As accountability practitioners, the fundamental question we ask is - why is this allowed to happen? What is the link between these shifting policies and the preventable yet unabatedly continuing morbidity and mortality? Beyond rhetoric, does the current discourse of SDGs address the underlying causes or strategies to achieve the same?

The inevitable link being pointed out in recent research is the growing role played by non-state and private-for-profit actors in setting priorities in the global as well as national spheres, which has had damaging consequences on the health care system of many low and middle income countries. The shrinking of the public health care sector occurs in tandem with the unregulated expansion of the private health care players in an environment facilitated by state policies. In many countries the poor and even their governments find themselves caught between the devil and the deep sea! They are either left at the mercy of the benevolent aid agencies or face the onslaught of the private health care providers. The inevitable consequence of these developments is a fragile public health care system.

The spread of Ebola virus and casualties in African countries are a grim reminder of the consequences the absence of a strong public health system can have on a society. A robust, vibrant, sensitive and responsive health care system which respects the needs and rights of the most marginalized is a *sine-qua-non* to respond to people’s health in normal times and in emergencies. Is the health care system in Latin America strong enough vis-a-vis the African countries to respond to the onslaught of the Zika virus? We are yet to find out. What we have learnt from the epidemics, though, is an ever enduring lesson that the preparedness of a health care system to be responsive in emergencies will depend significantly on its optimal functioning in providing preventive - promotive – curative – rehabilitative care as *routine* entitlements to the people.

The current accountability framework is placed within the state-citizen relationship and presumes the responsibility of the state towards the welfare of citizens. In a state with subdued role in making policies for the welfare of its citizens, or constantly being under undue pressure of non-state actors, or worse still, when the state itself is taken hostage by the non-state actors and policies are dictated by them, the citizens are rendered completely helpless. They will con-
continue to face double jeopardy, viz. non-availability of services from the public sector and exploitation from the unregulated private sector. As most of the public services now have the participation of for-profit-private and other non-state actors in varying degrees, and in health care at times they account for the continuum of services with a referral from public to the private, the accountability discourse requires that the private and non-state actors are now brought within the ambit of social accountability framework. Fixing of the regulatory framework is the first step in such a venture, without which, calling for the accountability only of the state to meet policy outcomes becomes an empty rhetoric.

As MDGs now turn to SDGs one wonders: ‘What has changed?’ The questions that we ask or the answers that we seek or the strategies we pursue? While the participation of the private sector is being encouraged through the SDGs, one is concerned about whether sufficient attention is being given to address its lack of regulation in the pursuit of meeting the new goals? Are the terms and conditions of such participation negotiated on the basis of equity and human right to health care? To what extent have such negotiations been successful in making the profit motive of the private-for-profit and non-state actors subservient to the cause of health and well-being of all people, especially the most marginalized? The global policy makers such as the United Nations are now required to turn their attention to this issue if they are serious about changing the lives of people through various initiatives such as SDGs.

This COPASAH Communiqué (edition 13, January 2016) comes to you in a rapidly changing, challenging and ambivalent global scenario. The experiences and stories from the various practice nodes of COPASAH bring out the tireless efforts of empowering communities and strengthening the health care systems through the framework of social accountability in health. Usage of various strategies and multiple experiments in addressing the challenges in accessing health care continue in South Asia, Eastern Europe, Eastern and Southern Africa and Latin America. We believe that what will sustain the SDGs is the strength and power of the communities, the democratization of health care systems, fixing the responsibility of the non-state actors and establishing a health system which are accountable to the people. We need community oriented policies and programmes in an era where fragmentation is engineered in innumerable ways.

We do hope all our readers will appreciate the richness of the stories of practice from diverse communities of accountability practitioners across the globe.

About the Author

Edward Premdas Pinto is the Global Secretariat Coordinator for COPASAH. As an Advocacy and Research Director at the Centre for Health and Social Justice (CHSJ), India, he facilitates the thematic area of social accountability with a special focus on processes of community and accountability in health. He also coordinates the South Asia region for COPASAH. He is a Human Rights Advocate and Public Health practitioner, scholar actively engaged in processes of social justice issues of the communities of Dalit women, rural unorganized labourers and other disadvantaged communities for the last 22 years. To know more about the work of CHSJ and COPASAH please visit, www.chsj.org and www.copasah.net

COPASAH Organised Session in the 4th Global Symposium
On Health System Research, Vancouver
14-18 November, 2016

Selected abstract for the organised session:

COPASAH as a global collaborative partnership of public health accountability practitioners for engaging with and strengthening health system for increasing access to health services

Abhijit Das 1, Jonathan Fox 2, Geoffrey Opio 3, Renu Khanna 4, Borjan Pavlovski 5

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Overview: Social Accountability (SA) practices have often emerged from field innovations. Critical challenge faced, however, is knowledge translation and capacity building of practitioners for sustained change. COPASAH, a global collaborative platform of SA practitioners, describes strategies of building multi-stakeholder platform and ‘how-to’ of influencing health system for sustaining positive changes.
Improving Family Planning Services through Community Score Cards in Khyber Pakhtunkhwa

An initiative in Family Planning Services from Khyber Pakhtunkhwa, Pakistan suggests that citizen led performance monitoring employing community scored cards is leading to improvement in health

GULBAZ ALI KHAN, MUDASSIR AHMAD

Background
Pakistan is one of the fastest growing countries on the globe with a population of over 180 Million at an annual growth rate of 2.03 percent. Based on current trends, Pakistan stands to double its population by 2050. The latest figures released from Pakistan Demographic and Health Survey (PDHS) 2012/13 point out that fertility rate stands at 3.8 with highest amongst rural poor women with low levels of literacy and education. Contraceptive Prevalence Rate (CPR), though slightly improved but hugely behind the anticipated targets, reflects 0.5% increase since the start of family planning programme in 1964. CPR has remained stagnant in 2000-11 and this has raised several questions about the efficiency and effectiveness of the Family Planning (FP) initiatives. Challenges identified in variety of reviews pointed out demand and supply constraints (Karim and Zaidi, 1999; Rukanuddin, 2001; TAMA, 2008). This has led to the argument that FP programmes could not perform as anticipated.

Poor performance of the FP sector is attributed to the structural inefficiency, weak demand and poor supply side response. A plethora of evidence based studies have come up with variety of reasons including poor management, inadequate coverage, low quality of services, inadequate oversight and weak governance, staffing gaps, poor human resource management, inappropriate stock management, and weak implementation of devolution in subordinating units. Budgetary allocations are also an area of immediate attention after the 18th amendment as FP is now a provincial subject. Khyber Pakhtunkhwa (KP) is a conservative province with weak FP outcomes, critically hampering the national efforts of bringing fertility rate to the accepted levels. The KP Health sector strategy 2017 has promised to expand Health Services Package (HSP) for primary and secondary healthcare services to at least 70% of its population, increase the CPR to 55% by 2017, and revitalize the delivery of family planning services in public sector health facilities with a mechanism for forecasting contraceptive requirements and ensuring the uninterrupted supply of contraceptives to the facility, Lady Health Workers (LHWs) and Community Midwives (CMWs).

The current political government of KP has introduced visionary steps towards improvement of good governance while introducing Sukhi Ghar Mehfil at Khazana
pro-poor legislation and innovative oversight and feedback mechanisms. Independent Monitoring Unit (IMU) in the health sector is considered an agent of change in the service delivery, owing to the reason that it touches on the most pressing service delivery issues. KP government is also formulating its first ever-provincial Population Policy that will provide a basis for concrete actions towards positive outcomes.

EVABHN is a project managed by Palladium Pakistan and funded by DFID to strengthen empowerment, voice and accountability in health service delivery in KP and Punjab provinces. Under this demand side initiative, a Health Innovation Fund (HANIF) has been established to promote, adopt and replicate innovations in variety of areas affecting health services. CUP, a national organization, was awarded a pilot proposing a citizen led performance monitoring while employing Community Score Card (CSC) to solicit citizen feedback and closing the loop through establishing citizen joint monitoring committee to oversee and track the progress. This CSC was applied in nine selected Family Welfare Centres (FWCs) and Basic Health Units (BHUs) in district Peshawar.

**Implementing Community Score Card**

**Phase One:**
- A two-day staff orientation workshop
- A one-day inception workshop duly participated by Secretary Health and Population Welfare Departments.
- Over 60 men and women community members identified, and screened 36 members.
- A total of 656 community members out of which 356 females participated in the nine mobilization sessions.

**Phase Two:**
- Input tracking sheets conducted separately for FWCs and BHUs.
- A total of 806 members including facility staff, out of which 365 female attended 27 sessions.

**Phase Three:**
- Separate sessions held with men and women community members
- A total of seven performance indicators¹ agreed upon against which the perceptions were recorded.
- Voting was employed to determine modus operandi of perceptions of the community members in which a rank of 1-5 was employed.
- A total of 430 persons participated in the 18 sessions out of whom 233 were male and 197 were female.

**Phase Four:**
- A total of seven performance indicators were agreed upon
- A total of 90 staff members perception was recorded.

**Phase Five:**
- Three interface meetings conducted
- Nine joint action plans developed
- Three joint citizen monitoring committees established

**Joint Citizen Monitoring Committees (JCMCs)**

To effectively implement the agreed action plans, Joint Citizen Monitoring Committees (JCMCs) were developed and their TORs were shared with the community, being approved by the district Health and Population Welfare Departments. Each JCMC met three times in last 10 weeks time to follow-up on the implementation tasks. The cornerstone of JCMC is that it endeavours to implement its decisions expeditiously and through consensus. In circumstances where unanimity is not achieved, decisions are taken by a vote (simple majority of members present). This was headed by DPWO and DSM-PPHI with representation from facility staff, men and women community activists.

**Outcomes of community engagement**

1Basic amenities and infrastructure, human resources, behavior of staff to clients, awareness, mobilization, follow ups, monitoring, working hours, referral system, family planning equipment and commodities.
facilities: The condition of the buildings is extremely poor owing to the fact that FWCs are housed in rented buildings at the lowest rate of rent ranging between PKR1500 to PKR4000. This shows apathy on part of the policy and decision makers who are unable to address this core issue of standardized building for FWCs. The DG-Population Welfare has now taken up the concerns of poor infrastructure and facilities, the District Mayor and Secretary Population Welfare too are equally committed to addressing these concerns. The FWCs located within BHUs is crippling with limited space, as the room that is allotted to FWC is actually in shambles. Majority of the FWCs are housed within a small room where IUCD insertion and client consultation is performed. After coordination between the Health and Population Departments at the facility level, it is mutually agreed that FWW can perform insertion in the labour room that is maintained by the BHU staff at Chamkani and Khanaza. An additional room is also allotted to FWC at BHU Jhagra, Pakha Ghulam and Lalla Kallay. Repair and maintenance of BHU Pakha Ghulam has also been carried out by the DSM, Health department. Likewise, furniture including chairs, bench, and cupboard is provided to the FWCs by the DPWO office.

Building Human Resources: Male -Female assistants in Latifabad were not posted for many months and the seats continue to be vacant. The DPWO showed immense responsiveness to this issue and ordered immediately transfer of a MFA, instructing the incumbent to report within 15 days. The community also highlighted the absence of Female Field Assistant at FWC Aachar. The DPWO briefed the participants that a case is pending in the Supreme Court of Pakistan against the Population Welfare Department. As this matter is subjugated, no orders can be issued until the resolution. A mapping exercise was conducted by CUP in consultation with LHS to find out the uncovered LHWs areas attached to the selected BHUs. This exercise was shared with the Provincial and District Coordinator-National Programme to take up this matter. Recently, job interviews were conducted at the selected BHUs to fill the vacancies of LHWs.

Provision of Family Planning Equipment: It is highly undesirable that many of the FWCs and BHUs do not have the requisite family planning equipment to serve clients. Each FWC is given only one IUCD kit that is used for the insertion purposes and clients are kept waiting for longer hours until that kit is sterilized. It was resonated during the JCMC meeting that the sterilizer machine must be functioning but unfortunately the sterilizer is worn out and still in use by the staff. DPWO provided additional IUCD kits to all the selected FWCs, however, lamented over low budgetary allocations, which restricted the department to purchase new equipment. He mentioned that his office has to send single facility specific case to the Finance department for purchases and repairs that took longer time. In addition to these, Blood Pressure apparatus, screen, bed, footsteps, baby and adult weighing machines are handed over to FWCs. This has shown encouraging response from the DPW Office. Likewise, the family planning staff housed within BHUs has allowed operating in the labour rooms that has all the requisite IUCD insertion equipment.

Revitalizing Community Outreach: The Community reported that the outreach activities by the field worker such as the LHW and Male/Female Field Assistant are limited in number. It was noted that significant educational and knowledge gaps exist between men and women towards FP services. LHWs are unable to reach out to communities in some areas. Community activists and outreach workers jointly expanded the motivational and educational activities through conduction of “Sukhi Ghar Mehfil” and Support Groups meetings. Population Welfare and Health departments were unable to provide IEC material that could be handed over to participants towards dissemination of information. The DPWO promised that a sizeable budget would be allocated in the coming year to manage the printing of literature, to make information available to maximum population. The National Programme has also appointed additional LHWs in the catchment areas of selected facilities to manage uncovered areas.

Expanding Stakeholders, Strengthening Capacitates and
Establishing Referral System: In KP province, population welfare is now a devolved department offering opportunities to work in tandem with the local government representatives. The DPWO and CUP oriented the district leadership on family planning services and CSC for its prioritization and adoption. This is quite dismaying, as the technical staffs have not been trained for the last five years. A five-day training on counselling was arranged at Regional Training Institute, Family Planning Department. 15 staff members from FWCs and BHUs attended the training. Referred clients were not issued any slips for record keeping or tracking the clients for future references. Referral slips has been designed, printed and handed over to DPW office that is further delivered to all 62 FWCs in district Peshawar. DPW office will ensure that these referral slips must be used and accurately recorded.

Monitoring is a decrepit area to be focused while employing citizen engagement mechanisms to ensure community participation and oversight. The DPWO admitted that his office does not have the bandwidth to visit each and every facility in the district, so citizen engagement is a panacea to maintain oversight at the FWC level. He lauded the efforts of community activists who frequently visited FWCs and reported problems for its resolution. The DPWO also shared that the District Mayor has devised a plan to install local level oversight committees comprising of local neighbourhood/village council members to facilitate and monitor the FWCs. The DSM appreciated the efforts of community activists, the increased monitoring visits and prioritized community feedback.

Recommendations for Service Improvements in Family Planning
- Construct standardized family planning service outlets (FWCs and BHUs) with consultation room, insertion room, waiting area, drinking water supply and washrooms.
- Train the staff (LHVs and FWWs) on all the family planning services.
- Print IEC materials for display and use in outreach activities including male and female sessions (Satellite and Sukhi Ghar Mehfil).
- Install public information board displaying information on the family planning methods, its fee, list of sanctioned and appointed staff and methods of grievance redressal.
- Establish a Complaint Management system at the family planning service level duly integrated with the district and provincial redressal portals.
- Increase budgetary allocations to address the core issues of shortage of staff, standardized building, family planning equipment and furniture.
- Increase the monitoring visits of district officials and devise citizen inclusive oversight mechanisms that must ensure community involvement (Women Support Groups and Male Committees).
- Enhance coordination amongst key delivery departments including DPWO, DSM and National Programme for effective service delivery.
- Immediate appointment of LHWs to leverage outreach activities in the uncovered areas, including establishment of committees of men and women.

About the Authors

Gulbaz Ali Khan, is the Chief Technical Advisor at Centre for Inclusive Governance (CIG), Pakistan. He holds a masters degree in Economic Development & Policy Analysis from University of Nottingham, UK and is a pioneer Social Accountability Practitioner who successfully tested Citizen Report (CRC), Community Score Card (CSC), Budget Tracking and Public Expenditure Tracking Survey (PETS) in the primary education, basic health, rural drinking water and family planning sectors in Pakistan. He has published a book on “Pro-Poor Growth: Cross Country Analysis Focusing on South Asia.” He conducts trainings, delivers lectures and writes to English daily newspapers in Pakistan on social accountability, budget analysis and transparency and local governance.

Muddassir Ahmad is a Public Health professional with Masters in Public Health and a post graduate diploma in Public Health Management. He has an extensive experience of working on public health issues with national and International Organizations in Pakistan. He has successfully worked with communities and improved human lives in areas of TB, MNCH, family planning, and primary health care with rigorous applications of gender and social accountability tools. He is also amongst the few public health experts who piloted different social accountability tools in Pakistan.
The Roma Community in Bulgaria faces one of the most severe exclusions in access to health. The health status of Roma is significantly lower than that of the majority of the population of Bulgaria. Bridging the health gap requires intervention from both the Roma community and health system institutions. Since 2011, the CenterAmalipe, a national Roma organization in Bulgaria has been introducing Community monitoring for Roma women and children on healthcare services. This initiative is supported by Accountability and Monitoring in Health Initiative Program of Open Society Foundation. It is used as an approach for strengthening community-informed and community driven advocacy to improve health service delivery and health outcomes.

The two rounds of monitoring are conducted every year, to examine women and children’s health indicators and the emergency medical services. The monitoring uses standardized tools, to follow-through the changes that are observed in the health system with respect to the quality of services provided. It is due to the monitoring, community involvement and advocacy activities that there has been much progress made. The result of the monitoring is shared with the community and health institution staff to take further actions to better improve the different aspects of health care services provided to women and children. Based on the results from each survey, an action plan is designed to address the harshest problem where the action items of recommendations made are implemented the next half year.

The approach of community development and involvement in monitoring health care services and follow-up advocacy actions have led to significant changes in the health status of the Roma community. Besides, it has proved helpful in raising awareness among the Roma community about healthcare rights and health services. For instance between the first two rounds of community interventions, Roma women who could identify their local primary care physician increased from 83% to 94%. However, all the rounds of community survey reflected significant concerns that communities encounter in their access to healthcare. For example, over 50% of women over 18 years did not have health insurance and so on.

The actual monitoring is preceded by various community mobilization activities in the field of healthcare. Following this approach a campaign was organized by Center Amalipe and the Community De-
velopment Center in Pavlikeni to raise awareness and encourage people to restore their health insurance status. This was further necessitated by a change in the Bulgarian health insurance law that introduced a change in the period of insurance for a person, after which insurance status would have to be restored. The order came into force on December 28, 2015, where the period of insurance was increased from three to five years. If this change was not implemented, then it would be practically impossible to secure the health needs of the socially disadvantaged people of Roma to get back again into the health system.

**Preparing for Community Monitoring Exercise**

The campaign was based on the approach of shared responsibility. Center Amalipe with the support of the Fundamental rights agency (as part of the project LERI, implemented by the European Union Fundamental Rights Agency (FRA)) has offered ten of its most active community volunteers to cover half of their health insurance tax. In turn, they need to cover the other half and start paying their monthly health taxes regularly in order to continue to be active, and to further engage intensively with community health issues. On December 21, Center Amalipe supported 10 active volunteers at the Community Development Center of Pavlikeni to restore their health rights. The approach for supporting persons without health insurance ensures their participation and engagement: they have to pay half of the amounts for the previous 3 years as well as the entire amount since January 2016. It also stresses the community engagement: every grantee is a volunteer of the Community Development Center - Pavlikeni or the local clubs in Byala cherkva, Batak and Stambolovo. They will continue their community volunteer work.

**Conclusion**

Changes in policies often reflect on the most vulnerable groups and sometimes this impact does not bring a positive development. In this sense, the increase of the years to be covered in order to get back into the health care system would result in a harsher exclusion of the most vulnerable groups such as Roma. At the same time a strong community development and monitoring approach towards the healthcare services and the changes in health policies might help these groups react timely and decrease the gap through improving the access and quality of healthcare services.

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**About the Author**

Teodora Krumova is a Roma activist from Bulgaria. She holds Masters in History and Archaeology from Veliko Turnovo University, Bulgaria, and in medieval studies from Central European University, Budapest, Hungary. She is the Program Director of Center Amalipe in Bulgaria and one of the co-authors of the Roma Culture Classes Program, which is being implemented in more than 250 Bulgarian schools. She has also written a number of publications on Roma history and culture, textbooks on Roma culture, monitoring and evaluation reports on Roma-oriented policies and impact of national and European policies on the Roma community, and other scholarly publications. She is an evaluation expert for applying the model of community monitoring of healthcare services in the Roma community implemented by Center Amalipe in Bulgaria since 2011. To know more about Amalipe visit [http://amalipe.com/index.php?nav=home&lang=2](http://amalipe.com/index.php?nav=home&lang=2)
As I sit down to write about the role of social movements and grassroots organizations for state accountability, I’m drawn to reflect on the significance of today, January 25, 2016. Five years ago, thousands, and eventually millions, of Egyptians took to the street to protest a corrupt and illegitimate regime. Tahrir Square became the epicenter of this movement, and in a few short weeks Egypt’s strongman resigned and a democratic opening began.

If only the story ended there. Unfortunately, it did not, and Egypt is today under another military government, one that has learned the lessons of the past and has suppressed civil society with renewed vigor. What lessons should we draw from this experience? In my own reflection on the Tahrir Square movement, I highlight the need to build grassroots organizations, not just bring people into the streets with social media-enabled mobilizing.

The broader point is that we need to have a more sophisticated understanding of the role of mobilizations, social movements, and membership-based organizations in promoting more democratic and accountable governance. What can we learn from historical experiences? And what insights need to be captured from the day-to-day struggles and decisions made by organizations? What can external actors do to support citizen-centric organizing for accountability? These questions were raised in a 2014 workshop organized by the TALEARN community of practice, with COPASAH members Walter Flores and Premdas Pinto among those leading the call.

Over the next two years, a working group of COPASAH and TALEARN members has served as a space to explore the role of popular movements and organizations for state accountability. I’ll briefly highlight the lessons and insights that have emerged from this engagement and where we might go from here.

The TALEARN community of practice brings together funders, researchers and civil society organizations that share a common interest in strengthening learning about how to improve our efforts to ensure more transparent, participatory and accountable governance. The working group on grassroots organizations and movements saw an opportunity to generate a more robust conversation in the TALEARN group, as well as among a broader set of actors. The first step was a set of three think pieces around the title Mobilizing Accountability, to frame the issues and provide new insights and ideas.

These think pieces focus on moving beyond narrow understandings of citizen engagement as either professional NGOs or individual/
community participation in externally-sponsored processes. The think pieces argued instead for increased attention to the forms of mobilization and organization the citizens undertake to bolster their collective agency. Finally, the think pieces offered suggestions for how to support, not just financially, these more diverse forms of grassroots organizing. The engine room collaborated on the second two notes in the series.

The think pieces were generally well received as useful resources for a range of actors trying to engage with these issues, complementing other recent papers making similar arguments. To follow up on this base, TALEARN and COPASAH cohosted a small roundtable to shape a learning agenda around social movements and grassroots organizing.

Participants deliberating in a group exercise in TALEARN and COPASAH collaborative roundtable

The meeting brought together researchers, NGO representatives and activists with broad experience in social movements, particularly in the Indian context. Over the course of two days we had a wide-ranging conversation about the experiences of movements, hard-won lessons, and questions that remained. These questions formed the basis for a movement-centric learning agenda. This learning agenda raises questions about leadership, mobilization and how movements and grassroots organizations engage with wider governance systems. The roundtable participants were particularly interested in pursuing these questions through action research, case studies and real-time learning methods. We hope the learning agenda will be a resource both for movements and organizations themselves, to orient their internal learning, and the wider community of organizations interested in citizen engagement and accountable governance. Please feel free to make use of it if you find it interesting.

Reflecting on the discussion on learning with, from and for movements, I was struck by the rich experiences of the participants as well as the need to have a more systematic focus. Indeed, most of the lessons coming from the movements and grassroots organizations reinforced ideas from the conceptual framework that T/AI and others have been proposing for ‘Accountability Ecosystems’. Thinking about the systems of actors and mechanisms for promoting accountability focuses our attention on the multiple pathways, points of engagement, tools and tactics, and contextual factors that must be addressed to get at the root causes of unaccountable governance and corrupt practices.

Late last year, at the most recent TALEARN workshop, we brought these perspectives together, sharing lessons learned from the working group on social movements/grassroots organizations and presenting ideas about strengthening accountability ecosystems. The workshop highlighted five key challenges for the TALEARN community, as well as the broader set of organizations working for more open and accountable governance. Most of these five issues spoke to the experiences and challenges of citizens movements and grassroots organizations, such as the need for political analysis, to strengthen connections between actors and movements, to leverage a diversity of tools and tactics, and to learn and adapt as we go. Much of this is instinctive for activists around the world, but more project-oriented efforts may find it difficult to incorporate these elements in their work. Thus, TALEARN serves as a frank space for conversation about how funders and NGOs can work to enable more strategic approaches, and ones which take into account and support the efforts of broader movements and mobilizations.

As participants reflected on the TALEARN workshop, they demonstrated a more nuanced understanding of the value and challenges of learning, both within organizations and across stakeholder groups. There seems to be a growing consensus that practice-oriented learning can enable the kinds of nimble, adaptive approaches that seem to be more effective than pre-determined, linear projects, particularly in the challenging terrain of politics and governance. But learning is not a silver bullet, and it must be combined with more strategic approaches, including more active engagement with movements and grassroots organizations. Learning about effective and strategic NGO-movement coalitions is an area

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COPASAH is a global community of practitioners on accountability and social action in health. It strives for communities actively engaging in promoting accountability and transforming health systems towards the realization of wellbeing dignity and social justice. COPASAH has nurtured, strengthened and promoted collective knowledge, skills, capacity of community-oriented organizations in the field of accountability and social action in health for promoting active citizenship to make health systems responsive, democratic, equitable and people centric. Along with several strategies of handholding and facilitating systemic exchange of knowledge, practice and resource sharing with a peer learning methodology, COPASAH has envisaged the Facilitated Learning Exchange (FLE) visits. Facilitate learning exchange is modelled on the peer learning theory and is built in the learning processes of COPASAH. These learning exchange visits aim to provide practitioners an opportunity to visit a relevant organization’s work and learn from their social accountability practice using a common set of principles. The FLE visits usually are a three-pronged process: an introductory workshop, a field visit and later a debriefing session to agree on the way forward to implementing the learnings. These visits are envisioned to facilitate cross and collective learning and enable strengthening of the practitioners’ forum.

A three day FLE was organized in December 2015 in Nairobi, Kenya with National Taxpayers Association (NTA) to strengthen solidarity amongst the Africa COPASAH partners in the East South Africa (ESA) region and to mutually learn from experiences of accountability in the region. The 13 participants in this exchange visit comprised of representatives of organizations such as National Taxpayers Association (Kenya); Uganda National Health Consumer Organization (UNHCO), Uganda Debt Network (UDN and Action Group for Health Human Rights & HIV/AIDS (Uganda); Ministry of health (Zambia) and Zimbabwe Association of Doctors for Human Rights (Zimbabwe).

The objective of the FLE was to facilitate peer learning amongst the regional ESA COPASAH members and to learn from National Taxpayers Association of Kenya, along with other participants from Uganda, Zambia and Zimbabwe. The first day of the programme witnessed an orientation to the health care system in Kenya, NTA and its Community Health Monitoring project (which is aimed at working with Health Facility Management Committees (HFMCs); besides fostering mutual exchange of community monitoring experiences by team members of Kenya,
Uganda, Zambia and Zimbabwe. On the second day participants were taken on a field visit to NTA project site, where they interacted with the HFMC and health facility management members at Maiella Health Centre. The third day saw the participants exchanging their personal stories and experiences from the field visit and the many insights they received from the many nuances of community monitoring and the different yet unique health experiences of people.

Introduction to NTA

Irene Otieno, Nairobi Regional Officer and Project officer in charge of Health Project in NTA oriented the participants about health care in Kenya, NTA and the work towards accountability of NTA in health. She highlighted that Kenya is among the African Union countries that have pledged to set a target of allocating at least 15% of their annual budget for improving the health sector. The goal of the health sector is to improve health status with reduced mortality and morbidity, by providing equitable and accessible quality health services. The health sector pyramid in Kenya is in tiers with health service delivery done at different levels.

The different levels include:

- **Level 1**: Community health services- This level comprises all community-based demand creation activities i.e. the identification of cases that need to be managed at higher levels of care, as defined by the health sector.
- **Level 2**: Primary care services - There are the dispensaries, health centers and maternity homes for both public and private providers.
- **Level 3**: County referral services- These are hospitals operating in, and managed by a given county and include public and private facilities.
- **Level 4**: National referral services- This level is comprised of facilities that provide highly specialized services and includes all tertiary referral facilities.

Elaborating on NTA, Irene added that NTA is a national, independent, non-partisan organization focused on promoting good governance in Kenya. Since 2006, NTA has been implementing programs focused on citizen demand for accountability through monitoring of the quality of public service delivery and the management of devolved funds. It has achieved this through the development of social accountability tools (Citizen Report Cards), civic awareness, and citizen capacity building, partnerships with government agencies, service providers, private sector, and civil society and community action groups. In addition to monitoring devolved funds, NTA oversees the school report card project that aims at improving the education indicators in Kenya.

Currently NTA is involved in the Community Health Monitoring project in collaboration with the Ministry of Health (MOH), which involves working with health facility management committees (HFMCs) to improve the right to health and elevate the health indicators. Open Society Foundations (OSF) funds the project where today the second phase is being implemented in eight randomly selected Level- 3 health centers situated in Keringet, Maiella, Chepkigen, Kiambara, Mweru, Kuinet, Kilala and Mukuyuni.

The objectives of the initiatives are to:

- Empower the HFMC to demand the right to health.
- Create linkages between Health Facility Committees (HFMCs) and government health service providers and communities to strengthen community voice in demanding quality health care through improved transparency and accountability.
- Improve the quality of health services at the county level through dissemination and advocacy for the implementation of Government commitments, policies and standards.

The health facility management committees (HFMCs) are representatives of the community who are involved in the management and governance in the health centres. The 10-committee members comprise local community representatives, county administration and the facility management. The HFMCs are mandated to ensure that community members access their right to health. The HFMC has the mandate to overlook the management of the health facility. The committee as established by law should be democratically elected and carry out its mandate democratically with utmost trans-
The project seeks to work with health centres and the community to ensure that the HFMC are democratically elected, hold office for the stipulated period, create and sustain linkages with the community and share with the community their mandate as per the establishing government document.

NTA’s areas of intervention

NTA work expands to many of the following:

- Engaging in sensitization and training of HFMCs on the gazette notice, their mandate, health norms and standards, budgets, project plans, and effective monitoring and evaluation.
- Supporting the members of HFMC to attending meetings. NTA offers monthly allowances in order to facilitate meetings and activities.
- Building the capacity of the community, through the process of engagement is a mandate that NTA follows through. Build the capacity of the community on local governance structures and how communities can utilize them and share it helps to elevate the government service delivery standards.
- NTA works with the health service providers to improve their appreciation of social accountability and democracy. It seeks to bring the service providers and the community to an understanding of increased democracy as an effective tool for improved service delivery.

Challenges encountered in the project. Some of the challenges encountered in the project include

- Staff members at the lower levels see major concerns across all Level -3 (County referral services) health facilities in Kenya. In most facilities the numbers of trained health staff are less than 10 against a standard of 65.
- HFMC are usually handpicked or the membership is influenced by local leaders and politicians thereby affecting the democratic right of the citizens to make their choices.
- The HFMC members lack adequate training especially on their mandate.
- The government delays funding of the HFMC members since they are supposed to hold their meetings quarterly.
- Some community members are not aware of who are the HFMC members, who are involved in the management and governance in the health centre.
- Funding of the health sector has reduced since the government is focused on putting its resources on infrastructural developments.

Comparative analysis by participants

Following the orientation on NTA implementation of the community monitoring in health initiative, the participants in the FLE discussed in detail the outcomes, challenges, similarities and comparisons revolving around community monitoring in health issues.

- The representatives from Zimbabwe concurred with the Kenyan challenges that Kenya encounters in the area of health on the issue of lack of information from the health practitioners citing the challenge of bureaucracy. Most junior officers fear giving critical information as they must seek approval from their seniors. This challenge was cross cutting with all member countries alluding to it.
- Zambian team members stated that there is inadequate funding for their health facilities. Each of their 36 health facilities gets an approximate of 20 dollars that is insufficient for them to effectively discharge their mandate.
- The Ugandan team pointed out that community monitoring cannot be separated from politics: they are intrinsically interconnected. For them they used politics by mobilizing communities and the civil society to demand that the Ministry of Health employ more staff. This worked well and 7,000 additional staff members were brought on board.
- It was acknowledged that managing politics is a delicate matter but can be harnessed creatively as in the Ugandan case since it has a bearing on the political incentive structure.

Field Visit

The field visit was held in Maiella health centre, which is a project site of NTA. The participants...

Continued on page 19
COPASAH is a community of accountability practitioners who share an interest for the field of community monitoring for accountability in health. The focus of COPASAH is to enable, support and enhance the capacities of accountability practitioners through mutual learning and exchange, capacity building, sharing of health rights accountability practices and lessons, through knowledge-generation and dissemination at the grass roots. The accountability practitioners use the grassroots knowledge using a bottom-up approach, working upwards to empowering communities towards health rights.

Community engagement of field-based practices helps generate a platform for practitioners to share and exchange their experiences. The resultant is that COPASAH has fostered capacity building of grassroots practitioners’ by developing and implementing different practitioner and peer led learning strategies in the South Asia region. The learning strategies include training workshops, hands-on experiential learning, opportunities to practitioners such as facilitated exposure visits, learning exchange visits, technical assistance to member organisations in social accountability practices.

This approach is based on community partnership to promote mutual learning and mentorship. This is veered in a participatory manner so that it enhances shared learning where practitioners can utilize their experiences to strengthen their individual practices and can apply it in their own contexts.

Through this distinctive manner of capacity building at the regional level of community accountability practitioners in South Asia (India) and building a strong ‘community’ of practitioners’, COPASAH has initiated capacity building of grass roots practitioners through a Contact and Distance Learning Certified Course on Health System Accountability for Grassroots Activists in the state of Maharashtra (India) since April 2015. The distance-learning course is anchored by COPASAH and Support for Training and Advocacy to Health Initiatives (SATHI) in collaboration with a social work college, the Karve Institute of Social Services (Maharashtra, India) which has accredited the course. SATHI, based in Pune, works on the issues of health rights, through partnerships with civil society organisations. It facilitates advocacy at the local, district, state and national levels.

Concept and Design of the Contact and Learning course on Health System Accountability
COPASAH espouses a vision of capacity building that is a continuous ongoing process, with sufficient handholding and peer support as a key avenue for learning. Thus the methodology adopted for the course consists of contact sessions (comprising of group work and
activity, group discussions, presentations, showcasing films/documentaries), field exercises that includes practical work, as well as distance learning. The student practitioners are regularly mentored so that they can apply the learnings hands-on in their practices and contexts.

The course is offered in the local language, Marathi. This facilitates an easy interaction with the practitioners and strengthens regional solidarity. The contact sessions aim to build a conceptual understanding on various themes such as: right to health care, accountability and community monitoring and planning, determinants/constituents of democracy and participatory planning of health services, importance of regulating the private sector and advocacy. The distance learning courses involve learning from reading and reference materials provided in different modules under the guidance of the mentors. In the practical exercises, students organise participatory monitoring of one health institution. The mentors visit the organisations of the student practitioners and provide guidance to the field activity the mentee is involved in. They maintain regular contact with them, providing the assurance that they are supported through their fieldwork. To diversify and maximize the outreach of the course across the state, it is rolled out across five regions of Maharashtra including the Vidharba (Eastern region); Khandesh and North Maharashtra region, Konkan, Marathwada and Western Maharashtra.

The training session is divided into two parts:

- **First contact session:** is a three days training programme that provides a basic orientation to the course.
- **Second Final Contact Session:** summates the experiences of the practitioners. Engagement of mentors is ongoing with the student practitioners with handholding in the periods in between of the two contact sessions.

**Drawing Participants for the training**

After an initial call made to organisations for the course, 115 practitioners registered for the training from the five regions of Maharashtra. 90 students from 40 different organizations attended the first contact sessions held in the three cities of Nagpur, Pune and Nasik respectively. Out of the 90 practitioners who attended the first contact sessions, 41 were female practitioners. The participants for the course were drawn from Community Based Monitoring and Planning (CBM&P) network organizations in Maharashtra. The participants for the course were from Community Based Monitoring and Planning (CBM&P) network organizations in Maharashtra. The participants for the course were drawn from Community Based Monitoring and Planning (CBM&P) network organizations in Maharashtra. The participants for the course were drawn from Community Based Monitoring and Planning (CBM&P) network organizations in Maharashtra.

**Modules of the Course on Health System Accountability**

Modules on the themes of social accountability in health through the lens of human rights were introduced in the first contact sessions. The modules include a range of thematic topics such as:

**First Contact Sessions**

The first contact sessions started with a mutual introduction of the participants, following which a written pre-test was conducted to map the basic understanding of the participants on the issue of social accountability and the right to health. Following the introductory rounds the practitioners were oriented to the different technical sessions based on the five Modules (see Table 1: Snapshot of the Modules) to the diverse experiences of accountability and the various approaches and strategies that can be used for grassroots advocacy. The sessions were a mix of presentations, practical sessions, group work, role-play, group discussion, showing film and documentary to allow the practitioners to engage with the subject matter in a participatory manner and also share their concerns and interests. Each day of the contact sessions ended with reflections from practitioners. On the final day of the first contact sessions, a post-test was conducted to map the understanding gained on the themes through different exercises at the contact session.

The consolidated reports of the first three contact sessions can be accessed here:

Community of practitioners: COPASAH, health rights, right to health care, ethics and accountability, community based monitoring, gender equality, patients’ rights violations, health rights violations in private sector, use of photo stories to document experience of violation and use the evidence to negotiate for health rights among others.

**Plan and Practice**

On the final day of the first contact session, the participants plan individual community-based activities with achievable goals as a way forward. The community-based activities are in the area of public health systems and aspects related to the determinants’ of health and wellness. Activities include:

- Organizing awareness programmes on guaranteed health services, health and sanitation in the village and primary health centre through poster exhibition, corner meeting, and data collection.
- Monitor village level public

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**A Snapshot of the Modules**

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<thead>
<tr>
<th>Module I</th>
<th>Right to Health and Right to Health care</th>
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<tr>
<td>Reflects the right to health care from the perspective of human rights and rights based approach. The Module orients practitioners on different aspects of health system in India, health services from the village to district level, and how the Constitution of India and law protect human rights. The module also touches upon the themes of gender and health inequity, perspective of equality and equity and also explains how gender discrimination exists in accessibility to health and how this discrimination can be tackled through health and human rights perspective.</td>
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<tr>
<th>Module II</th>
<th>Concept of Community Monitoring for accountability of Health Services</th>
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<tr>
<td>Details the concept of community monitoring, steps in monitoring, important components of monitoring and crucial steps, how it can be implemented at the village level and how dialogues for people’s health rights can be initiated with service providers. It summates how people’s participation can make the public system answerable.</td>
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<tr>
<th>Module III</th>
<th>Constituents of Democracy and Participatory Planning of Health Services</th>
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<tr>
<td>Focuses on the local self-government institution at the village level the Gram Panchayat (village council), how village level planning can be done to access health services and how Jansunwais (Public Hearings) can be conducted with collective planning at the village level besides other constituents of local self-government. It briefly introduces to the provisions under the Mumbai Gram Panchayat Regulation Act 1958. It also dwells on certain strategies like social audit of health services and Right to Information (RTI) to make the Government accountable for services and how these strategies can be utilized for monitoring of public services.</td>
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<tr>
<th>Module IV</th>
<th>Need for Regulation of the Private Health Sector</th>
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<tr>
<td>Explores the theme of the private health sector, patients’ rights in the private health sector, the need for regulation of the private health services in wake of instances of overcharging, irrational and unnecessary tests administered by private doctors, insistence on purchasing medicines from specific pharmacies etc. It orients the practitioners to mechanisms like creation of Doctor-Patient Committees in rural settings to regulate services provided by private hospitals. Also lists out certain provisions and information in the private health sector for example reservation of 10% beds for poor patients and provision free treatment in Trust hospitals. It also orients briefly on the topic of clinical trials, involvement of patients in clinical trials without adequately informing them or without taking their consent etc.</td>
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<tr>
<th>Module V</th>
<th>How to create a photo story</th>
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<tr>
<td>Focuses on the practical work and orients on how photo story as a medium to negotiate for health rights. It highlights that photo story is a method of collective research and participation through which the community can collate evidence and present to health service providers for better provision of services.</td>
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It reflects upon the different steps involved in making of a photo story- like holding meetings with the community on developing photos, deciding upon the issue to take photos upon with collective decision from the community, collating evidence, analyzing information, selecting photos after analysis of the information, presenting evidence before the concerned authorities/policy makers. |
health services in association with the community.

- Organise Gramsabha (Elected Village Council meeting) for village level public health worker planning.
- Conduct meetings with Auxiliary Nurse Midwife (ANM) on vaccination programme. Conduct discussion groups to emphasise the importance of vaccination, responsibilities of the ANM.
- Conduct Health rights awareness activity.
- Conduct meetings with Self Help Group (SHG) members to discuss the health services offered at the village and sub centres.
- Discuss the utilization of VHND funds at the Village Health Nutrition Day (VHND).
- Organise public hearing at the Primary Health Centre level
- Conduct Village meetings on providing 10% bed facilities for poor patients in trust hospitals.
- Hold Poster exhibition in villages and provide information to the community in villages about patient rights and doctors - patients relationship as well on malpractices in private hospitals.
- Develop video clippings and photo stories on issues related to the violation of health rights.

Practice and Mentorship

After the first contact session, the student practitioners implement the learnings of the sessions practically in the field. Three mentors mentor the student practitioners to pursue field activities. The role of the mentors includes visiting the organizations of the student practitioners to provide them with regular guidance for field level community monitoring activities. In the meetings with student practitioners, the mentors take stock of the progress of the activities that are planned during the contact session. Mentors help the student practitioners to deliberate a set of questions/exercises of the reading material provided to them.

Second Contact Sessions

As a follow up to the first contact session, the second contact sessions were conducted in Pune, Nagpur and Nasik respectively in February. In the second sessions the practitioners shared their experiences through presentations of the field level activities conducted under the guidance of the mentors, besides sharing the insights, learnings and lessons on accountability, health rights, advocacy as experienced through the contact and distance learning course on Health Systems Accountability.

Evaluation and Certification

Based on the summation of the experiences outlined in the second contact session and the practice of the course work carried out by the student practitioners in the field, the student practitioners are honoured with certificates for the completion of the course.

Karve Institute of Social Services accredits the course.

SATHI is further working on the dimensions of the course through documenting the profiles of practitioners, collating case studies of accountability practices from the field as developed by the practitioners, including developing a module on health rights and accountability, which is scheduled for completion in April 2016.

Learning

Enthused by the experience the course allows for practitioners to engage on aspects of social accountability, the student practitioners have taken initiative of creating a Whatsapp group by the name ‘SathiyoneSathi’ besides developing a Facebook page where regular updates of health rights violations and information on issues surrounding health rights are shared. Across the sessions it discerned that student practitioners have conducted village level meetings to spread awareness on issue of health rights, heath care and other learnings made from the first contact session and on basis of four Modules provided to them for course work learning.

One student practitioner from Sawantwadi, in Sindhudurg District of the Konkan region, shared information on the Whatsapp group about an incident where a poor patient was deprived of treatment in a Trust hospital. One of the student practitioners, a Video Volunteer (VV) community correspondent, shot a film on a dysfunctional sub-centre in Nasik and this video was showcased at a recently held regional public hearing, following which constructive ...

Continued on page 21
Learning about mobilizing accountability...

Continued from page 10

of particular need, as some of these have shown great promise in enabling strategies that work at multiple levels (e.g. local and national) and leverage both pressure tactics and evidence-based advocacy, for example. Movements, grassroots groups, and membership-based organizations must be part of a holistic approach to strengthening accountability ecosystems, and although we have more evidence than ever, we are all still learning how best to build partnerships, capacities and strategies that reflect these insights. There are tentative steps in the right direction, particularly with a shifting focus from ‘open government’ to ‘open governance’, but we need to get better at putting our insights into practice.

References:

- Transparency and Accountability Initiative. www.transparency-initiative.org

About the Author

Brendan Halloran is Program Officer – Impact and Learning with Transparency and Accountability Initiative. He is leading the T/AI’s workstream on Impact and Learning. Brendan coordinates TALEARN, a community of practice involving individuals from the different groups, all working on T/A work from all around the world. He also leads T/AI’s involvement in supporting new research and other learning efforts around transparency and accountability issues, ranging from social accountability to international multi-stakeholder initiatives. For more information on Transparency initiative please visit www.transparency-initiative.org

MARCH 16, 2016 (10 am, EST)

- COPASAH Steering Committee member Renu Khanna will share the experience of outcomes and lessons learned of a project implemented by SAHAJ to improve maternal health in Gujarat, India.
- Daniela Ramirez from Fundar will comment this webinar and share Fundar’s experience working on maternal health in Mexico.

Details about the webinar and participation details can be accessed on: http://gpsaknowledge.org/events/social-accountability-for-maternal-health-a-case-study-from-india/#.VtZqJH197rc
interacted with health facility management committee (HFMC), the health facility management and NTA staff. In charge of the Maiella health center, Mwaura provided an overview of the facility. He discussed the history of the facility, the level of health care within the Kenyan health system and the general data and statistics of the area. He enumerated the roles of the HFMCs and discussed the partnership with NTA and how it has positively impacted their work.

Critical questions were raised by the visiting team on a host of issues like the role of youth representatives and community in the HFMC, working of the Constituency Development Fund (CDF), the feedback mechanism followed by the HFMC and so on. Community Development Fund (CDF) projects is a major source of funding. According to the HFMC representatives, the CDF is a fund that is predominantly a discretionary fund and is managed by the local politicians. The structure of this fund has in most times been devoid of transparency. They added that, lack of transparency, is well depicted by the CDF project in the facility, as it has not been completed within the stipulated six years. The HFMC usually writes a proposal to the local political leader to fund a project that they and the community identify. If the leader agrees to the proposal then it is funded. It was also pointed out that CDF funds only physical infrastructure projects. On the feedback mechanisms, the HFMC pointed that the suggestion boxes, complaints and compliments register are maintained and the HFMC itself is a feedback channel. Apart from this, the community health volunteers and staff form another channel.

- Team members from Uganda and Zambia pointed out that they make use of the community radios to propagate message about family planning. Taking clues from the success of the community radio experiments, NTA was encouraged to explore the possibility of making use of community radio, to have male action groups to undertake family planning.
- The team from Zimbabwe shared that in Zimbabwe many communities do not agree to immunization, and one sees forced immunization, where the police are present in the religious building of these sects during immunization. Motivation of the Community Health Volunteer (CHV) was cited as a key issue in improving service delivery. It was pointed out by the team from Zambia that in Zambia they have established projects for the CHVs such as fishponds and financial groups to raise funds.
- The issue of shortfall in the staff members at the Maiella health centre was pointed out as a major concern, as it made the utilization of the available equipment and infrastructure less than optimal. The team discussed the possibility of the Maiella team coming up with strategies to push the duty bearers to address this glaring gap. The committee can help in recruiting additional staff when they meet the Ministry of Health (MOH). The Maiella HFMC also reached out to the NTA team to explore the possibility of assisting them to reach the concerned stakeholders. The Ugandan team proffered a way forward for the measures taken that has worked in their country. The medical institutions have collaborated with health personnel training institutions so that their students carry out their internship there.
- To address the staff shortfall in Zambia, assistance of casual workers and traditional midwives is sought to carry out deliveries in facilities. This approach was however not tenable in Kenya as this contributed to high maternal deaths. However, retired nurses and clinical officers are allowed to assist with deliveries but they report to the facilities.
- According to the HFMC representatives, the Government gives them Ksh.239, 962 per quarter. Colleagues from Uganda indicated that this amount is what their facilities get in a one financial year. This comparative analysis was useful to the extent that it pro-
vided the Ugandan team with the impetus to advocate with their Government for increased funding to facilities. This comparative analysis of countries within the East African Community is useful as the social economic climate is similar.

The issue of outreach services was discussed, as the participants were keen to establish how these are carried out by the Maiella facility. The HFMC suggested that they carry out three outreach programmes every month in Ngondi, Narasha and Nkambani villages, where MCH services are mainly offered.

Having gained a firsthand experience of NTA’s approach from the field and after interaction with community in the field, the visiting members analysed the strengths, gaps and suggested action for improvement (See Table1: Strengths Gaps Actions for Improvement)

### Strengths, Gaps and Actions for Improvement

<table>
<thead>
<tr>
<th>STRENGTHS</th>
<th>GAPS</th>
<th>ACTIONS FOR IMPROvement</th>
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<tbody>
<tr>
<td>Involvement of the community</td>
<td>Low staffing levels</td>
<td>More training and sensitizations</td>
</tr>
<tr>
<td>Good working relationship between HFMCs and staff</td>
<td>Low community level of advocacy</td>
<td>Health/client service charter to be translated to local languages</td>
</tr>
<tr>
<td>Presence of NTA</td>
<td>Overworking of staff</td>
<td>Establish community radio</td>
</tr>
<tr>
<td>High level of commitment of the HFMC</td>
<td>Lack of incentives for staff</td>
<td>Multi-stakeholders action in and advocating</td>
</tr>
<tr>
<td>Public display of health service charter</td>
<td>County governments seem so detached from the HFMCs</td>
<td>Internship/attachment opportunities for trainee students</td>
</tr>
<tr>
<td>Accountability of public expenditures</td>
<td>Limited referral mechanism</td>
<td>Strengthen linkages for change</td>
</tr>
<tr>
<td>Good infrastructural developments</td>
<td>Wide area of coverage of facility</td>
<td>Continued and greater community engage-ment</td>
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<tr>
<td></td>
<td>Ignorance and illiteracy of some community members</td>
<td>Proper dissemination of information</td>
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### Conclusion

All the participants reflected that facilitated learning exchange visit was an excellent opportunity for experience sharing. These experiences if taken on board with the country context in mind would go a long way in ensuring robust health systems where the power was with the community, allowing it to take centre stage.

Some key suggestions made by the participants deriving from the FLE:

- The HFMC are a robust mechanism and can work in alliance with the community to improve the shortfall of staff in health systems.
- Partnership creation-NTA should carry on more initiatives to boost partnership

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**About the Author**

Robinah Kaitiritimba is the Executive Director of Uganda National Health Users’/Consumers’ Organization (UNHCO). She is a prominent Patients’ Rights Champion in Uganda. She is also member of the Global Steering Committee of COPASAH and the regional coordinator for East South Africa region of COPASAH. UNHCO is a membership NGO based in Kampala Uganda. UNHCO has been implementing programmes that advocate for a strong institutionalized platform that is able to articulate voices of consumers of health goods and services. UNHCO has championed the Rights Based Approach (RBA) to healthcare delivery and contributed to efforts to improve community participation and accountability. To know more about UNHCO visit: [http://unhco.or.ug/](http://unhco.or.ug/)
steps were taken to make the health centre functional by the health service providers. Some practitioners have shot videos of a case of immunisation related death in Ghatanji Primary Health Centre of Yavatmal, and this was showcased in a regional public hearing. Due to media advocacy done on the basis of a video shot by another practitioner, also a VV community correspondent, a Medical Officer (MO) has been positioned in a Primary Health Centre in the Vidarbha region. As a result of the social audit (learnt through the first contact session) conducted by practitioners in Kurkheda area in Gadchiroli district of the Vidarbha region, the unutilized fund of Village Health and Sanitation Committee (VHSC) was utilized which was lying unutilized.

**Conclusion**
The process of the contact and distance learning course for practitioners on Health System Accountability is an ongoing one as SATHI is collating the experiences of grassroots practitioners from across the five regions. These initiatives taken by the student practitioners though are in a nascent stage but are emblematic of a growing solidarity network amongst the grassroots practitioners in the region as well that of strengthening accountability practice. It reflects that the mutual learning and handholding of practitioners by peers and mentors has the potential to encourage grassroots communities to negotiate for their health rights.

_COPASAH acknowledges the initiative of SATHI to roll out the course for grassroots practitioners in the state of Maharashtra (India). Thanks are due to Bhausaheb Aher, project coordinator of the course for successfully completing the contact sessions and training in the course._

**About the Author**

_Surekha Dhaleta_ is a team member of COPASAH Communication hub and also supports the COPASAH Global Secretariat team. Apart from coordinating the Communiqué with the team she coordinates some of the COPASAH – COPASAH listserve, social media and COPASAH blog. She is associated with the Public Health Rights and Accountability (PHRA) team at CHSJ. She has experience in public health and journalism. To know more about the work of CHSJ and COPASAH please visit, [www.chsj.org](http://www.chsj.org) and [www.copasah.net](http://www.copasah.net)
In Conversation with Borjan Pavlovski

Roma Community in Eastern Europe is one of the most ostracized and oppressed ethnic communities in the European continent. Friends from Bulgaria and Macedonia are strongly linked to COPASAH through their work on social accountability. Extracts from the interview with Borjan Pavlovski are presented here.*

Could you shed some light on the context of the Roma population in Macedonia, in terms of their socio-economic situation, numeric strength etc.

Roma minority in Macedonia is the most vulnerable group; their vulnerability comes forth in form of their poverty, poor housing, education and high incidence of unemployment and also poor health status in comparison to other ethnic groups in Macedonia. This is a situation that has carried on for decades for the Roma People. Inspite of Macedonia dedicating an entire decade for Roma inclusion, there has been less progress in their situation.

Could you provide a backdrop of Association for Emancipation, Solidarity and Equality of women in Macedonia (ESE) and its initiatives around social accountability processes in Macedonia and involvement in community monitoring processes?

Association for Emancipation, Solidarity and Equality of women in Macedonia – ESE was established in 1995. In the beginning it was working around the issues of gender equality and health. Since 2004, Macedonia, drawing the decade for Roma inclusion, ESE started to work on Roma health, because Roma health status is much poorer than other groups of other population. With poor social health determinants their health is much more vulnerable than other groups. ESE has previous experience of working in health, on improvement of women’s health in Macedonia, especially the vulnerable groups of women including Roma women. Thus, since 2004, we have taken the work towards improvement of health and access to healthcare services of Roma people. Because Roma people not only face poor socio-economic determinants of health, but also face many barriers to access of services, including inability to pay for services, cases of hidden discrimination in healthcare services towards Roma still exist, distance from health care facilities etc. So ESE, started to work on this issue to enable improvement in accessibility to healthcare services. And we started implementing social accountability methodologies, first with budget monitoring in 2009, and since 2011 we started working on community monitoring and social methodologies. Community monitoring and social audit helped improve access and coverage of Roma children in immunization and access of Roma mothers and children to preventive health care services as well as access of women to preventive programs of the Government for reduction of cancers that are related to women’s reproductive system.

What major successes and challenges do you see in social accountability practices in your region?

As we work on different issues of the Roma population, we feel one of the major challenges is the situa-

*The Interview was conducted at the COPASAH Secretariat, Centre for Health and Social Justice (CHSJ), New Delhi (India) when Borjan Pavlovski and ESE team members had visited CHSJ, for a Facilitated Learning Exchange Visit in October, 2015.
tion of the Roma minority itself. They have been excluded and discriminated in the society so long they don’t feel they have enough power within themselves to initiate into or advocate for change. This was one of the main challenges in the beginning of our work. Cumulative efforts of our different Roma partner NGOs have helped mobilize and initiate the Rome community to involve in the fight for health rights and to proactively demand fulfillment of their rights and entitlements, demanding that there should be equal treatment in healthcare as all other groups of population. The situation of Roma is similar in other countries of our region of South Eastern Europe but this is specific to Macedonia. Other challenge lies with relevant stakeholders, for example in Macedonia, the government officials feel threatened by accountability work, and community monitoring pursued by civil society organizations, they feel offended by our findings and work. The entire trend is that the Ministry of Health is becoming increasingly closed and less receptive; it rarely accepts suggestions and practices from the civil society.

Could you tell us about the association of ESE with COPASAH and the response of practitioners in Macedonia has been toward COPASAH.

ESE is a member of COPASAH since three years. ESE has contributed to the COPASAH Communiqué by submitting articles; we have shared our work on social accountability practices with Roma minority. ESE’s staff uses COPASAH’s website and resources for our work on social accountability to find about social accountability practices and it enables to link with civil society organizations, practitioners, partners and networks working on social accountability across the globe. The practitioners find the network quite interesting and helpful for updates on accountability issues in health.

About ESE

Borjan Pavlovski is coordinator of the program for public health and women’s health in Association for Emancipation, Solidarity and Equality of women in Macedonia (ESE). ESE – develops and assists the women’s and civic leadership (especially that of Roma community) for development and implementation of human rights and social justice in Macedonia using approaches of monitoring and budget analysis, monitoring of human rights and providing assistance and information. ESE primarily focuses on meeting the urgent needs of citizens, in particular the vulnerable groups of citizens, and on influencing the creation of long-term changes. ESE also provides legal and paralegal protection, as well as information to different categories of citizens and introduces them with the possibilities for protection of their rights.

Community monitoring and social audit helped improve access and coverage of Roma children in immunization and access of Roma mothers and children to preventive health care services as well access of women to preventive programs of the Government for reduction of cancers that are related to women reproductive system.'
The video describes the work of some community leaders that promote Citizen’s Vigilance as a way to deal with problems rural communities face in Guatemala in terms of access and quality of healthcare. Citizen’s Vigilance of healthcare services is a form of participation by the population in public matters. It aims to monitor the quality and failings of public services delivery and reports the findings to authorities and engages in advocacy process for improving the public services. It describes how the community leaders carry-out monitoring for local health care services and demand accountability. It also presents people’s view on the need to use tools that would generate audiovisual evidence like photographs, voice recordings for accountability.

**Citizens´ Vigilance of Health Care Services and Accountability: Guatemala**

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**About CEGSS**
(Center for the Study of Equity and Governance in Health Systems), a civil society organization in Guatemala specialized in research, capacity building and advocacy around issues affecting indigenous populations He is member of the COPASAH Global Steering Committee and COPASAH coordinator for the Latin America region. To know more about CEGSS visit www.cegss.org.gt

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